

# **HIV Counselling and Testing (HCT) in Schools: Ethical Implications to Long Term Support Structures**

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## **Abstract**

The argument of this article is that if the recent proposal by the department of Health and Department of education in South Africa for a school-based HIV counselling and testing programme were to be effective, then there is the need to pay much attention to the long term support structures such as Parents, Carers, Guardians and Spiritual leaders as those who will carry the long term responsibilities of the teens once the test is completed. This argument is based on the fact that though the recent promises a potential and positive response in seeing that a number of people know their status and those who test positive can access early medication, the programme may well have negative consequences for families ill-equipped to deal with the outcome of the testing. Through the lens of ethical theory of Consequentialism, the article suggest that there are long term implications for the families as well as, communities therefore all key role players in the adolescent's life need to rethink their approach of engagement to issues around sex and sexuality, HIV infections and sexual behaviours

**Keywords:** Support structures, Teenagers, HIV and AIDS, sex education, sex and sexuality

## **Introduction**

Even though the recent proposal by the department of Health and Department of education in South Africa for a school-based HIV counselling and testing programme promises a potential and positive responses, there are a number of

ethical implications which has not surfaced in the discourse around the campaign that needs to be considered. One of such implications is that if the campaign is to be effective, we need to pay much attention to long term support structures such as Parents, Carers, Guardians and Spiritual leaders as those who will carry the long term responsibilities of the teens once the test is completed. There is need to reconsider their communication and support skills and strategies around sex and sexualities as a response to the HIV and risk behaviour among the teens in their care. This is because their responsibility in the campaign has been peripheral and overlooked. Currently the two public debates around the campaign are that while some people have grave concerns regarding the campaign and its impact on a number of young people, others argued that this move promises an effective potential to contribute to the reduction of infection (Gwandure *et al.* 2014: 42).

It is with this background that the article through the lens of ethical theory of Consequentialism, suggest that the programme may well have negative consequences for families ill-equipped to deal with the outcome of the testing. There are long term implications for the families, community, schools and even religious sectors directly consequent on the outcome of testing. Consequentialism as George Chryssides and John Kaler (1993) has noted premises on the fact that the consequences of an action determine whether that particular action is ethical or not (Okyere-Manu 2014: 30). This article must not be misconstrue as suggesting that testing is bad and should not be done, but rather aims to ensure that we do not overlook the practicalities on the ground and the implications for those involved. Therefore, there is need for all key role players in the adolescent's life to rethink their approach of engagement when it comes to communication around issues of sex and sexuality, HIV infections and sexual behaviours that may prove risky.

The article is divided into four sections: first, it begins with the background that necessitated such a drastic campaign, second it discusses the discourses around the campaign taking into consideration the arguments for and against testing learners particularly teenagers in schools. Third, it examines the possible ethical implication of such a move not only on the children as has been mentioned above but also for parents and all long term support structures as well as spiritual leaders. Finally for support structures to be relevant, the article ways of reconstructing teaching on sex and sexuality in order to restore effective communication skills in the face of the challenge HIV infection.

## **The Background to the Campaign**

Since the first case of Human Immune deficiency Virus (HIV) was recorded over 30 years ago, globally and nationally, governments and other organisations have sought to embark on prevention campaigns and strategies to control the spread of infection. Yet still HIV and AIDS remains a challenge to nations globally and more so sub-Saharan Africa.

The global estimate of people living with HIV as at the end of 2015 was 36.7 million, of which 1.8 million were children (<15 years old). There were 2.1 million new HIV infections, of which 150,000 were children. About 1.1 million people died of HIV-related disease the same year.

It was estimated that about 25.5million of all people living with HIV in 2015 were from Sub-Saharan Africa, which suggests that about 71% HIV positive people in the world live in sub-Saharan Africa. The report continues to say that 40% all people living with HIV do not know that they have the virus (Global Statistics 2015). The above figures clearly show that the pandemic has claimed and continues to claim an astounding number of lives. People are affected in their most productive years, leaving behind a number of orphans to be cared for by their older siblings and in most cases by their grandmothers. This in turn makes them more vulnerable because of their age as well as overburdened by the workload and limited resources in terms of financial support and for the grandmothers in particular, deteriorating health issues (Okyere-Manu 2012).

