26 May 2015

To: The Acting Director General - DBE

Att: Ms A Dano
DBE Acting Director - Health Promotion

PER EMAIL: dano.a@dbe.gov.za

EE & EELC JOINT COMMENT

ON THE DBE DRAFT NATIONAL POLICY ON HIV, STIs AND TB GN 38763, GG 395 OF 2015; 5 MAY 2015

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A. Introduction

1. This is a joint submission by the Equal Education Law Centre (EELC) and Equal Education (EE).

2. The EELC works closely with EE in pursuit of their mutual goals of an equal education system and quality education for all.

3. Over the course of the last three years, a large portion of EE and EELC's efforts have been directed at ensuring that all public schools have adequate basic infrastructure, including water, sanitation and adequate class sizes. All of these services and resources have a direct bearing on learner health and well-being.

4. EE has also been repeatedly vocal in its stance that it is unlawful to deny teenagers access to HIV preventative measures and has demanded that Basic Education Minister, Ms Angie Motshekga ensures that condoms are distributed in schools.

5. More recently, EE learner members marched to the offices of the Western Cape MEC, for Education, Ms Debbie Schafer, demanding that learners be "*provide*[d] *access to quality sex education and condoms, so that learners know how to be safe, how to look after their health and how to avoid pregnancy."*

6. The EELC has also been involved with issues regarding HIV and pregnancies in schools. This includes assisting an HIV positive learner by ensuring that he obtained *appropriate* placement in a school within close proximity to a health facility, and assisting pregnant learners unlawfully excluded from their schools.

7. When tackling these issues EELC has engaged with SGBs, district officials and provincial officials in the Western Cape, Gauteng and KwaZulu-Natal, as well as officials in the Department of Basic Education (DBE).

8. EELC has also represented EE, as a 'friend of the court', in a Constitutional Court case ('Harmony and Welkom') concerning the unlawful exclusion of pregnant learners from their schools. Here EE argued that discrimination on the basis of gender is even more reprehensible when viewed in the light of the societal dynamics that lead to young girls falling pregnant, which include skewed power relations, lack of organised sexual counselling in schools and the non-availability of condoms.

9. EE and EELC welcome this opportunity to provide input on a Draft Policy which has the potential of addressing the high rates of unplanned pregnancies and the scourge of HIV infections amongst our youth.

10. We have examined the Draft Policy and for the purposes of this submission we are restricting our comments to provision 6.2: *"Prevention"* of HIV and STI's among learners.

11. We are of the view that all learners who are engaging in sexual activity are entitled to discreet and easy access to condoms in their schools.

12. We will point out in this comment why it is that the Integrated School Health Programme (ISHP) mobile clinics are not a practical way of ensuring that condoms reach learners who require them. This is so for a number of reasons including the shortage of professional health practitioners and transport that currently mar the successful roll out of the ISHP.

13. We will also explain why it is that a policy concerning HIV and STI's in schools cannot be determined devoid of the issue of learner pregnancy.

14. Finally we examine international, regional and national laws that apply to the DBE and explain why it is that a further round of public comments are necessary so as to adequately ensure that learners, as the principal stakeholders, are able to meaningfully participate in the decision-making process.

B. Analysis of the Draft Policy

15. As already mentioned, EE has marched for the provision of quality sex education and condoms in schools. EE and EELC therefore commend the DBE for making provision for quality, age-appropriate and accurate sex education in the Draft Policy.

16. For the purpose of our submission we will document our comments under the headings of the relevant sub-clause[s].

(i) Access

Sections 6.2.2.4 and 6.2.5.3

17. We are pleased that these two sub-sections stipulate that *"Access to male and female condoms . . . will be made available to ALL learners"* in the Basic Education Sector.

18. However, these sub-clauses are vague in that it is unclear what is meant by access. Does this entail discreet access, unlimited access, acces only under certain circumstances or purely through mobile clinics in terms of the ISHP?

