ALTERNATE REPORT COALITION – CHILD RIGHTS SOUTH AFRICA

COMPLEMENTARY REPORT TO THE AFRICAN COMMITTEE OF EXPERTS ON THE RIGHTS AND WELFARE OF THE CHILD

A RESPONSE TO SOUTH AFRICA'S SECOND COUNTRY REPORT TO THE AFRICAN COMMITTEE OF EXPERTS ON THE RIGHTS AND WELFARE OF THE CHILD ON THE AFRICAN CHARTER ON THE RIGHTS AND WELFARE OF THE CHILD

21 JULY 2017

This complementary report to the African Committee of Experts on the Rights and Welfare of the Child is prepared by the Alternate Report Coalition – Child Rights South Africa (ARC – CRSA). ARC – CRSA is a civil society alliance on children's rights in South Africa. This report is written with the 2015 alternate report to the United Nations Committee on the Rights of the Child as a basis.

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The opinions expressed and conclusions arrived at, are those of the authors based on work experience and research.

Contributions to the content, strategic priorities and recommendations were received from people that submitted written comments and attended a consultative workshop held on 22 May 2017.

For a full list see **Annexure A**.

Table of Contents

PART 1 INTRODUCTION

1. South Africa's child rights protection framework is relatively comprehensive. The Government of South Africa (GOSA) and civil society have for a number of years invested significantly in its development. Progress made in this regard includes amongst others: a children's rights clause in the Constitution of the Republic of South Africa; legislation, that entrenches the statutory protection of children's rights, such as the Children's Act (No. 38 of 2005) [the Children's Act]; the Child Justice Act (No. 75 of 2008); and the Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007) [Sexual Offences Act]. We also note the existence of strong jurisprudence from the superior courts – High Courts, the Supreme Court of Appeal and the Constitutional Court – affirming and protecting children's rights as contained in the Constitution. We recognise the strong practice of public participation in the development of law and policy relating to children. Furthermore, we commend the social assistance available to poor children and families, noting the positive impact on children's lives.

2. However, despite the above laudable progress, some aspects of the framework are problematic, and the lives of the majority of children in South Africa are characterised by serious challenges. It is thus important to set out our views on these challenges and provide recommendations on how they can be addressed.

3. This alternative report sets out to respond to the country report submitted to the African Committee of Experts on the Rights and Welfare of the Child (ACERWC), by the GOSA. We would, from the outset, like to point out that the manner in which the GOSA has opted to structure the country report, i.e. only responding to the 2014 concluding recommendations of the ACWERWC, results in the report not addressing a number of issues arising after the concluding recommendations were issued in 2014.

4. This alternative report is a product of contributions made by 36 authors representing different civil society and/or academic organisations and institutions. The report is accompanied by a Children's Complementary Report (**Annexure 1**) compiled by Save the Children South Africa in collaboration with the Nelson Mandela Children's Fund and Molo Songololo. A National Children's Consultation workshop was held on 27 and 28 May 2017, during which children's views and opinions on different issues

reflected in the country report were captured. These views and opinions were consolidated and a Children's Complementary Report produced.

PART 2 GENERAL MEASURES OF IMPLEMENTATION

2.1. INTERNATIONAL COVENANT ON ECONOMIC SOCIAL AND CULTURAL RIGHTS

5. We recognise that in 2015, subsequent to its previous report to the ACERWC, the GOSA ratified the **International Covenant on Economic Social and Cultural Rights**. Of concern is the GOSA's reservation relating to the right to education which states: "[t]he Government of the Republic of South will give progressive effect to the right to education, as provided for in Article 13 (2)(a) and Article 14, within the framework of its National Education Policy and available resources."

6. GOSA's reservation supports the progressive realisation of the right to basic education. This conflicts with the provisions of the South African Constitution, in which basic education is regarded as an immediately realisable right. The South African Constitutional Court has confirmed the unqualified nature of this right.[1]

Recommendation

7. The Committee should urge GOSA to withdraw this reservation to the ICESCR.

2.2. REALISING CHILDREN'S RIGHTS IN SOUTH AFRICA'S SOCIO-ECONOMIC CONTEXT

8. The realisation of children's rights to which GOSA has committed to fulfil under the African Charter on the Rights and Welfare of the Child (the Charter); those enshrined in South Africa's Constitution; and those contained in the country's relatively robust legal and policy framework, is dependent on political leadership and commitment, prioritisation and resourcing.

[1] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* 2011 (8) BCLR 761 (CC) at para 37: "It is important … to understand the nature of the right to – a basic education under section 29(1)(a) [of the Constitution]. Unlike some of the other socioeconomic rights, this right is immediately realisable. There is no internal limitation requiring that the right be – progressively realised‖ within – available resources‖ subject to – reasonable legislative measures."