With the 2011-2015 global vision aiming at zero new HIV infections, zero discrimination and zero AIDS-related deaths, Michel Sidibé UNAIDS Executive Director argued for the need to do all that is needed to reach the goal by saying that ‘To reach these targets and bring the end of AIDS in sight we must step on the Accelerator’ (2011: 7). To him this vision will be realised only if the efforts of governments, NGOs and others are intensified in terms of rethinking and improving our strategies of responding to the disease. With the number of infections dropping and majority of people on treatment, various governments have committed to getting at least 15 million people onto lifesaving antiretroviral by 2015 and increasing it to 20 million people by 2020 as propagated by UNAIDS (UNAIDS 2013:4). After 5 years and in an interview with *aidsmap* in 2016 he again said that:

‘If we take our foot off the pedal I am convinced that we will be unable to double the number of people on treatment again, and we will not see the

major decline that we are expecting. Because of competing priorities, 13 countries out of 14 reduced their contribution to the HIV response globally. If this trend continues we will have a rebound, we will not be able to achieve our goals of 90-90-90 and [a reduction in incidence] by 2030' (Keith Alcon 2016). This suggest that in order to reach the new global vision, all countries need to step up to the call for 90% of people living with HIV to know their status, 90% of people living with HIV to be on HIV treatment, and 90% people viral load suppressed.

According to UNAIDS, the number of people living with the virus has increased from an estimated number of 4 million in 2002 to 7 million by the end of 2015 and 380.000 new infections (UNAIDS GAP Report 2016). One of the reasons for the escalating number of new infections is that there is a lack of persistent HIV effective prevention strategies. According to the mid-term review of the National Strategic Plan 2007 - 2011, the Human Sciences Research Council (HSRC) reported that even though the HIV pandemic in South Africa has stabilised to some extent as a result of the multi-faceted programs available, the majority of South Africans still do not know their HIV status (Shisana *et al.* 2009:4; Makhunga-Ramfolo 2011:2). Despite Shisana *et al.*'s observation, it must also be noted that currently South Africa is the country with the largest antiretroviral (ARV) programme in the world, as at 2013, there were about 2.4 million people receiving anti-retroviral treatment (ART) (Stats South Africa 2013:150). Suggesting that almost a half of all those known to be positive have access to medication, a positive sign on the part of the government's effort to respond to the global call. At the same time the question that is raised is why is it that there is availability of medication yet as noted by the HSRC above, most people do not know their HIV status: could it be that people are not aware of the availability of the medication? Has all the educational programmes been effective? Are there some significant group that have been overlooked? Clearly there seems to be a gap that requires our attention.

According to the South African National Prevalence (SANP) incidence and behaviour survey 2012, South African youth, particularly from 15-24 years who are currently classified as among the key population (2014: 53) continue to demonstrate high rates of practices such as drug use, drinking and sexual activities that places them at risk for HIV and other sexual transmitted infection. For instance it has been noted that 'Globally, over 100 million STIs occur each year in people under the age of 25 years' (UN Report

cited in Sales & DiClemente 2010: 1). A UN report, in 2010 the global statistics of children aged < 15 years who were HIV positive was 3.4 million and out of this number, 90% were living in sub-Saharan Africa (UN 2010). In addition, the mid-year population statistics revealed that out of the 5.26 million people living with HIV in South Africa, young people between the ages of 15 and 24 accounts for 8.5 per cent of the people living with the disease (2013:53). Without a doubt young people are at risk and in need of the nation's attention.