19. The need for clarity on the logistics of condom distribution is significant as this ought to occur in a discreet manner, one which adequately safeguards a learner's right to privacy. A right which:

> *"fosters human dignity insofar as it is premised on, and protects, an individual's entitlement to 'a sphere of private intimacy and autonomy'"*[1]

20. Research undertaken in the area of condom distribution reveals learners' reluctance to obtain condoms when issued by an authority figure.[2] It also reveals learners reluctance to attend Department of Health (DoH) out-of-school services[3] where they had been referred to one.

21. Two researchers examining condom access in KwaZulu-Natal schools found that:

> *"At one school a box of condoms issued by the DoH was brought to the school by a NGO and placed in the principal's office. In the more than a year that the condoms remained in the office, not a single student approached school authorities to request condoms.*
>
> *In another school, an educator obtained a box of condoms from a local clinic and placed it in an unlocked cupboard drawer in the school library. Students had to ask for the key to the library, but the educator who had the key said that she never questioned the student's reasons. She reported that the condom box was quickly empty."*[4]

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[1] *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* ZACC 35; 2013 (12) BCLR 1429 (CC); 2014 (2) SA 168 (CC); 2014 (1) SACR 327 (CC) at para 64. Accessible: http://www.saflii.org/za/cases/ZACC/2013/35.html

[2] Bennish ML, Hun J, *Condom Access in South African Schools: Law Policy and Practice;* Public Library of Science - Medicine, vol 6, issue 1, January 2009 at page 0027. Accessible: http://www.globalyouthdesk.org/index.php?option=com_k2&view=item&id=163:condom%20access%20in%20south%20african%20schools:%20law,%20policy,%20and%20practice&Itemid=63

Holt K, et al. *Assessment of Service Availability and Health Care Workers' Opinions about Young Women's Sexual and Reproductive Health in Soweto, South Africa*; African Journal of Reproductive Health, June 2012 at 16(2) 284. Acccessible: http://www.bioline.org.br/request?rh12037

Blake SM et al, *Condom availability Programs in Massachusetts High Schools: Relationships with Condom Use and Sexual Behaviour*; American Journal of Public Health, vol 93, No. 6, June 2003 at page 960. Accessible: http://www.researchgate.net/profile/Susan_Blake/publication/10738008_Condom_availability_programs_in_Massachusetts_high_schools_relationships_with_condom_use_and_sexual_behavior/links/0c96052422f2beb83f000000.pdf

[3] Beksinka, ME et al., *The Sexual and Reproductive Health Needs of Youth in South Africa – history in context*; South African Medical Journal, vol. 104, No. 10, October 2014 at page 677. Accessible: http://www.scielo.org.za/pdf/samj/v104n10/17.pdf

[4] Bennish ML, above note 2.

These findings are telling and support the need for condoms to be available freely and discreetly to learners.

22. If reducing teen pregnancy and the risk of contracting and transmitting HIV is a key priority, then condoms ought to be made *easily and discreetly available* in conjunction with appropriate and tailored sex education programs.

23. The way condoms are made available is significant, since this might affect the willingness and ability of learners to access them, heightening their risk of contracting HIV and/or facing unwanted pregnancy.

24. **Recommendations** —

- **EE and EELC recommend that clauses 6.2.2.4 and 6.2.5.3 be reformulated so as to clarify and ensure that all learners will have easy and discreet access to condoms.**

- **Examples of easy and discreet access include placing unmonitored condom dispensers in male and female bathrooms or other more *private* areas frequented by learners.**

- **In particular, learners ought to be able to access condoms free of any intermediary serving as a gatekeeper.**

(ii) Qualified Access?

Section 6.2.2.4 read together with sections 6.2.5.1, 6.2.5.2 and 6.2.5.3

25. Adding to the lack of clarity on the question of "*access"* is clause 6.2.5.1 which states that through the ISHP programme (mobile units) contraception would be *offered* to ALL senior and FET phased learners as well as intermediate learners, where required.