2.2.1. Poverty and Inequality

9. The majority of South Africa's children live in poverty. Of the total population of 18.5 million children, 11.7 million (63%) live below the Statistics South Africa upper bound poverty line (This is equivalent to R923 per capita in 2014). The level of inequality is significant, the national average masks striking provincial and rural-urban variations in child poverty. For example, in the KwaZulu-Natal, Eastern Cape and Limpopo provinces, over 75% of children live in poverty while in the Gauteng and the Western Cape provinces the rate is 39%. Child poverty is the highest in the rural areas of the former homelands at 84% compared to 68% in informal urban areas and 44% in formal urban areas.

10. When looking at the lowest poverty line, the food poverty line (equivalent to R415 per capita per month in 2015 Rands), nearly a third of children (30% or 5.5 million) still live below this line. These children are not receiving the minimum nutritional requirement of 2100 kilocalories per person per day. These children's basic nutritional needs are not being met and as a result their rights to education, food, development and survival are severely compromised.

11. Children tend to be disproportionately concentrated in poor households with 62% living in households that fall into the lowest income quintiles (quintiles 1 and 2), compared to 44% of adults. Thirty percent of children (or 5.5 million) live in households where the adults (their care-givers) are not employed.

12. In spite of the aspirations of the National Development Plan, to date, no effective economic policy measures have been put in place to address the extremely high level of income inequality in South Africa which remains among the highest in the world.[2]

13. Within this context of high levels of poverty and unemployment, the important role of social assistance comes into sharp focus. While child poverty is still unacceptably high, it has been steadily declining from 79% in 2002 to 63% in 2014. This decline is primarily attributed to the availability of social grants and the expansion

[2] World Bank "Overview: South Africa" (last updated 3 May 2017), available at http://www.worldbank.org/en/country/southafrica/overview.

in reach of the Child Support Grant over this same period. Please see part 7 below on social security.

Recommendations

14. The recommendations in this regard are as follows:

a. Strengthening social assistance and related programmes is necessary to ensure continued decline in high levels of poverty.
b. Further strengthening South Africa's tax regime is important to address gaps in the tax framework that exacerbate the high rate of inequality. This must be coupled with a robust public engagement process that includes the participation of poor people and of children. The possible introduction and strengthening of wealth taxes is important and GOSA must avoid reliance on measures that disproportionately and negatively affect the poor, such as increases in Value Added Tax.

2.2.2. Macro level

15. At the macro level, there are a number of challenges that are impacting negatively on the amount of money GOSA has available for allocation and expenditure of services to children and families. These include low economic growth, decreasing GDP per capita, high inflation and even higher food price inflation, questionable political decisions concerning substantial budget allocations and expenditure, and non-adherence to procurement rules resulting in delays in delivery of basic goods and services to children.

16. South Africa's GDP is currently growing at less than 1% per year.[3] Economic growth is thus lower than both inflation (currently at around 6%) and the annual increase in the population of around 1.6%. GDP per capita is therefore decreasing over time. This means constrained resources both at the individual and household level, thus limiting private expenditure on children, and constrained ability of government to raise revenue through taxes and charges for service. This has resulted

[3] Information for this section is sourced primarily from four Budget Briefs produced by UNICEF South Africa and the International Budget Partnership in 2016. The briefs are available at: http://www.internationalbudget.org/publications/children-and-south-africas-budget/.

in government's introduction of austerity measures which, among others, severely constrain employment of additional government personnel.

17. Food inflation is higher than overall inflation. This impacts the poor negatively as they spend most of their money on food. Official statistics confirm that children are more likely than adults to live in poor households. [4]The high food inflation rate is therefore especially problematic for children for whom poor nutrition can have lifelong consequences (see section 2.2.1 above and parts 6 and 7 below for more detail on children's poor nutritional status).

18. In this context of low economic growth, high inflation and even higher food price inflation, it is important that GOSA prioritises budgetary allocations to pro-poor policies and services.

19. However, there are a number of questionable decisions that have prioritised less important issues over the realisation of children's basic rights to nutrition, care, protection, health services and education. These include the 2010 FIFA World Cup, the arms deal,[5] bailouts to State Owned Enterprises such as South African Airlines, South African Broadcasting Corporation and Eskom, and the proposed nuclear energy deal that could cost a trillion rand if approved. Decisions of this nature are frequently undertaken without following the prescripts of the law, in particular there is non-adherence to the rules on transparency and public participation. This was highlighted in the recent judgement of the Western Cape High Court which declared a proposed nuclear deal invalid due to non-adherence to prescribed state procurement rules.[6]

20. Recent allegations of state capture by private interests are of grave concern and linked to the question of expenditure priorities. The amount of money that is currently being reported in the media as being diverted away from public services in order to enrich a few individuals has a serious negative impact on government spending on children's rights and services.