Despite the high prevalence of HIV among both adult and children in the country, It has been argued that Health-facility-based HIV counselling and testing (HCT) fails to capture all children and adolescents who are at risk of HIV infection (Strode *et al.* 2013:161), suggesting that the numbers of HIV positive children and teenagers could be higher than reported. Ramirez-Avil *et al.* has reiterated Shisana *et al.* that 'HIV prevalence rapidly rises through adolescence with an HIV prevalence of 3% among 2–14 year olds, 15% among 15–24 year olds, and 24% among those 25 year olds. In spite of the high HIV prevalence, youth testing rates are low in the country (2012:1). My experience in working with an HIV and AIDS organisation<sup>1</sup> for about 11 years and particularly working closely with the youth has shown that the low rate of testing among adolescents are as a result of a number of barriers. Ramirez-Avil *et al.* agree that the barriers may include the fact that most young people think that they are not sexually active or because they are using condoms therefore there is no need of testing. To most of them, testing is only for those who are sexually active and those who are involved in sexual risk behaviours without using condoms. Others also convince themselves that because they look healthy and not showing any signs of sickness there is no need of going for testing. Sadly those who want to go for test are unsure of age of consent especially those who do not want their parents or caregivers to know their intentions for fear of questioning, stigmatization and discrimination should they present with positive results (2012: 2). I also believe that a number of teenagers may not want to participate for fear of being pressurized by their caregivers, teachers or peers to disclose their confidential results of which they may not be prepared for.

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<sup>1</sup> The author has been part of the community care project in Pietermaritzburg since 2002. This is an HIV and AIDS project that serves Pietermaritzburg and its surrounding areas on educating the learners in High schools, churches and families on HIV and AIDS issues.

In addition to the barriers discussed above, Ramirez-Avil *et al.* continues that other barriers that account for the unwillingness for the adolescents to go for testing may include ‘concern for confidentiality, stigma of using a testing facility, unfriendly clinic staff, and that South African youth over 12 years are regarded as adults and managed in adult healthcare programs’ (2012:4). Clearly for lack of human capacity and resources, there are currently no healthcare programmes and facilities for young people in the country and therefore the general facilities available to all citizens young and old alike may pose as a barrier for teenagers to be involved in the testing should their result require them to access further healthcare programmes. In my interaction with most young people, another major obstacle is using health facilities within one’s own community. This barrier seems to be a major concern not only because of the perceived unfriendly clinic staff but also those who may overlook their ethical and obligations and spread rumours about the teenagers and their HIV results in the neighbourhood.

Another important obstacle to young people going for testing is ‘the fear of death’ (Mpintshi 2010:1), since up till now many people associate HIV with death, despite the availability of medication that can help people manage the disease. All these concerns are accumulated by the fact that we live in a country where particularly among the black communities, it’s a taboo to discuss issues around sex and sexuality openly or with adults particularly parents and caregivers. Yet the reality is that whether we like it or not, globally most young people from 12 years and above are sexually active rendering them vulnerable to the disease by their own sexual activities as has been noted by Strode *et al.* (2013: 161). For instance a study in the US reported that about ‘47.8% of all high school students are involved in sexual intercourse and about 7.1% had their first sexual encounter intercourse for the first time before age 13 (Sales *et al.* 2010:2). Even though this study was based on teenagers in the USA, I believe the situation is similar to the experiences of teenagers in other parts of the World. In South Africa, there is a growing amount of scholarship that has indicated that there is a decline in teenage pregnancy in the county. Yet a recent survey conducted among teenagers indicated that about 30% of all teenagers between the ages of 15-19 reported of having been pregnant before (Willan 2013: 7). Evidently even with the decline in teenage fertility in the country, for 30% to declare that they have been pregnant before suggest that the rate of teenage pregnancy remains high and a comprehensive education remains a critical need.

In most African communities, silence around sex and sexualities forms an indispensable part of the African culture in order to keep it from those considered un-entitled to it. It must be noted that issues around sex and sexualities in the African worldview is seen as sacred and preserved in secrecy by taboos. Therefore one's ability to preserve this sacred knowledge is rewarded with virtuousness (Diallo 1987) and 'empowering' (Sylvia Tamale 2011: 13). In the same way breaking it is seen as disrespect and dishonour, and as such people opt for the silence theory. Yet as has been noted by a number of scholars, in this era of HIV and AIDS, sexual silence is seen as an aspect of contention and its viability has been challenged (Okyere-Manu 2010).