26. This section of the Draft Policy excludes a category of learners that are at risk of contracting HIV and/or falling pregnant from being able to access condoms uninhibitedly.

27. Instead their ability to obtain condoms is subjected to some unspecified circumstances ("*where required*") that would most likely constitute an arbitrary judgment call by the professional practitioner dispensing condoms to a particular learner.

28. **Recommendations** —

- **Recommendations on how this issue should be addressed are made below**.

(iii) ISHP – documented difficulties

Sections 6.2.5.1 and 6.2.5.2

29. Section 6.2.5.1 states:

> *"Through the mechanism of the ISHP, in the short term, counselling on sexual and reproductive health issues and services via mobile health units will be offered to all senior and FET phased learners – as well as to intermediate learners where required. This should include the offer of provision of dual protection, contraception and HIV counselling and testing."*

30. From an examination of 6.2.5.1 it appears that the successful distribution of condoms in schools depends, almost entirely, upon well-functioning mobile clinics operating under the auspices of the ISHP.

31. This, however, raises a number of concerns regarding the feasibility of this model as a means to ensure that condoms reach learners. To put these concerns into perspective it would be useful to look at the failures of the ISHP's predecessor, the National School Health Policy (NSHP) introduced in 2003.

32. The NSHP was intended to provide school health services but, from inception, was plagued with a number of challenges:

- Infrequency of school site visits / No visits;
- Large inequities in service provision between and within provinces (majority of sites with no or infrequent visits located in poor urban and rural areas);
- Inadequate nurse to school ratios;
- Sub-optimal quality of service.[5]

[5] Dr Shung King, M, *Review Report: Implementing the NSHP in South Africa 2003-2009*, December 2009. Accessible:http://www.expandnet.net/PDFs/South%20Africa_evaluation%20School%20Health%20Policy_2009.pdf

33. Concerns were raised at the outset that the ISHP would not be immune to some of these challenges either. Potential barriers identified included, amongst other things, staff shortages, a lack of transport and inadequate referral systems.[6]

34. Staff shortages, in particular, must be highlighted as presenting an acute barrier to condom access. This is because clause 6.2.5.2 of the Draft Policy states that

> *"Services on sexual and reproductive health will ONLY be provided by a professional nurse or other trained health professional in a manner that protects the privacy and confidentiality of learners. Where this cannot be guaranteed, learners must be referred to a health facility to receive these services."*

35. Extreme shortages of professional nurses in general and especially in rural areas, would therefore constitute a major obstacle for all learners and particularly rural learners seeking condoms:

> *"Successful implementation of the . . . ISHP is hampered by a critical shortage of health and allied professionals as well as social service professionals, particularly in rural areas. While there are plans to increase the numbers of professionals available and to incentivise work in rural areas, the shortages are so bad that more inventive approaches are needed to see improvements."*[7]

36. A lack of transport for those few nurses who are available to render their services to schools adds an additional barrier to condom access:

> *"the lack of regular transport significantly affects the ability of school health teams to reach schools . . . in numerous locations school health nurses use public transport at their own expense to get to and from school."*[8]

37. These barriers to access have been acknowledged by the DoH itself. In its Annual Report for the 2013-2014 period, the DoH states that their ISHP targets for coverage of quintile 1 and 2 schools in grades 1 and 8 were not met (by a substantial percentage) due to limited human resources and a lack of transport.[9]

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[6] Draga L, Jamieson L, Lake L and Proudlock P; *Child Gauge, Part One: Children and Law Reform - Legislative and Policy developments* 2012/2013, at page 16. Accessible: http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2013/Gauge2013LegiDevelopments.pdf

[7] Draga L, above note 6 at page 20.

[8] Dr Shung-king M, Slemming S, Orgill M; *School Health in South Africa: Reflections on the past and prospects for the future*, the South African Health Review 2013/2014, at page 68. Accessible: http://www.health-e.org.za/wp-content/uploads/2014/10/South-African-Health-Review-2013-14.pdf

[9] DOH Annual Report for the 2013-2014 financial year at page 40. Accessible: http://www.gov.za/documents/department-health-annual-report-20132014

38. The ISHP is intended to be progressively phased in[10] starting with grades 1 and 8 in quintiles 1 and 2. This raises the question of how learners in schools that are not presently covered by the ISHP will be able to obtain condoms.