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[4] See para 11 above.
[5] Equal Education *15 Ways to pay for decent schools. The norms and standards for school infrastructure are affordable if government collects sufficient revenue and does not waste it* (2015).
[6] *Earthlife Africa and Others vs Minister of Energy and others. High Court of South Africa* [2017] ZAWCHC 50.

21. Many socio-economic goods and services are delivered to children by private (for profit) companies on contract with the state, for example school stationery, furniture and textbooks as well as social grants and school feeding schemes. If tender processes do not follow the rules for state procurement, aggrieved companies can approach the court for review. When procurement is stalled due to litigation or ultimately set aside by court orders, children's rights can be negatively affected by the resultant lengthy delays in delivery of the goods or service. This impact on children's rights was brought to the attention of the courts by the Centre for Child Law (CCL) intervening as an amicus in three state procurement disputes.[7] Due to the CCL's intervention the courts for the first time grappled with crafting appropriate orders and remedies that would balance the commercial interests of the aggrieved private company, the need to prevent and discourage maladministration and corruption, and the best interests and rights of children.

22. While the courts have crafted remedies aimed at minimising the negative impact on children, over 600 000 of the poorest learners in the Eastern Cape still experienced long delays in the delivery of stationery and furniture which impacted negatively on their ability to enjoy their right to basic education. The primary responsibility for the lengthy delays falls on the state due to multiple instances of incompetence, maladministration, and corruption.[8]

Recommendations

23. The recommendations in this regard are as follows:

a. GOSA must commit to and demonstrate pro poor budgeting.

b. GOSA must demonstrate commitment to fully implementing the National Anti-Corruption Strategy including that GOSA must urgently establish an

[7] *Freedom Stationery (Pty) Ltd v The Member of the Executive Council for Education, Eastern Cape and Another* 2011 JOL 26927 (E) ('*Freedom Stationery*'); *Rickshaw Trade and Invest 49 (Pty) LTD v MEC Education Eastern Cape and Others* Case No 469/2013 Eastern Cape High Court: Bhisho (9 September 2013)('*Rickshaw Trade 2013')* and *Allpay Consolidated Investment Holdings (Pty) Ltd and Others v Chief Executive Officer of the South African Social Security Agency and Others* 2012 (ZAGPPHC) 185 ('*SASSA 2012 HC*').

[8] For contextual information on the struggles in the Eastern Cape with regards to the delivery of school furniture see *Madzodzo and Others v Minister of Basic Education and Others* 2014 (3) SA 441 (ECM) and Sephton et al "To sit and learn: Furniture shortages and the struggle to see the right to education realised in South Africa's Eastern Cape" (2014) Available at http://www.nylslawreview.com/wpcontent/uploads/sites/16/2014/11/Sephton.pdf.

independent inquiry into the allegations of state capture as well as conduct any necessary criminal investigations into the related matters.

2.2.3. Allocations and expenditure

24. South Africa has three spheres of government – national, provincial and local. Provinces bear the main responsibility for delivery of non-tertiary education, health and social development services. Provinces and local governments receive funding from nationally collected revenue in the form of a block grant (the equitable share) and conditional grants which must be spent on specified purposes. The formula for the provincial equitable share includes components for education and health, but does not have a social development component. This is concerning given that several laws place increased social development mandates on the provinces including, in particular, the Children's Act and the Child Justice Act.

25. In 2016/17, the consolidated budget (national and provincial, social security funds and public entities) was R1 309.6 billion, with an additional R147.7 billion allocated for servicing of government debt and R6 billion for contingencies. Basic education accounted for 16% of the consolidated budget, health for 12%, and social development for 11%. Defence, public order and safety accounted for 12%, and debt service costs were nearly as large as the social development allocation.

26. Irregular expenditure is a grave concern as its wastes money that could rather be spent on services to children. In the 2015/16 financial period irregular expenditure amounted to R46 billion, an increase of 80% from the previous financial year.[9] This amounts to seven times the budget allocated to social welfare services for children and families (R6.7 billion in 2016/17). As critical as basic education and health services are to children, the departments responsible for these services are among the worst performing. The 2015-2016 Auditor General's Report draws attention to the fact that the national and provincial Departments of Basic Education and Health, along with the Department of Public Works – who together are responsible for almost 37% of the total spending by government departments – have the poorest audit outcomes among government departments.[10] The report states that 40% of these departments received

[9] Auditor General South Africa *PFMA 2015-2016 Consolidated General Report on the national and provincial audit outcomes* (2016) at 19.
[10] Id at 26.

financially qualified or disclaimed opinion in 2015/16 and there are only two clean audits amongst them. This compares poorly against the figure of 13% of all other departments receiving financially qualified or disclaimed opinion. The Auditor General's report highlights the seriousness of this and urges that these outcomes '*receive urgent attention from all role players to ensure accountability and improved service delivery*'.

