Initial Complementary Report to the African Committee of Experts in response to South Africa's Initial Country Report on the African Charter on the Rights and Welfare of the Child

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Sexual Assault Clinic

Sign Language Education and Development (SLED)

Teddy Bear Clinic for Abused Children

Think Twice

Mtata Child Abuse Resource Centre (UCARC)

Western Cape Network for Community Peace and Development

World Vision South Africa

Yezingane Network

Voice Movement Therapy Eastern Cape

Warehouse Trust

List of acronyms

ACERWC	African Committee of Experts on the Rights and Welfare of the Child
ACRWC	African Charter on the Rights and Welfare of the Child
AMD	Acid Mine Drainage
ANC	Antenatal care
ART	Anti-retroviral therapy

ARV	Anti-retroviral
CBR	Community-based rehabilitation
CCTV	Closed-circuit television
CDG	Care Dependency Grant
CEMD	Confidential Enquiries into Maternal Deaths
CHH	Child-headed household
CHW	Community health Worker
CJS	Criminal Justice System
CLPA	Child Labour Programme of Action
COAV	Children involved in organised and armed violence
CoMMiC	Committee on Morbidity and Mortality in children under 5
CROC	Committee on the Rights of the Child
CSEC	Commercial Sexual Exploitation of Children
CSG	Child Support Grant
CSO	Civil society organisation
CUBAC	Children Used by Adults [or older children] to commit Crimes
CYCC	Child and Youth Care Centre
DBE	Department of Basic Education
DH	Department of Health
DHA	Department of Home Affairs
DJCD	Department of Justice and Constitutional Development
DWAF	Department of Water Affairs and Forestry
DWCPD	Department of Women, Children and People with Disabilities
DPCI	Directorate of Priority Crimes Investigations
DQA	Developmental Quality Assurance
ECD	Early Childhood Education
EDL	Essential Drug List
EMS	Emergency Medical Services
FCG	Foster-Care Grant

FCS	Family Violence, Child Abuse and Sexual Assault Units
FFC	Financial and Fiscal Commission
GDP	Gross Domestic Product
HDACC	Health Data Advisory Coordinating Committee
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
ICU	Intensive Care Unit
IDP	Independent Develop Plan
IMCI	Integrated Management of Childhood Illness
ISHP	Integrated School Health Policy
LGBTI	Lesbian, gay, bi-sexual, transgender and intersex
LHR	Lawyers for Human Rights
MRC	Medical research Council
NMR	Neonatal Mortality Rate
NSP	National Strategic Plan
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PSTD	Post Traumatic Stress Disorder
RACAP	Register of adoptable Children and Adoptive Parents
RMS	Rapid Mortality Surveillance
SACE	South African Council for Educators
SAM	Severe acute malnutrition
SANAC	South African National Aids Council
SAPS	South African Police Service
SASL	South African Sign Language
SGB	School Governing Body
SIU	Special Investigative Unit
SOC	Sexual Offences Court
SSA	Statistics South Africa

TB	Tuberculosis
UIF	Unemployment Insurance Fund
UNCRC	United Nations Convention on the Rights of the Child
UPR	Universal Periodic Review
WFCL	Worst Form of Child Labour
WHO	World Health Organisation

"[A better society] will and must be measured by the happiness and welfare of the children, at once the most vulnerable citizens in any society and the greatest of our treasures."
President Nelson Mandela.[1]

1 INTRODUCTION

1. South Africa's Initial Country Report on the African Charter on the Rights and Welfare of the Child (ACRWC) is several years overdue, and the country has also been tardy in its obligations to the African Charter on Human and People's Rights. Domestication of the ACRWC has not seemed to be a priority for the government, and it seems that international instruments are given a higher priority. There is little evidence of consultation with civil society in the preparation of the Initial Country Report. The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) is urged to hold South Africa accountable for the late report and to ask for clarity on the process by which the Initial Country Report was developed.

2. South Africa's legislative framework is, in general, protective of children and their rights and there have been significant developments in this regard since South Africa ratified the African Charter on the Rights and Welfare of the Child in 2000. The Constitution[2] itself contains a section on the rights of children (section 28) and legislation such as the Children's Act as Amended (No. 38 of 2005) [hereinafter the Children's Act] has further entrenched the statutory protection of children's rights. The social assistance available to poor children and families has had a significant positive impact on child outcomes.

3. Nevertheless, the lives of children in South Africa are characterised by numerous challenges. It is important, at the outset, to examine the context in which children in South Africa are born and live out their lives.

1.1 Corruption, negligence, lack of capacity and a lack of accountability

4. Governance in South Africa is routinely bedevilled by high levels of corruption at every level. This has reached epidemic proportions and threatens the implementation of the good law and policy which is in place. Money lost due to government corruption could have been used to better the lives of all South African citizens, especially the poor.

5. According to Global Financial Integrity, the illegal outflow of money due to corruption in the public sector between 1994 and 2008 was R185 billion.[3] It is estimated that in 2009 alone, government corruption totalled R70 billion.[4] In 2011, the Special Investigating Unit (SIU) informed Parliament that between R25 billion and R30 billion of

[1] Nelson Mandela's Nobel Peace Prize Acceptance Speech. 10 December 1993. Oslo, Norway. Available at www.anc.org.za/show.php?id=4114, accessed 26 January 2014
[2] Constitution of the Republic of South Africa, 1996.
[3] Corruption Watch. *The Big Picture: Economic Implications of Corruption*. Accessed at www.corruptionwatch.org.za/content/economic-implications on 24/01/2014
[4] Ibid.

government's annual procurement budget was lost to corruption, incompetence and negligence.[5] In 2012, the Council for the Advancement of the South African Constitution said: "It's estimated that 20% of the Gross Domestic Product (GDP) is lost to corruption annually".[6]

6. The Dinokeng Scenarios[7] highlighted the lack of capacity "in several government departments at the coalface of service delivery (which has resulted in the) accountability and financial management of the public service (being) severely compromised".[8] The lack of state capacity is particularly critical at local level, and seriously compromises service delivery to vulnerable communities, including children. The skills and managerial gap in government departments has resulted in many civil servants displaying a lack of commitment to serving the public, and has created a deficit in the culture of delivery, performance and transparency promised by the Constitution. Instead, a culture of mediocrity, incompetence, fraud, corruption, nepotism and entitlement prevails.[9]

1.2 Implementation gaps

7. The high levels of corruption, lack of capacity and absence of accountability and transparency make a significant contribution to the implementation gaps that are reported by civil society service providers who work to address the challenges faced by children in South Africa.

8. Implementation gaps are evident across the spectrum of services to vulnerable children and families. The effect of these gaps is that relatively sound law and policy is undermined or entirely negated. Detailed evidence of these implementation gaps will be provided in the different sections of this Complementary Report as they relate to specific groups of children.

9. These implementation gaps arise from several sources, including lack of political will, lack of training, inadequate and poor management of expenditure, inadequate resourcing, a lack of knowledge, inadequacy of services when they are available, inaccessibility of services, particularly in rural areas and the culture of corruption and lack of accountability referred to above.

10. The serious short-fall in qualified social service professionals also plays a significant role in creating implementation gaps. The *Khusela Rapid Assessment* found that "[t]here are insufficient numbers in the social work workforce to deal with the overwhelming needs for child protection in South Africa [and] that the existing workforce is poorly prepared and exposed to work in child protection, and that there is a need to

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[5] Ibid.
[6] Blaine, S. 2013. *State of the nation address must go beyond platitudes on corruption, says Cesa*. Financial Mail. Accessed at www.bdlive.co.za/national/2013/02/13/state-of-the-nation-address-must-go-beyond-platitudes-on-corruption-says-cesa 24/01/2014
[7] The Dinokeng Scenarios, developed after 15 years of democracy, grew out of a scenario-planning process that attempted to answer questions related to what South Africa would look like in 2020, how its citizens would fare and what its status in the world would be. See www.dinokengscenarios.co.za/index.php
[8] The Dinokeng Scenarios. 2009. *South Africa Today: Our Liabilities — Political Challenges.* Accessed at www.dinokengscenarios.co.za/sa_lia_political.php 24/01/2014
[9] Ibid.

build a base of knowledge and skills in child protection, and to build a cadre of highly specialised and proficient child protection specialists."[10]

1.3 A culture of violence

11. South Africa has high levels of interpersonal, community and sexual violence. Various groups of children, including children with disabilities, are particularly vulnerable to violence.[11]

12. The country has arguably the highest levels of **rape and sexual assault** in the world. Between April 2012 and March 2013 66,387 rapes were reported to the South African Police Services (SAPS)—in excess of 180 a day.

13. South Africa has some of the highest incidences of child and infant rape in the world. The 2012/2013 crime statistics report 25,862 child victims of sexual offences, representing 40.1% of all sexual offences.[12] A third of the cases are committed by a family member or close relative. Child welfare groups believe that the number of unreported incidents could be up to 10 times the reported figure. The rate of child rape of children under 7 has seen a significant increase.[13]

14. Close to 50,000 children were **victims of violent physical assault** in 2011/12.

1 The number of reported cases of **domestic violence** is high, but as many cases go unreported, it is difficult to estimate incidence and prevalence. However, the World Health Organisation (WHO) reported in 2012 that around sixty thousand women and children in South Africa were victims of domestic violence every month—the highest reported rate in the world.[14]

2 In 2011/2012, SAPS reported that over 23,000 children were **physically assaulted** with almost half of them suffering grievous bodily harm in the process.

3 According to the 2011/2012 crime statistics released by SAPS, nearly 800 children were **murdered** in South Africa and a further 800 were victims of **attempted murder** during that period.[15]

15. Despite concerted civil society efforts to prohibit **corporal punishment in the home** in 2007 when the Children's Act was passed, it is still legal in South Africa.

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[10] National Department of Social Development. 2012. *Conceptual Framework for Capacity Building of Social Service Professionals and Occupations in Child Protection.* Khusela Project. Pretoria: National Department of Social Development, p21.
[11] Hesselink-Louw A, K Booyens and A Neethling. 2003 Disabled children as invisible and forgotten victims of crim. *Acta Criminologica 16*(2) p.165-180.
[12] South African Police Service. 2013. Police Crime Statistics. Pretoria.
[13] Rape Crisis Cape Town.Undated. *Rape in South Africa* accessed at http://rapecrisis.org.za/rape-in-south-africa/ on 31 January 1024
[14] Hunter-Gault, Charlayne. 2 March 2013. *Will the Pistorius case change South Africa?* New Yorker. Available from www.newyorker.com (accessed 5 March 2013).
[15] News25. 2012. *2 children murdered every day.* Accessible at http://www.news24.com/SouthAfrica/News/2-children-murdered-every-day-20120920.

16. Levels of corporal punishment in the home are relatively high. A 2005 study found that 57% of parents smacked or beat their children, with 33% admitting that they used sticks or implements to do so, in addition to smacking with the hand.[16] Service providers report that the majority of serious physical abuse cases that come to the attention of their offices relate to 'discipline gone wrong' or 'getting out of hand'.[17]

17. **Corporal punishment in the education system** has been prohibited since 1996; nevertheless, a large number of children are still experiencing it on a daily basis in South African schools. The 2012 Report by the Centre for Justice and Crime Prevention on violence in South African schools found that "seven out of ten primary school learners and almost half of secondary school learners reported that they were physically beaten, spanked or caned when they had done something wrong at school".[18]

18. Efforts to implement prohibition in the education system are hampered by the fact that it is still legal in the home. Government and the Department of Basic Education (DBE) themselves acknowledge that their efforts in this regard are hampered by parents and communities' overall acceptance that corporal punishment is an effective way to discipline children. Evidence of the wide-spread acceptance of corporal punishment in the home is provided by the fact that, during public hearings on the *Review of the Criminal Justice System*, hosted by the Portfolio Committees on Correctional Services, Justice & Constitutional Development and Safety & Security on joint public hearings, in February 2009, participants commented that there is too much freedom and emphasis on children's rights, and that this significantly contributes to problems when adults (parents and teachers) attempt to discipline children. Significantly, members of the Portfolio Committees did not directly address this in their response to the concerns raised during the public hearings.[19]

19. The ongoing experience of **violence in schools** aggravates the development of a culture of bullying, which often impacts most seriously on vulnerable children and contributes to the acceptance of a culture of bullying, fear and anxiety in an environment that should be safe and nurturing.

1.4 Poverty and inequality

20. Although some progress has been made in addressing inequality in South Africa, progress is patchy. In some areas, there has been either no progress or the situation has worsened, and at 0.68, the country's Gini coefficient[20] is one of the highest in the world, and one of the fastest growing. While absolute income poverty has decreased in the

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[16] Dawes A, Z De Sas Kropiwnicki, Z Kafaar and L Richter, L. 2005. *Corporal punishment of children: a South African national survey*. Pretoria: Save the Children (Sweden).
[17] Van Niekerk J, National Training and Advocacy Manager, Childline South Africa - personal communication, joanvn@childlinesa.org.za.
[18] Burton P. 2012. *Snapshot results of the CJCP National Schools Violence Study*. Cape Town. Centre for Justice and Crime prevention
[19] Parliamentary Monitoring Group. 2009. Report on public hearings by the Portfolio Committees on Correctional Services, Justice & Constitutional Development, and Safety & Security. Accessed on 14 February 2014 at www.pmg.org.za/docs/2009/comreports/090302pcjusticereport5.htm.
[20] Finn A & M Leibbrandt. 2013. *Mobility and Inequality in the First Three Waves of NIDS.* SALDRU Working Paper Number 120/ NIDS Discussion Paper 2013/2. Cape Town: SALDRU, University of Cape Town

2000s, income inequality has increased.[21] Although South Africa is a middle-income country, resources are not evenly distributed and children are dying from preventable conditions such as diarrhoea, which is a national disgrace. Claims in the Initial Country Report that poverty is declining cast an unnaturally rosy glow over the inter-generational complexities at play in situations of poverty in South Africa.

21. **Access** to basic services, adequate housing, educational facilities and health care is often challenging, especially in the more rural provinces; access to prevention and protection services for vulnerable children is inconsistent; and the criminal justice system routinely fails the victims of, in particular, sexual crimes. This inequitable access to services is aggravated by the fact that government service providers frequently do not understand their role and legal obligations, or the laws which they are supposed to be implementing and upholding.

22. Nearly 67% of South African children live in poverty, and 35% of all children live in households where there is no employed adult;[22] 43% of female-headed households do not include a single employed person.[23] This lack of adequate income compromises the health of children and their access to services. It also frequently leaves them in situations where their physical safety is threatened[24].

23. The negative consequences of high levels of poverty and inequality are evidenced by the large numbers of children infected or affected by HIV and in the high malnutrition rates among children in South Africa.[25]

1.5 The role of civil society and the challenges it faces

24. The incapacity and failure of government to provide services to vulnerable children has led to a situation in which the burden of this provision falls on civil society organisations.

25. Civil Society Organisations (CSOs) have a long and rich history of 'filling the gaps' in service delivery to vulnerable groups, especially children and women. During the apartheid era, many of these CSOs were set up to provide services to vulnerable people who were completely ignored by the welfare sector at the time. In the post-apartheid era, a growing number of CSOs have continued to provide such services, but in a fundamentally altered funding scenario. The withdrawal of a significant number of traditional international donors from funding basic service delivery and the reluctance by

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[21] Sudhanshu S. 2012. Rising inequality in South Africa: Drivers, trends and policy responses. *Consultancy Africa.* www.consultancyafrica.com/index.php?option=com_content&view=article&id=1142:rising-inequality-in-south-africa-drivers-trends-and-policy (accessed 6 March 2013).
[22] Hall, K, I Woolard, L Lake, and C Smith. 2012. *South African Child Gauge 2012*. Cape Town: Children's Institute, University of Cape Town.
[23] Statistics South Africa. 2010. *Social profile of South Africa, 2002–2009*. Pretoria: Statistics South Africa. Available from www.statssa.gov.za/publications/Report-03-19-00/Report-03-19-002009.pdf (accessed 6 March 2013).
[24] Hall, K, I Woolard, L Lake, and C Smith. 2012. *South African Child Gauge 2012*. Cape Town: Children's Institute, University of Cape Town.
[25]Shisana O, D Labadarios, T Rehle, L Simbayi, K Zuma, A Dhansay, P Reddy,WM Parker, T Maluleke. S Ramlagan, N Zungu, MG Evans, L Jacobs,M Faber and SANHANES-1 Team. 2013. South African National Health and Nutrition Examination Survey SANHANES-1). Cape Town: HSRC Press.

government to fully fund these service providers has placed many CSOs in a very precarious position, with many having either closed or facing closure in the near future.

26. This withdrawal of funding by traditional international donors is related to perceptions that South Africa is a middle-income country, and as such, should be able to pay for the delivery of legislatively mandated services from the government purse. While CSOs deliver the majority of child welfare services in South Africa on sub-contract to government, they are only partially funded by government to do so. The funding provided by government to CSO's also falls far short of the actual cost of providing quality services.[26]

27. The requirement of the current funding model that CSOs find their own partial funding has resulted in CSOs having to cut back on their services, focusing mainly on the 'crisis' situations and not being able to focus sufficiently on prevention and early intervention.

28. The Free State High Court has ruled that government's funding policy for CSO service providers is unfair and unreasonable.[27] However government is yet to amend its funding policy to ensure the sustainability of child protection services in South Africa. The Financial and Fiscal Commission (FCC) tabled a report in Parliament in 2013 alerting Parliament to the crisis; however Parliament has not yet engaged with the report.[28]

1.6 Inadequate data collection and monitoring and evaluation systems

29. Much of the data needed to fully understand the realities facing children is not available in South Africa. This is in part due to the manner in which statistics are collected, where much of the information is hidden because the statistics are not disaggregated, or to the fact that systems are not in place to ensure proper collection of data. This has a negative impact on monitoring and evaluation, making it difficult both to establish baselines and to monitor progress. Thus, despite the fact that legislation, national plans of action and strategies mandate monitoring and evaluation, this is frequently impossible.

30. Further, the dearth of nuanced and reliable data impacts negatively on planning and budgeting for children. The consequences of this can be seen throughout this Complementary Report.

1.7 Budgeting for and resourcing of services for children

31. As was shown in section 1.5 at para 25 above, the government sub-contracts CSOs to deliver the bulk of child protection and alternative care services available in South Africa, but only partially funds these CSOs.

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[26] Budlender D and P Proudlock. 2013. *Funding of the Children's Act: Assessing the adequacy of the 2013/2014 budgets of the provincial departments of social development*. Cape Town: Children's Institute, UCT

[27] National Association of Welfare Organisations and Non-Governmental Organisations and Others vs the Member of the Executive Council for Social Development, Free State and Others. Case no: 1719/2010. Free State High Court.

[28] Financial and Fiscal Commissio. 2013 *The provision and funding of Child Welfare Services in South Africa.* Midrand: South Africa

32. Although it is difficult to determine national spending allocations across the range of child care and protection services, comparisons between the predicted costs of implementing these services and the amounts allocated show that they have been continuously under-funded since 2007/08.[29] However, under-resourcing of the system is not merely a matter of insufficient money for the task. Some provinces routinely fail to spend their allocations, as was reported by the FFC: "Total unspent funds by Social Development Departments over the four-year period (2007/2008–2010/2011) amounted to R1.2 billion, with unspent funds in 2010/2011 accounting for more than half this amount (R690 million)".[30] The FFC report goes on to suggest that departments are failing in their responsibility to channel the funds available to the CSOs that are delivering services on their behalf.

33. All provinces rely heavily on CSOs to deliver the majority of child social welfare services, but on average transfer less than half of their total social welfare programme budgets to CSOs to deliver these services.[31] Although an increase in allocation within child care and protection services for all provinces has been noted between 2012/13 and 2013/14, this increased allocation is primarily for the roll out of the Isibindi[32] programme and expansion of Early Childhood Development (ECD). While this investment in ECD and Isibindi is a step in the right direction, the challenge is that other prevention and early intervention programmes are not receiving increased funding. These include parenting skills programmes, programmes to equip parents to use non-violent forms of discipline, child and family counselling and diversion of child offenders. Child protection services and child and youth care centres are also not receiving increased funding.[33]

1.8 Multiple vulnerabilities and exclusion

34. The consequences of these contextual factors can be readily observed if the reality on the ground for particularly vulnerable children is considered. This would include: children with disabilities; migrant and refugee children; lesbian, gay, bisexual, transgender and intersex (LGBTI) children; rural children; orphaned children; children living and working on the street; children in prison; and poor children. Of course, often these vulnerabilities overlap.

35. For example, for children with disabilities in rural areas, accessing an appropriate learning environment is fraught with difficulties. These include the fact that most local schools are not accessible for children with physical disabilities (i.e. they do not have

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[29] Budlender D & P Proudlock have analysed the budget for children's social services every year since the Children's Act was enacted. The series can be downloaded at: http://ci.org.za/index.php?option=com_content&view=article&id=493&Itemid=185

[30] Financial and Fiscal Commission (2013) *The Provision and Funding of Child Welfare Services in South Africa*. FFC Midrand, p13

[31] Budlender D & P Proudlock. 2013 *Funding of the Children's Act: Assessing the adequacy of the 2013/2014 budgets of the provincial departments of social development*. Cape Town: Children's Institute, UCT

[32] Isibindi is a community based prevention and early intervention programme that responds to the needs of vulnerable children, youth and families in a holistic manner. A team of child and youth care workers provides services in remote, rural areas with high rates of unemployment, poverty, HIV and AIDS and large numbers of orphans.

[33] Budlender D & P Proudlock. 2013 *Funding of the Children's Act: Assessing the adequacy of the 2013/2014 budgets of the provincial departments of social development*. Cape Town: Children's Institute, UCT

level paths, buildings and/or toilet and playground facilities) and do not cater for children with hearing or intellectual disabilities. There are also transport difficulties with getting to school. As a result, many children with disabilities enter school long past the age of most other children.[34] Further, the challenges associated with rural living—including long distances (and high costs) in getting to facilities, and the need for collection of water and firewood—create additional burdens for children with disabilities and their families.

1.9 The Department for Women, Children and People with Disabilities

36. The Initial Country Report goes to considerable lengths to highlight the creation of the Department for Women, Children and People with Disabilities (DWCPD). While we acknowledge the potential value of such a department, we are concerned about a number of issues in relation to its creation in South Africa.

37. Significant questions have emerged over the past five years regarding the role, functioning and effectiveness of the DWCPD. Included in our concerns is the potential for children's issues to be marginalised rather than mainstreamed as a result of setting up a separate ministry and relegating to it all children's issues. A further concern is the side-lining of children's issues within the DCWPD in favour of those of the women's and disability sectors. The fact that the DWCPD's power, relative to other ministries, is limited is also a concern. Finally the mandate and focus of the DWCPD as well as the resources available to it are problematic in terms of its ability to affect actual change in children's lives. However we do not advocate increasing the Ministry's mandate, staff or budget as such resources would be better invested in actual services for children—especially in the child protection arena where there is gross underfunding.

2 GENERAL MEASURES OF IMPLEMENTATION

38. South Africa has yet to sign or ratify the third Optional Protocol to the United Nations Convention on the Rights of the Child on Communications Procedures (2011). The Initial Country Report provides no indication of the country's plan regarding this Optional Protocol.

39. In spite of a Cabinet decision in 2012 to ratify the International Covenant on Economic Social and Cultural Rights (ICESCR), South Africa's persistent failure to do this nearly 20 years after signing it is concerning. Having ratified the African Charter on Human and People's Rights and having included a wide range of justiciable socio-economic rights in the South African Constitution, this may not appear to be problematic. However South Africa, in spite of its legal framework, faces significant challenges in the realisation of these rights. By not ratifying the ICESCR, the country is able to avoid one level of monitoring and reporting to the broader international community regarding these obligations. Associated with this is that South Africa has ratified neither the Optional Protocol to the ICESCR nor the Optional Protocol on the Rights of Persons with Disability which would allow for marginalised and excluded groups to lodge individual complaints at the international level regarding violations of their rights.

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[34]Dept of Social Development, Dept of Women, Children and Persons with Disabilities & UNICEF. 2012. *Children with disabilities in South Africa: a situation analysis 2001-2011*. Pretoria: DSD, DWCPD, UNICEF.

2.1 Measures taken to realise the rights and welfare of the child

40. There is a broad range of legislation and policy in South Africa which is protective and promotive of the rights of children. However, as was shown in the Introduction above, a challenging context renders much of this law and policy meaningless for large numbers of children.

2.2 Measures taken to promote positive cultural values and prevent harmful practices

41. While customary law in South Africa implicitly requires the protection and nurturing of family members, including the children, such laws and practices have changed over time. This has resulted in some protective customs falling into disuse or not providing the same level of protection for children in keeping with the changing environment, while other practices and customs create a risk for children. Furthermore, some practices or customs that were previously not viewed as harmful are now seen as a transgression of legal prohibitions or obligations.[35]

42. The Children's Act prohibits **male circumcision** (except when it is for religious practice or for medical reasons) and **virginity testing** of children under the age of 16 years. The Children's Act further requires circumcision or virginity testing of children older than 16 years to be performed with the child's consent, after proper counselling and in the prescribed manner.