39. A connected question is how will learners with intermittent access to health professionals through the ISHP programme, be able to access condoms during the periods when there are no health professionals on site?

40. Another worrisome aspect of clause 6.2.5.1 of the Draft Policy is revealed by an examination of section 2.7 of the ISHP. Section 2.7 states:

> *"Learners below the age of 18 years should only be provided with school health services with written consent of their parent or caregiver. However learners who are older than 14 years may consent to their own treatment, although they should be advised to inform and discuss their treatment with their parent or caregiver."*[11]

41. Although section 6.2.5.1 states that learners in particular grade phases will be *"offered"* dual protection and contraception, it is not clear if this "offer" would nevertheless be a qualified one as a result of section 2.7 of the ISHP.

42. Given all the challenges and difficulties which have marred the implementation of the NSHP, and which appear to have been somewhat inherited by the ISHP it is clear that dispensing condoms to learners through ISHP mobile units is unworkable at best.

43. **Recommendations —**

- **EE and EELC recommend that clauses 6.2.5.1 and 6.2.5.2 be removed.**

(iv) Delineation of Age Groups

Section 6.2.5.1

44. To recap, this section reads:

[10] ISHP at page 3. Accessible: http://www.education.gov.za/LinkClick.aspx?fileticket=pj7cIv8qGMc%3D&tabid=390&mid=1125

[11] ISHP, above note 10 at pages 16 to 17.

> *"Through the mechanism of the ISHP, in the short term, counselling on sexual and reproductive health issues and services via mobile health units will be offered to all senior and FET phased learners – as well as to intermediate learners where required. This should include the offer of provision of dual protection, contraception and HIV counselling and testing.*

45. The Draft Policy therefore links the offer of contraceptives through mobile clinics to particular grade phases. The purpose for doing, as explained by the DBE in its briefing to Parliament on 12 May 2015, was based on the increased HIV infection rates occurring from around 15 years of age.[12]

46. However, from a reading of clause 6.2.5.1, it is not clear precisely which age groups will be offered condoms. In particular the mention of *"where required"* in relation to learners in the intermediate phase is quite obscure.

47. Linking the distribution of condoms to particular grade phases, as a targeted intervention, is impracticable. This is because of the inevitability that learners of the same age may be in different grade phases, thereby excluding them from the offer of condoms either entirely or subjecting them to a qualified offer when their peers of the same age have an unqualified one.

48. We are pleased to see that the DBE has specifically asked for the input of stakeholders, including civil society, so as to guide its final determination on the age at which condoms ought to be made available in schools.[13]

49. Factors which must inform such a decision must go beyond the age bracket within which the highest HIV infection rates amongst adolescents occur. It would also require an examination of the realities of the situation, both from a legal and factual perspective.

WHAT THE LAW SAYS

50. Section 5(3) of the Choice of Termination of Pregnancy Act reads:

> *"In the case of a pregnant minor, a medical practitioner or a registered midwife, registered nurse, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated:*

[12] *Social Cohesion and Learner Wellness Programmes implementation: Governance & Management in School:* DBE briefing, 12 May 2015, Minutes. Accessible: https://pmg.org.za/committee-meeting/20830/

[13] *Social Cohesion*, above note 12.

Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them." [14]

51. The law therefore confers upon minors the unbridled agency to make a decision whether to proceed with a termination of their pregnancy. A minor, however young, can choose to forgo first consulting with her parents before making this difficult and emotionally challenging decision.

52. It would be senseless and arbitrary for the law to confer this grim choice on all minors at this later stage but for DBE policy to deny minors of certain ages access/uninhibited access to safer (preventative) choices from the outset.