2.2.3.1. Social development

27. In 2016/17 the budget for the National Department of Social Development (DSD) was R149 billion, while the combined budgets for provincial DSD amounted to R18 billion. Together there was a consolidated budget of R167 billion.

28. Social grants are provided for in the national DSD's budget, and accounted for 84% of the consolidated national and provincial DSD budget (R141 billion). More than a third (36%) of the social grant budget is for child grants. These include the child support grant, foster child grant and care dependency grant. Nevertheless, the value of the child support grant – which is the most common child grant – is less than the monthly amount needed to meet the food needs of a child.

29. The nine provinces combined allocated R6.7 billion for the children and families budget programme within the DSD in 2016/17 – 38% of the provincial budgets. The average amount per child ranged from R245 per child per year in Eastern Cape Province to R609 – more than double – in Northern Cape Province. The amount allocated for prevention and early intervention services was only 18% of the children and families budget.

30. Non-profit organisations (NPOs) deliver most social development services in South Africa, and government partially subsidises some of them to do so. However, the share of provincial children and families budgets allocated to NPO subsidies dropped from 64% in 2012/13 to 55% in 2016/17.

31. The 2016 report[11] of the Ministerial Committee that reviewed the Welfare White Paper for Social Welfare, 1997 found that social development services were far from

[11] Department of Social Development *Comprehensive Report on the Review of the White Paper for Social Welfare, 1997* (2016).

being adequately funded and made several recommendations aimed at improving the funding of social development services. These included that a social development component be added to the equitable share formula or, alternatively, the poverty share be increased (proposal 3); that DSD budgets be increased incrementally by increasing the total social development allocation by 1.9% per year for five years, reserving all the additional funds for delivery of social welfare services (proposal 4); and that standardised subsidy amounts for different services be introduced and implemented across all provinces (proposal 5). Cabinet approved all the recommendations made by the Ministerial Committee, however the 2017/18 budget shows no sign of their being implemented in the next three years.

2.2.3.2. Education

32. In 2016/17, the nine provincial departments of education had a combined budget of R212 billion, equivalent to 79% of the combined budgets for national and provincial education (R267 billion).

33. In 2016/17, the amount allocated by the nine provinces combined for learner and teacher support materials was estimated at R3 166 million, giving a mean amount of only R235 per learner in public ordinary schools. This would not be enough for even two textbooks per learner.

34. For all provinces combined, only 5-6% of the provincial education budget was allocated to infrastructure over the period 2012/13 – 2018/19. This includes conditional grant funds provided by national government. Meanwhile substantial deficiencies in school infrastructure and facilities persist (especially in the Eastern Cape Province) despite the existence of legislated norms and standards for school infrastructure and timelines for achieving them (See part 6.1 on the right to education).

2.2.3.3. Health care services

35. In 2016/17, the budget of the National Department of Health was R38.5 billion. Of this amount, R34 billion (88%) consists of conditional grants which are transferred to provincial budgets. The budgets of the nine provincial departments amounted to R164 billion (including the conditional grants). The total health care budget was therefore R168 billion.

36. Primary health care services provide preventive and early intervention services that are particularly important for young children's development. Across the national and nine provinces, primary health care budget sub-programmes amounted to 29% of the health budgets in 2016/17.

37. The full extent of health's funding on nutrition interventions is difficult to estimate because nutrition is sometimes addressed through general service delivery. The dedicated nutrition sub-programme within district health services has a smaller allocation than all other budget sub-programmes in eight of the nine provinces. For the nine provinces combined, the allocation was only 0.5% of the primary health care budget in 2016/17. The Department of Health's dedicated funding for nutrition is equivalent to only 4% of the Department of Basic Education's funding for the National School Nutrition Programme. This is concerning because it is mostly infants and young children under 5 years who depend on nutrition support from the Department of Health's programmes to combat malnutrition, under-nutrition and stunting (See part 6.3 on health and welfare for details on malnutrition and stunting).