Another most important observation is the fact that clinics in the country are opened during weekdays from 8am to 4pm during which most adolescents are in schools. Therefore despite recent studies and campaigns that have shown that HIV testing may be an efficacious strategy for identifying HIV-infected youth, in the primary clinic setting this has become a challenge. More so as there is no specific health services allocated to young people in the country and Africa as a whole (Morobadi *et al.* 2014: 5), getting young people to voluntarily test for HIV needs reinforcement. Morobadi is of the opinion that HIV positive children in transition into adulthood, are overlooked a group therefore there is need for programmes and policies to address their needs because they as 'Adolescents evidently contribute substantially to hospital admission in sub-Saharan Africa and this can be avoided by early diagnosis and timeous initiation of ARV therapy' (2014:5). It is with this background and the fact that South Africa is among the countries with the highest number of people living with the virus in the world that the department of education and health proposed the HCT campaign (Integrated School Health Programme 2012:3). Among other programmes, HCT was to be part of the integrated school health program which outlines the role of our respective departments in addressing the health needs of learners, with the aim of ensuring that a strong school health service operates according to clear standards across the country. This is to enhance the all-inclusive sexuality education that is considered an important means of addressing adolescent risk behaviours (Kirby 2007; and Wellington *et al.* 2006, cited in Harrison *et al.* 2010: 2). The discussion above constitute the background to which the campaign was introduced.

## **Current Discourses around Testing Teenagers in South African Schools**

As noted above, as part of the South African government 'putting children first' in line with United Nations Convention on the Rights of the Child (UNCRC) (1996), the Integrated school health programme, proposed a package of school health services which includes oral health, mental health etc. In addition, learners who are 12 years and over in all secondary schools in the country will be given the opportunity of taking an HIV and AIDS test in school. It must be noted that this is in line the age of consent according to the Children's Act requirement for consent (Children's Act 2005), 'however, learners who are older than 14 years may also consent to their own treatment, although they should be advised to inform and discuss their treatment with their parent or caregiver' (Integrated School Health Programme 2012: 17).

This legal document explains that children have the rights to consent independently not only to HIV testing but also to a number of health interventions (2011: 69). The Children's ACT describes clearly when and how HIV testing may be done with children. Sections (s) 130 - 133 of the Children's Act specifically has four guidelines for regulating HIV testing. These include the following: that a child (i) may only be tested for HIV in specific circumstances (s 130 (1)(a) - (b); (ii) must be counselled before and after the HIV test (s 130 (1)(a) and 132); (iii) can consent independently to an HIV test from the age of 12 years (s 130(2)); and (iv) has a right to privacy regarding their HIV status (s 133) (Children's Act 2005).

The above suggests that any child from 12 years onwards can independently choose to go for an HIV test with or without parents or carers consent. The government proposed HCT to be performed in schools as part of the sexual and reproductive health services. The aim is also to speed up access to care and support even though all participation will be voluntary; parents as well as children have the right to decline. The policy provides that to make this campaign successful:

the parents of that school are actively consulted and given the opportunity to agree to, or decline the service (see section on SRH and rights above); human and infrastructure resources are available to maintain privacy and confidentiality; - ongoing psychosocial support is available; - HIV testing and counselling services are offered by a



professional nurse in a private consultation; and - active parental consent and learner assent (12 years and older) are sought (HCT Policy Document 2012).

In addition the school governing body will also have a role to play in making sure that this program runs smoothly. Children who opt to undergo this test will be counselled before they participate. All nurses involved are supposed to hold each learners cases and information confidential (HCT Policy Document 2012). As noted above, the campaign is to enhance service delivery to teenagers who may test positive so they can access prompt treatment care and support at the earliest stages of their infections (*The Lancet* 2011: 528).

Since the announcement of the HCT campaign, there have been discussions and debates on the efficacy of such a drastic move. As has been mentioned above whilst some are positive about it, the vast majority of people have reservations. It is with this background that the department of health has promised that HCT will be professional and responsible (South African Government News Agency 2011). This statement is to assure parents and carers that all the necessary procedures will be taken to ensure the effectiveness of the campaign.