43. Although some cultural practices can be harmful to children, there are many positive aspects of cultural practice and custom that can be harnessed for the protection of children. Examples include the belief that it takes a village to raise a child; the positive elements of initiation rites that seek to educate children around sexual and reproductive health; and the inculcation of a sense of community and unity through certain ceremonies such as naming ceremonies.[36]

2.3 Mechanisms implemented for coordinating children's policies

44. The considerable effort that has been dedicated to the development of a coordinated approach to prevention, early intervention and protection at the level of law and policy has been undermined both by: the lack of inter-departmental cooperation among government departments (despite the fact that one of the roles that the DWCPD is mandated to play is that of coordination) and the under-funded reliance on CSOs to deliver essential services. This is exacerbated by the failure to integrate CSOs into the coordinated implementation of the Children's Act by not involving them in policy, budget and programme development.

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[35] Martin, P and B Mbambo. 2011. *An exploratory study on the interplay between African customary law and practices and children's protection rights in South Africa*. Pretoria: Save the Children Sweden Southern Africa Regional Office.
[36] Ibid.

3 DEFINITION OF A CHILD

3.1 The different ages at which children attain certain capacities

45. South Africa is, in general, compliant with the standards set by the ACRWC in relation to the age of majority, the minimum age for labour, the age of contracting and litigating, the minimum age for alcohol use and gambling, and the minimum age for defence force recruitment.

3.2 Concerns related to the age for different capacities

46. The Children's Act repealed the Child Care Act of 1993 and reduced the age of **consent to medical treatment** to 12 (provided that the child has the maturity and mental capacity to understand the risks, benefits and social implications of treatment), and enables children's caregivers to consent to treatment for younger children and those who lack capacity. In addition, children aged 12 and above can access contraception, and consent to HIV testing provided they also access pre- and post-test counselling. Their HIV status cannot be disclosed without their consent, and children who access contraception are entitled to confidentiality unless it is deemed in the best interests of the child to breach confidentiality, for example, in the case of sexual abuse.

47. The consent provisions of the Children's Act provide greater recognition of children's evolving capacities and right to participate in health care decision-making; however there are no clear guidelines to help health professionals assess children's mental capacity and this is left to their discretion. It is therefore vital that the new consent provisions are explicitly integrated into pre- and in-service education and training of health professionals as well as professional codes of conduct so that health professionals are aware of their obligation to provide information in child-friendly formats and to actively involve children in health care decision-making.

48. The 2012 *Integrated School Health Policy* (ISHP) outlines a range of health care services that will be delivered through schools. However the consent provisions of the ISHP stipulate that:

> "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".

49. These provisions violate the right of 12 and 13 year olds to consent to medical treatment. In addition, by stipulating the need for written parental consent, the policy violates children's right to confidentiality and may limit children's ability to access reproductive and other health services. Given the potential reach of school health services, it is vital that the consent provisions of the ISHP are brought into line with the Children's Act.

50. The age of ***sexual consent*** is 16 years. In addition to determining the age of consent, sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007) [hereinafter the Sexual Offences Act] also criminalised consensual sexual acts with adolescents below the age of 16 and criminalised adolescents between the ages of 12 and 16 should they commit any sexual acts with

each other. These sections stated that both children must be prosecuted if the prosecution decided to charge them with statutory rape or statutory sexual assault, i.e. both children are viewed as both victims and perpetrators.

51. It should be noted that these sections of the Sexual Offences Act were declared unconstitutional on 3 October 2013 by the Constitutional Court in the matter of *Teddy Bear Clinic and RAPCAN v The Minister of Justice and Constitutional Development and another* [2013] ZACC 35, which found that the drafting of the section and the subsequent criminalisation of adolescent sexual experimentation violated children's constitutional rights to dignity, privacy and to have their best interests considered paramount. These provisions have been suspended for 18 months from the date of the judgement and referred to parliament for redrafting.

52. Section 3.2 of the Initial Country Report implies that there is no minimum age limit for children to conclude a **customary marriage** and that parental consent is the only requirement. This is incorrect. The minimum age of marriage is set in common law, i.e. 12 for girls and 14 for boys. This is the age below which no child can enter into any type of marriage including a customary marriage. Section 12 (2) of the Children's Act prohibits the marriage or engagement of any child below the minimum age set by law for a valid marriage, i.e. 12 for girls and 14 for boys.

53. Different requirements apply regarding consent to the marriage of a child. All boys aged 14—17 years who wish to marry (whether in a customary or civil marriage) require the consent of the Minister of Home Affairs. However, for girls the requirements differ for different age groups and different kinds of marriages. Girls aged 12—14 years who wish to be married in a *civil marriage* require the consent of the Minister of Home Affairs, but older girls (15—17 years old) require only the consent of their parents/guardians. For *customary marriages* of girls aged 12—17 years, ministerial consent is required.

54. However, the Civil Union Act (No. 17 of 2006) does not allow children to enter into civil unions at all. Thus children are allowed to enter into civil and customary marriages but are prevented from entering into same sex marriages in terms of the Civil Union Act. It is therefore not true to claim, as the Initial Country Report does, at para 53 that "children under the age of 18 may marry" without qualifying that this excludes civil unions (a legal form of marriage in South Africa). These inconsistencies in the marriage laws violate various constitutional provisions including the right to equality.[37]

3.3 Ages impacting on customary law

55. Prior to the enactment of the Children's Act, some of the provinces had already embarked on developing legislation aimed at regulating **initiation schools and circumcision**. They provide a range of different standards and restrictions which differ from province to province, and from those provided for in the Children's Act. The better regulation of initiation schools is welcomed, but must be revisited in the light of the Children's Act, which prohibits traditional/cultural circumcision of a child under the age of 16 years and allows it for children older than 16 only with their consent.

[37] The draft Marriage Amendment Bill was intended to streamline the age requirements for girls and boys entering into civil marriages but that seems to have fallen off the legislature's agenda.

56. In so far as **virginity testing** is concerned, little information is available but anecdotal evidence suggests that girls under the age of 16 are subjected to virginity testing in contravention of the Children's Act. Monitoring of and research into the practice of virginity testing is needed to measure compliance and develop measures to protect young girls. However, some traditional leaders have openly stated their opposition to the provisions on virginity testing. For example, King Goodwill Zwelithini has rejected attempts by "critics of Zulu culture" to prescribe the age of maidens undergoing virginity testing and when they should attend the *uMkhosi woMhlanga* (reed dance) ceremony, saying the testing exposes cases of rape.[38]

3.4 Age of criminal capacity and sentencing

57. The Child Justice Act (No. 75 of 2008) falls short of international standards on the issue of age and criminal capacity in two ways. Firstly, the minimum age of criminal capacity is 10 years. Secondly, the law retains the *doli incapax* presumption for children between the ages of 10 to 14. The UN Committee on the Rights of the Child (CROC) made it clear in Concluding Observation 17 to South Africa[39] that the minimum age should be raised to 12 years. In addition, in General Comment 10 (para 32) the CROC stated that a minimum age lower than 12 years is not internationally acceptable. Furthermore General Comment 10 (para 30)[40] made it clear that having two ages of criminal capacity (*doli incapax*) is confusing and leaves too much to discretion, and may result in unequal treatment.

58. Notwithstanding the fact that the legislature was aware of all of the above, it set the minimum age at 10 years and retained the *doli incapax* presumption. However by March 2015 government must report to Parliament for the age of criminal capacity to be reconsidered with a view to raising it. Civil society has already held a workshop on the issue which revealed many practical implications of the current law.[41] A positive feature of the Child Justice Act not mentioned in the Initial Country Report is that the law sets out clear provisions on how to deal with children below the age of criminal capacity.

59. The number of children sentenced to imprisonment has been remarkably reduced. However, it is unclear whether this has been matched by a concomitant rise in the number of children held in secure care facilities. This information is not in the public domain. Another positive feature of the Child Justice Act is that almost all sentences of children in magistrates' court are automatically reviewed by the High Court, which provides an important check on sentencing.

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[38] www.iol.co.za/news/politics/virginity-testing-exposes-rape-says-king-1.1374488#.Uu9VHz2Sw4c

[39] Accessible at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2f15%2fAdd.122&Lang=en

[40] Committee on the Rights of the Child. 2007. *General Comment No. 10: Children's rights in juvenile justice*. Accessed at www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.10.pdf on 31 January 2014

[41] Skelton A and C Badenhorst. 2011. *The Criminal Capacity of Children in South Africa: International Developments and Considerations for a Review*. Cape Town: Child Justice Alliance

4 GENERAL PRINCIPLES

4.1 Non-discrimination

60. Although discrimination on any grounds, including age, is specifically prohibited by the Constitution, large numbers of children in South Africa routinely have their right to non-discrimination violated.

61. Inequitable access to services and resources, the absence of services and the poor quality of services create a situation in which a wide range of vulnerable children, including children living and working on the street, exploited children, abandoned and orphaned children, children with disabilities, migrant and refugee children, poor children, abused and neglected children, and rural children, suffer discrimination.

62. The principle of non-discrimination requires that the State actively seeks to promote the well-being of those who are most vulnerable to discrimination (affirmative action)—i.e. the groups listed above. However, experience indicates that the status quo is replicated as the advantaged increase their advantage, while the disadvantaged become more so. This highlights the generally high levels of inequality experienced in South Africa, as for example, when we see that poor children are the recipients of the poorest quality of services, which constitutes discrimination against them.

63. All children in South Africa, regardless of their nationality or whether or not they have an asylum claim, enjoy full Constitutional and legal protection in terms of access to basic healthcare and primary education, and protection from abuse, exploitation and child labour. Foreign children in South Africa form a particularly vulnerable group as they often experience rights violations directly resulting from government's inability or unwillingness to protect them. (Although it is fair to say that most vulnerable groupings of children also often experience violations of their rights for the very same reason).

64. **Refugee children** in South Africa (whether accompanied, separated or unaccompanied) are eligible for protection under the Refugees Act (No. 130 of 1998). Unlike in most African countries, refugees in South Africa are not restricted to refugee camps. They enjoy freedom of movement and all of the relevant rights as contained in the Bill of Rights of the Constitution. However, refugees' equal access to basic services, which is heavily dependent on being in possession of valid refugee/asylum-seeker documentation issued by the Department of Home Affairs (DHA), is regularly hampered. Continued barriers to accessing basic healthcare, education and birth registration service, institutional and community xenophobia and lack of reliable documentation issued by the DHA are major concerns for this sector.

65. **Unaccompanied or separated refugee children and other foreign migrant children** also experience discrimination in accessing the South African child protection system. The reasons include lack of detailed operational guidelines (by the DHA and the Department of Social Development [DSD]); a lack of knowledge or sufficient training of government officials including social workers, Children's Court magistrates and DHA officials; and blatant xenophobic attitudes.

66. Although both the ACRWC and the South African Constitution provide for the right not to be discriminated against, **deaf children** in South Africa experience discrimination on grounds of language pervasively in every aspect of life.

67. Despite some positive developments, most notably the adoption of the Grades R to 12 South African Sign Language (SASL) Curriculum by the DBE for 2015, there are many challenges ahead in terms of the skills and resource base from which to implement such a curriculum, and strategic preparation to build such a skills base and develop resources. The introduction of the SASL curriculum also does not solve the issue of SASL as the language of learning and teaching in schools for deaf children.

4.2 The best interests of the child

68. Developments regarding the best interests of the child principle in South Africa are illustrative of the role played by civil society in increasing the protection of children's rights by means of litigation. In its examination of the case law in this regard, the Country Report fails to set out the internationally acclaimed developments in case law regarding the best interest principle that have come about as a result. Justice Sachs's judgement in 2008[42] constitutes a watershed moment in constitutional litigation regarding children's rights, and has set the standard for how children should be dealt with and their rights considered in all cases where children are concerned:[43]

69. These principles have impacted on cases in several other fields of law, including assets forfeiture,[44] child offenders,[45] removal of children from their parent or care-giver,[46] intercountry adoption,[47] education of children with disabilities,[48] and treatment of child victims and witnesses[49]. These challenges to government by civil society have significantly informed the development of a child-centred approach in every matter concerning a child.

4.3 The right to life, survival and development

70. The right to life, survival and development for children in South Africa is entrenched in some good legislation, but is constantly undermined by the many challenges outlined in various sections of this report. The issues are fully discussed in section 7.1 below.

4.4 Respect for the views of the child

71. Participation rights are included in a number of laws affecting children, providing South Africa with a strong platform to promote participation and citizenship rights. However, barriers and challenges often prevent these participation rights from becoming a meaningful process and gaps remain between these provisions and actual implementation. The participation rights in the legislation reviewed are focused on

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[42] The matter of *S v M (Centre for Child Law as Amicus Curiae)* (2008) 3 SA 232 (CC)
[43] *S v M* at para 15.
[44] *Van Der Burg and Another v National Director of Public Prosecutions* (Centre for Child Law as Amicus Curiae) (2012) 2 SACR 331 (CC)
[45] *Centre for Child Law v Minister of Justice and Constitutional Development* and another (2009) 6 SA 632 (CC)
[46] *C and others v Department of Health and Social Development and others* (2012) 2 SA 208 (CC)
[47] AD and another v DW and others (Centre for Child Law as Amicus Curiae; Department of Social Development as Intervening Party) (2008) 3 SA 184 (CC)
[48] *Western Cape Forum for Intellectual Disability v Government of the Republic of South Africa* (2011) 5 SA 87 (WCC).
[49] *Director of Public Prosecutions, Transvaal v Minister of Justice and Constitutional Development* (2009) 4 SA 222 (CC).

providing children with decision-making powers in terms of obtaining their consent and expressing their views on matters affecting them directly. For these rights to become entrenched in society and in children's lives, adults must be willing to listen and learn from children, and to understand and consider their views.[50] For an example of the disjuncture between legislation and practice, please see annexure 1.

72. Regarding children's **participation in court matters** which affect them, the information provided in the South Africa's Initial Country Report refers only to preliminary inquiries—which fall under the Child Justice Act and involve only children in conflict with the law. However, figures in relation to the Children's Court, where decisions regarding care and protection matters are made, are not reflected. In addition, statistics where children are victims and witnesses in cases are not provided. It is apparent that the table only focuses on one part of the criminal justice and child protection systems. The government should gather more information about children participating in court proceedings to provide an accurate reflection of children's participation in these spheres.

4.5 Provision of information

73. The Protection of State Information Bill was introduced in 2010, and passed by Parliament at the end of 2013; it awaits the signature of the President. This legislation was met by severe criticism from a number of quarters. It sought to allow the State Security Agency to classify a very wide range of information on vague grounds, and introduced severe penalties for breaches of the law. In one of the most criticized aspects of the Bill, no provision was made for persons in possession of classified information which exposed unlawful activity to 'blow the whistle', or make such information public.

74. The draft legislation was significantly changed, after civil society mobilization against the most egregious features of the draft law. The number of agencies who can classify has been reduced, the scope of information that can be classified has been narrowed, and protection for a limited group of whistle blowers introduced. The law as it has been passed is still described by the Right2Know campaign as failing to pass constitutional muster, as well as containing ill-advised policy decisions.

75. The most significant impact of the legislation is on the **right to freedom of expression and the right to access to information**. These rights, contained in the South African constitution, may only be limited by a law of general application to the extent that this is reasonable and justifiable in an open and democratic society. These rights apply to all persons under the South African constitution, including children.

76. Concerns regarding the impact of the legislation on children arise in several areas:

- Limiting the right of access to classified information by Chapter Nine institutions, may result in these constitutionally mandated agencies being unable to access government records in order to assess the implementation of human rights,

[50] RAPCAN. 2010. *A brief review of issues emerging from recent studies on children's citizenship and participation*. Cape Town: RAPCAN. Unpublished report; Lundy, L. 2007. 'Voice' is not enough: conceptualising Article 12 of the United Nations Convention on the Rights of the Child. *British Educational Research Journal, 33*(6), 927-942.

including the rights of the child, and in order to investigate maladministration in the public sector, including in relation to children.

- The area of most concern in relation to children is the classification of police information, and the information held by prison services. Information in relation to children in conflict with the law and the subject of either police or correctional services action may be classified on what are overbroad and unclear grounds. While this is of immediate concern to those dealing with children, the question of access to the information by researchers has been raised as a concern.

- The Secrecy Bill allows classification of police activity at station level by relatively junior police personnel. The question of information in relation to children in conflict with the law remains of concern. Should such information be released by those who come into possession of it, even where unlawfulness is disclosed, both the discloser and the subsequent possessor of the information are criminalised.

- The right to informational privacy is now regulated by South African law in the Protection of Personal Information Act. This was signed into law towards the end of 2013 by the President, but is yet to come into effect.

- The Act regulates the privacy of all individuals, in that it regulates the processing of all personal data. Known as data protection, this is "the legal protection of a person with regard to the processing of data concerning himself by another person or institution."[51] This processing can threaten privacy in two ways:[52] the compilation of the data threatens the individual's privacy, and false data leads to an infringement of identity.

- The legislation takes a strong line on the processing of personal information of children, and in general, prohibits the processing of the personal data of children, with certain exceptions. One of the consequences of this may be access to social media by children. Providers of social media generally require children to be over a minimum age before they can use social media, which requirement relies on the child self-disclosing their age. However, children under 18 do use social media, and providers need to comply with the heightened requirements around the processing of personal data.

5 CIVIL RIGHTS AND FREEDOMS

5.1 Name, nationality, identity and registration at birth

77. Children and their caregivers need to produce their birth certificates and identity documents in order to access a range of government programmes and services such as education, social grants and health care. The UN CROC has made clear that this practice is misguided: The absence of a birth certificate should not be used to deny children access to services.[53] However this is common practice in South Africa. This makes access to birth certificates and identity documents even more important in the South African

[51] Neethling, Potgieter, Visser (eds). 2010. *Law of Delict*. Johannesburg: Lexis Nexis.
[52] Ibid.
[53] Hodgkin R and P Newell. 2007. Birth registration, name, nationality and right to know and be cared for by parents. In *Implementation Handbook for the Convention on the Rights of the Child*. Fully revised third edition. UNICEF. Geneva. Pg 99

context as denial of these essential documents can result in a denial of a range of other rights.

78. It is not possible to determine with accuracy how many children in South Africa are born each year versus how many are registered. However, two self-reporting surveys reveal a significant number of unregistered births. Analysis of the 2008 National Income Dynamics Study revealed that 11% of children in South Africa under 3 did not have a birth certificate.[54] Analysis of the 2011 General Household Survey produced similar results.[55]

79. As set out in the Initial Country Report, it is clear that South Africa has made progress in improving children's access to birth certificates and their parent's access to identity documents. This improvement is mainly in ensuring increasingly good rates of birth registration within 1 year of the child's birth. However 50% of children are only registered after the prescribed period of 30 days—with the percentage being higher in the more rural provinces. Despite this fact, South Africa is about to implement a 2010 Amendment to the Births and Deaths Registration Act that will make birth registrations after 30 days (but before a year) more difficult to access by imposing stricter requirements of proof of birth registration and the payment of a prescribed fee. It is the more vulnerable groups of children who will be disadvantaged by these stricter requirements, particularly children in rural areas, and orphaned and abandoned children. We request that the Committee advise South Africa not to implement these higher requirements of proof and fees for the period of 30 days to 1 year as this is when the majority of caregivers currently register their children. There is also a growing tendency to only allow the mother to register the child despite over 4 million children in South Africa not living with their biological parents but with extended family members. The law must recognise and support the child care role played by grandparents in particular and not put in place barriers to prevent them from caring for and protecting the children in their care.

80. **Orphaned and abandoned children** and other categories of children in need of protection and care have to go through a Children's Court inquiry before they can be placed in foster care or at a Child and Youth Care Centre (CYCC), or adopted. To finalise the process, the child's birth certificate needs to be produced. However it is challenging to register the birth of a child without his or her parents' identity documents. These challenges result in delays in finalising the protection and care decisions which ultimately delays permanency planning for the child's care.

81. **Children living in rural areas** are more vulnerable to being unable to access documents because DHA offices are not within reach. The transport costs involved in traveling long distances to the nearest DHA's office are often a prohibitive factor. Orphaned children living in rural areas in the care of relatives are particularly disadvantaged as they face the double burden of long distances and multiple trips, and the additional proof needed once a parent has died.

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[54] Hall K. 2008. *Analysis of the National Income Dynamics Study 2008*, Wave 1. Cape Town: Children's Institute, University of Cape Town.
[55] Hall K. 2011. Analysis of General Household Survey. Cape Town: Children's Institute, University of Cape Town.

82. Some categories of **foreign migrant children** are at risk due to lack of access to birth registration and identification documentation. Refugees and asylum seekers who are registered with the DHA are entitled to register the birth of a child, and, despite some barriers, are generally able to do so and obtain birth certificates.

83. In contrast, **foreign children born to undocumented migrant women** in South Africa are at serious risk of becoming stateless. In addition, when unaccompanied foreign children (without asylum claims and who cannot be reunited with family or returned to their country of origin) who lack identification documents, reach the age of majority and must exit the South African child protection system, they risk remaining undocumented. Without the ability to prove or access a nationality, they will be unable to access basic human rights such as education, health care, employment, equality, liberty and security of the person. These children should be considered for naturalization in South Africa prior to age of majority, or have access to a South African identity document, issued by the DHA. Government is also urged to reconsider its position and sign the Statelessness Convention as it has previously pledged, in order to develop a legal framework and mechanisms to assess, prevent and reduce statelessness.

84. The Births and Deaths Registration Amendment Act (No. 18 of 2010) and its draft 2012 regulations (not yet in effect) aim to introduce a new requirement that a foreign parents who wishes to obtain a birth certificate for their child must provide proof of legal residence in South Africa and a copy of their passport. This amendment has been strongly criticised by Lawyers for Human Rights (LHR). There are many migrants in South Africa without proof of legal residence. There are also many refugees without passports who will be unable to obtain them from their country of origin. The result of the imposition of this requirement will be that many children born in South Africa to migrant parents will be unregistered and are likely to grow up stateless. They will also be denied access to a range of socio-economic services which will deny them the enjoyment of many of their internationally and constitutionally protected rights. We ask the committee to remind South Africa that birth registration should not be the time for immigration enforcement.

5.2 Protection against child abuse and torture

85. As pointed out in the Initial Country Report, South Africa has yet to harmonise domestic law with the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (CAT) and to ratify the Optional Protocol to the Convention against Torture (OPCAT).

86. The South African Government is commended for its prohibition of corporal and humiliating punishment in all spheres of the public life of children, but its failure to extend that protection to the private life of children is deplored.

87. This is in contravention both of its own Constitution and of the Concluding Observations delivered by the UN Committee on the Rights of the Child in 2000; it is also in contravention of other international and regional treaties to which South Africa is

party. For example, in 2012 the government accepted the recommendation of the Universal Periodic Review (UPR) process to prohibit all forms of corporal punishment.[56]

88. Although a further Amendment to the Children's Act is, at the time of writing, being prepared and includes an explicit prohibition of corporal punishment in the home, CSO role-players in South Africa are not convinced that the clause will survive the process of enactment of the new Amendment.

89. It is an open question whether the current exceptions to the prohibition against assault are constitutional, given South Africa's international legal obligations which demand the prohibition of corporal punishment in all settings. This is especially so in the light of the Articles concerning dignity, bodily integrity and the best interests of the child principle.

90. The validity of the common law position that parents have the right to reasonably chastise their children is in fact questionable in the light of South Africa's current legislation, in particular, its Constitution. Common law decrees that corporal punishment must be "moderate" and "reasonable". What is "reasonable" is determined by the *boni mores* (obligations arising from morals or honour that may be enforced by law) of society as laid down in the Constitution, where the value and bodily integrity of each individual is protected. This means that exceptions to the general rule that any assault on another person is a criminal offence, while legal, can only be considered in the most extreme cases.

91. The **common law rule** that allows parents to use 'moderate' physical violence on children infringes on the rights of the child—in particular the rights protected by sections 12 and 28 of the Bill of Rights. In this regard section 12(1)(c) of the Constitution states that everyone has the right to freedom and security of the person, which includes the right "to be free from all forms of violence from either public or private sources". Section 12(2)(b) also guarantees for everyone the right to bodily and psychological integrity which includes the right "to security in and control over their body".

92. These sections must be interpreted with reference to South Africa's **international law obligations**. This is so because section 39(1)(b) of the Constitution states that international law *must* be considered when interpreting the provisions of the Bill of Rights. Against this background there can be little doubt that the present legal regime infringes on the rights of children. Parliament therefore has a legal duty—based on its international law obligations and on its constitutional duty to take steps to "respect, protect, promote and fulfil" all the rights in the Bill of Rights—to abolish corporal punishment in the home.

6 FAMILY ENVIRONMENT AND ALTERNATIVE CARE

6.1 Parental guidance

93. The Initial Country Report has failed to note that, alongside the growing emphasis on the importance of families, there is a growing acknowledgement that the family is

[56] Global Initiative to End All Corporal Punishment of Children. 2012. *Ending Legal Violence Against Children: Global Report 2012*. London: Global Initiative.

difficult to define and, certainly in the South African context, must not be assumed to be nuclear. The draft *White Paper on Families* acknowledges that 'the family' is a complex and contested concept, may encompass a range of attributes other than consanguinity, and is not necessarily the same as a residential unit.[57]

94. The Children's Act defines a family member as including a parent; any other person who has parental responsibilities and rights in respect of the child; a grandparent, brother, sister, uncle, aunt or cousin of the child; or any other person with whom the child has developed a significant relationship, based on psychological or emotional attachment, which resembles a family relationship. In other words, the conceptualisation of families is appropriately broad in the legislative framework.

95. The Initial Country Report refers to the Children's Act 38 and states that "the first and priority objective of the Children's Act is to promote the preservation and strengthening of families" (p43). Furthermore, children's rights to "family care or parental care or to appropriate alternative care when removed from the family environment" are protected by the South African constitution and regulated in the Children's Act.

