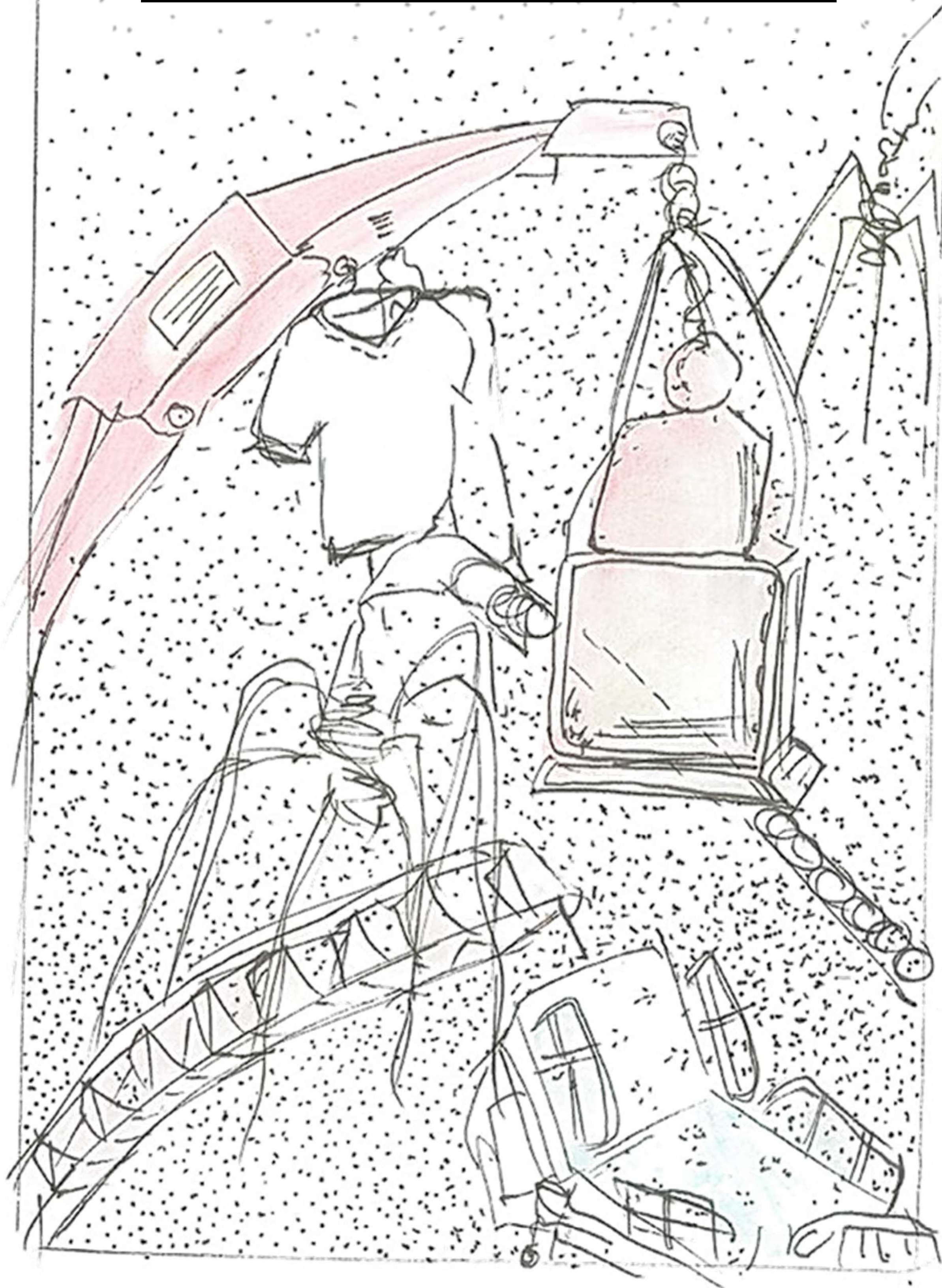
HEALTH SCIENCES STUDENTS' COUNCIL

SENSITISATION BOOKLET - 2019



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Introduction

Written by Rendert D. Hoekstra.

(Secretary General – 2018 HSSC)

What is the purpose of this booklet?

This booklet aims to offer new students a theoretical background to some of the major discussions that have been shared at the University of Cape Town (UCT) and have become relevant to the health sciences.

We hope to introduce the reader to the UCT setting by discussing critical thinking and transformation, briefly introducing the most recent history of the university, and clarifying terms such as victimisation and sensitisation in the context of the Faculty of Health Sciences. It is our hope that having the recent historical context of the university may offer the necessary perspectives when engaging in discussions similar to those that prompted these activities.

We will be premising our presentation on the theory of intersectionality and will explore individual topics thereafter. Each topic will further be presented in the context of healthcare. For each topic, there is a corresponding section in the "Discussions" chapter. This is a chapter dedicated to discussion around the preceding topics. The aim is to facilitate critical debate and encourage further questioning. We hope that this will give the reader an opportunity to explore the perspectives of their peers and to integrate these into their understanding of these theories.

We wish to elucidate that this text aims to present to the reader not only some of the most important contemporary social and political theories that have been developed and have stepped into the vanguard in academic discursive settings, but also to act as an exposition of individual experiences and perspectives in the context of the themes which we aim to explore here. The text is therefore in no way a technical reproduction of facts or a prescription, but rather an empirically informed examination of how theories such as intersectional and structural theory become applicable in the context of a South African university whose student narrative has incorporated discussion around decolonisation, as well as in the context of South African healthcare services, which act as microcosms of the wider socio-political dynamics that characterise the historically-moulded country we inhabit. The content of this booklet is in no way comprehensive and therefore values the opportunity for future contributions and updates, as well as further research by the reader. A reference list and further reading suggestions can be found at the end of the booklet.

We hope that this booklet will help the new student to form a strong foundation for the student-directed transformative project at the UCT Faculty of Health Sciences.

The Critical University

A university's culture is mostly dependent on the beliefs of the individuals that compose it.[1]

Universities prompt arguments. They provide a space for students to undergo constant intrapersonal and interpersonal interrogation. We challenge others through discussion, debate and critical thinking, and compare our own views with others' through reflection and the sharing of experiences. This exposure to the critical university helps to further mould our individual beliefs and ideals, and to use these to contribute to the overall university culture.

This system of constant feedback between the individual and the university community, and the individual with themselves, may be considered the hallmark of a healthy university. Such a university should not only encourage this culture of argumentation, but also facilitate it by providing its members with acceptable platforms to do so. This is the university culture which we wish to cultivate.

A key component for achieving a university of this nature is promoting a culture of **critical thinking** and **directed transformation**.

Critical Thinking

Critical thinking can be explained by considering how we contrast what we believe to be objective with what we believe to be subjective.

That which is objective is often thought of as a "closed" idea, and is the product of either:

- an onslaught of criticisms and empiric evidence, leading to a highly refined idea that seems undeniable (such as the theory of gravitational force),
- a lack of critical opposition, for reasons of traditional obstinacy (e.g. when traditional stances dictate that questioning some things is wrong or unnecessary), primordial ignorance (e.g. the question has simply never been asked), and so on.

Contrary to this, we consider that which is subjective, or "open", as that which is still malleable by our opinions and still offers a chance for refinement. The subjective idea has the freedom to be tossed towards the one side or the other based on the views projected onto it. It is only restricted if its foundations are considered "closed" and therefore may restrict it to a particular field of thought.

When we engage in critical thinking we essentially take ideas which we have until now considered to be objective (or certain) and put them through the same process which subjective (or uncertain) ideas go through. Ultimately, we build a balance of certainties and uncertainties in the "closed" and "open" ideas respectively, and we use these ideas as the bases for our subsequent opinions. One might be said to be constantly arguing with oneself,

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1 We know that this is not completely true, i.e. that institutional affairs like financial contracts, political influences, public relations, and so on, are some of the other major contributors to university student stances; but for this edition we will focus on the more grassroots level.

and indeed, this is how arguments and philosophical wondering come about. Someone might say “X is Y”, proposing it as fact, as a certainty; whereas if you were to approach it critically, you might wish to challenge the claim and open it up once more for discussion. Ultimately, after debate and argument, you will hopefully have a closed idea (or a verdict in this case), which has the potential to be opened again one day. Needless to say, the process of critical thinking, whether through self-interrogation or interrogation of others, is exhausting; but it is instrumental to establishing a critical university.