## **The Argument for Testing in Schools**

The argument amongst those who see the potential of the campaign is that the 'Widespread HIV counselling and testing is likely to be feasible in South African schools and provide many benefits including HIV prevention education and familiarisation with the testing process' (*Lancet* 2011: 528). It is seen as an opportunity for those who will test negative will be counselled to continue to protect themselves from future infection. The assumption is that they will be able encouraged to evaluate their behaviours and make some lifestyle changes and stick to the ones that will protect them. In the same way the South African National AIDS Council (SANAC) also argues that:

Based on the understanding that HIV Counselling and Testing (HCT) is an entry point to prevention, as well as treatment, care and support services, the campaign's aim is to bring about positive behaviour change, encouraging individuals and communities to take responsibility for their health by knowing their HIV status (2010).

Clearly just like any other health program in schools, testing is ‘ideal for early detection and treatment’ (Clayton *et al.* 2010: 1594), of HIV for teenagers. For those who will test positive, early treatment as well as support and care can be readily accessed. They will also be counselled to make lifestyle changes to live ‘positively’ with the virus. As has been noted by Makhunga-Ramfelo *et al.*, that ‘Early diagnosis improves health outcomes of those who are HIV positive, while ensuring that they are provided with information to reduce transmission’ (2011: 3). In addition, it can also be seen as cost effective in delivering services at the door step of South African teenagers in the comfort of their own familiar environment. This is because as noted above, most young people are not able to access these services because their schools schedule clashes with that of the clinics and also clinics are not open to the public over the weekends. Holiday’s period is not an option for most of them because they may be required permission from family members which will compromise confidentiality. Again the proximity from most homes to the clinics is a challenge, Some of them live very far therefore bringing the services to where they spend most of their time can be effective way of reaching them (Clayton *et al.* 2010: 1594). In addition to the above, follow up can easily be made in the school-based testing programme compared to testing services provided in the clinics. On the basis of the above arguments the HCT campaign seems set to promise a good result, therefore needs to be embraced by all.

### **Arguments against Testing in Schools**

Apart from the foreseeable issues around testing teenagers in schools discussed above, a number of people have raised their concerns about the campaign. Most people have argued about the readiness of civil society for such an initiative that encourages children as young as 12 years to go for an HIV test independently. For instance in an interview with some parents, Gwandure *et al.* reported that out of the 20 parents, only 6 supported the idea of the campaign but felt that a positive result will be stressful to the child, and that their relationship with the child will be ruined by the results (2014: 40). The article continued that 5 of the parents were concerned that if the child tested positive at school, the result will affect the child’s performance and some children may even decide not to return to the school (Gwandure 2014; 40). I tend to agree with the above statements because if the test is not carefully planned out, and strict confidentiality issues adhered to, children who test positive are liable to

be ridicule in the school and as a result of peer pressure, the consequences may be disastrous. If the processes involved are not handled well, children will be made vulnerable in an environment that should be considered safe and nurturing. At the same time, whether or not the service is provided at school may not be an issue because the 12 years can decide to access the service from any clinic without parents concern.

Another major ethical concern that testing in schools has raised is in area of vertical transmission. Vertical transmission refers to transfer of the HI Virus from mother to child at any point from pregnancy to soon after birth. Some of these teenagers may present with positive results not because they have been sexually active but rather that they have been infected vertically and parents either do not know or have not disclosed to them. Therefore allowing them to test independently in schools might expose most parents before planned disclosure. Such situation is likely to cause trauma, distrust, rebellion and in extreme cases suicide because of parental failure to disclose to the children their HIV status. In these situations most of them are likely to test positive before ever indulging in any risky sexual activities and they may want answers from parents and family members who have kept the truth from them. A number of scholars such as Nglazi *et al.*, 2012 and Dowshen and D'Angelo have noted that about 62% of HIV positive young people in South Africa between the ages of 9-28 had acquired the disease around the time of birth and are surviving because of the efficacy of medication (Hornschuh *et al.* 2014: 421). The assumption is that if disclosure has not taken place, allowing those children to test independently will be a big challenge. This point confirms an experience that confronted me during my involvement at the community care project where a teenager needed answers because she was told by her grandmother that she was on medication as a result of asthma yet from her life orientation class she could identify with the symptoms of an HIV positive person. She therefore went for a test independently from a local clinic and her suspicions were confirmed. Her argument was that she had never been sexually active and yet she tested positive and again the family had lied that she had asthma instead of telling her the truth that she was infected perinatally. As can be imagined from this story, disclosure to a child where vertical transmission has occurred is a very sensitive issue that requires much tact, planning and sensitivity. This is because there are a number of issues to consider such as age appropriate, location of disclosure, maturity, emotional intelligence, stage at