Recommendations:

38. The recommendations in this regard are as follows:

a. GOSA should implement the recommendations in respect of funding of social development services that are contained in the 2016 Report of the Ministerial Committee that reviewed the White Paper for Social Welfare, 1997. In particular the recommendations to:
    - add a social development component to the equitable share formula or, alternatively, increase the poverty share (proposal 3);
    - increase the DSD budgets incrementally by increasing the total social development allocation by 1,9% per year for five years, reserving all the additional funds for delivery of social welfare services (proposal 4);
    - standardise the subsidy amounts that are paid for the various categories of services delivered by NPOs across all provinces (proposal 5).

b. GOSA should increase the value of the monthly Child Support Grant so that it at least covers the cost of basic nutrition for a child.

c. Within the education budgets, GOSA should increase the budget allocated for learner and teacher support materials and ensure efficient procurement and delivery of materials.

d. GOSA should explain what steps it is taking to improve effectiveness in expenditure with respect to improving school infrastructure, especially in the Eastern Cape Province.

2.3 PREVALENCE OF VIOLENCE

39. South Africa has high levels of interpersonal, community and sexual violence. We believe that the "normalisation" of violence against children is a matter of extreme concern. Marginalised children (e.g. children with disabilities and children in rural areas) are even more vulnerable to violence. The relatively solid legal frameworks in place to address child protection and the criminal justice system have not contributed to prevention or increased protections to children (see part 8 below for more detail).

Recommendation

40. Addressing the extreme levels of violence against children must be given urgent political priority, including increased focus on evidence-based prevention programmes. The frameworks and systems in place, require urgent budgetary and programmatic intervention.

2.4 DESIGNATION OF A NEW COORDINATING BODY

41. The Department of Women Children and Persons with Disabilities (DWCPD), mandated to improve monitoring and coordination of children's rights (and the rights of women and persons with disabilities), was established in 2009 and disbanded in 2014. Its functions relating to children moved to DSD. Civil society organisations (CSOs) were critical of the performance of the DWCPD, on the basis of its limited capacity; it was not an implementing department; and had little authority over implementing departments (Basic Education, Health, Justice, Police and DSD). These problems have not been adequately addressed by moving the mandate to DSD, particularly regarding DSD's relatively weak political authority over the range of implementing departments.

42. Overall, political leadership for realising children's rights is extremely poor, and the policy for inter-departmental cooperation is poorly implemented. CSOs are excluded from many forums, and where invited, they are expected to fund their own travel, thus excluding the participation of the majority of organisations.

43. The Child Care and Protection Forum, in particular, established under the DSD does not serve as an effectively functioning coordinating body. Firstly it is limited in scope to child care and protection and does not encompass the full range of child rights. CSOs are only able to attend if they have the funding to do so, due to no funds being allocated to enable the participation of CSOs, in spite of the significant role they play in delivering services to children. CSOs also have no influence on the agenda of the forum. Those CSOs that do succeed in participating in this forum argue that the forum fails to achieve coordination between departments, that it is weak in translating the discussions and decisions taken in that forum into substantive changes in various departments programmes for delivering on children's rights. Finally some provinces do not have functioning forums, this is a serious problem given the fact that delivery is located at this level.

Recommendations

44. The recommendations in this regard are as follows:

a. Stronger political leadership and commitment is essential, without this the persistence of implementation gaps in the child rights framework will not be addressed. This must include effective national monitoring and coordination of programmes to realise children's rights.
b. National and provincial coordination mechanisms must be established in the framework. These must cover the full range of child rights, and be located politically to ensure that they have the necessary authority to implement decisions.
c. Civil society engagement, consultation and participation in governance, implementation and monitoring processes must be routine and funded.

2.5 ESTABLISHING AN INDEPENDENT CHILD RIGHTS MONITORING BODY

45. GOSA does not address the issue of South Africa establishing an independent child rights monitoring body. This is surprising, given the United Nations Committee on the Rights of the Child General Comment 2, issued in 2002, the 2014 Concluding Recommendations from the ACERWC to the GOSA, and the 2016 Concluding Observations of the United Nations Committee on the Rights of the Child, which all stress the importance of such a body. More recently a recommendation was also given in the May 2017 draft report of the Working Group on the Universal Periodic Review that South Africa should "[d]evelop an independent child's rights monitoring mechanism and allocate adequate financial resources to ensure effective implementation of the relevant international obligations (Mongolia)".[12]

46. CSOs agree that South Africa requires an independent child's rights monitoring body. The ideal form that this should take is not yet clear, some favour the creation of a Children's Ombudsperson, while others argue for the appointment of a dedicated Children's Rights Commissioner within the Human Rights Commission (HRC), with greater resources.

47. We recognise the dangers of competing interests drowning children's rights out if incorporated into a broader human rights monitoring body, however we also recognise the problem of under-resourcing which bedevils many such bodies in South Africa. We are cognisant of the current deliberation regarding the consolidation of some existing human rights structures established under the Constitution. The question of a child rights monitoring body must feature in this process. There is strong consensus in ARC-CRSA that such a body must be properly resourced and capacitated and have the necessary independence and authority.