Critical thinking is an important consideration in conflict resolution. Any conflicts, no matter how complex, can be unravelled down to a series of disagreements – arguments, doors that were opened. Of course, the best way to deal with such a conflict is to work through it and decide on an outcome that benefits both parties. In the university context, this is where transformation comes in.

Transformation

Transformation seems to imply a process of accelerated critical thinking with an emphasis on a particular idea. We have aimed to redefine transformation in our setting in order to reflect the context of our faculty and as a protest against the institutionally driven transformative project which has historically prioritised university public relations and financial benefits over student concerns.

Our definition of transformation has five parts to it.

Transformation is:

1. **The interrogation of a specific idea that has been identified as one that underlies inequality or extreme conflict, i.e. systemic or ideological violence.**
2. **The provision of a platform for the interrogation and refinement of this idea.**
3. **The provision of a means to enforce the application of the refined idea.**
4. **The provision of a means to recompense the physical, emotional, psychological and social trauma, as well as the socio-political (and therefore economic) inequalities.**
5. **Achieving eventual equality through equity measures.**

Our definition emphasises the ultimate establishment of a state of socio-political (and therefore economic) equality and is informed by the inequalities that compose our society. This state of equality is an eventual state of socio-political equilibrium which is a theoretical point towards which we gradually move through minor projects. Human society is characterised by deviance from this equilibrium, as this is what individualises and contextualises us, making this only a theoretical point and emphasising the importance of awareness and constant social refinement.

The definition uses critical thinking as a tool to empower systemically oppressed groups. This is so that the natural process of tending towards equality becomes supported in a way that gives those groups with less influence a chance to prioritise their voices and direct the refinement towards a state of equity.

Often the facts that are presented to us are presented without the accessory platform to question it (especially within the hierarchal world of the health sciences) and this reflects the way in which power dynamics may result in tensions and inherent inequalities. Two types of tension that one may experience:

- **Theoretical tension**, which manifests itself due to a categorical conviction of one's position being justified, a conscious dissatisfaction with a claim's certainty; i.e. it is tension originating from one's position either not being considered or its presentation being refused outright. This is the result of disempowerment.
- **Physical tension**, as may be seen, for example, in a situation of not having the right to sit on a particular bench because of one's skin colour. It is the physical effect of a system on an individual, which may lead to further social, emotional, and other conflicts.

This tension fuels rebellion and may push it to its threshold resulting in **directed action** – affirming the existence of a borderline (of course the thresholds are variable). In its extreme form, this rebellion may manifest in violent behaviour, which may at times be the only way to achieve the platform to question or recompense something.

Here we must take note that while chaotic or violent behaviour, even in response to gross inequality, might seem instinctively wrong or counterproductive, it is often the only way for a group of previously marginalised people to gain any social, political, legal or economic platform, and should therefore always be contextualised historically and contemporarily to establish an understanding of its origins and assist the addressing of inequalities instead of taking an accusatory stance. This contextualisation is also a key principle in healthcare – it is our duty as healthcare professionals to approach any behaviour with a consideration of the individual's context and perspective. So, to start the process of directed transformation, we must be able to actively gain perspectives of experiences which we may not have had.

Ultimately, transformation aims to minimise unnecessary suffering through the early identification of sources of inequality and extreme conflict – effectively to prevent the need for directed action. It is a system of maintenance that should be approached proactively instead of reactively. It should prioritise the narratives of those undergoing systemic oppression, as these are the groups who have not been granted platforms to share their views previously.

The relevance of all this theory is to understand that, among others, cultural or ideological disagreements, particularly those surrounding race, sexuality, gender, ability, and so on, are often implicated as the sources of tension and will undoubtedly be called up as topics for critical discussion in your university career. Moreover, the extended implications of each of these in the healthcare sector means that a thorough understanding of the main theories and arguments around each topic is an invaluable part of your curriculum. These topics do not only form the basis of holistic healthcare practice, but they are also the most significant contributors to what we define as pathology.

Have a look at the "Discussions" chapter before continuing.

A History of Transformation at UCT Faculty of Health Sciences

Written by members of *#OccupyFHS*.

The most influential movements in all of history were established at a time when there was an overwhelming impetus for such structures to exist and when there was a call for revolutionary change as deemed necessary for a particular collective. Those that assume the lowest position in the social strata – the position of the oppressed, the peasant with no say on matters affecting their own lives. This is no different from the inception of *#OccupyFHS*, formed at a time when student advocacy was of paramount importance and a sudden eruption of decolonial student movements took place.

With the *#RhodesMustFall*, *#FeesMustFall*, *#EndOutsourcing* and other student movements, many students and workers were given the platform to voice their thoughts on the oppressive nature of the institutional system. As the Faculty of Health Sciences (FHS) we formed a breakaway movement, *#OccupyFHS*, whose mandate was to stand in solidarity with the main student movements while also tending to issues that specifically affected health sciences students, such as financial exclusions, victimisation of students and learning needs within the faculty.

Of course, many of the students actively involved in the protests were students of colour, in particular black students. It does not take long for it to become clear that the institutional culture fails to recognise the unique circumstances that are often at play for the black student when pursuing tertiary education. This culminated in the collective realisation that black students in the faculty were either ignored or overlooked. Much of what is taught assumed that all students had common characteristics, i.e. that everyone has stable university funding presumably from parents, that there are university graduates in every family, that English is everyone's first language, that your eloquence equates to your intelligence, that your only reason for being absent from school is being on vacation, that you cannot be late to school because everyone owns a car, and that as a black student you are lucky to be here, thanks to the admissions policy.

This, and the lack of black academics and clinicians, meant that much of our education was often biased and didn't quite appeal to the needs of black African students. In such an environment, there was no space to consider matters that affect academic performance. We issued a list of demands to the faculty which covered most of the pertinent issues, which we had compiled with public participation and consensus from the FHS student body.

The current system places undue burden and expectation on students to perform academically while choosing to remain indifferent to the social circumstances of their student populous, as well as their role in making tertiary education accessible to students from purposefully underserved communities. *#OccupyFHS* aims to defy this *status quo.*

Fuelled by the student movement across the country that aims to remove exorbitant fees as an obstacle to quality education, #*OccupyFHS* capitalised on this opportunity to transform the faculty and address the stifling nature of the system that assumes that the students "privileged" enough to attend this institution would not share in the societal ills that continue to plague those of colour.

#OccupyFHS maintained the momentum of the previous student movements, within the faculty (i.e. *Decolonising Health Sciences*, the Faculty Transformation Committee etc.), through organisation and through the mobilisation of other students to participate either as members or as allies. The faculty movement also embraced the values of the main student movements, viz. *#ShackvilleTRC*, *#FeesMustfall*, *#EndOutsourcing*, which also had a focus on black consciousness, black feminism as well as Pan-African political ideals. Although we had our own demands the nature of the movement was guided by these principles.

The movement embodies the principles of decolonisation, an instrumental concept concerning the emancipation of those who are oppressed. We made it our mission to address academic and financial challenges experienced by the student body.

#OccupyFHS is made up of undergraduate students that volunteer their time to participate in various task teams, which have been successful in igniting an interest among the student population in the everyday injustices faced in UCT and similar institutions, like the fact that hiring masses of private security is a better investment than settling the fees of poor students. The group has attracted local and international media to its narrative and has been instrumental in drawing up agreements with the Faculty Deanery to work towards making the faculty more accommodating to all students by addressing the issues raised in student demands. Tasks teams have driven institutional transformation projects such as the mural on our campus recognising the place and contributions of black professionals in academia and in advancing the health sciences. The group continues to advocate for students of colour and their challenges within learning space, including cases of academic and financial exclusion, raising awareness of the specific barriers to accessing funds and learning resources, and assisting in developing bursary funds such as the Impilo Bursary Fund. Finally, the group plays an invaluable role in assisting students who have been unfairly treated by academic staff and cases of harassment in clinical settings.

Remember that all accommodation and "transformation" that the university has offered to students and staff is a result of outcries against injustices. We have fought hard to be where we are and we must never forget that the university has thus far remained reactive instead of being proactive, a clear indication of the prioritisation of public relations over student and staff livelihood.

What is Victimisation?

Written by Siyanda Sibiya.