school, presence of support systems, confidentiality issues, co-existing neurodisabilities (Morobadi *et al.* 2014:3; Kmita *et al.* 2002).

Another important question that arises with the testing in schools is what about those who are not in school for various reasons: either they are drop out, or cannot access formal education for various reasons but are sexually active? What incentive do they have to encourage them test for their status? Since such a group exist in the communities and some possibly dating the school going teenagers, their neglect will be detrimental to the whole programme. Another concern about the testing in schools is that teachers may want to know the result from those who choose to access the service. Again sexually active teenagers who test positive may find it difficult to disclose their status to family members which may have implications for long term care and support.

### **Ethical Analysis of the Debates on the HCT**

So far the article has given the background to the HCT campaign and the various discourses generated by parents and civil society as a whole since its proposal. As noted above this campaign is situated in a culture that perceives issues around sex and sexuality as taboo (Okyere-Manu 2013: 44) and as such people do not openly and frankly discuss it among themselves let alone with their teenage children. Issues of sex and sexualities have always been perceived as a private issue. But as Haddad rightly put it, the consequences of the pandemic in terms of the millions of young people it had claimed had to 'forced such issues onto its public arena' (2009:16), suggesting that in the era of HIV the issue of sex and sexuality cannot be seen as private issue anymore, because of the potential consequences of our silence. Clearly there are a number of ethical issues around the HIV pandemic that we failed to deal with and have claimed a number of lives and as such silence around issues of teenage sex and sexuality is no more an option. There is the need to embrace strategies aimed opening up communication lines in order to protect our current and future generations.

Unfortunately parents, carers and spiritual leaders, have not been equipped effectively with the necessary skills to interrogate such ethical complexities around the disease particularly issues to do with teenage sex and sexualities. Even with the various strategies such as ABC and other HIV prevention method through the media etc, long terms support systems still lack

skills in dealing with the cultural aspects of sex and sexualities. Our attempt to respond to such issues has been done through our deontological ethical approach. Irene Van Staveren says that ‘deontological ethics is about following universal norms that prescribe what people ought to do, how they should behave, and what is right and wrong, it is a morality of principles not of consequences’ (2007:23). Obviously such an approach that is concerned with the principles of morality can only approve the ethic of sexual purity for teenagers with no room for negotiations. However whether we like it or not as indicated above, most of the teenagers in our care are sexually active and some are involve in risky sexual behaviours rendering them vulnerable to the disease. So the issue is how long term support structures can educate teenagers not to underestimate their personal risk but embrace behavioural change and sexual responsibilities. It must be noted that our deontological approach has always centred on ‘dos’ and ‘don’ts’ without proper explanations or allowing young people the opportunity to ask their pressing and complex questions. Elsewhere I have argued that currently the media through technology is influencing the ethical behaviours of our children (Okyere-Manu 2013) so we cannot continue with our outdated approach to ethical behaviours. With the Children’s Act giving legal opportunity for 12 years to concern to HIV test there is need for us to relook at our approach of dealing with these teenagers. Particularly as we aim to become part of the long term care and support structures to those in our care who might test positive.