WHAT THE STATISTICS SAY

53. The vagueness of clause 6.2.5.1 creates the possibility that certain groups of learners, who are engaging in sex, will not have easy access to protection. This is worrying since there is evidence that learners' younger than 15 are engaging in risky sexual behaviour.[15]

54. *The South African Medical Council's 2nd South African National Youth Risk Behaviour Survey* (YRBS) found that learners 13 years and younger who are engaging in sex are significantly less likely to use condoms, compared to other age groups:

> *"significantly fewer learners [of] 13 years and younger (21.1%) used condoms as a method of contraception when compared to 16 year olds (45.6%), 17 year olds (47.4%), 18 year olds (50.6%) and those 19 years or older (45.8%)."*[16]

55. With regards to age of first sexual encounter, the YRBS states that:

> *"nationally, 37.5% of learners reported ever having had sex with 12.6% having had their first sexual encounter before the age of 14 years."*[17]

56. *The South African National HIV Prevalence, Incidence and Behaviour Survey* (PIBS) reports that 10.7% of respondents between the ages of 15 and 24 reported that they had

[14] 92 0f 1996.

[15] *The South African Medical Council's Second South African National Youth Risk Behaviour Survey* (YRBS) 2008 at page 34. Accessible: http://www.mrc.ac.za/healthpromotion/yrbs_2008_final_report.pdf

The South African National HIV Prevalence, Incidence and Behaviour Survey (PIBS) 2012 at page 147. Accessible: http://www.hsrc.ac.za/uploads/pageContent/4565/SABSSM%20IV%20LEO%20final.pdf

[16] YRBS, above note 15 at page 35.

[17] YRBS, above note 15 at pages 30 - 31.

engaged in sex before the age of 15.[18]

57. Regardless of the precise numbers recorded in these surveys, it is clear that there are minors of a very young age engaging in sexual activities and who face a real risk of contracting HIV/AIDS or falling pregnant.

WHAT THE SCIENCE SAYS

58. Research from various parts of the world supports the use of condoms in schools. In 2001, the highly reputable US Institute of Medicine published a report titled, *No Time To Lose: Getting More from HIV Prevention*.[19] The report considered the available evidence on HIV prevention programmes. The report stated:

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

59. It recommended that policy makers:

> *"eliminate requirements that public funds be used for abstinence only education, and that states and local school districts implement and continue to support age appropriate comprehensive sex education and condom availability programs in schools."*

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

> *"This systematic review supports the structural-level condom distribution intervention as an efficacious approach to increasing condom use and reducing HIV/STD. Given the urgency of the HIV epidemic, making condoms more universally available, accessible, and acceptable, particularly in communities or venues reaching high-risk individuals, should be considered in any comprehensive HIV/STD*

[18] PIBS, above note 15 at page 147.

[19] Institute of Medicine. 2001. No Time to Lose Getting More from HIV Prevention. Accessible: www.anypositivechange.net/8**Fed**Studies1.pdf

prevention program. Further exploration around how best to implement condom distribution programs to maximize their reach and impact should be considered."[20]

61. A highly regarded report in the United States titled, 'Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases', stated:

> *"According to a small number of studies of mixed quality, making condoms available in schools does not hasten the onset of sexual intercourse or increase its frequency. Its impact on actual use of condoms is less clear."*[21]

62. On balance, the evidence shows that it is not harmful to make condoms available in schools and that it reduces learners' risk of contracting and transmitting HIV and/or STIs.

63. **Recommendations** —

- **EE and EELC recommend that condoms should be made available in schools, along with comprehensive sex education with a strong emphasis on how to avoid contracting and transmitting HIV.**

- **This should be done in a manner that ensures condoms are easily accessible to all groups of learners who are engaging in risky sexual behaviour.**

C. General observations

(i) Failure to mention learner pregnancy

64. It is baffling how, in a Draft Policy addressing HIV, STIs and TB in schools, the word pregnancy does not appear once.

65. A policy concerning HIV/AIDS in schools is intricately connected to the issue of teenage pregnancy, and in order to address the one you need to engage with the other.