(Transformation Representative – 2018 HSSC)

The most basic definition of victimisation is that it is **wrongful treatment directed towards someone who has made or is believed to have made or supported a complaint**. There are many factors that can make someone become a victim of something, some of which I will outline below. Victimisation includes situations where a complaint has not yet been made but someone is victimised because it is suspected that they might make one. People often complain about systems that are unjust to them and then those in power will also apply different tactics to try and threaten those individuals who are mistreated, effectively silencing them. Putting this into a South African context where we have twelve official languages and so many different cultures and traditions, it is highly impossible that a word can only mean one thing to everyone. In UCT where there are people coming from more than one hundred different countries, it becomes even more difficult to adopt one definition and generalise it to the entire student-staff populace. The basic definition of victimisation is no exception. Things that are generally perceived to be normal where one comes from, might victimise someone in this space we are in and we constantly have to sit down with our own minds and think how we can avoid such things from happening.

Victimisation in the context of UCT FHS

Every individual is unique. We all have different ideas about something and different feelings around a certain concept. Our perceptions are influenced by so many different factors, environmental backgrounds playing a large part. This part is written based on experiences of different people on our campus, after having engaged in different talks around the concept of victimisation. Here I write about the most dominating kinds of victimisation at UCT, particularly in the Faculty of Health Sciences. It does not mean these are the only ones – there are a lot that I may have omitted, but omission does not mean rejection.

- **Student-Student victimisation**
  The University of Cape Town is known to be the best university on the continent. This means that some of the *crème de la crème* of Africa is found here. With an understanding of our environmental backgrounds and the different knowledge we have around a certain concept, as students we will always differ in our ideological opinions and there is absolutely nothing wrong with that. In fact, one can argue that having different opinions is good for our democracy and the university culture. However, in UCT it becomes a problem. People often confuse democracy with dictatorship, one would call it democracy when their opinions are taken into consideration by other students but the very same person will also victimise anyone

who challenges their opinion. This type of victimisation is when there is turmoil among students themselves.

- **Student-Staff victimisation**
  This is often caused by the difference of opinions between staff and students. It is when a staff member becomes a victim to students. Most students want to be listened to when they speak, we all want that, but they do not want to listen to anyone who does not agree with them. They often allow their emotions to cloud their judgment and look at victimisation from a one-sided view, that is, it is only victimisation when staff members are doing it but it is okay when they victimise staff members. This makes it very difficult to have a very robust yet progressive engagement with staff members because they fear that any point they make, it is already seen as being anti-students and will be disregarded. Staff members often find themselves in a position where they feel silenced by the majority of the very same students who invited them to meetings. Because of this, some staff members sometimes choose not to attend those gatherings because they feel like their presence makes no difference. This type of victimisation often gives rise to the above form of victimisation ("Student-Student victimisation") in a sense that any student who holds a different view from the student masses, but that view seems to be in agreement with what the staff member has said; that student is then victimised by other students and seen as being anti-movement and colluding with the staff members. Students also disrespect staff members (lecturers in particular) because they do not think that the lecturers know what they are doing. An example here will be the case of Dr Lwazi Lushaba who was undermined by a student that went straight to the HOD to report that there is no educational value to what he was teaching (see a link to the article below).

- **Staff-Student victimisation**
  This form of victimisation is an inverse of the previous one ("Student-Staff victimisation"). Here it is the staff member victimising a student. What makes this one more severe is that the student is being victimised by someone who is superior to them and has more powers, someone who can destroy their future. This makes it extremely difficult for some students to raise opinions that are against their lecturers. The power democratically given to them is taken away by their fear of the victimisation which they may encounter from staff members. The fear is often about the things staff members are capable of doing to students, like not allowing students into class because they have a potential of disrupting the class, marking them down because they participated in a protest or not allowing them to do certain activities because they do not look trustworthy. In this form of victimisation, race is always a factor. Students of colour, just by the virtue of being Black, are already the victims of bad conduct. The entire institution is built around anti-Blackness. It is already a crime to be Black at UCT, let alone participating in activities that seek to crush White Supremacy. It is extremely difficult for a Black child to reason with a White staff member about their own traditional or cultural ceremonies that they have to attend as a matter of urgency; they are perceived as people who do not want school and

always try to find excuses to be absent. Because of this “Staff-Student victimisation”, students constantly have to perform in order to validate their existence.

- **Staff-Staff victimisation**
  In this form of victimisation, staff members victimise each other for having contrasting views about a certain matter. The problem with this is that it often creates enemies among staff members. Having different opinions is healthy, but thinking that your opinion is superior and should prevail without being challenged is a problem. Other staff members agree with the opinions of the students but they keep that within themselves because of the fear of being victimised by their colleagues. Staff members also discriminate against each other based on the different subjects they teach. This is a very complex case because as we say in Zulu, *kubambene ingwe nengonyama,* which basically means that it is a war between people with equal powers. These powers may not necessarily be equal as someone might be of a race that is considered superior by the institution.

Sensitisation

Sensitisation is about making people aware of things that they previously were not aware of. When people are sensitised to an issue, they start reacting to issues that previously did not have an effect on them. Sensitisation speaks to an awareness of pertinent issues that are present and affect society, especially the people around us. Sensitisation embodies both awareness and action, because it is not only about being aware and knowing, but acting on the knowledge to empower sustainable action and change that brings improvement to the relevant issues. It is an important tool in dealing with victimisation at an institutional level.

Basic Theories

Written by Carla Tsampiras.

(Senior Lecturer in Medical and Health Humanities at UCT)

Privilege

Reading these words is no neutral, objective activity – any more than writing them is. Our exchange – your reading and this writing – reveals an aspect of our privileges: we are amongst those who are sufficiently literate to read and comprehend words. In 2017 UNESCO estimated, conservatively, that 750 million adults globally are illiterate, 500 million of those adults are people defined as women.

That we are doing our reading and writing at a university speaks to another aspect of our privileges, but the individual and collective journeys that allowed us to be here are not the same. The social, economic, historical, and political contexts into which we are born can help and/ or hinder our journeys, as can the multiple identities that form who we are.

Neoliberalism, classism, racism, sexism, patriarchy, homophobia, ableism and speciesism (amongst others) actively reinforce and create privileges for some at the expense of others. So neo-liberal capitalism favours the individual over society and glorifies the pursuit of profit at all cost, while ensuring that class structures and unemployment remain in place and the destruction of the planet continues unabated. Racism favours people of one phenotype over people of another phenotype using socially constructed categories of race; while patriarchy favours people defined as men over those defined as womyn[2] and uses sexism to reinforce this. In the same way, heteronormativity prioritises only relationships between heterosexual people and uses homophobia[3] to reinforce this. People understood to be normatively 'able' proceed with relative ease through the functions of their daily lives while people with

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2 Editor's note. Read more about the differences between 'women', 'womxn', 'womyn' and 'wimmin' in the reading list. Importantly, we aim to dissociate the defining of non-men by their relationships with men and wish to ensure that we do this in a manner which is inclusive to all parties affected by patriarchy. Whether transmen, transwomen, genderfluid, genderqueer, non-gender-binary and other non-conforming groups, for example, benefit from patriarchy requires an intersectional approach that understands the multiple forms of violence which these parties face. We would propose the usage of "non-men" to highlight the point of patriarchy in this case.

3 Editor's note. Homophobia is generally understood to be discrimination and stigma towards not only homosexual people, but all individuals who do not conform to heterosexuality (including homosexual, bisexual, asexual, pansexual, queer, and other non-conforming groups). Some terms have been used to ensure more inclusivity of these groups, such as queerphobia, but these have their own limitations.

disabilities (seen or unseen)[4] constantly have to address ableism. Finally, our self-constructed identity as a privileged species is such that we organise our world around the systematic exploitation and obliteration of all other species.

What this essentially means is that, in different spaces and places, we all enjoy some privileges (or a combination of privileges), but we may also be disadvantaged or have to overcome different burdens to partake in those privileges.

If we return to reading and writing as an example, there are a number of things that may have shaped our journeys to literacy. These could include the access to schooling that we receive, the languages we are taught in, the resources in our schools, our economic realities, our familial responsibilities, our gender, our sexual orientation, our race, or our means of engaging with text (written, signed, or audio). So, if you had easy access to a fully-staffed school, received your conceptual learning in your primary language in a well-resourced school, were encouraged to excel, were not bullied or teased, and were healthy enough to fully participate in all aspects of school life your path to reading might have been fun. If your access to school was more difficult, your conceptual learning was in a second language in an under-resourced, under-staffed school, little attention was paid to you, you experienced bullying or teasing, and you were not always well or did not have sufficient food, your path to reading might still have been fun, but also more burdensome. While the outcome in both scenarios is the same – you are privileged enough to be able to read and to be at a university – a lack of equality has shaped the scenarios.