Recommendation

48. The GOSA must undertake a directed process to investigate the legal and structural changes required for the establishment of an independent child's rights monitoring body which has the necessary resources, capacity and authority to operate

[12] Human Rights Council *Draft report of the Working Group on the Universal Periodic Review, South Africa* (May 2017) at 6.

effectively. These questions must be resolved through a broad consultative process, including civil society and the public, and must be finalised within two years.

PART 3 DEFINITION OF THE CHILD

3.1 THE AGE OF MARRIAGE

49. The minimum age of marriage is set in common law at 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. As noted in the GOSA report, at para 74, section 12(2) of the Children's Act prohibits the marriage or engagement of any child below the minimum age set by law, namely 12 for girls and 14 for boys.

50. There are different requirements that apply in relation to consent to marriage of a child. The Minister of Home Affairs' consent is required for boys aged between 14 - 17 years (for customary or civil marriages). The requirement for girls differs for different age groups and different kinds of marriages. Girls aged 12 - 14 years that wish to enter into civil marriages require the consent of the Minister of Home Affairs. Girls aged 15 - 17 years only require the consent of their parents. If girls aged 12 - 17 years wish to enter into customary marriages the consent of the Minister of Home Affairs is required.

51. The Civil Union Act 17 of 2006 does not allow children to enter into civil unions. Children are, as a consequence, allowed to enter into civil and customary marriages but are not allowed to enter into same sex marriages in terms of the Civil Union Act.

52. The inconsistencies in marriage laws violate a number of constitutional provisions including the right to equality.

53. The South African Law Reform Commission (SALC) began a process of carrying out stakeholder engagements and developing a discussion paper and draft legislative document on child marriages. The process stalled in 2016 after a discussion paper and draft Bill on the "prohibition of forced marriages and child marriages" was sent out for public comment. This delay is disappointing in light of the urgent need to affirm the constitutional rights of and to protect children vulnerable from harmful cultural practices such as unlawful child marriages.

Recommendations

54. The recommendations in this regard are as follows:

a. Removal of any discrimination between boys and girls and set a uniform age of marriage. Consideration must also be given to raising the minimum age of marriage to 18, irrespective of parental consent, to align with international standards.

b. The SALC processes relating to engagements on a discussion paper and Bill on the prohibition of forced marriages and child marriages must be resumed with the aim of beginning a governmental and eventually a parliamentary process of introducing new legislation.

3.2 AGE OF SEXUAL CONSENT

55. The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 determines the age of sexual consent at 16 years. As noted in the GOSA report, at paras 76 and 77, in 2014 sections 15 and 16 of the Act were declared unconstitutional by the Constitutional Court in the matter of *Teddy Bear Clinic for Abused Children and RAPCAN v The Minister of Justice and Constitutional Development*.[13] The sections, *inter alia*, criminalised adolescents between the ages of 12 and 16 who engaged in sexual acts with each other. They stated that both children should be prosecuted if the National Prosecuting Authority decided to charge them with rape or sexual assault, therefore both children were treated as both victims and perpetrators.

56. The Constitutional Court found that the criminalisation of adolescent sexual experimentation/activities violated children's constitutional rights to dignity, privacy and to have their best interests considered paramount. The court ordered Parliament to amend the sections. The amended sections of the Act that decriminalise consensual sexual activities between adolescents became law on 3 July 2015.[14] We welcome this development.

[13] *Teddy Bear Clinic for Abused Children and RAPCAN v The Minister of Justice and Constitutional Development and Another* [2013] ZACC 35; 2014 (2) SA 168 (CC).
[14] *Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act* 5 of 2015.

57. The GOSA report notes, in para 79, that with the amendments in force, children who were convicted in terms of the old sections 15 and 16 had to have their criminal records expunged and their names removed from the National Register for Sex Offenders. We are concerned about whether children have been removed from the Register or not as reports on this have not been made public.

Recommendation

58. GOSA must provide clarity on whether children who were placed on the register as a result of the impugned section were removed from the register as per the Constitutional Court order.

3.3 AGE IMPACTING ON CUSTOMARY LAW

59. The Children's Act sets the age for consent to virginity testing and circumcision at 16 years. Harmful cultural practices are discussed further in part 9 below.

3.4 MINIMUM AGE FOR CONSENTING TO MEDICAL TREATMENT AND HEALTHCARE

60. The Children's Act reduced the age of consent to medical treatment to 12 years (as long as the child has the maturity and mental capacity to understand the risks, benefits and social implications). This enables caregivers to consent to treatment for younger children and those who lack capacity. Children aged 12 years and above can access contraception, and consent to HIV testing provided that they also access pre- and post-natal counselling. Their HIV status cannot be disclosed without their consent, and children who access contraception are entitled to confidentiality unless it is deemed in their best interests to breach confidentiality.