[20] Charania, MR. et al. 2011. Efficacy of Structural-Level Condom Distribution Interventions: A Meta-Analysis of U.S. and International Studies, 1998–2007. AIDS Behav (2011) 15:1283 to 1297. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3180557/

[21] Kirby, D *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, 2007 at page 18, URL: https://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf

For instance a determination as to at what age learners ought to be able to access condoms should factor in statistics on learner pregnancy.

66. In this regard the DBE's *Annual Survey for Ordinary Schools 2009/2010* reveals that a total of 45 276 learners reportedly fell pregnant in 2009. Of that total 2 487 were in primary schools and 42 789 in secondary.

67. Pointedly, 12 120 learners fell pregnant between grades 3 and 9. A significant number of learners falling pregnant were, therefore, under 16. (27% of the total).

68. This survey shows that risk does exist in the intermediary phase, and even before that: There were 109 teen pregnancies reported in grade 3, 107 in grade 4, then 297 in grade 5, and 571 in grade 6.[22]

69. More recently *Education Management Information System (EMIS*) reports that in 2013, 20 833 learners fell pregnant nationally. [23] Of this total, 717 were primary school learners, and 20,116 were secondary school learners. Learners at primary school level are therefore also at risk of contracting HIV/AIDs or other STI's.

(ii) Steps taken to ensure that learner voices are heard.

70. Unfortunately, due to the short turnaround time from the release of the Draft Policy to the deadline for commentaries, EE was unable to consult and workshop with our learner members. This submission therefore lacks the significant value of their views.

71. This dearth is especially problematic because the issue of condom distribution in schools is a highly contested one which impacts most intensely and directly on learners themselves. In particular their rights to health, dignity and bodily integrity and to have their best interests taken into account, are affected. Arguably, it is also a life or death policy determination for them.

72. An examination of international, regional and national laws applying to South Africa shows why the DBE is under a legal obligation to ensure that learners' voices are heard in this particular policy formulating process.

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[22] DBE's *Annual Survey for Ordinary Schools 2009/2010* at page 29. Accessible: http://www.education.gov.za/LinkClick.aspx?fileticket=iY%2BR%2Bgav688%3D&tabid=57&mid=2632

[23] As cited in a written reply (27/02/2015) to question 433 to the Minister of Basic Education, posed by Ms Boshoff (DA), National Assembly. Accessible: https://pmg.org.za/question_reply/556/

73. South Africa ratified the UN Convention on the Rights of the Child (the UNCRC)[24] 20 years ago (1995). This is significant because article 12 of the UNCRC states that:

> *"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."*

74. The UN Committee on the Rights of the Child published a General Comment[25] on Article 12. The Comment states that, '*the right of all children to be heard and taken seriously constitutes one of the fundamental values of the Convention.*'[26] The Comment goes on to say that:

> *"The views expressed by children may add relevant perspectives and experience and should be considered in decision-making, policymaking and preparation of laws and/or measures as well as their evaluation."*[27]

> *"These processes are usually called participation. The exercise of the child's or children's right to be heard is a crucial element of such processes. The concept of participation emphasizes that including children should not only be a momentary act, but the starting point for an intense exchange between children and adults on the development of policies, programmes and measures in all relevant contexts of children's lives."*[28]

> *"States parties must assure that the child is able to express her or his views "in all matters affecting her or him….the child must be heard if the matter under discussion affects the child…"*[29]

75. In 2002, the UN General Assembly adopted a Resolution entitled, *A world fit for children*.[30] The following call to action was included in the Resolution:

> *"Listen to children and ensure their participation. Children and adolescents are resourceful citizens capable of helping to build a better future for all. We must*

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[24] The UN *Convention on the Rights of the child* (UNCRC). Accessible at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

[25] UNCRC *General Comment no. 12 (2009) The right of the child to be heard.* Accessible at http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf

[26] UNCRC *General Comment*, above note 25 at para 2.