This lack of equality is not merely a result of how individuals exist in the world; people with power can also deliberately build it into the structures that order our socio-political and economic systems. Once we become aware of our individual privileges, we may also become increasingly aware of more structural or systemic privileges in our social groups, communities, institutions, spiritual communities, sports clubs, media, or anywhere (and everywhere) else. For example, whiteness, maleness, or being middle-class may be privileged in certain spaces (consciously or unconsciously) and undermine or silence those who do not, or cannot, conform to those constructed norms, such as is seen in the socially constructed images we have of healthcare professions. The suggestion in a group context that a WhatApp group be set up can seem to be a good idea, but it assumes that everyone has a smartphone and access to data and displays class privilege. As an experiment, if you are in a new PBL group or tutorial group notice if some people are listened to more readily than others, if certain types of accents are listened to more closely than others, and observe who speaks the most. Think about what this might explain in terms of different types of privileges.

Your individual journey to the point where you are reading this writing has been shaped by your individual tenacity, social capital, and your social, emotional and financial support. You may have been able to shape some of that by working hard at school and overcoming personal obstacles, but in addition to personal privileges, there are also privileges that are structural or systemic.

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4 Editor's note. We propose the use of "observable" and "hidden" disability instead of "seen" and "unseen".

Structural and systemic violence

Academics such as John Ele-Ojo Ataguba have revealed how various structural or systemic privileges influence access to contemporary health care. In South Africa, the most obvious of these are the legacy of apartheid's racial discrimination and the inter-generational effects of this, and contemporary class dynamics that facilitate a public and private health care system where, depending on your financial status, you may be able to afford different types of access to care.

Your access to health care is also influenced by whether you live in a rural, peri-urban, or urban area and your family's access to land, property and choice of places to live may well have been influenced by the legacy of the Natives Land Act of 1913. The Act, passed when South Africa was a Union, gave about 7% of the land to people defined as 'Native' or 'African' and the remaining 93% of the land to the minority group of people defined as 'European' or 'White'. This was neither the first, nor the last Act that used legal structures to secure the privileges of some people over others. South Africa is not unique in having legal, or other, forms of structural violence. While there may have been a legal shift away from Apartheid in the 1990s, the discriminatory effects of it are still being felt today.

Understanding that structures of domination create what is referred to as 'structural' or 'systemic' violence means defining violence as more than violent physical interactions between individual people or groups of people. Mary K Anglin, a feminist academic explains that:

> **"violence also takes such forms as the expropriation of vital economic and non-material resources and the operation of systems of social stratification or categorisation that subvert people's chances for survival…. Through structural forms of violence persons are socially and culturally marginalised in ways that deny them the opportunity for emotional and physical well-being, or expose them to assault or rape, or subject them to hazards that can cause sickness and death.**
>
> **"…The net result of these and other practices is to engender a kind of structural violence that is normalised and accepted as part of the "status quo," but that is experienced as injustice and brutality at particular intersections of race, ethnicity, class, nationality, gender, and age."**

In terms of health care, Paul Farmer has written extensively on how structural violence has a direct impact on people's experiences of ill-health, clinical medicine, and suffering – particularly in relation to HIV and AIDS in Haiti and Rwanda. Thinking about HIV and AIDS in the South African context, Carla Tsampiras has shown how the early years of AIDS were shaped by the interactions of race, gender, sexuality and class in the last days of apartheid while Mandisa Mbali has written about post-apartheid AIDS activism and global health. Addressing AIDS requires awareness of differential privileges and structural violence and consider how issues like food insecurity and undernourishment; rape; lack of infrastructure;

and political will; have influenced how people living with HIV (or before treatment was available) died of AIDS.

When ARVs were first manufactured by global drug companies they priced the drugs well beyond the budgets of most majority world countries. In 1998, 15 years after the epidemic had been officially recognised in South Africa and four years after the transition to democracy, people who were HIV positive could not afford ARVs and the government was not willing to take on the multinational drug companies or commit to buying cheaper generics and making them available through the public health system. In light of this, the Treatment Action Campaign (TAC) was formed to fight for people's access to ARVs and used mass action and the legal system to ensure the rollout of ARVs by the government. Other forms of structural violence meant that winning the legal victory was not sufficient. To ensure that people can take ARVs there needs to be good infrastructure to ensure the delivery of medication to clinics; people also need nutritious food, clean water and sanitation; public servants need to fulfil their duties and politicians need to deliver on promises and policies; and the dynamics of sex, gender, and rape need to be understood. There also needs to be treatment literacy that empowers and informs people.

There are aspects of our identities influenced by structural violence that we may not be able to change – for example our age or abilities. Knowing, however, how structural violence works allows us to identify where and how oppressive identities and dominating privileges are created and enforced. This in turn allows us to consider how we can witness, challenge, change or remove structural and systemic violence and make gains for equity and equality.

Intersectionality

As indicated above, literacy can take many forms – we may be literate in the written word or the spoken (or signed) word, we may be treatment literate, or have skills in digital literacy, or financial literacy. One of the roles of a university education should be to make us critically literate – that is able to engage with academic texts and theories, analyse them, critique them and build on them so that we contribute to the development of academic knowledge. Ideally, we also want to be able to translate and apply that knowledge to areas that are important to us – health care, activism, our personal evolution, our disciplines, our social and personal lives.

Often people who came before us (and were also trying to make sense of things like structural violence and oppressive privileges) wrote things that contain ideas that we can investigate, engage with, and build on if we choose to. In 1989, Kimberlé Crenshaw, a black feminist Professor of Law at the University of California in the United States of America wrote an article that contained an idea that people are still talking about now.

In the article, Crenshaw analysed legal cases that revolved around antidiscrimination legislation, centred the experiences of black women, and introduced the concept of intersectionality. Drawing on the judgements of the cases, Crenshaw argued that understandings of discrimination that only focussed on one aspect of people's identities (what she referred to as 'a single-axis framework') erased the complex way that people could be 'multiply-burdened' by varying identities and varying forms of discrimination. She showed

how, in the cases she analysed, the interaction of racial and gender identities, and the associated experiences of racism and sexism, were ignored. The women could complain about racial discrimination or about gender discrimination but not about both.

Discussing how identities linked to gender and race interrelate, Crenshaw noted: “the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which black women are subordinated”. Crenshaw noted that because of the interplay of identities and hierarchies, people could be multiply disadvantaged and recognising this would allow approaches that could challenge whole systems (in these cases related to employment) and challenge those who sought to protect their privilege within the hierarchies. For example, gender privilege might ensure that men are paid more than women are, while race privilege might ensure that white people are paid more than black people are. If white women fought for equal pay but only for themselves and not black womyn and women, then they are challenging one hierarchy (gender discrimination) but using another (racial discrimination) to maintain some hierarchal privilege.

Crenshaw argued that “Black women can experience discrimination in ways that are both similar to and different from those experienced by white women and Black men”. Crenshaw concluded the article by suggesting that it was possible to restructure and remake the world and that “placing those who currently are marginalised in the centre is the most effective way to resist efforts to compartmentalise experiences and undermine potential collective action”. Crenshaw’s article dealt only with race and gender identities, but the idea of intersectionality was taken up by activists, organisers and academics, and was considered, analysed, and drawn on in relation to numerous identities.

In terms of healthcare it can be helpful when considering the multiple identities and experiences of health care providers or people seeking health care or in relation to health research. Jamie Rogers and Ursula Kelly argue that feminist intersectionality approaches that recognise the complexity of multiple forms of oppression, when applied to health research, provide a way to grapple with current hierarchies in research and with social inequalities that influence people’s health and wellness. A health researcher taking an intersectional approach, they conclude, “is actively working to unveil power inequity and build knowledge that eliminates unjust ideology, practice and research. The ultimate goal of intersectionality research goes beyond achieving statistically significant results to achieving social justice”.

Academics based in South and southern Africa have recently contributed to a special edition dealing with Intersectionality in Africa (See Meer & Müller in the reading list). So, when you are next inspired to evoke the privilege of literacy, read more about intersectionality, privilege, and structural violence. Engaging seriously and creatively with ideas like these is vitally important if we are serious about a truly holistic approach to health and healing.

Have a look at the “Discussion” chapter before continuing.

