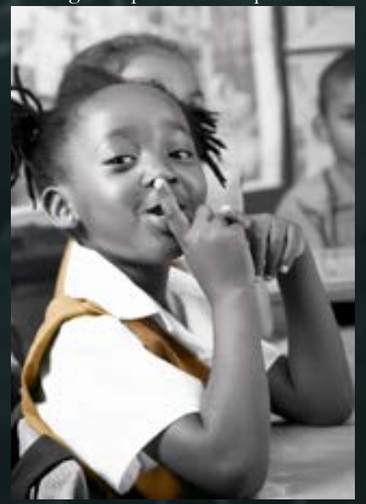
that they have been exposed to. These responses were combined to create an index of the extent of bullying; with three categories: 'almost never', 'about monthly' and 'almost weekly'.

A correlation exists between incidences of bullying and learners' mathematics achievement. Learners, who do not experience bullying at school, score on average 68 TIMSS points more than learners exposed to bullying, which is equivalent to more than a grade difference. In South African schools, 17% of Grade 9 learners are bullied on a weekly basis, which is double that of the international average.

The chances of being bullied regularly were higher for boys than girls, especially among lower performing learners. The difference between boys and girls being bullied became smaller as mathematics achievement improved.

School discipline

Principals responded to statements relating to aspects of discipline



in their schools and the results were divided in three categories: schools with 'hardly any discipline problems', 'minor problems', and 'moderate to severe problems'. The percentage of learners attending schools with severe discipline problems is three times higher in South Africa than the international average. There was a positive association between the level of school discipline and learners' mathematics achievement, with a score difference of 64 points between learners attending schools with hardly any problems and those attending schools with severe discipline problems.

Safe and orderly schools

Teachers responded to eight statements included in the safe and orderly school index. It included three categories: 'very safe and orderly', 'safe and orderly' and 'less than safe and orderly'. This index showed an achievement gap of 49 points on average between learners attending schools that are considered very safe and orderly, and those that are not safe and orderly. Compared to the international average (8%), schools in South Africa are almost three times less safe and orderly (22%).

A proactive approach needed to create healthy school climate

The 2015 TIMSS results show that learners that perform well in mathematics mostly attend schools that place a very high emphasis on academic success; whose teachers are faced with few challenges; that have low levels of bullying and very few problems with issues of discipline and safety. Within the South African context, these schools were most often the better-resourced ones, for example fee-paying schools. This suggests that learners from poorer households are trapped in schools with a poor school climate. A healthy school climate is one where all participants (learners, parents, teachers and school management) have a clear understanding of the ethos of the school and have a sense of belonging. For the majority of schools in South Africa to reach this point, all schools need to emphasise academic success and address challenges related to teaching, discipline and safety.

The Department of Basic Education has implemented initiatives, such as the National School Safety Framework and crime prevention programmes with the South African Police Services to improve safety in schools, however, more needs to be done. A proactive approach is required where school climate resides at the heart of the solution. Each hierarchy within the education system needs to be involved. Provinces have to ensure that schools implement the schools safety framework, and districts have to support schools to improve school climates. Schools have the responsibility to ensure that learners are safe, academically stimulated and disciplined. The ultimate objective is to have schools with a healthy school climate that supports learners' ability to learn and to live healthy and productive lives.

Author: Lolita Winnaar, senior research manager in the HSRC's Education and Skills Development research programme. Her PhD thesis focuses on developing new indicators for school climate in South Africa.

Contact: lwinnaar@hsrc.ac.za

RA
Review Article

A nuanced approach to **adolescent sexual and reproductive health** services legislation: **IS IT ENOUGH?**

South Africa has progressive legislation enabling adolescents to access various sexual and reproductive health services independently, without consent from their parents or legal guardians. However, are adolescents who engage in consensual sex sufficiently protected, especially the girl child? In a recent article in the *South African Medical Journal*, Prof. Ann Strode from the University of KwaZulu-Natal's School of Law and Dr Zaynab Essack, an HSRC senior research specialist, identified the strengths and weaknesses of this legislation.

Research has shown that adolescents in South Africa are at risk of HIV, sexually transmitted infections and pregnancy owing to high-risk sexual practices as well as other social, physical and structural challenges. Many adolescents have limited access to sexual and reproductive health services.

Statistics South Africa reported that 99 000 school-going adolescent girls fell pregnant in 2013. The 2012 National HIV Prevalence, Incidence and Behaviour Survey found an HIV prevalence of 7,1% for youth aged 12-14 years and that there were 113 000 new HIV infections among young women between 15-24 years, an incidence four times higher than their male peers.

It is therefore crucial that adolescents have sufficient access to sexual and reproductive health services, but requiring parental permission might deter adolescents from accessing these services. Studies have shown that many do not wish to disclose their sexual activity to their parents, often because they are concerned about disappointing their parents, they are embarrassed or because they feared punishment. The context of South Africa's child-headed households represented an additional challenge.

Previously, the dilemma was that South Africa's Children's Act enabled adolescents to access a range of sexual and reproductive health services independently,

but the Sexual Offences Act continued to criminalise consensual underage sex. This hindered access as children who sought these services could be reported to the police. The fact that this Act also requires that a person with knowledge of a sexual offence against a child had to report it, compounded the challenge.