[27] UNCRC *General Comment*, above note 25 at para 12.

[28] UNCRC *General Comment*, above note 25 at para 13.

[29] UNCRC *General Comment*, above note 25 at para 26.

[30] Resolution S-27/2. A world fit for children. Accessible: http://www.unicef.org/specialsession/docs_new/documents/A-RES-S27-2E.pdf

respect their right to express themselves and to participate in all matters affecting them, in accordance with their age and maturity.[31]

76. Closer to home, South Africa ratified the African Charter on the Rights and Welfare of the Child in 2000.[32] Article 7, on freedom of expression, states:

> *"Every child who is capable of communicating his or her own views shall be assured the rights to express his opinions freely in all matters and to disseminate his opinions subject to such restrictions as are prescribed by laws."*

77. Looking at our own domestic law, section 10 of the Childrens' Act,[33] specifically entrenches a child's right to participate in any matter concerning them:

> *"Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration."*

78. Our courts have recognised (in matters stemming from their parent's divorce), a child's right to participate in the legal decision making process that affects them.

79. In the context of a possible relocation abroad, of a child with her mother, Chetty J said:

> *"The [Children's Act]… not only vests a child with certain rights but moreover gives a child the opportunity to participate in any decision making affecting him or her. Thus section 10 of the Act explicitly recognizes a child's inherent rights in any matter affecting him or her*[34]*…*
>
> *By all accounts the children are of an age and maturity to fully comprehend the situation and their voices cannot be stifled but must be heard."*[35]

80. Regarding a maintenance battle, the Supreme Court of Appeal stated:

> *"Children's right to participate has been incorporated into domestic legislation in the Children's Act 38 of 2005, s 10 of which reads as follows:*

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[31] Resolution S-27/2., above note 30 at para 7, page 3.

[32]The African Charter on the Rights and Welfare of the Child. Accessible:

http://www.unicef.org/esaro/African_Charter_articles_in_full.pdf

[33] The Children's Act 38 of 2005.

[34] H G v C G (1408/2009) [2009] ZAECPEHC 48; 2010 (3) SA 352 (ECP) (10 September 2009) at para 6. Accessible: http://www.saflii.org/cgi-bin/disp.pl?file=za/cases/ZAECPEHC/2009/48.html&query=voice%20of%20child%20heard

[35] H G v C G, above note 34 at para 17.

'Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration. '[36]

As one of the general principles of the Children's Act, s 10 must guide the implementation of all legislation applicable to children (s 6(1))[37]*…*

…It is primarily a question of recognising the child as an autonomous individual whose right to express views and to be heard should be tested against the nature of the dispute and the role that the child can play in adding a significant dimension to the dispute. It is no longer the case that children should be seen and not heard…."

81. The significance of learners' views on issues that most directly impact upon them was expressed in a Constitutional Court case regarding corporal punishment in schools. Here Sachs J lamented the fact that no learner voices were contained in the papers:

> *"The children concerned were from a highly conscientised community and many would have been in their late teens and capable of articulate expression. Although both the state and the parents were in a position to speak on their behalf, neither was able to speak in their name. . .Their actual experiences and opinions would not necessarily have been decisive, but they would have enriched the dialogue"*[38]

49. In another Constitutional Court judgment about whether a learner was entitled to an exemption from her school's dress code, both Langa CJ and O' Regan J stressed the need for the learner's own thoughts to have been factored into the decision. Stating that it was unfortunate that this was not so.

50. Langa CJ focused on the fact that the learner in question was 15 years old, making her voice on the issue even more important because she was fast approaching adulthood:

> *"It is always desirable, and may sometimes be vital, to hear from the person whose religion or culture is at issue. That is often no less true when the belief in question is that of a child. Legal matters involving children often exclude the children and the matter is left to adults to argue and decide on their behalf…. The need for the child's voice to be heard is perhaps even more acute when it concerns children of Sunali's*

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[36] Brossy v Brossy (602/11) [2012] ZASCA 151 (28 September2012) http://www.justice.gov.za/sca/judgments/sca_2012/sca2012-151.pdf

[37] Brossy v Brossy, above note 36 at para 20.