Systemic Oppression in the Context of South African Healthcare Services

Each topic to follow will be discussed in the context of South African healthcare. This section is premised on the theory of intersectionality and no single topic can be considered in isolation. There is a section dedicated to each topic in the "Discussions" chapter, which should ideally be read after each topic. As with any theory, there are many strengths and limitations to each one presented here, and the reader should explore these further.

Race

Written by Sivuyisiwe Toto.
(Lecturer in the Public Health Medicine Division at UCT)

Adapted from *I ride to be free: the issues of race, class, access and power at UCT Health Sciences.*

Racism[5] is so entrenched in our society that I did not know where to begin. I have experienced many kinds of racism such as overt racism – I have been referred to as a baboon on social media. I have been called the 'k-word'. I have also experienced a kind of racism that you feel, but you often do not have the words to explain. So, in this piece I use my story of being a student at UCT to illustrate this kind of racism. My story also shows how the system (i.e. the University) limits access to opportunities and takes power from black students through oppressive actions. Finally, my story also shows how I fought and resisted all these forms of oppression. My hope is that you are fully armed and ready to resist racism if you are black, and if you are white I offer certain issues to think about.

My story begins in 2011, as a 2nd year occupational therapy student. I had to attend psychiatry lectures off campus, at Valkenberg Hospital (about 2 km's away from Health Sciences Campus). The university provided no transport for students like me, who could not afford a car. Most of the students who had no cars were black students, and most students who had cars, were white. This is what I see every day at UCT, this is the norm.[6] To get to the lecture, black students often had to depend on students who had cars (white students) to take them there. Our dependency on white students for transport took away all the power, even the little we had – it was firmly placed on white students. When I wanted to skip lectures on

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5 By now, I assume you know what racism is. But I will provide a definition anyway: racism may refer to discrimination by a group against another for the purposes of subjugation or maintaining subjugation.

6 This is an example of institutional racism, i.e. the structures, policies, practices and norms resulting in differential access to the goods, services and opportunities by race. It is found in the way things are done or in the way opportunities are afforded to others at the expense of many others. Institutional racism is so pervasive and powerful that most times it is impossible to identify the culprit.

Amafufunyane (as most black students do), I was unable to, because the white students wanted to stay and listen. Depending on someone else forces you to realise that you cannot speak your mind or be who you want to be when they are around. You cannot do anything that maybe viewed as different, and therefore 'offensive' against your sponsor.

The system – which I view to be the University – was and still is, silencing the voices of black students. For having lectures at Valkenberg serves no purpose whatsoever for all students. Psychiatry could have been lectured anywhere. But the insistence of the university to arrange lectures to be off campus when there is no need and when transport is unavailable can only leave the black student to see the university as in oppressive institution. As financially constrained students, we were forced to be 'extra' nice so that we don't lose our 'transport benefits'.[7] This of course is a dehumanising experience and words do no justice to it. As a black passenger in my white friends' cars – I could not criticise their political views; I could not argue back or say anything that could revoke my access to their cars. I had to listen to them complaining about a black lecturer's accent or how 'militant' and 'radical' some black students in class were just because they could not tolerate their racist attitudes. Even off the car, in class (participation in lectures, tutorials, lab practical sessions or class meetings), in social events outside the class – I had to be nice just in case…

Fed up of the set up, I decided to save up for a bicycle so that I could take myself anywhere and everywhere I wanted without having to depend on others. I rode my bicycle everywhere I went – to lectures, around campus, for grocery shopping. I took a bold step to resist the oppression; I found my voice when I started depending on myself.[8]

For as long as the university creates situations wherein black students have to depend on white students for resources, then there will always be inequality and injustice in all social engagements between these groups.

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7 Can you see the intersection of race and class here? This is called intersectionality – the concept that shows how the various ways in which we identify as people criss-cross to influence how we are treated. E.g. black students who do have cars do not have to be 'extra' nice to white students.

8 I didn't have language to explain the phenomenon then or express what was happening, but now in retrospect, the concept of occupational consciousness has provided me with words to tell my story. Occupational consciousness is the capacity for humans to recognize, interrogate and reflect - individually and collectively - on dominant practices in their everyday doing that help sustain oppressive systems and structures that may have an impact on their health and wellbeing (Ramugondo, 2012). Therefore the concern is about the way in which these systems support and promote certain occupations or certain ways of doing, to the exclusion of others and how these are sustained through what people do every day individually and collectively (Ramugondo, 2012).

Ability

Written by Maya S. Pillay.

Ableism is prejudice and discrimination against people who are disabled. That is, any person who does not fit into society's narrow definition of 'normally functioning' or 'able', whether they have a physical or mental disability, a chronic illness or a missing body part, may be othered, looked down upon, and treated as inferior to 'normal', 'able' people. Ableism is often overlooked and ignored, because it is so common in our society that people often do not perceive it as wrong.

Ableism may be anything from a lack of wheelchair ramps in a public building, a university not providing its students with mental healthcare, a person's place of work not providing accommodations for their IBS, or a Deaf person being ostracised by their hearing peers. These may all seem like obvious examples of discrimination, but there are other, subtler examples that play into the narrative of disabilities being 'bad' or 'less than'.

Someone who treats a visually impaired person with pity rather than with respect, or who speaks of a child with Downs syndrome as an 'inspiration!' rather than as an individual human being, may not consciously think that disability is a bad thing. But by failing to treat disabled people as people just like anyone else, they are still behaving as though disability is an inherently bad or tragic thing, and that people with disabilities are by their nature 'worse off' than other people. A disabled person may even internalise the ableism around them, and come to see themselves as inferior to others because of their disability.

Ideas about disability and ableism have changed over the years. Early views of disability as a problem needing medical correction and control gave way to ideas of socially constructed disability, in which a person's 'handicap' (for example, their depressive disorder, or their lost limb) is not responsible for the disadvantages they faced in society—the real problem is that the society we live in does not accommodate or accept people with those handicaps, thus excluding them from being able to live as well as other people. Most recently, disability activists have developed a 'critical theory of disability', in which they acknowledge that the handicap itself may make the person's life difficult, but that the exclusionary — ableist! — nature of our society makes it far worse.

In the healthcare system, where we deal with disability all the time, disability is often pathologised and medicalised. We want to fit everyone into a 'normal' body or a 'normal' mind, rather than seeing disability as a part of natural human variation. Once again, disability is 'bad' and people with disabilities are seen as 'abnormal'. How can we change this? It won't be easy—but a way to start is to think about the language you use and how it plays into ableist ideas. When you describe an unkind person as 'psychotic', something you don't like as 'lame' or someone you look down on as 'retarded', what are you saying about people with disabilities and how you see them? Consider your language and the ideas it expresses, and you'll have an idea of how pervasive ableism is. Question the way you think about bodies, minds and illness, and understand that disability is difference, rather than deficiency.

Gender, Sexual Orientation and Heteronormativity, and Health Disparities among LGBTI Populations

Written by Alex Müller.
(Associate Professor at the Gender Health and Justice Research Unit at UCT)

Gender

There is a difference between a person's *gender* and a person's *sex*. The hormones in their body, together with their internal and external biology, determine a person's biological sex. Currently, the options that are assigned to people when they are born are female, male, or 'intersex'. A more appropriate way of saying 'intersex' is to say people with *diversity in sex characteristics*. This is what people with diverse sex characteristics prefer to be called.

A person's gender is determined by their own identity – by who they know they are: a man, a woman, or a person who does not identify as either of these options. For many people, their gender identity matches their sex. This is called *cisgender* (cis = the same/ on the same side). For some people, their gender identity does not match the sex that they were assigned at birth. This is called *transgender* (trans = across). Transgender is an umbrella term for all people whose gender identity does not match the sex assigned to them at birth. This includes women who were assigned male sex at birth, men who were assigned female sex at birth, and people who do not identify as either men or women.

For a long time, people, including health scientists, assumed that there were only two possible genders - a *gender binary*: that people were either women or men. This is because people, including health scientists, assumed that gender was linked to sex, and that sex was binary: either female or male, and that people with diverse sex characteristics were rare and outside the norm. We know today that it is much more complicated than this: that there are many variations in sex characteristics (even among people simply classified as female or male), and we know that sex does not necessarily determine gender. However, we can still see the consequences of this in medicine today: diverse sex characteristics are classified as an illness (and called 'disorder of sex development'), and people whose gender identity does not match the sex assigned to them at birth are classified as having a mental illness (called 'gender incongruence'). This is slowly changing: The World Health Organisation has started to revise its diagnostic manuals to reflect what we now know about gender identity and diverse sex characteristics.