61. Despite the consent provisions there exist no clear guidelines for health professionals to assess children's mental capacity. The consent provisions must be explicitly integrated into pre- and in-service education of health professionals as well as professional codes of conduct. This will ensure 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.

62. The 2012 Integrated School Health Policy (ISHP) outlines a range of health care services to be delivered through schools. However the consent provisions of the ISHP state that: "[l]earners below the age of 18 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."

63. These provisions of the ISHP 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 important that the consent provisions of the ISHP are brought in line with the Children's Act.

Recommendations

64. The recommendations in this regard are as follows:

a. Policies dealing with children's rights to consent to medical treatment and access to sexual and reproductive health rights services must be aligned with the Children's Act which sets the age of consent at 12 years.
b. Provisions of the ISHP must be brought in line with the Children's Act.

3.5 AGE OF CRIMINAL RESPONSIBILITY

65. The Child Justice Act raised the minimum age of criminal capacity from seven to ten years of age. The Act also retained the presumption that a child who is 10 years or older but under the age of 14 years at the time of the commission of the crime lacks criminal capacity unless the State proves otherwise. This minimum age of criminal capacity standard falls short of internationally accepted standards, including standards set in General Comment 10 on Juvenile Justice by the United Nations Committee on the Rights of the Child.[15] The General Comment recommends that the minimum age of criminal capacity should be at least 12 years.[16] South Africa has a chance to come

[15] Skelton "Proposals for the review of the minimum age of criminal responsibility" (2013) 33 *South African Journal of Criminal Justice* at 257-8.
[16] Ibid.

in line with internationally accepted standards through section 8 of the Act which provides for a review of the current minimum age of criminal capacity. [17] This process was started in 2014 and seems to have stalled.

Recommendation

66. Re-ignition of the process to consider how the current provision on minimum age of criminal capacity has worked and amend the law in this regard particularly since the deadline for the review set in the Act was end of March 2015.

PART 4 GENERAL PRINCIPLES

4.1 CHILDREN WITH DISABILITIES

67. The legal framework affirming and creating the obligation to implement the rights of children with disabilities is scattered across a range of legislative and policy documents. We welcome the introduction of the White Paper on the Rights of Persons with Disabilities, 2015; and we applaud the significant provisions for children with disabilities in the Children's Act. 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. The 2009 DSD Integrated National Strategy on Support Services to Children with Disabilities is intended to guide the development and implementation of all government frameworks on children with disabilities, align budgets, remove barriers of access to and improve the quality of services. However, we are concerned about the lack of a binding nature of many of these provisions, namely, the White Paper on the Rights of Persons with Disabilities; the White Paper on Inclusive Education; and the Integrated National Strategy. These documents are in the most part comprehensive in identifying the manner in which barriers children with disabilities face are to be addressed but do not have the same binding authority that legislation has. As a result it is difficult to hold GOSA to account in its implementation and allocation of resources for the undertakings in the documents.

68. The Disabled Children's Action Group, a national membership organisation of parents of children with disabilities, argues that in spite of the above legal and policy

[17] Skelton n14 above at 259.

framework, access to the full range of services for the majority of children with disabilities is compromised. “Notable services which children with disabilities are denied, which lay the foundations for their development and social and economic inclusion as children, and later as adults, are education (starting with early education from birth); parenting support (psycho-social and material) to the caregivers of children with disabilities; and the provision of assistive devices and support to children identified with disabilities. The lack of access to appropriate services is caused by multiple factors, including inappropriate programming, inadequate resource allocation, as well as institutional weaknesses, such as the lack of effective coordination of health services.”[18] Inter-departmental collaboration and integration of services is seldom evident and that it is essential that GOSA prioritise this. There exists a serious lack of services and support for children with disabilities in rural areas; policies do not take a family-centred approach and thus services fail to provide effective support to parents to the ultimate benefit of the child.

69. The absence of disaggregated information on children with disabilities renders them invisible in data analysis and masks the disproportionate extent to which they are excluded from services. The woeful lack of data on the prevalence of disabilities in South African children, and of the numbers of children accessing services from various government agencies, severely impedes effective planning and budgeting to enable the full inclusion of children with disabilities in South African society. In addition, when a perusal is done of what little data is available on the prevalence of disability it is disappointing to note that GOSA’s statistics do not report on children under the age of 5, this essentially makes the data available “incomplete” as not all children with disabilities are taken into consideration.