96. Few people would disagree that children are best raised in secure, thriving family environments. However, there are a large number of children in South Africa for whom this is not a reality. Instead, alarming numbers of South African children are not being raised by their parents. For example, in 2011, which is the most recent year for which we have census statistics for South Africa, 4.5 million children (24.4% of children counted) were not living with either of their parents.

97. The number of **children living and working on the streets** is unknown, but this is considered to be a significant problem in South Africa, and in particular, in the Western Cape, by social workers in the field.

98. The Country Report appropriately notes that the proportion of children in **child-only households** is small and is not increasing. However the numbers provided in the tables seem incorrect. The heading for Table 48 indicates that the figures presented in the table are the total number of child-headed households (CHHs) per year (i.e. household level). However some of the numbers provided are closer to the individual-level totals (i.e. the number of children living in CHH) calculated in Children Count from the same data source.[58] Using nationally representative survey data released by Statistics South Africa (SSA), Children Count tracks child-focused indicators. The technical methods for deriving each indicator are rigorous, have been subject to peer review and are publicly available on the website: www.childrencount.ci.org.za. The methods used for the calculations that appear in the Country Report are not revealed so it is not possible to determine whether the numbers relate to households or individuals, and why there is an apparent upward trend in the number of CHHs, whereas the Children Count data suggest a slight decline. The respective numbers are shown in the

[57] Department of Social Development (2012) *White Paper on Families in South Africa* (Draft). Pretoria: DSD. Available: www.dsd.gov.za/index.php?option=com_docman&task=cat_view&gid=33&Itemid=39

[58] Children Count is a statistical monitoring project of the Children's Institute at the University of Cape Town

table below. The first line shows the numbers provided in Table 48 of the Country Report. The second line shows the Children Count calculations by the Children's Institute in respect of children (individual level) and the third line shows the Children's Institute calculations at household level.

	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Country report	77*	72	76	78	75	91	77	64	81	84
CI: children in CHHs	118	123	104	119	122	148	98	95	89	82
CI: # of CHHs	59	60	53	67	60	79	56	49	50	47

*Figures given in 000s

99. Table 47 in the Country Report provides the percentage breakdown of CHHs per province, totalling 100% nationally. While this shows slight changes in the proportional distribution of CHHs across provinces over time, it does not support the finding that the proportion of CHHs is small and not increasing, as claimed in the report. The Country Report neglects to note that, due to the very small incidence of this type of household, the confidence intervals around the numbers and proportions are very wide, and that all estimates should be treated with extreme caution.

100. The Country Report states that almost two thirds of CHHs are living in formal dwellings (as opposed to less adequate forms of housing). The conclusion derived from this finding is false and illogical: the authors state that "this observation supports the finding that many CHHs are created for a limited period of time only and often continue to be supported by an adult family member".[59] However, the majority of the child population in general (nearly three-quarters) lives in formal housing. Given the distribution of children in different housing types, it would be more accurate to claim that children in CHHs are disproportionately represented in 'traditional' housing. Other statistical analyses have previously found that remittances from family members living elsewhere are an important income stream for CHHs.[60]

101. The Country Report refers to the Children's Act's provisions for children living in CHHs. It is important to note that the definition of "child-headed household" in the Children's Act is slightly different to the definition of "child-only household" for which statistics have been provided in the preceding paragraph. The latter is defined as a household in which all resident members are under the age of 18. The legal definition

[59] Information regarding the transient nature of CHHs has emerged from qualitative work conducted over many years by the Children's Institute, but has not been substantiated through statistical analysis as the available data do not lend themselves to this type of analysis.
[60] See Meintjes H, K Hall, D Marera and A Boulle. 2010. Orphans of the AIDS epidemic? The extent, nature and circumstances of child-headed households in South Africa. *AIDS Care* Vol. 22, No. 1, January 2010, 40-49.
Available:http://www.tandfonline.com/doi/abs/10.1080/09540120903033029#.UutrYrQjS6w.

(contained in section 137 of the Children's Act) includes a household in which a child over the age of 16 has assumed the role of care-giver even if there is an adult living in the household who, for instance, is terminally ill. The definition of such CHHs is dependent on their identification by welfare services and a discretionary decision by the provincial head of social development that it is in the best interest of the children in the household for it to be defined as a child-headed household. This construction of 'child-headed household' is therefore conferred administratively; it is not a household form that can be quantified through national survey data and should not be conflated with the statistical estimates.

102. The Country Report states that the Social Assistance Act (No. 13 of 2004) makes provision for CHH by allowing for children of 16 years and older to access social grants on behalf of themselves and their younger siblings. However in reality children heading households cannot access a grant for themselves and their siblings at the same time as the SOCPEN[61] system will not allow the child to be both a primary caregiver and a child beneficiary. Children younger than 16 who head households are not able to obtain grants for themselves or their younger siblings. The policy implications of this gap still require consideration.

103. The Children's Act contains provisions on supporting positive and non-violent parenting at section 144. The Act clarifies the focus of prevention and early intervention programmes and the types of programmes that qualify as prevention and early intervention programmes. It also provides that programmes "must involve and promote the participation of families, parents, care-givers and children in identifying and seeking solutions to their problems".[62] This section of the Children's Act specifically provides for "preventing the neglect, exploitation, abuse or inadequate supervision of children and preventing other failures in the family environment to meet children's needs".

104. In the light of these promises to children in the Children's Act, the recent death of a young child in Diepsloot, who was found alone and dead with his foot bitten off by rats, is particularly distressing.[63] This case is illustrative of the need for support to parents, and is by no means an isolated one. There is a dearth of parenting programmes available to parents and care-givers in South Africa. Again, those programmes which are available are provided by CBOs rather than government. The lack of support to adolescent parents is of particular concern.

105. Data that are needed in order to inform policy and increase family reunification and placement in permanent families through kinship care, foster care and adoption are not available. These gaps in information about children's living arrangements would be addressed if there was information regarding:

- The number of children removed from their families due to neglect or abuse for the first time in a given year in relation to the most recent census figures for the same year e.g. 2011

[61] SOCPEN is the administrative data system of the South African Social Security Agency.
[62] Children's Act as Amended, s144 (3).
[63] SAPA. 2103. *Diepsloot couple accused of murdering baby appear in court.* Mail and Guardian, accessed at http://mg.co.za/article/2013-11-14-diepsloot-couple-accused-of-murdering-baby-appear-in-court on 4 February 2014.

- The cumulative number of children living in CYCC's a given year
- The cumulative number of children in foster care in a given year
- The number of children placed in foster care for the first time in a given year
- The cumulative number of children in corrective facilities in a given year
- The cumulative number of children in foster group homes in a given year
- The cumulative number of children in adoptive homes in a given year
- The cumulative number of children living permanently with relatives (kinship care) in a given year
- The number of children placed in foster care for the first time in a given year

6.2 Parental responsibilities

106. The overall legislative and case law developments on common parental responsibilities and rights mentioned within the country report are correct and current.

107. South Africa, through the national DSD, has developed and introduced to Parliament a *White Paper on Families*, with the objective of being "(…) a key development imperative [that] seeks to mainstream family issues into government-wide, policy-making initiatives in order to foster positive family well-being and overall socio-economic development in the country."[64] However, there is as yet no clarity on how the *White Paper on Families* will address or impact measures in relation to the common responsibilities and assistance to parents, as encapsulated within articles 18, 19 and 20 of the ACRWC.

108. The Country Report acknowledges that **ECD** is a form of childcare service; however, the report is vague on the findings of an ECD Diagnostic Review conducted by the Department of Performance Monitoring and Evaluation within the Presidency. This study seems to show a positive trend in the roll-out of ECD services and access to ECD services in terms of age categories. It recorded an 18.4% increase in 0—4 year olds attending ECD services from 2007 to 2011 and a 24.6% increase for 5 year olds over the same period.[65] This positive development cannot be overlooked by the Country Report

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[64] See section 1.3 of Department of Social Development *Draft White Paper on Families* October 2012. See section 1.3 of Department of Social Development *Draft White Paper on Families* October 2012. Accessed at https://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.dsd.gov.za%2Findex2.php%3Foption%3Dcom_docman%26task%doc_view%26gid%3D370%26Itemid%3D39&ei=I2vrUuGvB8fNhAfW8oHQDw&usg=AFQjCNFd9kZ4-wO178JPonLeEsPc5ZgzwQ&sig2=3Xqvm4TQkWl2V0Z9H0pe7w&bvm=bv.60444564,d.bGQ on 31Janaury 2014 See section 1.3 of Department of Social Development *Draft White Paper on Families* October 2012.

[65] See Department of Performance Monitoring and Evaluation *Development Indicators* (2012) page 52. See Department of Performance Monitoring and Evaluation *Development Indicators* (2012) page 52. Accessed at https://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.thepresidency-

on the situation of ECD for children, also as a form of childcare service and a major contributor to the protection of children in this age-group.

109. However, the R2ECwD (Right to Education for Children with Disabilities) campaign maintains that there are many difficulties for children with disabilities accessing quality ECD services. They highlight the following factors that impede delivery of ECD for children with disabilities:

- Services to children with disabilities are often marginalised due to lack of funding;
- Despite policy reform, services to children with disabilities remain disappointingly slow, fragmented and unequal. Government departments still work in silos and services are not coordinated;
- Poor systems of data collection on prevalence rates for disabilities in children and the number of children receiving services severely impede planning for services;
- Systems to identify and track children with disabilities at birth or as soon after as possible are sadly deficient. This affects especially children growing up in poor socio-economic conditions who need early intervention and support; and
- ECD centres are not always willing and able to admit children with disabilities. Personnel are concerned about their lack of training and their perceived inability to support the special needs of such children. Currently there is no provision for additional DSD funding to support inclusion."[66]

110. These are important challenges to ensuring accessible ECD services, not only in facilitating the cognitive development of children, but also as a form of accessible and inclusive childcare services for children.

6.3 Separation from parents

111. The Country Report highlights only the legislative developments made with regards to children separated from parents. It does not speak to the statistics in relation to children separated from their parents or caregivers, especially in relation to the applicability of the Children's Act, during child protection matters.

112. It must be noted that the protection of the rights of children separated from their parents has been strengthened by **civil society pressure via court action**, for example the finding by the Constitutional Court that sections 151 and 152 of the Children's Act are unconstitutional to the extent that they do not allow for the automatic

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dpme.gov.za%2Fdpmewebsite%2F_admin%2FImages%2FProductDocuments%2FDevelopment%2520Indicators%25202011.pdf&ei=gWrrUvmsIZSshQf5pYGYDA&usg=AFQjCNGJIMgQTw81uo9F9NOCBCdd7u8A&sig2=M3krnRZBg_fIkgOnI_XSfQ&bvm=bv.60444564,d.bGQ on 31 January 2014 See Department of Performance Monitoring and Evaluation *Development Indicators* (2012) page 52.

[66] See R2E CwD campaign *Factsheet 9: Early Childhood Development.* Accessible at: http://www.saaled.org.za/R2ECWD/docs/Factsheet%209.pdf. (Accessed on 20 January 2014).

review of a decision to separate a child from his/her parents or caregivers during a child protection matter within 24 hours since such removal.[67]

6.4 Family reunification and children deprived of family environment

113. The Children's Act requires that a child be placed in alternative care for as short a time period as possible and that effort is made for the reunification of the child and parent or caregiver. A major concern expressed by CSO service providers is a lack of time on the part of designated social workers, due to high case loads, to provide family re-integration services. As a result of the lack of reunification services, some children remain in CYCCs for longer than they should.

114. The Children's Act includes a range of alternative care options including 'cluster foster care'. However, the Act and the Regulations do not detail how these options should operate nor do they establish norms and standards; as a result there are concerns that in reality such schemes will operate as unregistered CYCCs without having to meeting the norms and standards required for CYCCs.[68]

115. Legally, placement in alternative care is done via a Children's Court, for a maximum period of two years, whereafter it must be reviewed; however, in 2012, 56% of children in unregistered centres, and 16% of children in registered centres did not have a court order placing them in care.[69] And in 2010, 43% of children in registered CYCCs had court orders or extensions that were dated 2008 or earlier i.e. over the two year minimum, and 9% of orders had a date of 2003 or earlier meaning that those children had not had their placement reviewed in over seven years.[70]

116. Whilst the Children's Act and its Regulations state that children must be placed in the programme "best suited" to their specific needs, and that all children in formal care should have care plans and independent development plans (IDPs), only 59% of the children in CYCCs had IDPs, and only 47% had both.[71]

117. **Training and education** is vital to realise the vision of creating therapeutic environments in CYCCs. Delays in the finalisation of the reform of the Social Service Professions Act (no.110 of 1978) and the publication of the Regulations to this Act mean that after three decades, child and youth care workers are still not regulated. There are

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[67] See for example *C, M and Centre for Child Law v the Department of Health and Social Development, Gauteng and City of Tshwane Metropolitan Municipality and others* CCT 55/11 [2012] ZACC 1

[68] Moses, S and H Meintjes. 2007. *Submission from the Children's Institute, University of Cape Town on residential care in the Children's Amendment Bill [B19B of 2006]* Children's Institute, University of Cape Town.

[69] CASE. 2012. *Unregistered Child and Youth Care Centres and Temporary Safe Care*. Pretoria: Department of Social Development and UNICEF, pg. 38, *and* CASE. 2010. *Baseline Study on Registered Child and Youth Care Centres*. Pretoria: Department of Social Development and UNICEF, pg. 61.

[70] CASE. 2010a. *Baseline Study on Registered Child and Youth Care Centres*. Pretoria: Department of Social Development and UNICEF, pg. 61 and CASE. 2012. *Unregistered Child and Youth Care Centres and Temporary Safe Care*. Pretoria: Department of Social Development and UNICEF, pg. 38, *and* CASE. 2010. *Baseline Study on Registered Child and Youth Care Centres*. Pretoria: Department of Social Development and UNICEF, pg. 61.

[71] CASE. 2010. *Baseline Study on Registered Child and Youth Care Centres*. Pretoria: Department of Social Development & UNICEF, pg 61.

no legal requirements in terms of education and training; consequently few child and youth care workers are fully qualified. The government has invested hundreds of millions of rand to recruit, train and deploy child and youth care workers in the community-based prevention programme, Isibindi, but there are no bursaries or support for child and youth care workers who seek employment in the residential care sector.

118. The Children's Act provides for a process of Developmental Quality Assurance (DQA) that links quality assurance mechanisms to training and capacity building so that standards can be constantly improved. In 2010 only a quarter (25%) of all CYCCs had been through a DQA, although most had had some form of inspection or monitoring and evaluation process; however, 8% of centres reported no form of assessment[72].

119. The government's claims that it has conducted an audit of 'all' unregistered centres nationally "to assist them in complying with the prescribed norms and standards and enable them to become registered" cannot go unchallenged. Firstly, the audit recognizes that it is not comprehensive—the authors acknowledge that there are unregistered facilities that would not have been captured by the survey. Secondly, a large majority (72%) of the unregistered centres have attempted to register and are awaiting a response. The Children's Act contains provisions empowering the DSD to conditionally register child and youth care centres. Conditional registration would allow these centres to access government funding and support to meet the norms and standards; however, these provisions are not being utilized.

120. The audits conducted by DSD revealed that there were 345 registered child and youth care centres in 2010 and at least 115 unregistered facilities in 2012. Unregistered centres do not receive subsidies from the government and consequently most of them do not meet the Children's Act norms and standards.

121. The subsidies paid by the government to registered CYCCs, vary from province to province[73] but in all cases fall below the real cost of providing quality alternative care for a child.

122. The information provided in the Country Report regarding family reunification is superficial and lacks important content on the implementation of the Children's Act and the national norms and standards in relation to child protection matters. Importantly, statistics and analysis are needed on the numbers of children removed from their families, together with the reunification of such families, and challenges and successes in this regard.

123. It is recommended that the South African government provide statistics and analysis of such statistics in order to gauge the implementation of article 10 of the United Nations Charter on the Rights and Welfare of the Child (UNCRC) and further articles of the ACRWC, such as article 25.

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[72] Ibid, pg. 41,
[73] Budlender, D. & P Proudlock. 2013. *Are children's rights prioritised at a time of budget cuts? Assessing the adequacy of the 2013/14 social development budgets for funding of Children's Act services*. Cape Town: Children's Institute, p60.

6.5 Maintenance of the child

124. In terms of the recovery of maintenance for children, South Africa has put in place very sound legislation to ensure that the best interests of the child in this regard are met. However, it is plagued by implementation challenges. Evidence shows that custodian parents are still struggling to access maintenance due to inefficiencies in the system, lack of adequate resources and capacity.[74]

125. The greatest of these challenges seems to be the issue of capacity. There are inconsistencies between the personpower stipulations in the Maintenance Act (No. 99 of 1988) and actual appointments of either maintenance officers or maintenance investigators.[75] In this vein De Jong cites that there are too few maintenance court officials. In cases where there have been some appointments, it appears that some courts do not have legally qualified maintenance officers while others do not have maintenance investigators[76]. There is also a lack of uniform or standard qualification set for maintenance investigators in all the nine provinces in South Africa.

126. Linked to the issue of capacity is the issue of access. Some maintenance courts and offices are in secluded parts of magistrates' court buildings and are therefore not readily accessible to the many complainants and defendants who visit these courts every day. In some cases there are no dedicated maintenance courts and as a result, general or criminal courts are used.

127. In 2002 the Constitutional Court[77] pointed out that some of the legislative remedies of the maintenance court were ineffective to protect the rights and the best interests of children. For example there is a challenge with emolument attachment orders, as some employers are not willing to cooperate and this frustrates the purposes of having such remedies in place.

128. The most commonly used remedy is the laying of criminal charges against the defaulter. However, the criminal justice system is slow and the matter takes many months to finalise; this leads to some of the custodian parents losing confidence in the system.[78]

129. Hailed as progressive legislation, the problem with the Maintenance Act continues to be one of implementation. There is no uniformity in the courts in terms of how the law is applied.[79]

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[74] De Jong M. 2009. Ten-Year Anniversary of the Maintenance Act 99 of 1998 - A Time to Reflect on Improvements, Shortcomings and the Way Forward. *African L.J. 596 (2009)*
[75] Ibid, p601.
[76] Ibid.
[77] *Bannatyne v Bannatyne and Another* (CCT18/02) [2002] ZACC 31; 2003 (2) BCLR 111 ; 2003 (2) SA 363 (CC) (20 December 2002)
[78] http://www.hopeonline.co.za/working-your-way-through-the-maze-in-maintenance-courts/ [Accessed 18 December 2013]
[79]Tshwaranang Legal Advocacy Resource Centre. Undated. Fact Sheet 5 *Maintenanace and Child Support.* https://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.genderlinks.org.za%2Fattachment.php%3Faa_id%3D9455&ei=YR0UrTBJKiR7AbFl4GwAw&usg=AFQjCNGVLP_6NeAmWKjewXD2G_QgiHHskA&bvm=bv.58187178,d.ZGU. Accessed 4 February 20144

6.6 Adoption and periodic review of placement

130. There is significant uncertainty regarding the procedures connected to the Register for Adoptable Children and Adoptive Parents (RACAP). The purpose of the register is to facilitate matching of available **adoptable children** with prospective adoptive parents.[80] However, it is not clear whether every adoptable child and adoptive parent must be placed on RACAP or whether they should only be placed on RACAP if they cannot be matched. This confusion is exacerbated by the information provided by the DSD. During the period mentioned above in 2011 to 2012 only 456 children and 111 adults were placed on RACAP despite there being 1,620 adoptions.[81] During the period between 2012 and 2013 only 508 children and 237 adults were placed on RACAP but there were 1,694 adoptions.[82] Whether placement on RACAP is mandatory is significant as the time periods prescribed for children placed on RACAP may significantly delay the conclusion of an adoption.[83] In addition, only persons who are South African citizens or permanent residents may be placed on RACAP as prospective adoptive parents.[84] The Children's Act is not clear on whether you may qualify as a prospective adoptive parent if you cannot be placed on RACAP but the statistics from DSD seem to indicate that it is possible. There is concern, however, that this will prevent foreign citizens who are working in South Africa on valid permit from adopting children.

131. The statistics quoted in the report are outdated and do not reflect the sudden decrease in adoptions that occurred in 2010 when the Children's Act came into operation. Since then, there has been an annual decrease in adoptions. However, the Annual Report of the DSD for the year ending March 2012 and the year 2013 show that there has been a slow increase in adoptions. During the period April 2011 until March 2012 there were 1,620 adoptions, of which 194 were inter-country adoptions. During the period April 2012 until March 2013 there were 1,696 adoptions of which 174 were inter-country adoptions.[85] The submissions by Child Protection Officers (CPOs) and private adoption social workers to DSD for amendment of the Children's Act reflect concern that there are unnecessarily difficult bureaucratic requirements for adoption that have led to a decrease in the number of adoptions. In particular, section 239(1)(d) of the Children's Act requires that an application for adoption must include a letter from the provincial DSD recommending the adoption. This requirement has had the effect of delaying

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[80] Skelton and Carnelley (Eds). 2010. *Family Law in South Africa.* Oxford University Press.
[81] Annual Report for the year ending March 2012, National Department of Social Development page 72.
[82] Annual Report for the year ending March 2013, National Department of Social Development page 63.
[83] A child must be on RACAP for 30 days within the province where the child was found or originates from, before the child may be matched nationally. This is in order to facilitate matching of the child with adoptive parents that have the same cultural background as the child. A child must be on RACAP for an additional 30 days to facilitate a national adoption before the child may be made available for inter-country adoption. The requirement that the child must be placed on RACAP for 60 days before the child becomes available for inter-country adoption was included in the Children's Act to comply with the principle of subsidiarity as set out in the Hague Convention relating to the inter-country adoption of children. See section 261(5) of the Children's Act and Skelton and Carnelley (Eds) *Family Law in South Africa* (2010) Oxford University Press 290.
[84] Section 232 of the Children's Act.
[85] The Annual Report for the year ending March 2012, National Department of Social Development and the Annual Report for the year ending March 2013, National Department of Social Development available at www.dsd.gov.za.

adoptions in provinces where it could take between 6 to 18 months to obtain this letter from the provincial department. The section must be amended to provide time frames and procedures for the issuing of such a letter that are standard and uniform across the whole country.

132. The report notes that customary law adoptions are public events that confer parental responsibilities and rights within a specific culture. While these adoptions may be considered informal and not regulated by the Children's Act or any other law, the South African courts have in a number of court cases recognised these forms of adoptions to the benefit and protection of the adopted child.[86]

133. The Children's Act did not contain a provision that the removal of a child had to be **reviewed by a court** shortly after such removal. This fell short of the international and regional standards set by article 9(1) of the CRC and article 19(1) of the ACRWC which requires separation of children from their parents to be subject to judicial review. The gap in the law was challenged in court by public interest lawyers and government did not oppose the application. The Constitutional Court, in *C and Others v Department of Health and Social Development, Gauteng, and Others* 2012 (2) SA 208 (CC), declared the law unconstitutional and read words into the statute to provide that the children's court must review a removal by a social worker or police official on the first court day after the removal, and that the caregivers must be notified timeously of this.

6.7 Abuse, neglect, exploitation and social integration

134. Very few sources of support for recovery from abuse and neglect are available to children in South Africa, and where services are available, they are inadequate and under-resourced. This is one outcome of the crisis in the foster-care system detailed above.

135. The experience of service providers who refer children to formal child protection services for risk assessment, safety planning and possible removal is that large numbers of these children never receive any support or intervention from the child protection system.

136. The Initial Country Report under consideration focuses on dealing with sexual abuse and exploitation through the criminal courts. Because of the lack of court support and preparation services appropriate to the special needs of children in the majority of courts, the lack training of service providers in the criminal justice system, and the lack of adequate protection for vulnerable witnesses during the investigation and trial periods, the trauma of children is often amplified during this process. The failure to address victimisation, particularly for boys, also enhances the risk of externalising trauma into abusive behaviour.[87]

137. The failure to address the continued risk to and safety of the child after abuse has been disclosed leaves children in situations of abuse and neglect, where the very fact

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[86] *Maneli v Maneli* 2010(7) BCLR 703 (GSJ); *Metiso v Road Accident Fund 2001*(3) SA 1142 (T) and *Kewana v Santam Insurance Co* Ltd 1993(4) SA 771(TkA).

[87] Bentovim A. 2002. Preventing sexually abused young people from becoming abusers, and treating the victimization experiences of young people who offend sexually. *Child Abuse & Neglect* 26 pp 661–678.

that they have disclosed exacerbates their trauma. Children are sometimes punished by families for the disclosure if services do not follow. Children then perceive the system as ineffectual, sometimes withdraw their disclosure, and choose not to disclose again if the abuse continues or re-occurs.

138. Lack of suitable placement options for children with disabilities remains a challenge. As a result, children who may need to be removed from their homes as a result of abuse cannot be placed due to lack of availability of suitable facilities and trained staff.[88]

7 HEALTH AND WELFARE

7.1 Survival and development

139. **Trends in child mortality** have been difficult to pin down accurately and published estimates vary widely, though there is a growing consensus on the general trend. Under-five mortality rose from an estimated 50—60 death per 1,000 live births in the early to mid-1990s to an estimated peak of 70—80 deaths per 1,000 births in 2003—2005, driven primarily by the HIV pandemic.[89] Thereafter the rates started to fall—coinciding with the rollout of Prevention of Mother to Child Transmission (PMTCT) following successful litigation by the Treatment Action Campaign in 2002.