The assumptions that gender is binary, and that there are certain behaviours or traits that are 'typical' for women or men, is still widely used to organise society. It is directly linked to heteronormativity (see the next section). We can see it everywhere: in bathrooms, hospital

wards, locker rooms, etc. that are for either women or men, in toys that are made 'for boys' (e.g. trucks or science sets) or 'for girls' (e.g. dolls or tea sets). This means that people who do not fit in the binary often experience marginalisation, discrimination and violence.

This also means women are widely believed to be inferior, based on their sex characteristics, and the assumption that because they (usually) bear children they should remain in the home, are nurturing and weaker. Across most cultures, men are seen as superior to women: as physically stronger, as more rational, better leaders etc. Historically, most positions of power (whether in government, in religion, or in everyday social life) were held by men. Until 100 years ago, most women were not allowed to vote. This system where men are still believed to be superior, and men are enabled to be in positions of power is called the patriarchy (patriarch = 'ruling father').

The norms that underlie what women and men should do, how they should dress, how they should behave, and how they should interact with other people are called *gender norms*. They are different in different countries, in different times, and in different cultures. For example, it is 'normal' for men in Scotland to wear skirts; the colour pink was considered a colour for boys in early 1900s Europe (because the colour red signified strength, and pink was the 'little red' just as boys are 'little men'); and in many African cultures, it is 'normal' for men who are friends to walk in public holding hands.

Sexual orientation and heteronormativity

Romantic and sexual relationships between people of the same sex or gender have always existed. Historians have shown that in pre-colonial African countries, for example in the territories of the countries that are now Zimbabwe and Lesotho, relationships between two women or two men were often as accepted as relationships between a woman and a man. This changed over the last 300 years, with the influence of religion and colonial rule.

Today, across the world, heteronormativity (hetero = other, normativity = what is considered 'normal') is a widely existing idea in society that assumes that relationships between two people of the opposite ('other') sex or gender are the norm. This makes lesbian, gay, bisexual, transgender and intersex people, as well as heterosexual people who do not fit the norm – by, for example, people who are in relationships with more than one partner – invisible. Because of heteronormativity, people unconsciously assume that every patient, every research participant, every student and every healthcare provider is heterosexual, cisgender and has a relationship with one partner of the opposite sex or gender.

Culturally and socially, heterosexual relationships between two partners are advantaged – for example, by laws that allow marriage only between two partners of the opposite sex or gender, or by what society and people consider socially acceptable. In South Africa today, we

see many examples of this: when religious leaders blame LGBTI people for natural disasters like the Cape Town water crisis, when students are being bullied because of their sexual orientation or gender identity or expression, when people make jokes that are homophobic, when all romantic relationships that are portrayed in high school curricula are between people of the opposite sex or gender, or when people are being beaten up, raped, or killed because someone thinks they are a lesbian women, a gay man, or a transgender person.

Until the 1970s, medicine and medical knowledge supported the idea that homo- and bisexuality was not 'normal'. When medical researchers started to think about homosexuality, they thought it was a mental illness that could be cured – because it went against what society considered 'normal'. Until 1972, the American Psychological Association considered homosexuality a mental illness. This meant that lesbian, gay and bisexual people could undergo 'treatment', which included psychoanalysis, but also aversion therapy and electroshock therapy. Today, research evidence shows that none of these treatments work, and forcing someone to 'treat' their homosexuality has been recognised as a form of torture.

Health disparities among LGBTI populations

Over the past two decades research on the health and well-being of lesbian, gay, bisexual, transgender and intersex people (LGBTI people) has shown many health disparities based on sexual orientation and gender identity, in many parts of the world. We now know that LGBTI populations, when compared to heterosexual, cisgender populations, have worse health outcomes due to mental health concerns (depression, anxiety, suicidality and substance use), infectious diseases, including HIV/AIDS, experiences of violence, and because they have less access to preventive care services. This is not because LGBTI people are inherently less healthy, but it reflects the consequences of stigma, social exclusion, and discrimination based on sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC). SOCIESC are thus important social determinants of health.

Currently, however, health sciences students hardly learn about sexual orientation, gender identity and expression, or about diversity of sex characteristics during their studies. This is in part because, despite the information we now have on LGBTI health, most health research has always assumed that all people are heterosexual and cisgender, and we therefore do not know about specific healthcare needs of LGBTI people. In addition, healthcare and medicine itself thought that homo- and bisexuality was an illness until 40 years ago, and still considers non-conforming gender identity and diverse sex characteristics as illnesses. This has impacted the attitudes of many healthcare providers towards LGBTI people.

This means that healthcare providers are ill-prepared to have the knowledge and skills to advise LGBTI patients about their health concerns that might be influenced by SOGIESC. For example, many health sciences students do not know how to provide sexual health advice to people who have sex with a partner of the same sex or gender, and don't know about the

specific chronic disease risks of, for example, older lesbian women (one example is that lesbian women are at higher risk of cervical cancer and breast cancer, because they do not use preventative care as often as heterosexual women). In addition to this, because of societal views and values that are negative towards non-conforming sexual orientations and gender identities, some LGBTI patients experience discrimination at healthcare facilities because of their sexual orientation and/ or gender identity. For example, a recent South African study showed that LGBTI patients are being called names, or are ridiculed in the waiting room by healthcare staff.

As new health sciences students, this is something you should keep in mind when you start learning about how to be a healthcare practitioner, when you learn about health and illnesses, and when you start seeing patients. Keep in mind that you and your colleagues, teachers, and patients will have a wide and diverse range of sexual orientations and gender identities. Keep in mind that sexual orientation and gender identity might influence people's health and wellbeing. When you learn about taking patient histories, make sure you do not assume all your patients are heterosexual and cisgender. When you learn about new illnesses, ask your lecturers about the risks that LGBTI people specifically might face. Be aware of the history of medicine and healthcare and how it in the past considered non-normative sexual orientations as not 'normal', and how it still considers non-confirming gender identities and diverse sex characteristics as pathological. Stay informed. If you identify as cisgender and/ or heterosexual, read up on the experiences of people who identify as lesbian, gay, bisexual, transgender or gender diverse and how their sexual orientation, gender identity and/or gender expression impacts their health, their wellbeing, and their experiences.

Class, health professions and health services

Written by Roshan Galvaan.
(Associate Professor in the Division of Occupational Therapy at UCT)

Entering into and becoming part of a university such as UCT may be an exciting yet daunting experience for many. While you may be entering the university so that you can acquire the pre-requisite knowledge, skills and attitudes to enable you to pursue a health sciences profession, it also brings the opportunity to think about what a university is and how matters related to class privilege and oppression may relate to health science disciplines and professions. The concept of social oppression describes a relationship of dominance and subordination between people based on different categories of their identities, where one group of people benefits from the systematic discrimination, lowering of status or exploitation directed toward the subordinate group of people. This oppression is not experienced merely because of the qualities of individuals but rather because social relations exist that are based on social hierarchies. This means that people may be more (or less) valued or may have more (or less) power based on their group identities and their location(s) within a system. Also, people who hold power within such systems may benefit and remain complicit in maintaining it by not challenging or even questioning the effects of such a system on others. For example, members of certain professions or professionals practicing in certain disciplines may be held in higher esteem compared to colleagues and may not question the power imbalance.

A useful exercise as a first-year student would be to listen to the conversations that your senior peers have about the different blocks that they are a part of or colleagues that they interact with and then to ask yourself: What value is attached to varying disciplines and why is this so? What is the effect of this on those disciplines or professions that are held in lower regard?

Focusing on health science students, some of the very important factors that influences students' entry into and becoming part of the university are not just individual and personal but come about as a result as the dynamics of our society. One such factor is social class, which refers to a system of ordering a society in which people are divided into sets or categories based on their economic status. People from diverse social classes enter the university, however, traditionally, universities have been elitist spaces where middle and upper social class values have been privileged. This often leaves members of these social groups to feel a sense of belonging since they have access to the necessary resources and feel affirmed, while leaving some feeling confronted and even excluded. Social oppression based on class is often invisible and excludes groups of people from social, economic and political participation. Within the health sector this is often experienced in relation to access to basic health services and policy formulation.