Age of consent

The Sexual Offences Act provides that the age of consent to sex is 16 years old, but it has been amended to provide that those between 12-15 years old may engage in consensual sex with peers in the same age category. The Sexual Offences Act also decriminalised underage consensual sex between 12-15-year-olds and 16-17-year-olds, if there is less than a two-year gap between them. This approach follows from the Constitutional Court's finding that sexual activity and exploration is part of normal adolescent development into adulthood.

Adolescents at various ages also have the right to services such as HIV testing, male circumcision, contraceptives and virginity testing without the involvement of their parents, provided that certain capacity and public policy requirements are satisfied. Sterilisation is the only sexual and reproductive health service that they may not consent to below the age of 18.

South Africa's liberal approach

Strode and Essack write that South Africa can be commended for expressly identifying an age of consent that applies equally to boys and girls and that does not discriminate based on sexual orientation. By absolving service providers such as doctors and nurses from reporting consensual sex among the younger children to authorities, it is hoped that the uptake of sexual and reproductive health services will improve.

International guidelines recommend that legislators ensure that adolescents can consent independently to medical treatment before the age of 18. South Africa addressed this issue by creating both an age and capacity requirement for consent to medical treatment. The assumption is that more complex forms of treatment may require greater maturity. South Africa also chose to deal with consent to accessing prescribed drugs, contraceptives, HIV testing and male circumcision separately from medical treatment.

Concerns remain.

Strode and Essack write that there remains some disjuncture between the approach in criminal and children's law pertaining to adolescents when there is more than a 2-year age gap between older and younger adolescents who engage in consensual sex because both parties can still be prosecuted.

'This has a disparate impact on girls, who are more likely to have older partners. Where such cases are reported, young girls may be required to testify against their older partners, which may result in social harm to them. Furthermore, the legislature retained the strict mandatory requirements, and as a result, if adolescents declare that they have older partners whilst seeking sexual and reproductive health services, this information may have to be reported to the police,' they write.

The legal framework only recognises sexual and reproductive health services rights for adolescents over the age of 12 years, except for termination of pregnancy, which can be accessed by girls of any age granted that they meet certain maturity requirements. This ensures that there is consistency between criminal and children's law. The Sexual Offences Act provides that adolescents below 12 years do not have the capacity to consent to sex. However, it also means that the Act is not in sync with the World Health Organisation's approach or with recent empirical research showing that children aged 10-11 have the capacity to consent to medical research. According to Strode and Essack, it can be argued that many research-related decisions would be similar to sexual and reproductive health services choices. They recommend that pragmatic guidance for service providers on how to assess children's capacity to consent, should be drafted.

According to Strode and Essack, the Children's Act does not define medical treatment leaving uncertainty if adolescents would have access to new forms of HIV prevention such as vaccines and microbicides, should they be proven effective and registered for that purpose in future.

Virginity testing?

There is also concern that the Children's Act has legitimised the contentious cultural practice of virginity testing. The Act allows girls who are over the age of 16 years to consent to be physically examined to establish whether they are virgins. The authors cite Prof. John Mubangizi from the University of KwaZulu-Natal who argued that making this customary practice lawful in certain circumstances, violates children's rights to privacy, bodily integrity and dignity.

While Essack and Strode encourage other countries to follow South Africa's nuanced approach around specifying that access to contraceptives, HIV testing and male circumcision fall outside the area of medical treatment; they caution legislators about consent regarding practices like virginity testing.

HSRC Contact:
Dr Zaynab Essack, senior research specialist in the HSRC's Human and Social Development research programme

zessack@hsrc.ac.za

RA
Review Article

Enhancing **healthcare services** for sexual and gender minorities in Africa: MORE INCLUSIVE POLICIES NEEDED

Natasha Gillespie and *Dr Finn Reygan* reflect on the reduced health and wellbeing that sexual and gender minorities continue to experience and the need for more inclusive policies

The idea that homosexuality is unAfrican is widespread in Africa. Resistance to decriminalisation of same-sex sex acts in many African countries is often underpinned by a reluctance to yield to Western pressure calling for the acceptance of sexual and gender minorities. Yet an increasing body of research by African scholars suggests that homophobic attitudes are largely driven by colonial era legislation and religious morality that continues to marginalise people who are seen as different.

Emerging research on pre-colonial attitudes towards sexual orientation and gender identity (SOGI) shows a greater openness to social inclusion. Thus, African advocacy that strategically positions lesbian, gay, bisexual, trans and intersex people as historical and contemporary members of the societies in which they live, holds the potential to create more enabling and inclusive environments for the provision of healthcare services to sexual and gender minorities that are currently severely limited across the continent.

Enabling environments

The baseline results of an HSRC study, *Situational analysis and critical review of sexual and reproductive health and HIV services for men who have sex with men in eastern and southern Africa*, indicate that simply increasing healthcare services is not enough to improve the health and wellbeing of sexual and gender minorities. The study, led by Prof. Heidi van Rooyen, Dr Zaynab Essack, and Dr Finn Reygan, indicates an enabling environment that promotes positive attitudes toward sexual and gender minorities is key to improving the uptake of healthcare services.

Currently, multiple barriers hinder sexual and gender minorities from accessing healthcare. These include negative attitudes of healthcare providers, the lack of SOGI training for healthcare providers and limited access to tailored sexual and gender minority healthcare information. There are also safety concerns related to disclosing SOGI, ongoing stigmatisation or criminalisation of same-sex sex acts and gender nonconformity, as well as sexual and gender minority human rights violations, including widespread abuses by states and police forces. Other barriers include cultural and religious arguments against sexual and gender diversity, the perpetuation of discourses of hate