140. HIV infection is a key driver of under-five mortality in South Africa, and was associated with over 50% of child deaths in hospital in 2005 — 2009.[90] Other leading **causes of death** for young children include perinatal conditions (24%); childhood infections such as diarrhoea (21%) and lower respiratory infections (18%); and injuries (5%),[91] most of which are preventable.

141. While **malnutrition** is not classified as a cause of death, it is a key risk factor: 35% of young children who died in hospital between 2005 and 2009 were severely malnourished and a further 30% were underweight for age.[92]

142. The high level of **violence** in South Africa is of particular concern with nearly three child homicides a day in 2009.[93] The overall child homicide rate was 5.5/100 000, more than double the global rate of 2.4/100 000. Child homicides are highest amongst teenage boys. Nearly half of child homicides are due to child abuse and neglect; and three quarters of fatal child abuse were concentrated in the 0-4 year age group with

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[88] Umgungundlovu Disability Forum . 2010. *Shadow report to the Committee on the Rights of Persons with Disabilities*. KwaZulu Natal, South Africa.
[89] Nannan N, RE Dorrington, R Laubsche, N Zinyakatir, M Prinsloo, TB Darikwa, R Matzopoulos and D Bradshaw. 2012. *Under-5 mortality statistics in South Africa: Shedding some light on recent trends and causes 1997 – 2007*. Cape Town: Medical Research Council.
[90] Stephen CR, LJ Bamford, ME Patrick and DF Wittenberg. 2011. *Saving Children 2009: Five Years of Data. A sixth survey of child healthcare in South Africa.* Pretoria: Tshepesa Press, MRC, CDC.
[91] Nannan N, RE Dorrington, R Laubsche, N Zinyakatir, M Prinsloo, TB Darikwa, R Matzopoulos and D Bradshaw. 2012. *Under-5 mortality statistics in South Africa: Shedding some light on recent trends and causes 1997 – 2007*. Cape Town: Medical Research Council.
[92] Stephen CR, LJ Bamford, ME Patrick and DF Wittenberg. 2011. *Saving Children 2009: Five Years of Data. A sixth survey of child healthcare in South Africa.* Pretoria: Tshepesa Press, MRC, CDC.
[93] Mathews S, N Abrahams, R Jewkes, LJ Martin and C Lombard. 2013. The Epidemiology of Child Homicides in South Africa. *Bulletin of WHO*, 91:562–568

most deaths occurring in the home. A concern is that many fatal child abuse deaths may be misclassified as natural deaths in the absence of a post mortem examination.[94]

143. The National Committee on Confidential Enquiries into Maternal Deaths (CEMD)'s most recent recommendations focus on priority districts and problem areas including HIV, hypertension and haemorrhage.[95] For example, systems improvements introduced in the Free State include emergency obstetric skill training, the introduction of onsite ambulances for emergency obstetric transport, and the rationalising of obstetric services at district level.[96] Many of the recommended strategies for improving maternal health are also effective in preventing **stillbirths and new-born deaths** and should be integrated for midwives and doctors providing care.

144. The incompleteness of vital registration data and lack of recent reliable survey data has led to a prolonged period of uncertainty around the extent and causes of child mortality. In response to these challenges, we welcome the **Health Data Advisory Coordinating Committee** (HDACC)'s efforts to strengthen data systems. The HDACC has recommended using the rapid mortality surveillance (RMS) system to monitor infant and under-five mortality,[97] and recent data suggests that under-five mortality rates are decreasing sharply — from 69/1000 in 2006 to 42/1000 in 2011.[98]

145. RMS data still need to be benchmarked against a **national survey** (as the last reliable survey data date back to the 1998 South African Demographic Health Survey). Such a survey should include detailed pregnancy histories to help ascertain changes in the relative contribution of neonatal, post-neonatal and child components of under-five mortality.

146. **The Child Healthcare Problem Identification Programme** (www.childpip.org.za), audits the deaths of children in hospital, and has proved an excellent initiative in improving understanding of the underlying causes of child mortality, and in identifying modifiable factors required to improve the quality of care at hospital, clinic and community levels. However these data are not suited to measuring levels of infant and child mortality at a national level. More needs to be done to expand the reach of ChildPIP and to strengthen this and other data systems for monitoring the extent and causes of child mortality. In particular it would be helpful to track the correlation between income and under-five mortality in the context of rising income inequality.

147. **A high proportion of child deaths are preventable**. Preventable factors at home include inadequate nutrition, failure to recognise the severity of illness and delays in seeking care. Failures at primary level include failure to manage childhood illnesses in

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[94] Mathews S, N Abrahams, R Jewkes and L Martin. 2013 Underreporting child abuse deaths: Experiences from a national study on child homicide. *SAMJ*. March 2013
[95] Department of Health. 2012. *Saving Mothers 2008-2010: Fifth report on the confidential enquiries into maternal deaths in South Africa*. Pretoria: Department of Health.
[96] Schoon M. 2013. Impact of inter-facility transport on maternal mortality in the Free State province. *S Afr Med J*, 103(8): 534-537
[97] Department of Health. 2012. *Health Data Advisory and Co-ordination Committee (HDACC) Report.February 2012.* Pretoria: Department of Health
[98] Bradshaw D, RE Dorrington and R Laubscher. 2012. *Rapid Mortality Surveillance Report 2011*. Cape Town: Medical Research Council

line with Integrated Management of Childhood Illness (IMCI) guidelines and to identify and respond to growth faltering.[99]

148. While under-five mortality rate are on the decline, **neonatal mortality rates** (NMR) have remained relatively static —with a marginal decrease in early NMR from 14.2 deaths per 1000 live births in 2009/2010 to 12.6 per 1000 live births in 2011/2012 (and 12.3/1000 in 2012/2013).[100] Key causes of neonatal mortality in South Africa are prematurity and hypoxia. Analysis of avoidable factors in the Perinatal Problem Identification Programme[101] indicate that it is vital to improve training in antenatal and labour management, neonatal resuscitation, kangaroo mother care, and breastfeeding support. Improvement of quality of care at district hospitals and access to early antenatal care (ANC) are also essential. South Africa has a high stillbirth rate which raises questions about the quality of ANC. There is a disproportionate number of extremely low birth weight babies (< 1kg) and amongst this group ANC attendance is poor—mothers fail to book themselves for ANC (14.6%), book late (4.6%) or attend erratically (3.4%).[102]

149. **Keeping mothers alive and healthy** is essential to the health and well-being of children, yet maternal mortality has increased significantly over the past two decades, driven primarily by the HIV pandemic. The most recent reports from the National Committee on indicate that maternal mortality within health facilities has started to decline for the first time since 1998 dropping from 176.2 deaths per 100,000 live births in 2008—2010 to 146.7 in 2012.[103] This is associated with a corresponding 22% reduction in deaths due to non-pregnancy related infections including HIV. This illustrates the success of the HIV strategy implemented in 2010 but there is still much room for improvement.

150. The National Committee on CEMD only reports on deaths in facilities, and is therefore likely to underreport the extent of maternal deaths in South Africa. However the WHO's estimates follow a similar trend — with maternal mortality rates rising from 250 in 1990 to 330 in 2000, and then dropping to 300 deaths per 100,000 live births in 2010.[104]

151. Other causes of maternal mortality include hypertension and haemorrhage — in particular bleeding associated with caesarean section which is now a national priority. These deaths reflect serious problems with the functioning of the health system and the competencies of health providers.

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[99] Stephen CR & LJ Bamford LJ. 2013. *Saving Children 2010-2011. A seventh survey of child health care in South Africa.* Pretoria: Tshepesa Press, MRC, CDC

[100] Pattinson RC (2013) *Saving babies 2010-2011: Eighth report on perinatal care in South Africa*. Tshepesa Press, Pretoria; and unpublished data from the perinatal problem identification programme for 2012/2013. www.ppip.co.za/saving-babies/

[101] www.ppip.co.za/saving-babies/

[102] Personal communication, Dr Neil McKerrow, 7 February 2014

[103] Department of Health (2013) *Saving Mothers: Tenth interim report on Confidential Enquiries into Maternal deaths in South Africa, 2011 - 2012*

[104] World Health Organisation (2012) *Maternal Mortality Estimation Inter-Agency Group (MMEIG). Trends in Maternal mortality 1990-2010.* WHO, UNICEF,UNFPA and the World Bank estimates.

7.2 Children with disabilities

152. In South Africa there is no single piece of legislation governing disability. Instead, the *Integrated National Disability Strategy* is used to guide all sector-specific legislation. The Children's Act has significant provisions for children with disabilities and this is welcomed.[105] The Act states that in any matter concerning a child with a disability, consideration must be given to enabling his or her participation and providing conditions which ensure dignity, self-reliance and community involvement.[106]

153. In 2009, the DSD compiled a draft *Strategy for the Integration of Services to Children with Disabilities*. It was intended to guide the development and implementation of all government frameworks on children with disabilities, align budgets, remove barriers of access to services and improve quality of services. This *Strategy* has subsequently been re-drafted and in the course of 2013 was circulated for comment. In its current form, it lacks coherence and a clear structure[107] and much work is still required before it can provide a useful tool to guide the development of co-ordinated and comprehensive services for children with disabilities. Among the greatest concerns is the lack of a monitoring framework upon which to base planning and on which to assess progress with respect to children with disabilities and their access to social services. Further, the lack of information systems disaggregated for children with disabilities continues to render children with disabilities invisible and mask the disproportionate extent to which they are excluded from social services.

154. The National Health Act (no. 61 of 2003) provides for Primary Health Care (PHC), embracing the continuum of services. Various policies including *Free Health Care*, the *National Rehabilitation Policy* and the *Standardisation of Provision of Assistive Devices* have been enacted to improve access and quality of health services for children with disabilities.

155. Despite provisions to improve access to health care for children with disabilities, research shows that in, addition to finance, other factors continue to restrict access to health services for children with disabilities. These include lack of access to medicines, shortage of staff, and difficulties with transport.[108] Inaccessible health facilities also continue to pose difficulties for children with disabilities and their families.[109]

156. Currently, a primary focus of the Department of Health (DH) is to reduce maternal and child mortality, with the IMCI being a major strategy for doing so. However, in focusing on preventive and curative care through IMCI, limited attention has been paid to the development of quality rehabilitative care for children with permanent

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[105] Jamieson L & P Proudlock. 2009. *From sidelines to centre stage: the inclusion of children with disabilities in the Children's Act. Children's Institute Case Study number 4*. Cape Town: University of Cape Town.
[106] Children's Act 38 of 2005 s11
[107] The concerns about this draft strategy are contained in a submission to DSD Development made by the ECD sub-group on the right to Education for Children with Disabilities, October 2013.
[108] Leatt A, M Shung-King and J Monson. 2006. Healing inequalities: the free health care policy in Monson J et al (eds) *South African Child Gauge* Cape Town: Children's Institute, University of Cape Town
[109] Schneider M, J Couper J and L Swartz. 2010. *Assessment of accessibility of health facilities to persons with disabilities* Report submitted to the Directorate: Chronic diseases, disabilities and geriatrics. Pretoria: DH.

impairments. Further, while the inclusion of a more detailed table of developmental milestones in the new *Road to Health* booklet is to be welcomed, much work remains to be done to ensure that developmental screening and early intervention become integral to promoting child well-being.

157. The Mental Health Care Act (no. 17 of 2002) is also welcomed in its focus on adults and children with particular impairments. However, the Act does not contain any specific provisions for children (for example, it does not refer to 'habilitation') and does not deal with the social aspects of disability i.e. the relationship between the person and their environment. Furthermore, the focus of rehabilitation in the Act is on those with 'severe and profound' intellectual disabilities, with an emphasis on care rather than independence and development.

158. The DH has recently drawn up the *Strategy for Re-engineering Primary Health Care,*[110] thereby signalling its intention to 'go back to the roots' of primary health care. The discussion document drawn up to guide this process includes community based rehabilitation (CBR) as an essential part of PHC. Given the absence of a national strategy for CBR (described as 'PHC for people with disabilities') it is hoped that this renewed emphasis will ensure that barriers to access and quality are addressed.[111]

159. The Social Security Act (no. 13 of 2004) provides for parents and caregivers of children requiring permanent care to receive a means-tested Care Dependency Grant (CDG), to the value of (as of December 2013) R1,260. While the take-up of the CDG has increased significantly from 102,292 children in 2008 to 120,268 in 2013[112] a concern remains that assessment criteria are still medically dominated with District Surgeons having to examine children to determine the extent of their disability. The primary focus is thus on the medical condition of the child with little cognizance given to other factors that impact on functional limitations or participation restrictions.

160. The South African Schools Act prohibits discrimination on the basis of disability. In 2001, *White Paper 6: Towards an Inclusive Education and Training System* was drawn up, containing a 20-year implementation plan. While some progress has been made in supporting special schools to become resource centres and certain identified primary schools to be equipped as full service schools (as envisaged in the *White Paper*) progress has been limited and the quality of education provided at many special schools tends to be poor.[113]

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[110] Department of Health. 2010. *Re-engineering Primary Health Care in South Africa: a discussion document*. Pretoria: Department of Health.
[111] Department of Social Development, Department of Women, Children and People with Disabilities & UNICEF (. 2012) *Children with disabilities in South Africa: a situation analysis 2001-2011*. Pretoria: DSD, DWCPD, UNICEF.
[112] SOCPEN database cited in Hall K. 2013. Income poverty, unemployment and social grants in Berry L et al (eds) *South African Child Gauge* Cape Town: Children's Institute, University of Cape Town
[113] Department of Social Development, Department of Women, Children and People with Disabilities & UNICEF (. 2012) *Children with disabilities in South Africa: a situation analysis 2001-2011*. Pretoria: DSD, DWCPD, UNICEF..

7.3 Health and health services

161. While there is considerable room for improvement in the delivery of health care services for children, it is also important to identify and address the **underlying social determinants of health**. These are fully dealt with in annexure 2.

162. Poverty, inequality and poor access to services are compounded by poor access to health care services and marked **inequalities** between public and private sectors and rural and urban areas.

163. Private health insurance accounts for 44% of total health care spending in South Africa,[114] supporting a primarily urban and hospital-based service that serves only 15% of the population. This leaves the majority of South Africans dependent on the public health system where resources are thinly stretched: Only 1/3 of medical practitioners, 1/4 of specialists and just less than 1/2 of professional nurses work in the public sector.[115] While rural areas house 47% of South Africa's children[116] only 12% of doctors and 19% of nurses work there.[117] Nearly two thirds of the 570 paediatricians in the public service work in the more urban provinces of Gauteng and Western Cape, while there are less than five paediatricians in more rural provinces of Mpumalanga, Northern Cape and North West province.[118]

164. South Africa has made significant strides in providing free PHC and expanding the network of primary health facilities. Children's **access to health care** has improved significantly since 2002, however nearly a quarter of children still travel more than 30 minutes to reach a health facility.[119] In addition, transport costs and safety concerns often lead to life-threatening delays in accessing treatment. Long distances to clinics have also been found to limit the uptake of immunisation and the use of the *Road-to-Health* booklet.[120]

165. Despite a range of policies promoting equality; foreign children, children with disabilities and pregnant teenagers continue to experience **discrimination** in accessing health care. For example, the Department of Health issued a revenue directive confirming that refugees and asylum seekers, with or without documentation, have the

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[114] McIntyre D. 2010. *Private Sector Involvement in Funding and Providing Health Services in South Africa: Implications for Equity and Access to Health Care*. Equinet discussion paper no 84. Health Economics Unit, UCT & Institute for Social and Economic Research.
[115] Day C & A Gray. 2008 Health and related indicators. In: Barron P, Roma-Reardon J (eds) *South African Health Review 2008*. Durban: Health Systems Trust.
[116] Hall K. 2012. Housing and Services—Urban-rural Distribution. *Children Count* website, Children's Institute, UCT. Accessed on 14 June 2012
[117] Hamilton K & J Yau J. 2004. The global tug-of-war for health care workers. Washington, DC: Migration Policy Institute. In: Cooke R & Versteeg M (2011) *The WHO Global Policy Recommendations on Increasing Access to Health Workers in Remote and Rural Areas through Improved Recruitment and Retention: The South African Context*. Discussion document for the WHO. Wits Centre for Rural Health, the Rural Health Advocacy Project, Africa Health Placements, the Rural Doctors Association of Southern Africa, the UKZN Centre for Rural Health and the UCT Primary Health Care Directorate.
[118] Health Professions Council of South Africa Register, 2011
[119] Hall K. 2013. Child health—Children living far from health care facility. *Children Count* website, Children's Institute, University of Cape Town. Accessed on 30 January 2014
[120] McLaren Z, C Ardington and M Leibbrandt. 2013. *Distance as a Barrier to Health Care Access in South Africa. A Southern Africa Labour and Development Research Unit working paper no. 97*. Cape Town: SALDRU, UCT

right to access basic health care services and anti-retroviral therapy at the same rate as South Africans. Yet medical service providers frequently obstruct refugees' and asylum seekers' access to health care due to a lack of understanding or xenophobic attitudes.[121] More recent reports suggest that this directive has been repealed, and that undocumented foreigners must now pay for health care services at the highest rates.

166. The delivery of public health services are a provincial competency with considerable variation across provinces. The Eastern Cape department has been plagued by corruption, mismanagement and shortages of staff, essential drugs and equipment, and emergency medical services. [122]The ongoing failure to address these issues is undermining anti-retroviral (ARV) and tuberculosis (TB) treatment programmes in the province and driving high neonatal and under-fiver mortality. Efforts to address these **systemic failures** are being spearheaded by the Eastern Cape Health Crisis Action Coalition.

167. **Quality of care**

1. A **National Audit of Health Care Establishments** in 2012 noted poor compliance with ministerial priority areas such as waiting times (68%), cleanliness (50%), patient safety (34%) and positive and caring attitudes (30%).[123] It is hoped that the introduction of Facility Improvement Teams and recent efforts to strengthen governance and accountability will improve the quality of care.

2. In 2011, the DH introduced **National Standards for Health Care Facilities** which offer a potentially powerful mechanism for driving quality improvement processes. However children's specific health care needs are rarely addressed beyond the confines of paediatric and neonatal wards, and there is a need to specify paediatric equipment, staff and child-friendly standards in other areas of the health care system such as clinics, emergency services and trauma wards.[124]

3. The Committee on Morbidity and Mortality in Children under 5 years (CoMMiC) was established in 2008 to determine the magnitude and causes of under-five mortality and to make recommendations to reduce childhood morbidity and mortality. In addition to recommending improvements in data systems, CoMMiC called for the development of an **Essential Package of Care** for children and **norms and minimum standards for child health services**—which would specify staffing, resources and clear targets—and it is vital that this framework is put in place in order to hold government accountable and ensure that child health services are adequately resourced.[125]

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[121] Dass, D. et al. Forthcoming in 2014. Socio-Economic Rights of Refugees in South Africa, in Khan, F. and T Schreier. *Refugee Law in South Afric.* Cape Town: Juta.
[122] Eastern Cape Health Crisis Action Coalition. 2013. *Memorandum to MEC Sicelo Gqobana about the crisis in Eastern Cape Health.* Viewed 2 February 2014: http://echealthcrisis.org/memo/
[123] Health Systems Trust.2012. *National Health Care Facilities Baseline Audit: Summary Report*. Durban: HST
[124] Department of Health. 2011. *National Core Standards for Health Establishments in South Africa.* (Abridged version). Pretoria: Department of Health.
[125] Department of Health. 2011. *First Report of the Committee on Morbidity and Mortality in Children Under 5 Years (CoMMiC) 2008-2010.* Pretoria: Department of Health

4. In addition, **budgets** for child health need to be disaggregated in line with the recommendation of the UN Committee on the Rights of the Child (General Comment 15 on the Right to Health) to ensure that children receive their fair share of resources.

168. **National Health Insurance (NHI) and Primary Health Care (PHC)**

1. We welcome plans to introduce **National Health Insurance** as a mechanism to promote the more equitable distribution of resources between public and private sectors and to ensure universal coverage and financial risk protection for the poor. However special effort will be needed to make sure that public health facilities serving poor and rural areas are able to meet the criteria and become accredited providers. If not, the NHI may simply serve further entrench the divisions between public and private, rural and urban health

2. We also welcome the proposed **reengineering of PHC** with its strong focus on maternal and child health. This includes the role of District-based Clinical Specialist Teams in driving population-based planning, quality improvement and inter-sectoral collaboration to address the broader social determinants of health, as well as the role of school health and ward-based outreach teams in providing community-based services. This will require an increase in the numbers of health workers at all levels, as well as reorientation and training to enable clinical staff to take on a broader advocacy and leadership role.

3. While **home- and community-based services** have the potential to improve the reach of PHC, the proposed ratio of households to community health workers (CHWs) of 250:1 may compromise the quality of this care. Increased investment is needed in the numbers, training and supervision of CHWs. In addition, CHWs' scope of practice needs to be widened to include the dispensing of oral rehydration solution to children with diarrhoea and first-line antibiotics for children with acute respiratory infections.[126]

4. As child mortality falls, emphasis needs to shift beyond survival to promote children's optimal development. The **first 1000 days** (conception to the second birthday) is a particularly sensitive period of development. Poverty, malnutrition, a lack of care and harsh discipline create 'toxic stress' which has potentially lifelong consequences for children's health and schooling —and many chronic diseases have their roots in early childhood.[127] Strengthening service provision in the early years is key to breaking this cycle. The health sector has a critical role to play in improving child outcomes by identifying risk factors, promoting health and development, supporting mothers and caregivers and providing a gateway to social grants, child protection and social

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[126] Sanders D, R Reynolds and L Lake. 2012. Spatial inequality: Persistent patterns of child deprivation. In: Hall K, I Woolard, L Lake and C Smith (eds) *South African Child Gauge 2012.* Cape Town: Children's Institute, UCT

[127] Morgan B (in press) *Biological embedding of early childhood adversity: Toxic stress and the vicious cycle of poverty in South Africa.* Research & Policy Brief series 2. Cape Town: Ilifa Labantwana; SP Walker, TD Wachs, J Meeks Gardner, B Lozoff, GA Wasserman and A Pollit. 2007. Child development: Risk factors for adverse outcomes in developing countries. *The Lancet*, 369: 145-157

services – starting in the antenatal period.[128] It is also important to expand the use of the IMCI Care for Development module at community level, and to strengthen early identification and referral systems to ensure continuity of care for children in need of additional support.[129]

169. **Access to PHC**

PHC is free to pregnant and nursing mothers and children under the age of 6. There are, however, significant barriers to **access to PHC**

1. **Early antenatal care (ANC)** is a critical opportunity to promote healthy pregnancies, identify mothers and babies at risk, and provide mental health screening and referrals. While almost all pregnant women (101%) attended at least one antenatal visit in 2010/11, only 43% had their first visit before 20 weeks.[130] It is therefore critical to promote early ANC and to address supply side barriers such as attitudes of nursing staff and clinic opening hours to make it easier for school girls and working women to access services. (see also section 7.1 above in relation to maternal and neonatal mortality).

2. The expanded ***Road-to-Health booklet*** is designed to promote continuity of care and has the potential to strengthen growth monitoring, developmental screening, early intervention and IMCI home and community-based practices, but it is not clear how the tool is being used in practice. It is therefore vital to monitor both coverage and quality of these essential services. Given the high levels of child poverty in South Africa, it would be also helpful to include a question in the booklet that specifically addresses children's eligibility for social assistance in order to promote access to social grants in the first year of life. (See also para 170 below, at point 6)

3. **PHC utilisation rates** amongst children under 5 have shown a "small but steady increase" to an average of 4.7 visits a year in 2011/2012.[131] However this falls below the national target of 5.5 visits. In addition, these figures include both scheduled well-child visits and unscheduled visits when ill, which suggests underutilisation. While national immunisation coverage at 1 year is good (94%),[132] Vitamin A coverage from 12 —60 months is low (43%)[133] and suggests poor attendance after the first birthday.

4. The introduction of the rotavirus and pneumococcal vaccines in 2009 is assisting in reducing child morbidity and mortality, but greater effort is needed to improve

[128] Slemming W & H Saloojee H. 2013. Beyond survival: the role of health care in promoting ECD. In: Berry L, L Biersteker, A Dawes, L Lake and C Smith(eds) *South African Child Gauge 2013.* Cape Town: Children's Institute, UCT
[129] Jacklin L. 2013. The future is in our hands. In: Stephen CR, Bamford LJ (eds) *Saving Children 2010-2011 A seventh survey of child health care in South Africa*. Pretoria: Tshepesa Press, MRC, CDC.
[130] Day C, P Barron, N Massyn, A Padarath and E English. 2012. *District Health Barometer 2010/11.* Durban: Health Systems Trust.
[131] Massyn N, C Day, P Barron, R Haynes, R English and A Padarath. 2013. *District Health Barometer 2011/2012*. Durban: Health Systems Trust
[132] Day C, P Barron, N Massyn, A Padarath and R English R. 2012. *District Health Barometer 2010/11.* Durban: Health Systems Trust
[133] Massyn N, C Day, P Barron, R Haynes, R English and A Padarath. 2013. *District Health Barometer 2011/2012*. Durban: Health Systems Trust.

immunisation coverage at district level. National figures mask significant discrepancies across districts with immunisation coverage at 1 year ranging from 123% to 49% in 2010/2011.[134] Coverage of the measles 2nd dose was less than optimal (78.5%) over the same period and may account for the outbreak of measles in 2010.[135] Despite achieving some success, mass immunisation campaigns have tended to disrupt other primary health care activities, and it is not clear whether they successfully target unreached groups in the process.[136]

5. The **Integrated Management of Childhood Illnesses (IMCI)** focuses on the prevention and treatment of the most common causes of mortality in children under five years old. While coverage of IMCI training is being monitored, this needs to be supplemented with effective supervision and support, as well as regular audits to ensure quality of care. Community health worker training in the 16 key messages also requires strengthening to ensure that caregivers know when to go for medical help and what they can do at home to prevent and treat illness.