[38] Christian Education South Africa v Minister of Education (CCT4/00) [2000] ZACC 11; 2000 (4) SA 757; 2000 (10) BCLR 1051 at para 53. Accessible: http://www.saflii.org/za/cases/ZACC/2000/11.html

age who should be increasingly taking responsibility for their own actions and beliefs."[39]

51. O' Regan J stated that a learner of 15 years ought to have participated in the decision making process by setting out her reasons either orally or in writing as to why she thought she qualified to be exempted.

> *"In this case, the learner has never set out either orally or in writing her view as to why she thinks the school should afford her an exemption. This failure is unexplained on the record. Only the learner's mother's voice has been heard. This is unfortunate. A fifteen-year old learner who is seeking an exemption from school rules should as part of a fair exemption process be required to set out in writing or orally her reasons for seeking an exemption. As citizens of a diverse society we need to be able to explain to the other members of society why it is that our cultural practices require protection. An exemption process in a school environment, particularly where one is dealing with learners in their teens, should require learners to take responsibility for the exemption they are seeking by setting out their reasons for requiring the exemption. Such a process contributes to an enhancement of human dignity and autonomy."*[40]

52. If the Constitutional Court has highlighted the need for a learner to participate in a decision regarding her possible exemption from a school dress code, how much more so imperative is participation, particularly adolescent participation, in the process of determining a national policy that ultimately impacts upon their rights to health, well-being and life.

53. Not only do learners have a right to participate in the decision making process, the DBE (like the Legislature) has an obligation to:

> "*create conditions that are conducive to the effective exercise of the right to participate in the law-making process"*[41]

Here the Executive in the national policy-making process.

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[39] MEC for Education: Kwazulu-Natal and Others v Pillay (CCT 51/06) [2007] ZACC 21; 2008 (1) SA 474 (CC); 2008 (2) BCLR 99 (CC) at para 56. Accessible:

http://www.saflii.org/za/cases/ZACC/2007/21.html

[40] MEC KZN v Pillay, above note 39 at para 177.

[41] Doctors for Life International v Speaker of the National Assembly and Others (CCT12/05) [2006] ZACC 11; 2006 (12) BCLR 1399 (CC); 2006 (6) SA 416 (CC) at page 132.

Recommendations —

- **EE and EELC recommend that the opportunity for commentary on the Draft policy be reopened.**

- **That the DBE takes specific steps to ensure that learner voices, as the principal stakeholders, are included in the finalisation of the Draft Policy.**

- **Examples of ways within which to facilitate learner participation include cross country workshops with learners, ensuring that through their schools learners are made aware of this opportunity and are encouraged to make written submissions.**

D. Recommendations - Summary

- **EE and EELC recommend that clauses 6.2.2.4 and 6.2.5.3 be reformulated so as to clarify and ensure that all learners will have easy and discreet access to condoms.**

- **Examples of easy and discreet access include placing unmonitored condom dispensers in male and female bathrooms or other more *private* areas frequented by learners.**

- **In particular, learners ought to be able to access condoms free of any intermediary serving as a gatekeeper.**

- **EE and EELC recommend that clauses 6.2.5.1 and 6.2.5.2 be removed.**

- **EE and EELC recommend that condoms should be made available in schools, along with comprehensive sex education with a strong emphasis on how to avoid contracting and transmitting HIV. This should be done in a manner that ensures condoms are easily accessible to all groups of learners who are engaging in risky sexual behaviour.**

- **EE and EELC recommend that the opportunity for commentary on the Draft policy be reopened.**

- **That the DBE takes specific steps to ensure that learner voices, as the principal stakeholders, are included in the finalisation of the Draft Policy.**

- **Examples of ways within which to facilitate learner participation include cross country workshops with learners, ensuring that through their schools learners are made aware of this opportunity and are encouraged to make written submissions.**