For example, Lorenzo and Cramm (2012) completed a study where disabled youth's access to assets that people use to support themselves and their families through economic activities, was compared to the access afforded to non-disabled youth. Their findings reflected that non-disabled youths' livelihoods in South Africa are more secure than disabled youths, particularly in the areas of "education, support in intimate relationships and engagement in free-time activities, work, and quality of facilities and access to services".

This disparity shows an intersection that may occur between identities associated with social class and ability. These findings have been highlighted as important for health professionals to consider when promoting the inclusion of disabled youth. Furthermore, in the health sector, social class has been known to not only influence access to health services, but also to influence the trends in the burden of disease amongst members of different parts of society. Although dominance of one standpoint over another is common and sometimes subtle, it should be identified and resisted as it limits possibilities for inclusion and promoting knowledge generation.

Since the University of Cape Town's strategic framework aims to stimulate social consciousness and promote engagement around the continued legacy of apartheid and colonialism, students are required to build their critical thinking, including exploring the application of a decolonial perspective. A decolonial perspective recognises that all knowledge and actions occurs from a particular place and time and that this affects what is known. It raises awareness that there are many views (which lead to diverse actions) and that these are underpinned by diverse class positions. Uncovering a fuller picture needs a pluriversal approach where multiple interpretations can be appreciated. To operationalise the concept of pluriversalism, for example, means asking deep questions in order to understand how taken-for-granted reality may be steeped in middle or upper-class experiences (called class privilege) rather than appreciating the diversity that may be based on different class experiences. Coming together as people from diverse class backgrounds presents the opportunity to find the class positioning informing policies and action and to advocate for more inclusion. It also calls on each person to use their position as a professional in the making to reject discrimination and to advocate for systems that promote social justice.

Discussions

Written by Rendert D. Hoekstra.

(Secretary General – 2018 HSSC)

This section aims to facilitate critical debate and encourage further questioning around the topics covered in this booklet. In order to maximise on the exercise, try to join a group whose members you are unfamiliar with or who you know have different backgrounds or perspectives from you. As mentioned before, this booklet does not aim to prescribe any views; it aims to lay out the various relevant theories in a comprehensive manner as they apply to the health sciences. Your job is to deconstruct and scrutinise the theories and form your own understanding of the complex social dynamics around you by integrating your own experiences and those of others into your ideology.

The Critical University

Think of some general beliefs that you had before coming to UCT that you might be questioning for the first time now.

Why are you questioning these beliefs?
(Think about your environment, your thoughts and your actions)
Why do you think you never questioned these beliefs before?
Where do these beliefs come from?
How have you influenced other people's beliefs?
How do your beliefs influence how you see yourself and how others see you?
Do you think universities and students should challenge your beliefs?

Transformation

Write down your own definition of transformation.

Which ideas or objects are implicated in your definition, and why do you think you chose these?
How should we decide which ideas or objects need to undergo transformation?
How would you implement what you have defined?
How does your definition of transformation relate to the health sciences and your practice of healthcare?
Upon whom does the duty of transformation rest?
Should recompensing form a part of transformation?
What does a state of complete transformation look like?
What is radical transformation?
Do you think chaotic or violent behaviour in response to gross inequality is justifiable?
Why is transformation important?

What is victimisation?

How do you understand victimisation?
How do you understand sensitisation?

Privilege

Think of some of your own privileges.

Why do you perceive these to be privileges?
How do historical factors contribute to your current privileges or lack thereof?
To what extent did your privileges contribute to your being here at UCT today?
Is the concept of privilege helpful?
How does privilege manifest in the world around you?
How does privilege relate to colonialism?

Structural and systemic violence

Just to get our definitions straight:

For our purposes, **systemic violence** is:

1. The systematic marginalisation of people,
2. according to a system of social categorisation,
3. that leads to some form of injustice towards that group.

Structural violence is when systemic violence is incorporated into or evolves into an institution (e.g. Christianity, the apartheid government, psychiatry, etc.) and is formally practiced and advocated for by that institution.

Think of some examples of structural violence.

Which institutions are implicated in your examples?
What do you think led to the formation of these institutions, or the incorporation of systemic violence into these institutions?
How does one avoid the institutionalisation of social systems? Should one?
What is the role of social systems, and how does one determine which systems are violent?
How do these social systems and their institutionalisation relate to colonialism?

Intersectionality

With the drive of social media and globalisation in the 21st century, and a growing international community of social activists, 'intersectionality' has really become a buzzword. Though this theory is a useful tool for understanding the multidimensional manifestations of privilege, we must be aware of its limitations.

We understand the aim of intersectionality to be to help us explore all the dimensions of our social identities, establish their implications, and acknowledge these. For some, this approach may suggest that oppression can somehow be quantified, that you can tally up your social identities, place them on their respective spectra of privilege relative to your context, and allocate yourself a quantity of privilege or lack thereof.

Is there validity in this approach?
Would it have a role in research and global action plans?
What are the practical implications?
Does this create disunity among social activists?
To what extent does social, cultural, political and economic context govern this quantification of social identities?
How do you balance self-identification and social identities?

"So… tell me a bit about yourself."

"I am a black, neurodivergent, transgender man from a poor socioeconomic background."

What role does defining your intersections play in social validation and self-validation?
Does acknowledging and fighting a colonial reality give it more power?
In what ways is this categorisation the result and cause of the pathologising of humans?
Does this lead to personalisation of perspectives on intersectionality?
Are these social identities socially constructed labels or a representation of intrinsic identity?
Are these social identities a valid description of this person's self?

Race

While race is a socially constructed concept based on limited biological observations, the impact and experience of race remains a reality and should not be negated. Racism is a touchy subject for most new students. It is therefore also unclear and unrefined. The nature of social definitions is that they will be subjective and will relate to the social context in which they are formulated. When it comes to racism, we base our definition on the issues that inform the topic. In this case, these are the persistent overwhelming socioeconomic disparity based on race in South Africa and the question of recompensing.

So, for racism to be present, you need:

1. Discrimination of a particular group of people based on a set of observable biological characteristics, such as skin colour, accent, hair texture, and so on,
2. where the discrimination may be physical or socioeconomical, and
3. where the group that is being discriminated against is in a socioeconomically disadvantaged position.

This is my definition. How would you define race and racism?
What did your parents teach you about race and racism?
How did your ideas about race and racism change at university?
Should we be "colour blind" about race?
Is reverse racism real?
What experiences have you had of racism?
Why do you think race is important in the health sciences?
How do race and racism relate to colonialism?

Ability

How do labels contribute to stigma?
How does society contribute to the extent of a disabled person's "handicap"?
How does language play a role in stigma?
How does language play a role in how we define ability and disability?
How do the health sciences contribute to ableism?
Why do we differentiate between abled and disabled persons?
In what ways does the health sciences faculty fail to accommodate disabled persons?
In what ways does the health sciences profession fail to accommodate disabled persons?
How does ableism relate to colonialism?

Gender

This topic is immensely important in the health sciences, with an enormously disproportionate burden of intimate partner violence, mental illness, metabolic disease and maternal morbidity persisting in our female population. In transgender and gender non-conforming individuals, the burden of intimate partner violence, mental illness and loss to suicide is significantly higher than any other group, with staggering rates across East and Southern Africa.

How does society decide on gender?
Why do we still incorporate the concept of gender into our society?
How do the health sciences contribute to gender-based violence?
How do the health sciences contribute to structural violence against transgender and gender non-conforming individuals?
What did your parents teach you about gender?
How did your views about gender change at university?

Sexual orientation and heteronormativity

The burden of disease here is also very high, again with a particular emphasis on mental illness, intimate partner violence and loss to suicide.

What did your parents and your community teach you about sexual orientation?
What else contributed to your views on sexual orientation?
How have your views on sexual orientation influenced your behaviour in the past?
How did your views on sexual orientation change at university?
How does language contribute to systemic violence against sexual and gender minorities?
How has your behaviour in the past contributed to systemic violence against sexual and gender minorities?