6. The **paediatric Essential Drug List** (EDL) currently in use was published in 2006 and went out of print in 2011/12, and the latest version was only released in February 2014. This reflects a broader trend within the national DH where policies, strategies & programmes for children are developed in draft form with lengthy delays before being finalised and adopted. **Procurement of medicine** nationally tends to focus on adults and often fails to consider children's special needs—including the need for lower doses and medicines that are palatable and easy to swallow. As a result pharmacists have to manipulate adult medicines to suit children and this unlicensed usage may put children at risk.

7. While a panel of paediatric experts provides guidance on appropriate and affordable drugs for children, the main EDL committee is not always sensitive to children's needs. A separate paediatric committee with a separate budget allocation may prove more effective in addressing children's health care needs (as is the case in many developed countries). In addition, it would be helpful to develop a pharmacopeia for children which would provide clear guidance on how to safely adapt adult medicines for children.

170 **Emergency and intensive care:**

While efforts to strengthen the district health system and primary health are essential for the prevention and treatment of common illness, it is also important to ensure that children's needs are met at secondary and tertiary level and that children in need are able to access emergency and intensive care.

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[134] Day C, P Barron, N Massyn, A Padarath and R English. 2012. *District Health Barometer 2010/11.* Durban: Health Systems Trust

[135] Day C, P Barron, N Massyn, A Padarath and R English R. 2012. *District Health Barometer 2010/11.* Durban: Health Systems Trust

[136] Sartorius B, C Cohen, T Chirwa, G Ntshoe, A Puren and J Hofman. 2013. Identifying high-risk areas for sporadic measles outbreaks: lessons from South Africa. *Bull World Health Organ*,91(3):174-83; Verguet S, W Jassa, MY Bertram, SM Tollman, CJ Murray and DT Jamison et al. 2013. Impact of supplemental immunisation activity (SIA) campaigns on health systems: findings from South Africa. *Journal of epidemiology and community health,* 67(11):947-52.

1. Children are profoundly compromised by the current paediatric **emergency medical services** (EMS): Ambulance crews have extremely limited training in the management of sick or injured children, paediatric emergencies or life support; and most EMS services do not carry the necessary equipment to manage the resuscitation and safe transport of children (e.g. equipment for intravenous therapy, airway management and to immobilise the cervical spine in the event of trauma). The CoMMiC) is also pushing for training in paediatric emergency care and triage.

2. Many hospitals are forced to turn away children due to a shortage of beds in **intensive care** with only 20% of Intensive Care Unit (ICU) beds dedicated to children and neonates—and only 4% of these for children.[137] These bed shortages are compounded by an acute shortage of ICU trained nurses—and those working in ICUs are prone to burnout and low morale.[138] Future plans should consider preferential development of paediatric facilities and address the shortage of trained nurses and doctors who are integral to paediatric and neonatal care.

171. **Malnutrition** is a key driver of under-five mortality.

1. About 60% of children who died in hospital over a five-year period were underweight-for-age, and one-third was severely malnourished.[139] Stunting rates were highest amongst very young children affecting 1 in 4 children (26%) aged 0—3 years[140] and are associated with poor schooling outcomes.[141] Vitamin A deficiency remained high at 44%. Overweight (15%) and obesity (6%) were also a concern, especially in urban areas.[142] Prevention of malnutrition in the first 1000 days is key, and this begins with ensuring adequate maternal nutrition during the antenatal period.

2. Breastfeeding has a significant protective effect for child health and nutrition so the Tshwane Declaration in support of exclusive breastfeeding is welcome especially given the previous lack of clarity around breastfeeding and HIV. Given that only 12% of infants were exclusively breastfed for the first four months in 2003,[143] there is an urgent need for more recent data to track progress. There is no data on the contribution of breastfeeding to postnatal HIV transmission. The Mother-and-Baby-

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[137] Scribante J and S Bhagwanjee. 2007. National audit of critical care resources in South Africa – unit and bed distribution. *South African Medical Journal*, 97 (12):1311-1314; Child C. 2012. Doctors: We must choose who lives. *Times*, 09 July, 2012

[138] Scribante J and S Bhagwanjee. 2007. National audit of critical care resources in South Africa – nursing profile. *South African Medical Journal*, 97 (12):1315-1318

[139] Stephen CR, LJ Bamford, ME Patrick, DF Wittenberg (eds.). *Saving children 2009: Five years of data: A sixth survey of child healthcare in South Africa*. Pretoria: Tshepesa Press, Medical Research Council, Center for Disease Control and Prevention; 2011

[140] Ibid.

[141] Grantham-McGregor, S., YB Cheung, S Cueto, P Glewwe, L Richter and B Strupp. 2007. Developmental potential in the first 5 years for children in developing countries. *The Lancet.* 369(9555):60-70. DOI:10.1016/S0140-6736(07)60032-4.

[142] Shisana O, D Labadarios, T Rehle, L Simbayi, K Zuma, A Dhansay, P Reddy, W Parker, E Hoosain, P Naidoo, C Hongoro, Z Mchiza, NP Steyn, N Dwane, M Makoae, T Maluleke, S Ramlagan, N Zungu, MG Evans, L Jacobs, M Faber and the SANHANES-1 Team (2013) *South African National Health and Nutrition Examination Survey (SANHANES-1)*. Cape Town: HSRC Press

[143] Department of Health. 2004. *South African Demographic and Health Survey 2003*. Pretoria: Department of Health

Friendly Hospital Initiative is an effective programme for initiating breastfeeding, but greater investment in advocacy, community-based breastfeeding support (peer and expert) and support for working mothers who breastfeed is required to ensure that breastfeeding is maintained. We commend the establishment of about 20 human milk banks in the country with a focus on ensuring that the most vulnerable babies in hospital have access.

3. Given South Africa's high levels of child poverty and malnutrition, it is vital to strengthen systems for identifying at risk children and supporting children whose growth is faltering. We therefore note with concern the delay in publishing *The South African Supplementary Feeding Guidelines for at Risk and Malnourished Children and Adults*. Growth monitoring and caregiver education and support have a role to play in preventing malnutrition and it is vital to monitor implementation of the new Road-to-Health booklet to ensure that it is being used effectively.

4. The implementation of guidelines on the inpatient and community-based management of **severe acute malnutrition** (SAM) to reduce the case fatality rate is needed in several districts in the country.

5. While **household food insecurity** declined from approximately 50% in 1999 to about 25% in 2008, there has been little progress since, with 1 in 4 households experiencing hunger in 2012 and a further 1 in 4 households at risk of hunger.[144] Strategies are needed at community level to address household food insecurity in the short- and long-term.

6. The **child support grant** (CSG) is associated with significant health and nutritional gains,[145] so we note with concern the low take up amongst children in the first year of life and amongst children of teen mothers.[146] The new ECD policy (currently under development) recommends allowing mothers to apply for the grant during pregnancy. It is also important to interrogate the value of the CSG (R300/month/child in October 2013) in the face of rising food costs.

7. Children living in poor households and rural areas are adversely affected by **rising food costs**. The cost of a basic food basket increased by 6.4% from 2012 to 2013,[147] and at a cost of R457 equates to 40% of the total monthly income of the poorest 30% of households.[148] Of particular concern is wide variation in prices across

[144] Ibid.
[145] DSD, SASSA and UNICEF. 2012. *The South African Child Support Grant impact assessment: Evidence from a survey of children, adolescents and their households*. Pretoria: South Africa
[146] SASSA and UNICEF. 2013. *Preventing exclusion from the Child Support Grant: A study of exclusion errors in accessing CSG benefits*. Pretoria: UNICEF South Africa
[147] National Agricultural Marketing Council.2013. *Food Price Monitor: February 2013 (media release).* NAMC: Pretoria
[148] Ibid.

different [149]retailers, and the higher cost of basic foods stuffs such as rice and maize in rural areas.[150]

8. Consumption of soft drinks, fast foods, sweets and confectionary has risen sharply between 2005 and 2010, and carbonated drinks rate as one of the top three food/drink items consumed by young urban South Africans (12 —24 months).[151] Greater efforts need to be made to regulate "**Big Food**"[152] and the marketing of unhealthy food to children, given the high levels of both under- and over-nutrition.

9. Poor micronutrient and vitamin coverage was highlighted by the South African National Health and Nutrition Examination Survey report, despite legislated food fortification of 13 micronutrients. A 2012 report highlighted lows levels of compliance with statutory fortification requirements by millers, both for bread flour and for maize meal.[153] This is likely the result of insufficient addition of premix at the mills. There is no regular monitoring of compliance by any agency.

HIV and TB

172. **HIV and TB** have exacted a particularly heavy toll on children in South Africa, who are affected by HIV and TB either directly through infection, or indirectly through the illness or death of their family members and caregivers.[154] Although various interventions have been implemented to prevent transmission of HIV to children and to protect child health in general, there are still multiple challenges in the delivery of health care services and these lead to negative health outcomes in children. These include: the continued transmission of HIV from mother to child; the lack of decisive policy action on the distribution of condoms at schools and on sexual violence at schools; medicines stock-outs that lead to treatment default, potential resistance, and increased morbidity and mortality; the lack of effective and tolerable treatment regimens for TB patients; poor information systems, which may contribute to late initiation of children on treatment; and insufficient support for community-level workers. The marginalisation of the children's sector in the South African National AIDS Council (SANAC) is also of concern. Following the restructuring in 2012, the involvement of the children's sector's has been limited to the civil society forum which has served to dilute the voice of the sector, and made it harder to ensure that children's specific needs are addressed.

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[149] Yusufali R, N Sunley, M de Hoop and D Panagides. 2012. Flour fortification in South Africa: post-implementation survey of micronutrient levels at point of retail. *Food Nutr Bull*. 2012 Dec;33(4 Suppl):S321-9

[150] National Agricultural Marketing Council.2013. *Food Price Monitor: February 2013 (media release).* NAMC: Pretoria

[151] Igumbor EU, D Sanders, TR Puoane, L Tsolekile, C Schwarz C, et al. 2012. Big Food, the Consumer Food Environment, Health, and the Policy Response in South Africa. *PLoS Med* 9(7): e1001253. doi:10.1371/journal.pmed.1001253

[152] The food industry (including supermarket chains, agri-industries and fast food chains)

[153] Igumbor EU, D Sanders, TR Puoane, L Tsolekile, C Schwarz C, et al. 2012. Big Food, the Consumer Food Environment, Health, and the Policy Response in South Africa. *PLoS Med* 9(7): e1001253. doi:10.1371/journal.pmed.1001253

[154] Slemming W and H Saloojee. 2013. Beyond survival: the role of health care in promoting ECD. In: Berry L, L Biersteker, A Dawes, L Lake and C Smith (eds) *South African Child Gauge 2013.* Cape Town: Children's Institute, UCT

173. The *National Strategic Plan on HIV, STIs and TB 2012-2016* (NSP) explicitly links efforts to reduce mortality and morbidity associated with HIV infection with efforts to improve maternal and child health. The NSP aims to reduce **mother to child transmission** to less than 2% at six weeks after birth and less than 5% at 18 months by 2016. The PMTCT programme, itself launched as a result of civil society pressure, has been largely successful. The most recent evaluation of the PMTCT programme shows that transmission rates have declined to 2.7%,[155] and yet 43% of under-five child deaths in South Africa in 2011 were still related to HIV.[156] While the progress made by the PMTCT programme is admirable, further strides towards ensuring that mother to child transmission of HIV is reduced will require strengthening the management, leadership and coordination of the PMTCT programme and ensuring its integration with maternal and child health programmes.

174. Children do not contract HIV solely through mother to child transmission and the **distribution of condoms** at schools is an important HIV prevention measure. The NSP encourages the increased use of condoms by people between the ages of 15 and 24. It envisions an increase from 40% in 2008 to 100% in 2016 by substantially increasing condom distribution at 'non-traditional' outlets, including schools.[157] The *Department of Basic Education Draft National Policy on HIV and TB, May 2013*, makes provision for the distribution of condoms in schools but such distribution is subject to "discussions with the school community led by the SGB concerned."[158] This is problematic in that it does not sufficiently guarantee easy, discreet access to condoms on school premises for all learners, and many schools are refusing to make condoms available. This is contrary to the requirements of the NSP and renders sex education on the importance of condom use (also part of the draft policy) superfluous.[159] While children from the age of 12 can access condoms and other forms of contraception, and efforts have been made to develop youth friendly clinics, anecdotal evidence suggests that staff continue to discriminate against sexually active and pregnant teens.

175. The issue of **sexual violence at schools**, in particular sexual abuse by teachers of learners, needs to be confronted. The South African Council for Educators (SACE) has recently noted an increase in the number of reported cases of sexual abuse by teachers of learners. Between 1 April 2012 and 31 March 2013 alone, SACE received 104 complaints.[160] This number clearly does not take into account the chronic under reporting of such cases. The *Department of Basic Education Draft National Policy on HIV and TB, May 2013* fails sufficiently to address this issue and the implications for HIV and STI transmission. This shortcoming of the policy requires urgent attention.

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[155] Goga A, TH Dinh, D Jackson, C Lombard, S Crowley and G Sherman et al. 2012. *Impact of the National Prevention of Mother to Child Transmission of HIV (PMTCT) Programme on Perinatal Mother-to Child Transmission of HIV (MTCT) Measured at 6 Weeks Postpartum, South Africa (SA): Results of the First Year of Implementation of the 2010 PMTCT Guidelines Recommended by the World Health Organisation (WHO).* Presented at the XIX International AIDS Conference, 22 – 27 July 2012, Washington, DC

[156] Department of Health. 2012. *Interim report of the Committee on Morbidity and Mortality in Children under 5 years (COMMIC).* Pretoria: DoH

[157] National Strategic Plan on HIV, STIs and TB (2012 -2016) p 46

[158] www.section27.org.za/wp-content/uploads/2013/10/National-Policy-on-HIV-and-TB.pdf p 6

[159] www.section27.org.za/wp-content/uploads/2013/10/SECTION27-Submission-on-the-DBE-Draft-National-Policy-on-HIV-and-TB.pdf

[160] South African Council for Educators 2012/2013 Annual Report at p 27-28

176. Medicines stock-outs, particularly stock-outs and shortages of ARVs and TB medication, continue to plague the South African health care system. In November 2013, the Stop Stock Outs Project, a partnership of civil society organisations, surveyed 2139 health care facilities and found that 403 facilities had had a stock-out or shortage of ARVs in the past three months while 68 facilities reported problems in TB medication supplies.[161] **Medicine shortages** have a catastrophic effect on people living with HIV, including children. While the ARV programme in South Africa, the biggest in the world, is certainly something to be proud of, without serious attention being paid to the reliable availability of ARVs, the programme is significantly weakened and people living with HIV suffer.

177. In addition to shortages of medicines, a major challenge in regard to the **treatment of TB** is access to effective, tolerable regimens for adults and children. Treatments for drug resistant TB especially have poor success rates, are extremely long and have "side effects", such as deafness, that are intolerable. There is an urgent need for TB treatments that are more effective, shorter and have fewer side effects.

178. A further challenge highlighted here affects early initiation of children onto treatment for HIV and TB and threatens efforts to ensure treatment adherence. This challenge is the poor management of **information systems**, particularly at facility level but also in the feeding of information through the national health system. This is a general problem across the health care system but has a negative effect on attempts to manage HIV and TB in the community at large and among children. Information-gathering is vital both for individual patient care and for the collection of data that may influence policy-making and prioritisation. As such, it is important that both horizontal and vertical data is gathered.[162]

179. Despite significant gains **early infant diagnosis and Anti-Retroviral Therapy** (ART), challenges remain in terms of ensuring that children are initiated on ART as early as possible and systems for tracking progress need to be strengthened. Follow-up support for ART continues to be the task of community health workers, adherence supporters and child and youth care workers who need to be recognised, remunerated, supported and effectively integrated into the health care system. Similarly greater effort is required from the DH to provide follow-up support to mothers and ensure that communities are informed about the latest guidelines on infant feeding.

180 The lack of reliable national data makes it impossible to evaluate the extent to which child rape victims have access to **post exposure prophylaxis**. The lack of support services and funding for civil society organisations providing psychosocial support is worrying. The measurement of compliance with ARV regimens following sexual assault is also important and not captured.

181. There have been significant reductions in the transmission of HIV to children and improvements in the roll-out of ARVs and TB treatment. Further effort is needed

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[161] Stop Stock Outs Project. 2013. *Stock Outs in South Africa: A National Crisis* p 8. Available at http://stockouts.org/uploads/3/3/1/1/3311088/stop_stockouts_report_2013pdf_1.pdf

[162] Ngoepe MS. 2008. An explanation of Records Management in the South African Public Sector: A Case Study of the Department of Provincial and Local Government. Available at http://uir.unisa.ac.za/bitstream/handle/10500/2705/dissertation_ngoepe_%20m.pdf;jsessionid=35EEF50269C8AC34430CD2AF35239570?sequence=1

however, to tackle the remaining challenges to ensure the realisation of the rights of children to access to health care services and to reduce the burden of HIV and TB, particularly on South Africa's children.

Adolescent reproductive, mental health and risk behaviour

182. In a study conducted by the Human Sciences Research Council (HSRC) for loveLife in 2012[163] the risks most often mentioned by young people were related to sex and alcohol, but they also discussed violence in their communities, the dangers of walking home late at night, and having older partners.

183. While young people grow up surrounded by risk, they increasingly have **access to services**, such as HIV counselling and testing (HCT), that help them better assess and manage their health. Young people are a major contributor to the success of the on-going HCT campaign.[164] The greatest barrier to the uptake of clinical services, however, remains the attitude of healthcare providers, many of whom still regard it their duty to scold young people who are either thinking of having sex for the first time, or who are already sexually active.[165]

184. The recent moral panic around **teenage pregnancy**, even in the face of clear evidence of an on-going population-level decline in young women falling pregnant,[166] has only worsened the situation. Though the DH has taken great steps forward in making clinics youth-friendly, much work still needs to be done. There are a total of 3,774 public clinics in South Africa and of these, at least 469 clinics have specific peer-motivation and adolescent-friendly lifestyle programmes in place. While extensive training on youth-friendly services has been conducted, externally validated assessments of youth-friendliness have not, and anecdotal feedback from adolescents about whether clinics are friendly tends to be negative,[167] even at accredited clinics, the service young people experience is not optimal for their needs.[168]

185. A national **child homicide study**[169] uncovered the hidden problem of dumped foetuses in South Africa. In 2009 more than 900 foetuses were found in a variety of spaces ranging from toilets, garbage dumps, trash bins amongst others. Although abortion and contraceptive services are available, these must be strengthened and there

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[163] loveLife (2012) *Talking Points: A study on HIV, sexual risk behavior, and access to opportunity among young people in South Africa*
[164] Personal correspondence with the Nerve Centre chairperson, Rev. Zwo Nevhutalu
[165] Jan M, I Mafa, K Limwame and A Shabalala. 2012. *Challenges to youths accessing sexual and reproductive health information and services in Southern Africa: A review of qualitative research in seven countries*. A paper presented at the 5th Africa Conference on Sexual Health and Rights, 19 – 22 September 2012. Windhoek: Namibia
[166] Panday, S., M Makiwane, C Ranchod and T Letsoal. 2009. *Teenage Pregnancy in South Africa: with a specific focus on school-going learners*. Human Sciences Research Council. Available at www.lovelife.org.za/corporate/index.php/download_file/view/103/274/.
[167] loveLife. 2012. *Talking Points: A study on HIV, sexual risk behavior, and access to opportunity among young people in South Africa. P 96.*
[168] Focus group discussions with loveLife Khayelitsha groundBREAKERS conducted in February 2014
[169] Mathews S, Abrahams N, Jewkes R, Martin L J., Lombard C. 2013. The Epidemiology of Child Homicides in South Africa. *Bulletin of WHO*. 91:562–568.

needs to be concerted public education programme to promote use of these services and to ensure a supportive rather than punitive response to pregnant teenagers.

186. The evidence around **condom use** among young people is unclear. The loveLife study in 2012 confirmed the trend of earlier HSRC studies which showed increasing condom use among young people (over 90% of young men and 80% of young women reported using a condom the last time they had sex with a non-regular sexual partner). But the national HSRC *Seroprevalence and Behaviour Survey* results presented in 2013 suggested that condom use among young people is actually on the decline, and that other risky behaviours are on the increase. One reason is that young people —especially young women —still find themselves at the bottom of the pile when it comes to access to opportunity and the mainstream economy. The spectre of so-called "**sugar daddies**" masks the reality that young women face. To gain access to the social bases of self-respect —a job, good clothes, a trip into town —they are sometimes forced to rely on help from a man. This man need not be much older. In fact, the pattern of infection suggests that many of the men who have unprotected sex with younger women are in fact in their late twenties and early thirties.[170] That the 'help' these men give young women is part of a *quid pro quo* involving sex should spur us on to improve the social conditions of young women in marginalised communities, including better public transport and access to opportunity. In the loveLife study, 1 in 5 sexually active young women and men reported having had sex for some kind of material gain, which points to the magnitude of the problem.

187. While both new HIV infections and pregnancies among young people have continued to decline, there are still **pockets of high risk**: three in four first pregnancies before 23 are unintended; and over 60% of the young people who have had transactional sex report never using a condom during those specific sex acts. Adolescent health seems to be increasingly polarised. Young people who find themselves furthest from available opportunity are the most likely to take massive risks with their health. The loveLife study found that when young people do not see a clear future for themselves, they are more likely to have multiple concurrent partners, and an adolescent pregnancy.[171] The most urgent battle for adolescent health is thus the battle for increased equality and **access to opportunity** for young people.

188. Staff capacity to deliver **mental health** care services is severely constrained across all levels of healthcare —especially child and adolescent services. About 40% of the population are under the age of 15; and prevalence calculations suggest that at least 17% will have a diagnosable and treatable mental health disorder.[172] This is similar to the prevalence of HIV in many parts of South Africa. In spite of the known impact of mental health problems on early child development, educational attainment, occupational and earnings potential and societal burden, there are only 35 subspecialists in child and adolescent psychiatry in SA; half of those (about 15) work in the state sector; of those 8 are in the Western Cape. South Africa therefore has provinces without

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[170] loveLife (2009) *A gauge of HIV prevention in South Africa, 2009*
[171] loveLife (2012) *Talking Points: A study on HIV, sexual risk behavior, and access to opportunity among young people in South Africa*
[172] Kleintjes S., AJ Flisher, M Fick A Railou, C Lund, C Molteno *et al*. 2009. The prevalence of mental disorders among children, adolescents and adults in the western Cape, South Africa. *South African Psychiatry Review* 9, 157–60

any specialist in child and adolescent mental health (CAMH). There is a dearth of training posts, and government has not allocated funding for training. The majority of funding goes to adult mental health problems which have their onset in childhood or adolescence. It therefore essential to invest in development of CAMH services across all levels of healthcare in South Africa.

189. The new ***Integrated School Health Policy*** provides for an ambitious range of services with a strong emphasis on health promotion and screening, and it has the potential to reach large numbers of older children, however it is not clear how government plans to address the staff, transport and equipment shortages that hampered the implementation of the previous *National School Health Policy*.[173] Screening for developmental delays and disabilities in schools is important, and it is vital that strong referral systems are in place to provide follow-up care. This is likely to be severely comprised, unless the current shortage of physiotherapists, occupational therapists, social workers and psychologists is addressed.[174] In addition, school health services may not be effective in reaching those adolescents most in need, given high levels of school dropout from Grade 10.[175]

190. **Alcohol use** was identified as the leading risk factor for death and disability in sub-Saharan Africa, and globally for person's aged 15 to 19 years.[176] In South Africa, in 2011 a national school survey of learners in grades 8 to 11 found that 37% of males and 28% of females reported drinking in the past 30 days, with an alarming 30% of male and 20% of female learners reporting binge drinking during the same period.[177] Direct and indirect consequences of drinking among children and adolescents in South Africa include rape, interpersonal violence, absenteeism, school failure, unwanted pregnancies, sexually transmitted infections, HIV, and foetal alcohol spectrum disorders (FASD).[178] Drinking during pregnancy can damage the unborn child, and rates of FASD in South Africa have been found to be among the highest in the world, with a recent study reporting population levels of between 14% and 21% for grade 1 learners in certain mainly rural communities of the Western Cape.[179]

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[173] Shung King M. 2009. Reviewer Report: Implementing the National School Health Policy in South cratic participation: Lessons from South Africa*. International Journal of Educational Development*, 26, 415-427

[174] Health Systems Trust. 2012. *National Health Care Facilities Baseline Audit: Summary Report*. Durban: HST

[175] Department of Basic Education. 2103. *The Internal Efficiency of the School System. A Report on selected aspects of access to education, grade repetition and learner performance*. Pretoria: Department of Basic Education.

[176] Lim, S.S, T Vos, Flaxman et al. 2012. The burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions 1990-2010: A systematic analysis. *Lancet*, 380, 2224-2260.

[177] Reddy SP, S James, R Sewpaul, S Sifunda, A Ellahebokus, NS Kambaran, and RG Omardien. 2011. *Umthente Uhlaba Usamila – The 3rd South African National Youth Risk Behaviour Survey 2011*. Cape Town: South African Medical Research Council, 2013.