In light of the HCT campaign, as noted, there is need to re-examine our cultural practices and spiritual teachings that encourages silence around issues of teenage sex and sexuality and reconstruct a life giving communication channels with teenagers. Musa Dube has warned that when it comes to HIV pandemic in Africa, there are a number of unanswered questions which calls for Consequential approach in dealing with them (Haddad 2009:17). This ethical approach according to George Chryssides and John Kaler, premises on the fact that the ‘result of our actions determines the truth or falsity of moral judgement about them (1993: 88). The above quotation from Chryssides implies that if the result that follows our action is of benefit to a number of people, then the action is considered ethically good, on the other hand it the result of the action does not benefit the greatest number of people but rather it brings harm to them, then the action is considered unethical (Chryssides *et al.* 1993:88). Currently the consequences of our ineffective communication skills that have resulted in the silence around teenage sex and sexuality do not bring

the greatest happiness to the greater number of teenagers. Their questions are not answered appropriately by those they trust, the dos and don'ts have not been beneficial to them. It only proposes issues around sex and sexuality as dangerous and unsavoury. Through the lens consequentialism explained above, it is clear that taking HIV test to learners at school and giving them the opportunity to know their status and protect themselves is an appropriate action. Without a doubt what this means to parents and carers is to reconstruct their approach in dealing with teenage sex and sexuality.

## **Towards an Ethical Response by Long Term Support Structures**

Clearly from above discussion there is the need for practical response from carers, parents and spiritual leaders, if we are to take the HCT campaign seriously. As noted the campaign challenges both our parental skills and spiritual support strategies for families and teenagers alike. Even though the national policy on HIV and AIDS for Learners and Educators requires parents and caregivers 'to provide their children with healthy morals, sexuality education, and guidance regarding sexual abstinence until marriage, and faithfulness to their partners' (National Policy of HIV and AIDS 1999), the challenge that arises concerns how to deconstruct the deeply rooted cultural practice of silence around the language and issues of sex and sexuality that proposes 'dos' and 'don'ts', which in many instances has resulted in dangerous as well as unsavoury sexual practices especially among teenagers.

As have been noted by most scholars '... effective approaches are multifaceted. All adolescents need access to quality youth-friendly services provided by clinicians trained to work with this population' (Bearinger *et al.* 2007:1220). To them the their focus is on trained clinicians to offer services including sex education programme for adolescents and the content of such education should be accurate and all-inclusive information and at the same time build skills for negotiating sexual behaviour. I am of the view that such an education should be opened to not only to clinicians but long term support structures as well. I also believe that in order to offer quality sexual education for them, there is the need to hear the voices of teenagers and the challenges that they experience. Such an understanding will foster a meaningful conversation without any judgemental attitudes. What I see coming out of the campaign is that it is challenging long term support structures to re-examine

the contest as well as the content of their sex education.

The content of such training must challenge long term support structures to deconstruct their approaches influenced by the different cultural beliefs and practices in order to communicate liberating sexual education messages that goes beyond condemnation, violence, 'do' and 'don'ts' to education that encourages behavioural change, responsible sexual activities that does not underestimate their own personal risk. Families and long term support structures are to be encouraged to engage in open discussions in the comfort of their home or available safe spaces. There has to be the engagement of young people in such educational programs so that they will be able to make responsible sexual choices.

## **Conclusion**

Thus far, the article calls for long term support structures such as parents, carers, guardians and even spiritual leaders to deconstruct their sexual educational strategies to teenagers in their care, in order to support the testing in schools campaign proposed by the departments of health and education. This is because even though the campaign has been received negatively by a number of people in the country, it promises to be an effective strategy to reach the young people who are considered among key population groups. A closure look at the campaign reveals that its prospective benefits far outweigh its potential risks if all the support structures are well informed to take their responsibilities seriously. It proposes that the content of such an education must move beyond the 'dos' and 'don'ts' deontological approach to a more liberal and life giving approach which allows for proper engagement with teenagers at the comfort of their homes and spiritual safe spaces. By deconstructing perceptions and attitudes, the content and the contest of our educational strategies and reconstructing a new form of strategy to meet the growing pressures and challenges that teenagers face, the success of the campaign can be assured.

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*Beatrice Okyere-Manu*

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