Class, health professions and health service

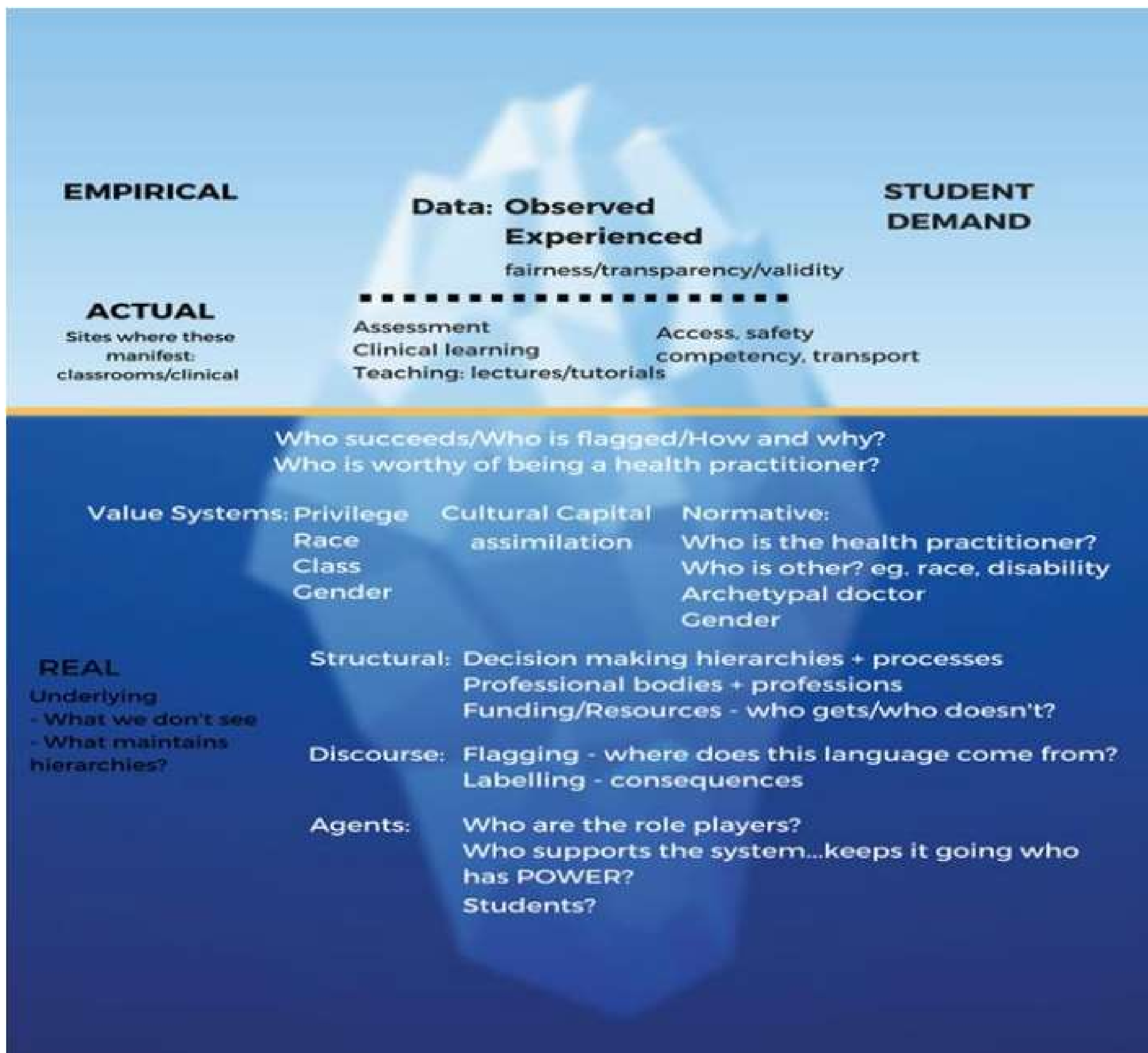
How would you define class and classism?
What did your parents teach you about class and classism?
How did your ideas about class and classism change at university?
What experiences have you had of classism?
Why do you think class and classism is important in the health sciences?
How do class and classism relate to colonialism?

UCT Faculty of Health Sciences: a case study

The following is an extract from the Curriculum Change Framework published by the CCWG in June 2018.

The Faculty of Health Sciences (FHS) is a premier training site for health professionals in the country, ranking in the top 60 health science faculties in the world (depending on the ranking system), attracting close to 50% of the total research funding generated by UCT, and also contributing close to 50% of the research output generated by the university. This view of the FHS rests uneasily alongside the observation that the Rhodes Must Fall movement of early 2015 and the associated protest action found significant support in the FHS, both among students and staff members. The disjuncture between excellence in terms of global rankings and research productivity and revenue, and appetite for protest calling for an inclusive and socially just academy, brings into sharp focus the key questions the CCWG framed as central to its university-wide engagements (What knowledge? Whose knowledge? What/ who gets privileged? Whose interests dominate?). The Faculty assembly held in 2015 highlighted feelings of alienation, disempowerment, and the reality of training and working in a space that seemingly valued many of the trappings associated with our colonial past, with little recognition or acknowledgement of the full diversity within this university and the country.

During the 2016 student-led Fees Must Fall protests, the FHS undergraduate students drafted a list of 34 demands, and postgraduate students submitted 26 demands (although these were submitted at a later date during the protest action). These demands spanned a wide spectrum of issues including: healthcare provision for students, transport problems, safety concerns, the right to protest, complaints of victimisation, dissatisfaction with teaching approaches and assessments methods, and the high cost of tuition. There was an arrangement between the Dean's Office and students that the demands would be addressed within a certain timeframe, and because students were unhappy with progress made with addressing the demands, a significant number of students occupied the Dean's Suite under the #Occupy FHS banner. It was at this point that the CCWG made contact with the students who were occupying the Dean's Suite – with a view of listening to the students and to engage with their concerns. During this period, CCWG members engaging with the student demands at the FHS site, articulated that the observations and experiences that students complained about, often reflected deeper underlying structures, values, beliefs and attitudes embedded in our educational framework. The Critical Realist (CR) analytical framework, given its powerful analogy of the iceberg, was useful in supporting the CCWG's approach towards understanding the students' demands (see figure below). Many of the submerged structures, values, beliefs and attitudes embedded in the curriculum reflect remnants of a colonial heritage, suggesting the imperative to engage with the concept of decolonising the curriculum.



An iceberg analogy for the Bhaskar's CR framework adapted from Fletcher, 2017

The ensuing discussions allowed the framing of important questions like: Why is the standard of success in the Bachelor of Medicine and Surgery (MBChB) programme often measured as the ability to function in the best medical institutions in the USA (or the UK)? Are students, as measured against this 'standard', able to function equally effectively at a rural clinic in South Africa? Why is there an apparent privileging of students from the MBChB programme, and students from the Health and Rehabilitation Sciences often feel like second rate citizens in the faculty, despite talk that managing patients ideally involves multi-disciplinary teams? Why is English privileged, and why are the indigenous languages not valued, especially considering that approximately 70% of the population access health care in the public sector, and that most of these patients are not mother-tongue English speakers?

CCWG members engaged members of #OccupyFHS, the Dean and the Deputy Deans in the faculty. In October 2016, the Dean team acknowledged the importance of considering the student demands in the context of the underlying colonial ontological and epistemic logics that undergird its curricula, and agreed that the FHS should engage with decolonising the curriculum. This was endorsed by the Dean's Advisory Committee (DAC), and subsequently by the Faculty Board. Following this, the CCWG was approached to assist the Dean team in

establishing the FHS-CCWG team. While engaging in this process, members of the broader UCT CCWG team who are based in HSF stressed the importance of the three principles that helped to safeguard the legitimacy of its work; that the team is black-led, with members that have had a good track record of striving for inclusive and socially just curricula; institutional support; and that the team's work should be seen as intimately intertwined with student mobilisation around curriculum issues. The FHS-CCWG team was constituted towards the end of 2017, and has since started doing its work.

Recounting the main features of the events that unfolded during the period of protest action in this detached manner (above), obscures the often extremely antagonistic and conflictual nature of the interactions between students (those who wanted to protest, and those who wanted to continue with classes), students and staff (those students who wanted to protest and those staff members who wanted to continue giving classes), between staff (those who supported the protest action, and those who did not), senior management (Deans) and staff (who felt unsupported). The engagements discussed above, transpired against this highly conflictual background, with many parties sustaining relational damage in the process. Because of the widespread fear of victimisation, students specifically requested that no notes be taken in some discussion spaces. This was prompted by concerns raised by some students that certain lecturers had commented on statements made by specific students in open assembly meetings. Despite these difficulties, a rich repository of information was gathered during engagements with staff and students, and based on these, a number of key themes emerged, listed below in no specific order:

1. Wellness
2. Safety
3. Victimisation
4. High cost of learning
5. Language
6. Representation
7. Pedagogy
8. Assessment
9. What knowledge, whose knowledge and why that knowledge
10. Transparency
11. Accountability

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