[178] Morojele, N., C Parry, J Brook, and C Kekwaletswe. 2012. Alcohol and drug use. In A. van Niekerk, S. Suffla & M. Seedat (Eds.), *Crime, violence and injury in South Africa: 21st century solutions for child safety* (pp.195-213). Tygerberg: MRC-University of South Africa Safety & Peace Promotion Research Unit.

[179] May, P.A, j Blankenhip, A-S Marais, JP Gossage, WO Kalberg, R Barnard, M de Vries, LK Robinson, CM Adnams, D Buckley, M Manning, KL Jones, C Parry, HE Hoyme, and S Seedat. 2013.

191. The South African government has attempted to address these problems by proposing to ban the advertising of alcohol, raise the legal drinking age, limit hours for alcohol sales, and lower the legal alcohol limit for drivers. While government has taken concrete action in a few areas, there is a lot more the government could and should be doing: equipping parents to be good role models and to set appropriate boundaries for their children; banning packaging that appeals to young people; increasing excise taxes on products that appeal to young people such as fruit flavoured alcoholic drinks; dealing firmly with venues that sell alcohol to underage drinkers; instituting a graduated driving license policy so that novice drivers may not test positive when driving under the influence of alcohol for a number of years; accrediting school based prevention programmes to improve quality; and ensuring that there are appropriate and quality treatment programmes available for young persons who need such an intervention.[180]

7.4 Social security, child care services and facilities

192. The Initial Country Report provides a clear overview of the origins, expansion and impacts of the **CSG**. Para 248 cites the DSD-commissioned evaluation of the CSG. In addition to this single evaluation, numerous independent studies have shown an array of positive outcomes associated with receipt of the CSG. Further studies have demonstrated similar effects of the Old Age Pension and suggest that positive child outcomes are achieved by targeting cash transfers to women, irrespective of the type of grant. An analysis of the impact of social grants on child poverty demonstrates that the larger grants (i.e. those other than the CSG) reduce income poverty levels more dramatically than the CSG, even though they are much smaller in number and are not necessarily targeting children. This is because the value of the CSG is so small relative to all other grants.

193. The increase in the number of **Foster Care Grant** (FCG) beneficiaries between 2005 and 2011 is the direct result of its deployment as an orphan grant. This was not the original intention and there has been some debate about whether support for orphans is an appropriate use of the FCG. Proponents argue that the additional amount of the FCG offsets the unanticipated and unplanned costs for caregivers who take in the orphaned children of family members, and that the inclusion of orphaned children in the foster care system means that these care arrangements are regularly monitored by the welfare system. Critics of this approach (i.e. those opposed to the targeting of orphans on the basis of their orphan status) list three main concerns: Firstly, the differential in the grant amount creates an inequality between orphaned and non-orphaned children in a context where poverty is widespread and orphaned children are not necessarily financially worse off than non-orphaned children. Secondly, the overwhelming majority of orphans are cared for by extended family members, and so the assumption that the care arrangements of orphaned children need to be especially monitored suggests that the state regards extended family care arrangements as being 'risky' compared with having co-resident parents. The problem with this logic is that many more non-orphans than orphans are cared for by extended family members. The CSG was deliberately designed to target *de facto* caregivers of children irrespective of whether they are

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Approaching the prevalence of the full spectrum of fetal alcohol spectrum disorders in a South African population-based study. *Alcoholism: Clinical & Experimental Research*, 37, 818-830.

[180] Morojele NK, CDH Parry, and JS Brook. 2009. *Substance Abuse and the Young: Taking Action* (Research Brief). Pretoria: MRC.

biological parents, in recognition of the complexities of family and household contexts and the role of the extended family in caring for children. Third, and perhaps most important, is that the welfare services do not have the capacity to keep up with the procedural requirements for monitoring and renewing such a large number of FCGs. The foster care system was not designed to accommodate such a large number of children and over 110,000 FCGs have lapsed[181] over the past few years as the social services and justice systems were not able to renew them in time. The issue of lapsing grants has been subject to litigation, with a court order to prevent further lapsing until a policy solution has been found. To date, such a policy solution has not been agreed upon.

194. **Contributory social insurance**, mainly in the form of the Unemployment Insurance Fund (UIF), can benefit children in that it reduces the financial shock of job-loss among adults in the household. It is therefore highly relevant in a context of labour market instability brought about by recession, for example, as well as in the context of HIV and high adult morbidity and mortality. The important gap is that there is no social security for the vast population of unemployed adults, as they can neither contribute to UIF, nor can they claim any social grants.

195. The Initial Country Report creates an overly rosy picture by neglecting to point out that South Africa has one of the highest **unemployment** rates in the world, with formal unemployment around 25% and a 'real' unemployment rate (including discouraged work-seekers) well in the 30%s.[182] Unemployment rates are particularly high in marginalised areas, which is also where children (and particularly orphans) are over-represented. Thus, while UIF, pension and provident schemes provide some income security for children who are co-resident with adult contributors and beneficiaries of these schemes, a large proportion of the child population is unlikely to derive benefits because they reside in households where no adults are employed—over a third of children live in "unemployed households" according to Children Count[183] analyses. The statement that unemployment insurance and workers' compensation schemes provide a death benefit to the children of the member is inaccurate. Beneficiaries are nominated by the member and are not necessarily the children of the member. The challenges of accessing death benefits are compounded by complications around succession and the fact that many South Africans die intestate.

196. The problems with the foster care system detailed in section 6.4 above impact negatively on the availability of **childcare services and facilities**. This is particularly so in relation to the shortage of social workers in the country. The inappropriate use of scarce social worker and court time and resources to channel applications for FCGs to relatives caring for orphans is undermining the capacity of the system to provide adequate protection services to abused, neglected and abandoned children.

197. These problems are exacerbated by the gross underfunding by government of CSOs delivering child protection services. CSOs cannot meet service standards if they do

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[181] Hall K and P Proudlock. 2012. *Towards revised options for orphans / poor / vulnerable children*. Presentation at a Department of Social Development consultative workshop on revised options for the provision of social assistance to children in non-parental care, 28 November 2012.
[182] The estimated unemployment rate in South Africa for the second quarter of 2013 was 25.60%. www.trading economics.com/south-africa/unemployment-rate. Accessed September 2013.
[183] See footnote 60.

not have funding to pay for the transport costs required to do home visits, and to get to court, or the necessary computers to compile reports, or to ensure they have enough social workers to do the work, and administrative staff to process the paperwork. In its annual report to Parliament in August 2013, the DSD did not acknowledge that the CSOs responsible for delivering more than 50% of the country's welfare services are in a funding crisis; neither did it give any indication of how it intends to address this looming crisis in the child protection system. Furthermore, none of the Members of Parliament raised this, despite the fact that the FFC had just tabled a report in Parliament on the challenges faced by CSOs delivering child welfare services and the urgency for government to address the funding challenges.

198. Of significant concern is the lack of management, accountability and transparency within the system. Children's cases often go unattended for many months, even years. Even when a child has an adult trying to help them through the system, their case can be neglected for years. This state of affairs is not visible except on a case-by-case basis because children's files are confidential and researchers struggle to gain the necessary access to undertake studies that would reveal these challenges.

7.5 Care for orphans

199. The majority of children who have been orphaned are in the care of extended family members. In general, their needs are largely financial; currently, extended family member care-givers seek access to the FCG in large numbers. This is seriously eroding the capacity of the formal child protection sector, as is shown in various sections of this Initial Complementary Report.

200. Once formally recognised as a child in foster care and in receipt of the FCG, children are entitled to free schooling and health services, among other things. However, the capacity, resourcing and accessibility problems highlighted in many areas of this Initial Complementary Report mean that, more often than not, services are either not accessible or of very poor quality.

8 EDUCATION AND LEISURE

8.1 Rights to education

201. Although there has been a steady and substantial increase in the education budget over the last decade, this has not necessarily translated into corresponding expenditure and use of those budgets. Considered against actual expenditure, and the comments of the Auditor General,[184] the significance of an increase in the budget seems much less praiseworthy. There has been a consistent frequency amongst both the national and some provincial education departments to overspend in areas where this cannot be afforded or was not necessary, and similarly to underspend in areas where effective and full spending is absolutely necessary. Sustainable and substantial progress in the education system will only be achieved with the efficient and effective expenditure of the allocated budgets.

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[184] SAPA. 2014. *Government bodies wasted R2bn last year, says AG*. Mail and Guardian, accessed at http://mg.co.za/article/2014-02-05-government-bodies-wasted-r2bn-last-year on 16 February 2014.

202. For example, in an area where proper expenditure is crucially needed, one of the greater immediate challenges faced by the state, the major problem is not a lack of funding. Rather, it is the inability (incapacity) of the state to spend the large amount of funds allocated for the improvement of school infrastructure.[185] In the 2011/2012 financial year only R76 million of the R700 million under the direct control of the DBE was spent. At the end of the third quarter of 2012/2013 financial year, only R476 million of the 2.3 billion allocated had been spent.

203. The policy and legal regulatory gains in the area of school infrastructure over the last four years are directly attributable to the sustained pressure which civil society has exerted upon the State through a combination of advocacy and litigation. The Minister of Basic Education until recently remained recalcitrant with regard to the need for the enactment of regulations containing the basic standards for school infrastructure countrywide. Indeed, the 2012 guidelines on school infrastructure were introduced by the Minister in an unsuccessful last minute attempt to appease civil society demands for legally binding school infrastructure standards. The regulations also require that all mud and asbestos schools be eradicated within three years, and that schools without access to water, electricity and sanitation be provided with these basic services within the same three year period. According to the most recent government reports on school infrastructure (National Education Infrastructure Management System [NEIMS] Report 2011)[186] notes that: 3,544 schools had no electricity supply; there are still 11,450 schools using pit latrine toilets; 2,402 schools have no water supply while a further 2,611 schools have an unreliable water supply; and 913 schools have not ablution facilities at all.

204. In November 2013 and as a result of an out-of-court settlement agreement, the Minister introduced binding norms and standards together with timelines within which the State must ensure that they are achieved. The norms oblige the State to deliver on classrooms, electricity, water, electronic connectivity and perimeter security for all schools by 29 November 2020.

205. Aspects of the regulations, however, remain worrying. These include the ambiguous commitment to deliver on physical school libraries for all schools and the unacceptably low sanitation standards which fall below the standards that have been recommended by international bodies such as the WHO and UNICEF. The infrastructure norms need to be urgently amended to ensure that these standards rise to an acceptable level.

206. In addition, implementation and delivery remains an ongoing challenge. The norms fail to provide a mechanism for the free flow of information to the public, in so far as plans and progress in achieving these norms. Provincial departments and districts must remain in constant communication with schools so that those affected are aware of what they can expect to receive, how their particular school has been prioritised and by when they can expect to see improvements. The feasibility of the regulations hinges

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[185] http://www.equaleducation.org.za/content/2013/10/15/2013-10-11-EE-comment-on-September-2013-norms-draft-regs-FINAL.pdf as at, 23 February 2014.
[186] Accessed on 23 February 2014 at http://www.education.gov.za/LinkClick.aspx?fileticket=hHaBCAerGXc%3D&tabid=358&mid=1802.

directly upon the ability of parents, learners and teachers being able to hold the State accountable to the standards which have finally been set.

207. Despite the improvement in retention rates, learner drop-out rates remain very concerning, particularly in the light of the generally low standard of literacy and numeracy. A report released by the Department of Basic Education in 2013 admits to "high levels of drop-outs [which] begin after the age of 16. Attainment of matric is still unequal across race groups, with white and Indian youths more likely to attain matric than black and coloured youths."[187] The same report notes that, while there has been a moderate increase in the number of learners who attain matric, a study of the cohort of learners born between 1985—1987, found that 17.5% of learners who achieve grade 10, and a further 28.3% of learners who achieve grade 11, received no further education. These drop-out rates are closely related to disproportionately high repetition rates in grades 10—12. Analysis of Community Survey data collected by SSA found children with disabilities to be disproportionally represented among school drop-outs. The data indicate that children with disabilities have a lower school attendance rate than other children, as 22.5% (38,000) were out of school.[188]

208. Effective expenditure in the South African context would of necessity constitute equitable and pro-poor expenditure. Whilst pro-poor funding policies linked to 'schools in the poorest income quintiles' are referenced in the Initial Country Report as a measure designed to aid vulnerable learners, the impact of these measures is curtailed considerably by the limited focus on non-personnel expenditure. Thus, while it is commendable that, in terms of the government's 'No-fee schools' policy almost 70% of learners in the public education system attend no fee school, barriers of access to schools have been removed, the 'pro-poor funding' funding of schools is not sufficiently aimed at aspects affect the quality of education at those schools, but are focused on 'operational expenditure' at schools (which includes expenditure on resources such as stationary, textbooks and school maintenance and do not include personnel expenditure). A key issue as yet not addressed on a pro-poor basis is the unequal distribution of teachers (and the spread of teacher qualifications) across South Africa's public schooling system. There are insufficient measures and financial incentives and funding aimed at providing a more equitable provision of more highly qualified teachers to schools catering for poor learners.

209. The allocation of teachers to schools in provinces takes place in accordance with a post provisioning model. Although the current model states that the "head of a provincial department must set aside a certain percentage of its available posts for poverty redress based on the department's relative level of internal inequality"[189] this is subject to the Minister of Basic Education exercising her statutorily conferred discretionary power to

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[187] *The internal efficiency of the school System*, Department of Basic Education, 2013, pg 4. See: http://www.education.gov.za/LinkClick.aspx?fileticket=Jaaol0vqeR4%3D&tabid=36 23 February 2014.

[188] Fleish B, J Shindler and H Perry. 2009. Children out of school: evidence from the Community Survey'. in Pendlebury S, L Lake L and C Smith (eds) *South African Child Gauge 2008/2009* Cape Town: Children's Institute, University of Cape Town

[189] Regulations for the Creation of Educator Posts in a Provincial Department of Education and the Distribution of Such Posts to the Educational Institutions of Such a Department, Annexure 1: "Weighting norms" at section 5(a)

"set the maximum percentage that provincial departments may use for this purpose". The Minister has set this maximum limit at a meagre 5%.

210. The current model of teacher post provisioning also fails to account for the number of additional teachers that privileged fee-charging schools can hire, or for the fact that most of the better suburban schools attract better qualified teachers who receive higher salaries from government. The resultant effect, in real terms and keeping in mind where the bulk of the budget is consumed, is that government spends more per learner in these better suburban schools than it does on learners in township and rural schools.

211. The Initial Country Report recognises that pregnant learners are a vulnerable group within the education system and makes a vague reference to measures that the State has taken to *"prevent early pregnancies and provide support to ensure the return of girls who become pregnant"*. The reality is that the 2007 *National Pregnancy Prevention Measures* introduced by the State to combat learner pregnancy and ensure support for pregnant learners did not only fail to deliver on its intended purpose but actually served to exacerbate the discrimination faced by pregnant learners. This is because these measures explicitly endorsed a punitive policy which encouraged schools to exclude pregnant learners for a period of up to two years. The DBE has finally acknowledged the unconstitutionality of the 2007 measures after the Constitutional Court recently handed down judgment in a case where two pregnant learners had been excluded from their schools.[190] The judgment places beyond any legal doubt that the 2007 measures are unacceptable and need to be replaced as a matter of urgency.

212 Foreign migrant children possess the right to basic education in South Africa by virtue of the Constitution, the Children's Act of 2005, the South African Schools Act of 1996, the Refugees Act of 1998 and international law. Despite these laws, serious barriers exist for this vulnerable group in equal access to education. Some of the reasons include being unable to afford school fees (although a parent can apply for an exemption, based on a means test); being without documents or holding expired documents; being unable to afford transport, uniforms or books for school; language difficulties; and, finding the local schools full.[191] Admission to school is conditional on the parent/caregiver being in the process of applying for documentation this may take up to a year to complete.

213. On a positive note, although as a direct result of the case of *Bulambo v Minister of Home Affairs*,[192] the DBE decided to amend its *Admissions Policy for Ordinary Public Schools* to specifically spell out that asylum-seeker and refugee children must be allowed to register in public schools, without South African birth certificates or study permits.

214. Xenophobic attacks in communities, such as those that took place across South Africa in May 2008, create additional obstacles to children's access to education due to,

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[190] See http://www.dailymaverick.co.za/article/2013-07-11-concourt-orders-free-state-schools-to-review-pregnancy-policies/#.Uwm_qc6VzOd

[191] Dass, D. et al. Forthcoming in 2014. Socio-Economic Rights of Refugees in South Africa' in Khan, F. and Schreier T. *Refugee Law in South Africa*. Cape Town: Juta.

[192] *Bulambo Miakomboka Mubake v Minister of Home Affairs* NGHC case no 72342/2012 in which the court issued an interim order stating that asylum-seeker and refugee children must be admitted to public schools and they do not need to produce a study permit to guarantee access.

among other things, parents' fears of allowing their children back into unstable communities and the cost of transport for those sheltered far from their original schools.[193] Non-national children in schools report being regularly subjected to xenophobic comments by teachers or other students.[194]

8.2 Aims and quality of education

215. The Initial Country Report makes many important admissions with regard to the challenges and symptoms of poor quality and unequal provision of education in South Africa. The general drop-out rate continues to be excessively high and should be considered directly against the touted improvements shown in the matric pass rate. Almost half of all learners who enter the schooling system do not reach matric (grade 12). In total, there were 1,407 schools with a pass rate below 60%, the standard used by the DBE to identify "underperforming schools". Eighty-six percent (1,209) of these schools are in Quintile 1, 2 and 3. These are the poorest and most under-resourced schools in the country. In comparison, only 36 schools in Quintile 5 had a pass rate below 60%.[195] Education Economist, Nick Spaull has concluded in a recent study that: "[analysis] of every South African datasheet of educational achievement shows that there are in effect two different public education systems in South Africa. The smaller, better performing system accommodates the wealthiest 20-25 percent of pupils who achieve much higher scores than the larger system which caters to the poorest 75-80 percent of learners."[196]

8.3 Leisure, recreation and cultural activities

216. It is difficult to obtain an objective overall understanding on what is actually happening with regard to leisure and play, as so many government departments and institutions take (or do not take) responsibility for play.

217. Generally speaking, play is not understood and valued and therefore for most children in South Africa, not systemically provided for in their families, communities and schools. Providing for play is not necessarily resource intensive, but does require resourceful and supporting adults to allow and create play spaces.

218. Regionally, the Southern African *Chance to Play* Network has directed its efforts to increasing its membership, and undertaking training on play within the NGO sectors in South Africa, Mozambique, Namibia, Zimbabwe and Zambia.

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[193] LHR/CoRMSA submission to the Portfolio Committee on Basic Education on the difficulties faced by refugees, asylum seekers and other foreign migrant children in accessing education, February 2010, available at http://www.lhr.org.za/policy/lhrcormsa-submission-portfolio-committee-basic-education, accessed on 3 February 2014.

[194] LHR/CoRMSA submission to the Portfolio Committee on Basic Education on the difficulties faced by refugees, asylum seekers and other foreign migrant children in accessing education, February 2010, available at http://www.lhr.org.za/policy/lhrcormsa-submission-portfolio-committee-basic-education, accessed on 3 February 2014.

[195] See http://www.equaleducation.org.za/article/2014-01-07-equal-education-ee-statement-on-the-2013-matric-resultshigher-pass-rate-but-drop-outs-poor-quality-passes-and-inequality-persists accessed on 23 February 2014

[196] South Africa'S Education Crisis: The quality of education in South Africa 1994 – 2011; Nicholas Spaull, October 2013, *Report Commissioned by Centre for Development and Enterprise*.

219. There are a number of initiatives at local and provincial level (such as *Imagine* in Durban and the KwaZulu-Natal Department of Sports and Recreation's *Play and Learn* programme). However, as noted in the Initial Country Report, there are still significant inequities and lack of provision.

220. CSOs undertaking work in the arena of play and leisure face the same challenges as those in the formal child protection sector—i.e. closure due to lack of funding.

221. Children's right to play should be integrated across sectors, including health, education, sports and recreation, local government, town planning, housing, public works, security, environment, social development and early childhood education, among others.

222. The UN CROC issued General Comment 17 in 2013. As yet, there is little awareness about the right to play or the value of play in South Africa, and an awareness-raising campaign is needed to highlight these issues. General Comment 17 should be used to promote an understanding of the right to play, and obligations to implement play programmes.

223. At local level, anecdotal evidence is strongly suggestive that municipalities, which have the responsibility (under the Constitution and the Children's Act) to provide facilities for children, are not in fact doing much to ensure that their Integrated Development Plans (IDPs) include funds for and actual provision of parks, playgrounds, libraries and other facilities for children.

9 SPECIAL PROTECTION MEASURES

9.1 Children in situations of emergency

224. South Africa is a major recipient of refugees, asylum seekers, and other categories of African migrants. African migrant children who are displaced in their countries of origin due to persecution, generalised violence or abject poverty, and subsequently flee to South Africa, are unquestionably a vulnerable group.

225. **Refugee and asylum seeker c**hildren, who are accompanied by their parents or lawful guardians experience serious hardships in South Africa, primarily as a result of the poor implementation by the DHA of the Refugees Act of 1998 and lack of equal access to basic services. Although on paper the Refugees Act is progressive in terms of the rights it provides refugees and asylum seekers, it is almost meaningless in practice. The country's asylum system is woefully under-capacitated and corruption is rife. Further, most asylum seekers must wait in excess of five years for their asylum claims to even be adjudicated, during which time they must regularly renew their documentation due to short extensions and they receive little to no social assistance by the government. The Refugees Act itself has been amended twice, in 2008 and 2011, in order to improve the system but the amendments have not been brought into force due to the Minister's unwillingness to draft regulations to the Amendments.

226. A noticeable shrinking of the asylum space has been observed in South Africa in the last few years. The government has recently embarked on a major shift in refugee

policy, and is currently focused on removing refugees from the urban centres, closing refugee reception offices in cities like Johannesburg and Cape Town, with the intent on creating refugee de facto detention centres along the country's northern borders.[197] This has severely impacted and will continue to negatively impact refugees, asylum seekers and their children in South Africa. The major access barriers to refugee children's basic rights have already been addressed in various other sections of this Complementary Report. Access to basic services is primarily hampered by lack of reliable identification documentation, massive delays in the asylum adjudication process, the lack of knowledge by frontline service providers of refugee rights, the social exclusion of refugees and xenophobic attitudes.

227. **Unaccompanied or separated foreign childre**n in South Africa, who do not have asylum claims and thus cannot be documented in the asylum system; and, who cannot be reunited with family in their country of origin or cannot be returned safely to their country, cannot be deported from South Africa. Unfortunately, magistrates, police officials, immigration officials and social workers continue to allow this unlawful practice to occur. The biggest challenge however is that there are no provisions in the Refugees Act or the Immigration Act to enable such children to obtain identification documents in South Africa. They therefore exist in limbo with no identity document and their access to all South African services that require an identity document is severely curtailed.[198]

9.2 Children in armed conflict

228. South Africa is home to many children who have been involved in or affected by armed conflict in their countries of origin; the issues relating to these children in the South African system are dealt with in the section dealing with refugee children.

229. Although few South African children are directly affected by armed conflict in the traditional sense, the issue of children involved in organised and armed violence (COAV) is a significant one affecting children living in urban areas with poor infrastructure and poor access to education, health and social services.[199] This largely takes the form of children being involved in and affected by gangs in a range of ways. (Please see the attached COAV South Africa report).

230. Frequently, children are enlisted into **gang and other criminal activity** deliberately by adults, this is considered a Worst Form of Child Labour and the gravity of this recognised in international law.[200] In addition to being enlisted in gangs by adults, research into the reasons for children becoming involved in gangs indicates that they join because it is considered normal to do so; to uphold family tradition, or conversely to rebel against the family; and for protection from pervasive violence. The research

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[197] Kerfoort W and T Schreier T. Forthcoming in 2014. Application for Asylum: Reception in Khan, F. and T Schreier. *Refugee Law in South Africa.* Cape Town: Juta.
[198] Schreier T. 2013. Critical Challenges to Protecting Unaccompanied and Separated Foreign Children in the Western Cape: Lessons Learned at the University of Cape Town Refugee Rights Unit. *Refuge* Vol. 28 No. 2, pp 61 - 75.
[199] Waterhouse S, C Frank and B Kelly. 2008. *Children and Gangs Project: COAV Cities Cape Town*. Policy Paper Series. Recommendations for key departments in the Western Cape. P4
[200] International Labour Organisation, Convention 82. Art 3; United Nations GA Resolution 45/115 (1990) on the instrumental use of children in criminal activities

indicates that children start to join gangs from as young as eleven and twelve years old.[201]

231. State responses to gangs are currently problematic. Most policies and programmes are blind to the role children play and the ways in which children are affected by gang activity and gang violence, where policies respond to the impact on children or their involvement, they are poorly implemented. Furthermore, the responses tend to focus on security and criminal justice initiatives and measures to address prevention and early intervention are weak. Finally, to prevent or respond to this situation requires a coordinated effort across a range of government departments; this is currently not in place. The lack of coordination undermines the programmes and initiatives that are in place to address aspects of the issue.

9.3 Children in the justice system

232 The Country Report provides minimal information on the situation of **child victims and witnesses**. The Constitutional Court has given guidance on how courts should elicit and measure the evidence of children, citing the UN Guidelines for Child Victims and Witnesses, and the General Comments 3 and 5 of the UN Committee on the Rights of the Child.[202] However, there are still cases where convictions of offenders have been set aside due to the lower court's incorrect handling of children's evidence. Ongoing professional development for judicial officers is required, and specialisation of sexual offences courts (which has been re-committed to by the Department of Justice and Constitutional Development in 2012) is highly desirable.

233. This failure to prioritise services to child victims is perhaps reflective of the state's stance in general towards such victims. A 2005 study conducted in the Western Cape found the 91% of the children who were interviewed reported exposure to traumatic events, including violent crime, domestic violence, rape and child abuse. Of these, 38% reported trauma symptoms severe enough to be classified as Post Traumatic Stress Disorder (PTSD).[203]

234. The Sexual Offences Act has redefined and extended **sexual crimes against children**, thus affording children better protection in law from child sexual abuse, sex tourism and child sex trafficking. However, the Sexual Offences Act does not fully deliver protection to child victims, who face significant challenges in accessing the therapeutic and practical services that they need. This has been exacerbated by the on again-off-again approach to (a) the specialised Family Violence, Child Abuse and Sexual Assault (FCS) Units within the South African Police Services and (b) the specialised Sexual Offences Courts. These have been piloted, rolled out, retracted and then reinstated more than once in the last 15 years.

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[201] Leggett T in Dowdney L. 2005. *Neither War nor Peace: International Comparisons of children and youth in organised crime.* Viva Rio/ISER/IANSA. P300; Kagee and Frank. 2005. *Rapid Assessment for Cape Town. COAV Cities Project.* ISS; Haefele B. 2003. *Gangsterism in the Western Cape: Criminal economy, gangs and child abuse in the Western Cape.* Department of Community Safety; Standing A. 2005. *The threats of gangs and anti-gangs policy: Policy Discussion Paper.* Institute for Security Studies. P9

[202] Director of Public Prosecutions, Transvaal v Minister of Justice 2009 (2) SACR 130 (CC).

[203] Suliman S,D, S Kaminer, Seedat, and D Stein. 2005 Child and adolescent trauma survey (CATS).*Ann Gen Psychiatry*. 4 (2)

235. In general, such services for child victims that do exist are offered by civil society organisations. These play a critical role in South Africa on a wide range of fronts, and often deliver services that government is constitutionally bound to, yet fails to, deliver. However, many of these services are being forced to close for a lack of funding or are on limited funding with a prescribed number of therapy sessions regardless of the child's and caregiver's needs. Government itself does not recognise their importance by dedicating resources towards them, seeing them as something of a 'nice-to-have'; funders believe that these are services that should be provided by government, as South Africa is viewed as a 'middle income' country, and are thus reluctant to fund them. However, inequality, which negates middle income status, is deepening in South Africa.

236. Despite the significant trauma that high levels of crime cause, South Africa has not as yet introduced **victim empowerment legislation**, nor has there been a sustained campaign to introduce such legislation for the survivors of crime.

237. In the early part of 2000 there was significant interest and high-level support for research into victim compensation, and in legislation for such a scheme. This interest arose from the high levels of crime, particularly violent crime, in South Africa. However, after the development of a Discussion Paper on the matter in 2001, no further indication of an effort to create legislation, particularly for victim empowerment purposes, is evident. In particular, there are no reasons provided for the non-release of the 2004 Report on Project 82, which is relevant for victim empowerment.

238. The DSD has committed to introduce legislation which would create a legislative framework for victim empowerment. They have made this commitment over a number of years, but not yet implemented it. Most campaigns and services for child victims of sexual abuse or exploitation focus predominantly on girls while side-lining boy victims. It is next to impossible to access services for boy victims.

239. Victims of crime, including child victims, in South Africa have the following needs that are not sufficiently catered for in the current framework: information about the criminal justice system and about their specific case, as well as psychosocial care. There is also a need for improved accountability of providers and better statistical information. These needs are particularly felt by vulnerable groups such as children.

240. Turning to the issue of **children in conflict with the law**, the Child Justice Act (No. 75 of 2008) which came into operation in April 2010 is a significant improvement to the statute book. However, a major concern with the implementation of the Act is the fact that there is a lack of reliable statistical information about the system.[204] In Government's first report to Parliament, it was apparent that the number of children coming into the system had dropped significantly since the commencement of the Act, and the reasons for this are not clear. Child justice analysts are of the view that this can be attributed to the police being unsure how to deal with child offenders under the new law, and thus informally deciding to take no action, which is not envisaged by the law.[205]

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[204] C Badenhorst. 2011. *Overview of the Implementation of the Child Justice Act, 2008 (Act 75 of 2008): Good Intentions, Questionable Outcomes*. Accessed at www.pmg.org.za/files/docs/110622**overview**2.PDF

[205] C Badenhorst. 2012. *Second year of the Implementation of the Child Justice Act: Dwindling numbers*. Accessed at

Although fewer children in the criminal justice system may appear to be a positive development, there is a concern that children are not being linked to services. Furthermore, the drop in the number of diversion options has caused civil society service providers to discontinue programmes and close offices, thus diminishing the services on offer.

241. Although the Child Justice Act has been in force since 2010, the provision of quality diversion programmes remains a gap in implementation. This is in part due to the first world norms and standards related to these programmes, thus excluding all but the mainstream NGOs from developing quality diversion programmes; lack of funding; and a lack of understanding of the therapeutic process on the part of DSD staff, who are involved in implementation of diversion programmes, or the assessment and accreditation of diversion programmes. Another issue is that although the norms and standards are applied to the NGO sector offering diversion programmes, they do not appear to apply the norms and standards to their own (DSD) staff/programmes.

242. The Country Report appears to confuse **diversion** and sentencing, but in fact the Child Justice Act is clear that diversion can occur prior to trial, or at the trial or before sentencing, and is predicated upon 'an acknowledgment of responsibility'. Sentencing occurs after a conviction of guilt. The use of a diversion option where children are placed in child and youth care centres, which is included in the Child Justice Act, is intended for use in only the most serious of cases, where the placement will not in any way disrupt the child's schooling. There is concern that this option is being over-utilised, possibly due to the lack of diversion options and treatment in the community.

243. There is a concern that the names children convicted of sexual crimes are automatically placed on the Sexual Offenders Register provided for in the Sexual Offences Act – in some cases for life. This was found to be unconstitutional by the Western Cape High Court[206] and a ruling by the Constitutional Court is expected.

244. The Country Report is silent on the issue of **CUBAC** (children used by adults [or older children] to commit crimes). [207]Besides the situation analysis and pilot design conducted by the Community Law Centre that found that the phenomenon of adults using children to commit crimes was commonplace among the 542 young participants (in conflict with the law) , there has been no further focus or prioritisation of victims of CUBAC.

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https://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&ved=0CDoQygQwAQ&url=http%3A%2F%2Fwww.childjustice.org.za%2Fpublications.htm%232ndYearReportCJA&ei=IeD9Ut3sCZKBhAe-pIEQ&usg=AFQjCNFi2jgpkKcViH2ial6dru-I8lq4-Q&sig2=nFFX8OWc3d79j9ZRICpCtg&bvm=bv.61190604,d.ZG4.

[206] The High Court judgment is reported as *S v IJ* 2013 (2) SACR 599 (WCC).

[207] Gallinetti J, D Kassan and J Sloth–Nielson. 2006. *Children Used by Adults to Commit Crime: Situation Analysis and Pilot Design*. Cape Town: Community Law Centre.

9.4 Reformation, family reintegration and social rehabilitation

245. As is shown in Chapter 6 of this Complementary Report, the legal framework is largely in place to achieve family reintegration and social rehabilitation. However, the serious implementation deficits described in various sections of this Report indicate the failure of protective measures.

9.5 Children of imprisoned mothers

246. The Initial Country Report correctly highlights the policy provisions in relation to special provisions made for children incarcerated with their parents (usually their mothers). It also correctly highlights the relevant case law with regards to the prevention of detention and custodial sentences for primary caregivers of children.[208]

247. However, it does not provide sufficient information in relation to the following factors influencing the provisions in relation to the protection of children with incarcerated parents:

a. **Prevention:** The Country Report mentions the Constitutional Court judgment of *S v M (Centre for Child Law as Amicus Curiae)* in which the Court held that non-custodial sentences should be considered when sentencing primary caregivers of children. Considering that this is a Constitutional Court judgment of 2008 that sets judicial precedent for all lower courts, the Country Report does not provide disaggregated data on the amount of primary caregivers that were subsequently given non-custodial sentences, in which children would benefit from not being placed in alternative care. Statistics of this nature would not only show the impact of this judgment on the home situation of children, but would also highlight South Africa's compliance with both the UNCRC and the ACRWC.

b. **Incarceration and special protection for children incarcerated with mothers:** The UN Human Rights Council Resolution 19/37 of 2012 stipulates that States Parties to the UNCRC should consider the best interest of children when deciding how long they should be incarcerated with their mothers.[209] The South African Initial Country Report quotes a draft policy for infants and mothers that is undated and stipulates that three prisons have wings for young babies up the age of 2 years. The latest statistics of active correctional centres that are available dates to the 2011/12 financial year. In terms of these statistics there are currently 241 active correctional centres, 8 of which are exclusively for women and 129 exclusively for men, while there are 91 centres that accommodate women in a section of the centre.[210] Therefore if only 3 centres have wings for young babies up to the age of 2 years, what about the rest of the centres that accommodate women who might have children? It would be of vital importance to gather disaggregated statistics on not just the number of children resident with their mothers, but also the situation of women in other prisons where there is no separate wing for mothers with infants. There are also concerns regarding the process of placement of

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[208] See 6.9 of Department of Women, Children and Persons with Disabilities The UN Convention on the Rights of the Child: South Africa's Combined Second, Third and Fourth Periodic State Party Report to the Committee on the Rights of the Child (Reporting period: 1998 – June 2012) paras 244 – 246.
[209] See Para. 69(b) of the Resolution.
[210] See http://www.dcs.gov.za/AboutUs/StatisticalInformation.aspx (Accessed on 07 January 2014).

children in alternative care once they reach the age of 2 years, and monitoring the care and protection of these children.

c. *Post incarceration and rehabilitation:* The UNCRC country report does not stipulate any information with regards to the post-incarceration, rehabilitation and alternative care of children once they leave an institution. In order to ensure that the best interest of children is at all times the primary consideration in all matters affecting them, information of this nature would be important and helpful.

248. In conclusion, paragraph 69 of the UN General Assembly resolution 19/37 provides further State Party obligations in order to ensure a holistic approach to the best interest of children of incarcerated parents. Information relating to these obligations specifically focused on South Africa is of vital importance to ensure compliance with both the UNCRC and the ACRWC.

9.6 Children in situations of economic exploitation and abuse

249. Although there is legislation and policy in place to ensure the protection of children from exploitation, implementation has been problematic, particularly when it comes to identifying and recording by service providers of children in situations of exploitation. Frequently, cases of child labour fall through the cracks as service providers such as the police and social workers do not know how to identify them as such therefore they are not recorded correctly and the appropriate services are not rendered to victims. There is also very little response and cooperative interaction between sectors with regard to the investigation and prosecution of commercial sexual exploitation, child sex tourism and child sex trafficking.[211]

250. The 2010 Survey of Activities of Young People referred to by the Country Report provides useful information about the numbers of working children, but is silent on the reasons why children are engaged in labour, and the detrimental effects of child labour. It also only looks at children in households and excludes children living on the streets and in CYCCs. It also does not look at the worst forms of child labour (WFCL) such as the commercial sexual exploitation of children (CSEC), CUBAC and begging.

251. Despite claims in the Country Report that government has performed relatively well in meeting the responsibilities assigned by the Child Labour Programme of Action (CLPA) to relevant role-players, experience of NGOs represented on the CLPA Implementation Committee indicates that the majority of designated government role-players who are supposed to oversee the implementation of the CLPA do not in fact even attend the meetings, or report on their progress regarding their action steps as stipulated in the national policy, let alone meet their obligations as most other government departments do not consider the issue of children's rights a part of their mandate.

252. The action steps of the CLPA are incorporated in the development of the *Child Exploitation Strategy* and the *Guidelines for the Prevention of and Response to Child Exploitation*, which are managed by the National Child Protection Committee, which falls

[211] Van Niekerk J. 2013. *Trafficking in South Africa*. Germany: ECPAT. Unpublished report forthcoming March 2014.

under the National DSD; implementation of the CLPA suffers from confusion at national level about who is responsible for what. This is exacerbated at provincial level, where implementation is supposed to take place.

253. The 2011 SSA General Household Survey found that girls were more likely than boys to be affected by child labour, and that 121,000 children were engaged in market economic activities. This makes a significant contribution to the numbers of children who are absent from school for more than 5 days in the year—over 40 per cent of those attending school.[212] The findings of the SSA 2010 report drew attention to the ineffective implementation of the regulatory framework to protect children from the harmful effects of child labour. Funding and budgetary prioritisation are serious challenges in this regard.

254. Little is known about the use of children in drug trafficking, but anecdotal evidence suggests it is wide-spread. Provincial consultations indicated that in some areas the use of children in drug trafficking is a matter of urgent concern requiring more initiatives specifically geared to addressing the problem.

9.7 Protection from substance abuse

255. ***Alcohol use*** was identified as the leading risk factor for death and disability in sub-Saharan Africa, and globally for person's aged 15 to 19 years.[213] In South Africa, in 2011 a national school survey of learners in grades 8 to 11 found that 37% of males and 28% of females reported drinking in the past 30 days, with an alarming 30% of male and 20% of female learners reporting binge drinking during the same period.[214] Direct and indirect consequences of drinking among children and adolescents in South Africa include rape, interpersonal violence, absenteeism, school failure, unwanted pregnancies, sexually transmitted infections, HIV, and foetal alcohol spectrum disorders (FASD).[215] Drinking during pregnancy can damage the unborn child, and rates of FASD in South Africa have been found to be among the highest in the world, with a recent study reporting population levels of between 14% and 21% for grade 1 learners in certain mainly rural communities of the Western Cape.[216]

256. The South African government has attempted to address these problems by proposing to ban the advertising of alcohol, raise the legal drinking age, limit hours for alcohol sales, and lower the legal alcohol limit for drivers. While government has taken

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[212] Statistics South Africa. 2012. *General Household Survey 2011*. Accessed on 24 February 2014 at www.statssa.gov.za/publications/P0318/P0318April2012.pdf

[213] Lim, S.S., T Vos, and Flaxman et al. 2012. The burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions 1990-2010: A systematic analysis. *Lancet*, 380, 2224-2260

[214] Reddy SP, S James, R Sewpaul, S Sifunda, A Ellahebokus, NS Kambaran and RG Omardien. 2013. *Umthente Uhlaba Usamila – The 3rd South African National Youth Risk Behaviour Survey 2011*. Cape Town: South African Medical Research Council.

[215] Morojele N, C Parry, J Brook and C Kekwaletswe. 2012. Alcohol and drug use. In Van Niekerk A, S. Suffla and M. Seedat (Eds.), *Crime, violence and injury in South Africa: 21st century solutions for child safety* (pp.195-213). Tygerberg: MRC-University of South Africa Safety & Peace Promotion Research Unit.

[216] May P.A, J Blankenhip, A-S Marais, JP Gossage, WO Kalberg, R Barnard, M de Vries, LK Robinson, CM Adnams, D Buckley, M Manning, KL Jones,C Parry, HE Hoyme and S Seeddat. 2013. Approaching the prevalence of the full spectrum of fetal alcohol spectrum disorders in a South African population-based study. *Alcoholism: Clinical & Experimental Research*, 37, 818-830

concrete action in a few areas, there is a lot more the government could and should be doing: equipping parents to be good role models and to set appropriate boundaries for their children; banning packaging that appeals to young people; increasing excise taxes on products that appeal to young people such as fruit flavoured alcoholic drinks; dealing firmly with venues that sell alcohol to underage drinkers; instituting a graduated driving license policy so that novice drivers may not test positive when driving under the influence of alcohol for a number of years; accrediting school based prevention programmes to improve quality; and ensuring that there are appropriate and quality treatment programmes available for young persons who need such an intervention.[217]

257. The leading causes of death from ***cigarette smoking*** are chronic obstructive pulmonary disease (COPD), tuberculosis (TB), lung cancer, and ischemic heart disease, IHD).[218] Analysis of death certificates from the 2011—2012 period revealed that, of 100 young people in South Africa who die from a smoking-related disease, 28 die of COPD, 19 of TB, 13 of lung cancer, 12 of IHD, 10 of cancer of the lip, mouth, pharynx and oesophagus, 9 of strokes and vascular disease and 9 of other conditions. It is estimated that if young people stopped smoking, 58 per cent of lung cancer deaths, 37 per cent of COPD deaths, 20 per cent of TB deaths, and 23 per cent of vascular deaths could be avoided.[219]

9.8 Abuse and torture

258. Corporal punishment is still allowed in the home, as was shown in section 5.2 above. Currently, it seems parents and the justice system believe that parents have the common law right to claim a defence of reasonable chastisement if accused of assaulting their child. It is an open question whether the current exception to the prohibition against assault (i.e. corporal punishment in the home) is constitutional, given South Africa's international legal obligations which demand the prohibition of corporal punishment in all settings. This is especially so in the light of the Articles in the African Children's Charter concerning dignity, bodily integrity and the best interests of the child principle.

9.9 Sexual exploitation and sexual abuse

259. References in South Africa's Initial Country Report to protection of children from victimisation through the provisions of the Domestic Violence Act (No. 116 of 1998) and the Protection from Harassment Act (No. 17 of 2011) are problematic. Neither of these laws addresses the issues of protections available to child witnesses or services to child victims. Furthermore, the implementation of these laws in respect of protecting children from victimisation is questionable. The many failures in the implementation of the Domestic Violence Act are widely documented.[220]

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[217] Morojele NK, CDH Parry and JS Brook JS. 2009. *Substance Abuse and the Young: Taking Action* (Research Brief). Pretoria: MRC.
[218] Department of Health and Human Services, USA. 2012. *Ending the Tobacco Epidemic: Progress Toward a Healthier Nation*. See: www.hhs.gov/ash/initiatives/tobacco/tobaccoprogress2012.pdf
[219] Saloojee Y.2012. *Tobacco Control In South Africa*. See: www.mrc.ac.za/chronic/cdlchapter5.pdf
[220] See for example www.shukumisa.org.za

260. Legislation does little to protect child victims of sexual offences, who face significant challenges in accessing the essential therapeutic and criminal justice services that they need.

261. The state piloted and implemented **specialised policing and court services** through the development of the Family Violence, Child Abuse and Sexual Offences (FCS) units within the South African Police Service and through the establishment of specialised Sexual Offences Courts (SOCs). This specialisation, while still fraught with limitations, represented an improvement in the quality of investigations and prosecutions in matters involving child victims and witnesses.[221] However, in spite of the nominal improvements, which indicated the necessity of strengthening and rolling these initiatives out further, decisions were taken by the relevant state bodies to close the FCS units and the SOCs. Subsequently, decisions were taken to reinstate both. However, the reintroduction of the FCS units has shown that the quality of these units has been drastically affected by the loss of expertise and experienced personnel and by the failure to commit resources to their full operationalisation.[222] The recently proposed Judicial Matters Amendment Bill which will provide for the re-establishment of SOCs is a step in the right direction. However, critique has been levelled at this Bill for failing to adequately provide substance to set out how these courts will be different from other courts and for failing to include provisioning clauses for their establishment. No doubt, the insecurity of these services and subsequent loss of quality of service to child victims is the result of a failure of national policy commitment and dedicated resourcing. This may be mitigated in the case of the SOCs if the Judicial Matters Amendment Bill is passed, but due to its limitations, it is unlikely to guarantee services of adequate quality to children across the country.

262. We commend the Department of Justice and Constitutional Development (DJCD), through the National Prosecuting Authority for the institution of **court preparation services to witnesses**. However, the standards for implementing these services have been undermined by a lack of specialisation of these services to child witnesses and in particular a failure in specialisation regarding child victims of traumatic crime such as sexual offences. This failure of specialisation has significant negative consequences to children both in terms of further victimisation of children as well as regarding the criminal justice outcomes.

263. There is no provision in the legal framework for essential **therapeutic services** for children who have been victimised or to support their caregivers. Currently, these services appear to be viewed as optional and not essential. The passage of the Sexual Offence's Act failed to include provisions of this nature for child victims. In addition the child protection system, governed by the Children's Act, is currently under-resourced and overwhelmed, and is unable to effectively cope with the provision of therapeutic

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[221] Parliamentary Monitoring Group (PMG). 2009. *Report on presentation to Parliamentary Portfolio Committee on Women, Children and People with Disability: Domestic Violence Act implementation*: *10 year review by Tshwaranang Legal Advocacy Centre & Gender Advocacy Programme; RAPCAN on impact of legislation in preventing violence against children*. Accessed on 10 February 2010 at www.pmg.org.za/report/20090909-tshwaranang-legal-advocacy-centre-outcome-study-pertaining-10-year-re http://www.pmg.org.za/report/20090909-tshwaranang-legal-advocacy-centre-outcome-study-pertaining-10-year-re.

[222] Frank C and S Waterhouse. 2009. One step forward, two steps back? The impact of the SAPS restructuring of the FCS Units. *SA Crime Quarterly no 28.*

services specific to child victims, being more focussed on issues such as foster care placements amongst others.

264. In general, such services for child victims that do exist are offered by CSOs. These play a critical role in South Africa on a wide range of fronts, and often deliver services that government is constitutionally bound, yet fails to. However, many of these services are being forced to close for a lack of funding or are on limited funding. Government itself does not recognise their importance by dedicating resources towards them, seeing them as something of a 'nice-to-have', and funders believe that these are services that should be offered by government. This is because South Africa is a viewed as a 'middle income' country; however, inequality, which negates middle income status, is deepening in South Africa.

265. The Sexual Offences Act includes amendments to the law of evidence and procedure relating to child victims in sexual offences matters, this has further been amended by the decisions of the Constitutional Court in 2013. In spite of these changes, there are significant and persistent problems with regard to the **rights of and protection to child witnesses** during court processes. This relates particularly to the processing of matters affecting children through the system and to their giving evidence and undergoing cross examination.

266. Problems reported by CSO service providers include:

- Cases are frequently struck off the court roll when child witnesses fail to arrive at court, primarily because the investigating officers, who are supposed to fetch the child witness, do not arrive to do so.

- The challenges of CCTV equipment still not working or working in one court only and cases being postponed which results in further delays inducing secondary trauma (prolonging the anxiety) to the child and the family.

- A high degree of insensitivity from police and court personnel is seen frequently. For example, CSO service providers report incidents such as a young visually impaired girl being informed that she would have to identify the alleged perpetrator in an identity parade. Magistrates in particular often prove insensitive and unaware in questioning children, and have been found to be unable to comprehend a delayed disclosure or even fragmentation of information provided by the child victim, leading them to question the reliability of the child's evidence.

9.10 Other forms of abuse and exploitation

267. National Guidelines have been developed on abuse and exploitation[223] The document aims to provide a holistic and integrated approach to service delivery to abused and exploited children. The document also aims to, "to assist social workers and social service professionals working with children by interpreting the Children's Act to guide practice regarding the prevention and response to child exploitation."[224]. Despite the fact that guidelines were formulated with these objectives, it is yet to be

[223] Guidelines for the Prevention of and response to child exploitation: Developed by the National Child protection committee 2012.
[224] Ibid.

implemented on a local level by Provincial Child Protection Forums. Full implementation of this document would not merely guide the relevant social service professionals but would ensure that cases of exploitation are identified and reported in order for affected children to access the range of relevant services.

9.11 Sale, trafficking and abduction of children

268. A lack of understanding on the part of service providers of victim assistance mechanisms and referral procedures regarding children who have been trafficked results in trafficked children being treated as anomalies. The Children's Act is clear that children who have been the victim of trafficking or child labour should be declared children in need of care and protection.[225]

269. The Prevention and Combatting of Trafficking in Persons Act (No. 7 of 2013) has yet to be fully implemented, with National Directives within the relevant departments in draft stage or not yet commenced and provincial enforcement of the *Guidelines on the Prevention and Response to Child Exploitation* yet to take place.

270. Services to accommodate both male and female child victims of trafficking remain a challenge. In the Western Cape, for example, accommodation for children aged 16—18 years is very difficult to find, and these remain the most vulnerable group amongst children requiring protection.

271 The Western Cape has a well-functioning inter-sectoral Trafficking Task Team comprising both government departments and CSOs and also an independent counter trafficking coalition of CSOs. The Trafficking Task Team's efforts focus on prevention, prosecution and protection of victims of trafficking. Its Rapid Response team has facilitated a strong collaboration between government and CSOs to investigate, assist victims and prosecute cases of human trafficking provincially.

272. Although there have been convictions under the Trafficking Act, challenges remain in garnering the full cooperation of all relevant stakeholders from specific departments. Within the Western Cape, the Victim Empowerment Directorate of the provincial DSD plays a lead role in victim assistance efforts; however the Directorate of Children and Families (specifically Child Protection) has minimal involvement on a provincial level. This results in cases of child trafficking remaining undetected and unreported, particularly when children are accommodated at CCYC and other residential facilities.

273. Illustrative of the failure to create a system to investigate and respond to both child labour and child trafficking is that, in early 2013 in the Western Cape, the Provincial Child Protection Forum meeting identified 22 child trafficking cases; to date no investigation or follow up on these reports has been undertaken, for them to be referred to the DPCI (Directorate of Priority Crimes and Investigation) for matters to go on the court role.

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[225] See for example section 289 (3) of the Children's Act

9.12 Victims of harmful social and cultural practices

274. The Minister of Justice and Constitutional Development has formally mandated the South Africa Law Reform Commission to conduct an investigation into the cultural practice of ***ukuthwala***.[226] This practice sanctions the abduction of women for the purpose of marriage. There is invariably an element of coercion to compel the intended bride to acquiesce to the proposed marriage. And, in contemporary South African society, it affects disproportionately girls below the age of 18. This practice has been impugned because it sanctions forced marriages and child marriages with devastating physical, developmental, psychological and social consequences for the girl child. Evidence of the existence of *ukuthwala* and the youth of many of its victims is provided in annexure 3.

275. Death and mutilation from botched ***circumcision*** are exacting a devastating toll on boys. Anecdotal evidence suggests that the rate of death is high, as is the rate of mutilation. For example, between May and December 2013, 62 initiates died due to botched circumcision in just two provinces—Mpumalanga and Eastern Cape. A further 300 were hospitalised in Eastern Cape alone.[227] Of grave concern is the evidence that initiates are forcibly abducted to attend initiation school, and their parents forced to pay 'protection money' to the abductors.[228]

276. Support for practice of ***virginity testing*** comes mainly from traditional leaders in Eastern Cape and KwaZulu-Natal Provinces. The practice has proved detrimental to the protection of children's rights. Children identified as non-virgins are exposed to physical and emotional danger.[229] Additionally, children who have been sexually abused and who are identified as non-virgins face increased risks of abandonment, rejection and violence[230].

277. Children identified as virgins are also at risk. Given the premium that most societies place on virginity, their 'value' in terms of potential exploitation and possible trafficking is linked to their virgin status. In a society with high levels of gang-related activities, where the rape and even murder of a virgin forms part of the initiation of gang members, public identification of virgins could be a death sentence.[231]

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[226] Project 138 of the South African Law Reform Commission is still underway. See further details at http://www.justice.gov.za/salrc/ .
[227] Makinana A. 2013. *Thirty circumcision deaths so far in Eastern Cape.* Mail and Guardian. Accessed on 11 February 2014 at http://mg.co.za/article/2013-12-24-30-circumcision-deaths-so-far-in-eastern-cape; SAPA. 2013. *Five boys die after botched circumcisions.* Mail and Guardian. Accessed at http://mg.co.za/article/2013-06-21-five-boys-die-after-botched-circumcisions on 11 February 2014
[228] Parker F. 2013. *Initiation has become criminal, says Motsolaedi*. Mail and Guardian. Accessed on 11 February 2014 at http://mg.co.za/article/2013-07-08-initiation-has-become-criminal-says-motsolaedi.
[229] Thipanyane, T. 2005. *Virginity Testing in South Africa: a Human Rights Perspective*. Unpublished submission delivered to the Select Committee on Social Services, National Council of Provinces, Republic of South Africa on 11th October 2005.
[230] South African Human Rights Commission. 2005. *Position Paper: Virginity Testing*, p2
[231] Bower C. 2005. Virginity Testing —in whose interest? *Aids Law Quarterly*. Cape Town: Aids Legal Network.

278. Children and young girls who are at risk of not passing a virginity test have been known to take steps which endanger their health to convince the testers that they are virgins. These measures include the insertion of meat and other foreign objects into the vagina[232]. There is also evidence that girls resort to anal sex in order to preserve the hymen[233].

279. While virginity testing and male circumcision are not always regarded as harmful cultural practices, they may be harmful if they are not practised or performed in accordance with the Children's Act and its regulations. In particular, the deaths of boys undergoing initiation and circumcision and the marking of girl as non-virgins indicate that there are shortcomings as to how the cultural practice is performed and therefore a concerted effort by government and traditional leaders towards eliminating the practices which violate children's rights, is required.

9.13 Orphans and other children made vulnerable by HIV

280. There are approximately 1.5 million orphans living with extended family carers in South Africa. There are also a further 3.4 million non-orphans living with extended family carers for other reasons—both cultural and economic. Care of children by family members other than their biological parents is therefore a common practice in South Africa. The unique wording used in s28(1) (b) of the Constitution, coupled with the large number of children being cared for by relatives means that the State should be providing support to extended family carers looking after orphaned children.

281. However, the government is currently attempting to channel all these children into alternative care instead of designing an appropriate mechanism to provide accessible social assistance support to extended family carers. The result is that less than a third of orphan children are being reached with social assistance in the form of the foster child grant, and abused and neglected children are receiving inadequate protection services because the protection and care system is overwhelmed by foster care applications.

282. The foster care system was designed to hold and care for 50,000 children —primarily children who had been abused, neglected or abandoned and had no family to live with. However, the foster care system currently holds over 550,000 children. The majority of these children are orphans who are living with relatives after the death of their mother or both parents.

283. Placing a child in foster care is a complex and labour-intensive process which requires social workers to provide a written report to the Children's Court. The Court then considers the case and decides whether or not to place the child in foster care. Thereafter the court order must be extended by the court every two years. This again requires a social worker assessment and a report as well as a court hearing. South Africa does not have enough social workers to deal with the demand for foster care applications

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[232] Policy Update- September 2004, *Virginity Testing: Increasing Health Risks and Violating Human Rights in the Name of HIV-Prevention*, quoted in: Children's Institute, UCT. 2005. *Virginity Testing and the Children's Bill: Discussion Paper*. Unpublished.

[233] W. Hlongwa. 2005. Teens turn to anal sex to keep virginity, South Africa: www.news24.com quoted in Children's Institute, UCT (2005). *Virginity Testing and the Children's Bill: Discussion Paper*. Unpublished. Accessed on 17th October 2005.

or the two-yearly extensions. This was clearly illustrated in 2010 and 2011 when over 110,000 FCGs were terminated because social workers and courts had not been able to keep up with the demand for the two-yearly extensions.[234]

284. The high demand is mainly driven by family members seeking the foster child grant of R800 because it is higher than the child support grant of R300. Most of the orphans in the care of their grandmothers or aunts do not need a social worker or Court to intervention—they just need a poverty alleviation grant. The CSG of R300 is clearly not adequate for the basic needs of a child; therefore family carers prefer to try to apply for the higher FCG of R800.

285. The DSD announced in 2012 its intention to introduce an "Extended Child Support Grant" (larger child support grant) for families caring for orphans to replace the foster care grant for this category of children. Civil society welcomed the proposal as it would resolve many challenges. However, there has been no movement on this proposal and the foster care crisis continues.

286. In fact, for the first time in ten years, a decrease was observed in the total amount of FCGs in payment when comparing April 2012 with April 2013.[235]

	2009/10	**2010/11**	**2011/12**	**2012/13**
Total FCGs in payment at end of financial year (31 March)	510,760	512,874	536,747	532,159
Actual increase in FCGs over period	36,001	2,114	23,873	-4,588

287. These data show that the crisis in the system is not being addressed but is in fact getting worse. This is despite significant growth in the number of social workers over this same period and a number of ad hoc measures taken by the Welfare Services Directorate to attempt to keep up with the demand for foster care.

288. These consequences impact not only on the significant backlog in the processing of foster care placements and grants, but also on the vulnerability of the very abused and neglected children the system was designed to support.

10 RESPONSIBILITIES OF THE CHILD

289. The notion that rights are inextricably linked to responsibilities seems, in South Africa, to be applied only to children. For example, the ***Bill of Responsibilities for the Youth of South Africa*** has no counterpart linked to the responsibilities of adults. While applauding the development of the *Bill of Responsibilities*, we urge government to pay the same attention to the responsibilities of adults. It is adults who are the duty-bearers in relation to children's rights. An over-emphasis on the responsibilities of children in a

[234] K Hall and P Proudlock. 2012. **Towards revised options** for orphans / poor / vulnerable children. Presentation at a Department of Social Development consultative workshop on revised options for the provision of social assistance to children in non-parental care, 28 November 2012
[235] K Hall analysis of SOCPEN/DOWBOX data, extracted by SASSA on request

context where the responsibilities of adults are not spelled out in such detail and where large numbers of children are vulnerable to abuse, neglect and violence is inappropriate.

290. Promoting a society in which all members of that society respect the rights of others is important. As such, promoting the responsibility of all citizens and people within a country, including children, is necessary. The provisions of the Children's Act, which recognise age and stage of development of children, are useful in this regard. However, given that children are commonly viewed as secondary citizens, caution must be exercised against perpetuating the belief that children are only worthy of having their rights protected if they exercise their responsibilities. Often engagements with children on their responsibilities fail to engage adequately with the responsibilities of all adults towards children, which is primary. Parental rights and responsibilities are very specific, and do not address the broader range of responsibilities that adults hold in respect of children.

291. A further concern regarding programmes that promote children's responsibilities, such as the National Department of Basic Education's *Bill of Responsibilities,* is that they in many instances promote **double standards for children and adults**. Although on the face of it, these principles are commendable, they become problematic within contexts in which many adults routinely flout rights, laws and rules, yet require children to commit to some of those same standards. For example, the *Bill of Responsibilities* requires that children commit to "treat people with respect, reverence and dignity"; "not to hurt, bully or intimidate others, or allow others to do so"; and to "solve any conflict in a peaceful manner". Importantly it includes the commitment to "obey the laws of our country, ensuring that others do so as well"; to be healthy by "not smoking, taking alcohol or taking drugs, or indulging in irresponsible behaviour that may result in my being infected or infecting others with diseases such as HIV and AIDS". Sadly, in South Africa, many teachers regularly flout the law which prohibits the use of corporal punishment, learners report some teachers coming to work drunk or taking alcohol during school hours, treating children in a disrespectful manner is another common behaviour of children.

292. In our view, the solution is not to remove the *Bill of Responsibilities* in respect of children, but rather to require a similar bill of responsibilities to be upheld by teachers. Furthermore stronger accountability systems must be put in place. This will foster a stronger culture of respect and responsibility.

Annexures

Annexure 1 Section 4.4: Respect for the views of the Child

An example of the disjuncture between legislation and practice is provided by the issue of children's participation in school governance. The South African Schools Act of 1996 specifically makes provision for children's participation in the governance of schools through representation on the Representative Council of Learners and the School Governing Body (SGB). Despite the South African Schools Act's progressive intentions, a number of issues have been highlighted within the broader functioning of school governing bodies which undermine the nature and extent of participation and decision-making in practice, and have implications for the participation of learners in school governance. Some of the issues highlighted are: a rigid implementation of the rules, roles and responsibilities stipulated in the Act, while ignoring the diverse cultures, gender relations, traditional values/customs, community dynamics, variations in socio-economic and historical contexts which impacts a school community;[236] [237] [238] a lack of consensus on what democratic decision-making means;[239] and a misunderstanding that the SGB is a political forum.[240] The participation of learners in school governance is impacted by the structural issues highlighted above, despite the assumption that representatives once elected, will participate fully.

Annexure 2 Section 7.3: Health and health services

Poverty, inequality and the social determinants of health

1. South Africa has made significant progress in addressing child **poverty** since 2003, and (given high rates of unemployment) these gains are likely to be associated with the rollout of the Child Support Grant (CSG) which reached 11.3 million children in March 2013.[241] However children remain disproportionately affected by poverty: in 2011 38% of adults lived in poor households with an income less than R604/month, compared to 58% of children.[242]

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[236] Grant-Lewis S. and J Naidoo. 2006. School governance and the pursuit of democratic participation: Lessons from South Africa. *International Journal of Educational Development*, 26, 415-427

[237] Brown, B. and N Duka 2008. Negotiated identities: dynamics in parents' participation in school governance in rural Eastern Cape Schools and implications for school leadership. *South African Journal of Education*, 28, 431-450.

[238] Joubert, R. 2006. *School governance in South Africa: Linking policy and praxis*. Conference paper. Retrieved at http://www.topkinisis.com/conference/CCEAM/wib/index/outline/PDF/JOUBERT%20Rika.pdf

[239] Grant-Lewis S. and J Naidoo. 2006. School governance and the pursuit of democratic participation: Lessons from South Africa. *International Journal of Educational Development*, 26, 415-427.

[240] Smit, M.H. &and IJ Oosthuizen. 2011. Improving school governance through participative democracy and the law. *South African Journal of Education*, 31, 55-73.

[241] Hall K. 2013. Income and social grants – Children receiving the Child Support Grant. *Children Count* website, Children's Institute, University of Cape Town. Accessed on 30 January 2014.

[242] Ibid.

2. **Income inequality** in South Africa is amongst the highest in the world with a Gini coefficient of 0.68.[243] Economic, spatial, social and political inequalities often converge creating 'poverty traps' for certain groups of children and driving an intergenerational cycle of poverty.[244] Work done by the Centre for the Analysis of South African Social Policy to map these multiple dimensions of deprivation illustrates that, by 2007, little had changed in the spatial pattern of inequality with children in the former homeland areas continuing to experience the highest levels of deprivation.[245]

3. South Africa has made steady improvements in enhancing access to **water and sanitation** and appears to have exceeded its Millennium Development Goals (MDG) targets, yet access for children lags behind the adult population, and nearly 1 in every 3 children were without adequate access to water and sanitation in 2011.[246] This is particularly worrying and is likely to be a key driver of diarrhoeal deaths amongst young children. In addition there are growing concerns around water quality.

In 2012, Carolina municipality in Mpumalanga experienced a serious water crisis when the town's main water source, the Boesmanspruit dam, was polluted by coal-mines, leaking high levels of manganese, aluminium, iron and sulphate directly into the dam.[247] While the origins of the crisis lie in the mining sector, this case also raises important questions about the capacity of local municipalities to ensure a safe water supply. The Department of Water Affairs and Forestry (DWAF) is the custodian of water in South Africa, but the provision of water and sanitation services is a function of municipal government. DWAF introduced the Blue Drop and Green Drop audits in 2010 which seem to have proved effective in setting standards and improving service delivery; however Carolina has consistently scored poorly in the Blue Drop report with DWAF warning residents in 2012 that the tap water was unfit for human consumption.[248] And whilst it is true that potable water supply has been restored in Carolina, residents are still concerned about the quality of the water. There are complaints about the taste and smell of the water and children suffer from stomach cramps and skin rash. Greater effort is therefore needed to not only monitor but build the capacity of local government to deliver safe water and sanitation services.

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[243] Finn A & M Leibbrandt. 2013. *Mobility and Inequality in the First Three Waves of NIDS.* SALDRU Working Paper Number 120/ NIDS Discussion Paper 2013/2. Cape Town: SALDRU, University of Cape Town

[244] Laryea-Adjei G & M Sadan. 2012. Children and inequality: Closing the gap. In: Hall K, I Woolard, L Lake and C Smith C (eds) *South African Child Gauge 2012.* Cape Town: Children's Institute, UCT

[245] Wright G and M Noble. 2012. Spatial inequality: Persistent patterns of child deprivation. In: Hall K, Woolard I, Lake L and Smith C (eds) *South African Child Gauge 2012.* Cape Town: Children's Institute, UCT

[246] Hall K. 2013. Access to basic services. In: Berry L, L Biersteke, A Dawe, L Lake and C Smith (eds) *South African Child Gauge 2013*. Cape Town: Children's Institute, UCT

[247] Kings S. 2012. Carolina's water woes indicate larger structural problems. *Mail & Guardian*, 19 July 2012

[248] Department of Water Affairs and Forestr. 2013. *2012 Blue Drop Report.* Pretoria: DWAF

4. High levels of **overcrowding** are also of concern—with 1 in 4 children living in overcrowded households.[249] This contributes to the spread of TB and other communicable diseases.

5. Access to **electricity** has increased from 58% in 2002 to 73% in 2011; however 8% of households are still using paraffin for cooking and 15% of households use wood burning stoves.[250] These fuel sources pose a number of health threats to children including burns, poisoning and increased risk of acute respiratory infections.[251] There were over 1000 fires in informal settlements between 1999 and 2005—caused primarily by paraffin (53%) and candles (30%),[252] and toddlers and young children are most at risk of burns and paraffin poisoning.[253] Government has introduced a national standard[254] for non-pressure paraffin stoves and heaters to promote safer stoves yet there has been little enforcement and unsafe stoves continue to be widely sold. Packaging paraffin in tamper-proof containers is another key preventative measure, yet there is neither legislation nor compulsory standards in place to enforce the practice. Government and industry need to play a more proactive role in ensuring safe sources of household energy.

6. **Mining** and associated industries have been responsible for extensive environmental contamination in South Africa, and children are particularly vulnerable to the adverse effects of toxins such as lead, arsenic and uranium – as their bodies and brains are still developing. It is therefore vital to put legislation and other measures in place to specifically protect children from exposure to environmental contaminants. Clear examples of such dangers can be seen in the coal mining region of Witbank in Mpumalanga.[255] In Ligazi informal settlement unemployed mothers take their small children with them to the dumps to dig for coal, while in nearby Maguqa, children play soccer on salt-encrusted fields (caused by acid mine drainage) and swim in holding dams—where the water is warm, although acidic and filled with heavy metals and carcinogenics derived from burning coal. Strict regulation should be in place to ensure the health of these fenceline communities. This includes the regular and transparent monitoring of children's health in exposed communities and ensuring that these

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[249] Hall K. 2012. Housing and Services – Overcrowding. *Children Count* website, Children's Institute, UCT. Accessed on 14 June 2012.
[250] Statistics South Africa. 2012. *General household survey 2011.* Statistical release P0318. Pretoria: StatsSA
[251] Kimemia D, C Vermaak, S Pachauri and B Rhodes. 2014. Burns, scalds and poisonings from household energy use in South Africa: Are the energy poor at greater risk*? Energy for Sustainable Development, 18*: 1–8
[252] Paraffin Safety Association of Southern Africa (PASASA). 21012. *Energy incidents surveillance database, from 2006-2012; 2012* [Accessed from www.paraffinsafety.org, December 2012].
[253] Schwebel D, D Swart, S Hui, J Simpson and P Hobe. 2009. Paraffin-related injury in low-income South African communities: knowledge, practice and perceived risk. *Bull World Health Organ 2009;87:700-6.*
[254] South African Bureau of Standards. 2006. *SANS 1906 Non-Pressure Paraffin Stoves and Heaters*
[255] Munnik V, with G Hochman, M Hlabane and S Law. 2010 *The Social and Environmental Consequences of Coal Mining in South Africa. A case study.* http://www.bothends.org/uploaded_files/uploadlibraryitem/1case_study_South_Africa_updated.pdf.

children have access to proper health care. In addition mining companies should be held responsible for clean-up costs and the health care costs of affected communities.

7. **Acid Mine Drainage (AMD)** is pressing environmental concern that adversely affects the health and future well-being of children living along the Vaal and Limpopo Rivers.[256] As water fills old underground mines it becomes contaminated with sulphides and other pollutants such as aluminium, lead, zinc and uranium which rise to the surface and contaminate the water supply (with up to 36 million cubic metres a day entering the Vaal region's water system). It is estimated that approximately 80% of South Africa's water will be undrinkable by 2015 as a result of severe over-pollution. There is currently no remedy to reverse this trend and the problem is likely to persist not simply for a few decades, but for centuries to come. From 1996, the scientific community and environmentalists have called on the Government and the mining industry to manage the AMD problem, yet the response from both sectors has remained alarmingly slow. Wider responses are needed including the institution of the 'polluter pays' principle, and closer and more rapid responses from the mining sector in collaboration with government.

8. **Climate change** is no longer a distant projection and warming trends are already firmly established with 2—4°C warming expected along the coastal areas of South Africa, and 4—6°C warming inland by 2100 if maximum and immediate mitigation actions are not implemented.[257] As the world and the country warms, South Africa is likely to experience water shortages and coastal flooding —and rising temperatures are likely to dramatically increase the incidence of malnutrition; water-borne diseases such as cholera, malaria and diarrhoea; respiratory illnesses and asthma.[258] Children are particularly vulnerable and the WHO[259] estimates that approximately 88% of the existing global burden of disease due to climate change occurs in children under the age of five, making climate change the most significant inter-generational justice challenge facing the world today.[260] Climate change has been caused by today's adults and previous generations. Yet it is children —those least responsible for climate change —who will feel the worst impacts —both now and into the future. Therefore climate change responses cannot only address the immediate impacts on child health, but should also encompass mitigation and adaptation actions to ensure that children have a viable and sustainable future earth system to inhabit. Inter-sectoral collaboration is needed in South Africa to effectively and rapidly implement the *National Climate Change Response White Paper*.

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[258] Thompson AA, L Matamale and SD Kharidza SD. 2012. Impact of climate change on children's health in Limpopo province, South Africa. *Int J Environ Res Public Health*, 9(3): 831–854.

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Annexure 3 Section 9.12: Victims of harmful social and cultural practices

A recent example of *ukuthwala* can be found on IOL News, accessed at http://www.iol.co.za/news/crime-courts/man-jailed-for-marrying-raping-girl-14-1.1646973#.Uwb7vuOSw4c on 21 February 2014.

Man jailed for marrying, raping girl, 14

A 14-year-old girl found herself in "modern-day slavery", in the words of a Wynberg magistrate, when she was sold for R8,000 and forced to marry a man who held her captive and beat her for sex.

On Thursday, Wynberg Regional Court Magistrate Daleen Greyvensteyn sentenced Mvumeleni Jezile to an effective 22 years in jail for three counts of rape, human trafficking and assault.

Greyvensteyn said the situation had been terrifying for the Eastern Cape teenager, who had just finished Grade 7. She went to a nearby shop on behalf of an elder and the next moment she was sold to marry a man she didn't know.

The girl was taken from her home in Ngcobo and forced to go through a customary marriage to Jezile, 32, on February 2010. She escaped and ran back home. But her uncle and grandmother, who participated in the negotiations for Jezile's bride, took her back to him.

Soon afterwards, the girl was put on a taxi bound for Cape Town. The girl lived with Jezile at his home in Brown's Farm, Philippi, and was raped several times and beaten with a broomstick, whip and belt. She escaped again and fled to the police.

She is back with her mother in the Eastern Cape.

The case is the Western Cape's first case of ukuthwala: the traditional practice of kidnapping a young woman in an attempt to force marriage negotiations. It is also the second human trafficking conviction.

Greyvensteyn said the girl was degraded and forced into a life of servitude. As a makoti "young bride" she was expected to cook and clean for her husband. "(But) the complainant was resilient and strong-willed with dreams of finishing school and marrying for love."

"It's intolerable that very serious crimes such as trafficking, rape and assault are committed under the guise of culture, tradition and religion. Both parties to any marriage must consent thereto. Hiding behind now defunct customs to satisfy one's own needs must be discouraged."

The court found substantial and compelling circumstances to deviate from the prescribed minimum sentence of life imprisonment for raping a child.

Greyvensteyn imposed a lesser sentence than life after considering Jezile's upbringing, level of education – he completed Grade 8 – his traditional beliefs, and the cumulative effect of the minimum sentences for each charge.

But his lack of remorse and the fact that he continued to rape the girl, despite a large wound on her leg, were aggravating factors.

"Jezile has never shown remorse. He persisted throughout that he was innocent, and blamed custom, the church and tradition. He had little insight into the pain and anguish that the complainant endured; instead he called her disobedient and cheeky," Greyvensteyn said.

The victim impact report states that the girl suffered from insomnia and when she fell asleep was haunted by nightmares.

National Prosecuting Authority spokesman Eric Ntabazalila welcomed the sentence, saying it was the most severe penalty handed to someone convicted of human trafficking in South Africa. In 2011, in Lusikisiki Regional Court, a human trafficker was sentenced to seven years in jail.

"This conviction and sentence is a result of the NPA's commitment to prioritising cases of this nature. Also, (it shows) our commitment to creating a society which is safe and secure for women and children and addresses issues that affect vulnerable groups such as women, children, lesbians, gays, bisexuals, transgender and intersex persons and persons with disabilities," Ntabazalila said.

Ukuthwala, commonly known as "forced marriage", is an ancient Xhosa custom.

The word means "carrying away".

Professor Jan Bekker of the University of Pretoria said the custom had changed from what it used to be.

"Ukuthwala was an initiation to marriage made by two young people in love.

"In the rural areas the girl would be at the river maybe, fetching water, when the young man, with a group of his friends, would accost her. She would then be taken to the young man's home, his father's hut, where she would remain."

The father of the young man would then go to the girl's home to speak to her father and lobola negotiations would start.

For the remainder of the lobola negotiations the girl would be returned home until the wedding took place.

However, over the years the romantic love tale had taken a turn in the wrong direction.

"It's a horrible phenomenon," said Bekker.

"Nowadays, it's middle-aged men who are accosting young high school girls, and because of the different backgrounds, parents take the lobola money they are given."

Bekker urged the government to intervene because child trafficking and abduction were being sugar-coated as ukuthwala.

"The government and police need to take action now because issues of abduction and rape occur in these cases."

An investigation carried out by the Commission on Gender Equality has found that most of the ukuthwala marriages have occurred in the Eastern Cape and in KwaZulu-Natal.

The commission's Taryn Powys said: "Today, young girls aged 13 or 14, and sometimes as young as nine, are being kidnapped on their way to school to be married to men who are in their 40s or 50s and polygamists."

When the girls' families objected, they were offered "damages" in the form of money, cows and blankets, Powys said.

"Many of them are poor, so they accept."

Although the custom might be traditionally acceptable, it violated the Recognition of Customary Marriages Act of 1998, which said the two people to be wed must be more than 18 years old, and the agreement had to be consensual.

"We are concerned that the abduction of girls by men, as well as the associated instances of sexual assault, underage lobola and pregnancy constitute a direct violation of girls' constitutional rights," Powys said.