Recommendations

70. The recommendations in this regard are as follows:

a. GOSA must put in place mechanisms to ensure accountability for actions (including budget allocations and expenditure) undertaken to protect the rights of children with disabilities.

[18] Patricia Martin “ECD and disability: Urgent priority and action are needed” (6 July 2016), available at http://ilifalabantwana.co.za/ecd-and-disability-urgent-priority-and-action-are-needed/.

b. Inter-departmental and inter-sectoral collaboration and integration of services must be prioritised to ensure that existing barriers preventing children with disabilities from accessing needed services are removed.
c. Data collection efforts on the prevalence of disability amongst children should be bolstered in order to account for all children with disabilities and to give a more accurate profile of the support that they require.
d. GOSA must indicate what plans are in place to ensure the availability of accurate disability prevalence data on children below the age of five. Technical support for this may be sought from UNICEF.

4.2 THE BEST INTERESTS OF THE CHILD

71. The role played by civil society in increasing the protection of children's rights by means of litigation can be seen in developments regarding the best interests of the child principle. These positive developments warrant attention. The Constitutional Court's 2008 judgement set the standard for how children should be dealt with and their rights considered in all cases where children are concerned.[19]

72. These principles have impacted on several cases involving different issues that children are involved in or affected by, including tender disputes,[20] child offenders,[21] surrogacy,[22] decriminalisation of consensual sexual activity between adolescents,[23] pregnant learners' access to education[24] and the right of separated children to be considered dependants of their caregivers.[25] These challenges to government by civil society have significantly informed the development of a child-centred approach in every matter concerning a child.

[19] *S v M (Centre for Child Law as Amicus Curiae)* (2008) 3 SA 232 (CC).
[20] *All Pay Consolidated Holdings (Pty) Ltd and Others v Chief Executive Officer of the South African Social Secuity Agency and Others* 2014 (1) SA 604 (CC).
[21] *J v The State (Centre for Child Law as amicus curiae)* 2014 (2) SACR 1 (CC); *MR v Minister of Safety & Security* 2016 (2) SACR 540 (CC).
[22] *AB and Another v Minister of Social Development* 2017 (3) BCLR 267 (CC).
[23] *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* 2014 (1) SACR 327 (CC).
[24] *Head of Department, Department of Education, Free State Province v Welkom High School and Another; Head of Department, Department of Education, Free State Province v Harmony High School and Another* 2014 (2) SA 228 (CC).
[25] *Mubake and Others v Minister of Home Affairs and Others* 2016 (2) SA 220 (GP).

4.3 The right to life, survival and development

73. South Africa has made significant progress in reducing child mortality over the past decade, but failed to achieve its 2015 under-five mortality MDG target of 20 deaths per 1000 live births, confirming that greater effort is needed to strengthen maternal and child health services, and to address the impact of poverty, hunger and inequality. Despite significant gains following the rollout of Prevention of mother-to-child transmission (PMTCT), there has been little, if any, **progress in reducing child mortality** over the reporting period. According to the Rapid Mortality Surveillance (RMS) report[26] under-five mortality peaked in 2004 at 80 deaths per 1000 live births (and infant mortality at 50 per 1000). Rates declined continuously until 2011 when the under-five mortality stabilized, and in 2015 the rate was 37 deaths per 1000 live births,[27] although the latest demographic health survey suggests that this may be even higher at 42 deaths/1000 live births[28].

74. **Cause of death** data produced from vital statistics cannot be taken at face value due to the misclassification of HIV/AIDS deaths; the high proportion of ill-defined causes, and the failure to specify the manner of non-natural deaths. We have therefore drawn on South Africa's 2nd National Burden of Disease study[29] which corrected for these biases. In 2012, key drivers of under-five deaths were neonatal causes (27.5%); HIV/AIDS(19.5%); diarrhoeal diseases (16%); lower respiratory infections (12.3%); other childhood conditions (6.6%); malnutrition (4.9%); injuries (5.5%); congenital disorders (2.8%) and TB, meningitis and septicaemia (all under 2% of the total).

75. The overall **neonatal mortality** rate has remained constant at 12 deaths per 1000 live births for 2014 and 2015[30], while the 2016 Demographic Health Survey

[26] This is the source recommended by the Health Data Advisory and Coordination Committee for monitoring infant and under-five mortality rates because the indicators have been adjusted for the under-reporting of deaths.
[27] Dorrington, Bradshaw, Laubscher and Nannan *Rapid Mortality Surveillance Report 2015.* (South Africa Medical Research Council, Cape Town 2016)
[28] *National Department of Health, Statistics South Africa, Medical Research Council and ICF (2017) South African Demographic Health Survey 2016. Key Indicator Report. Pretoria: NDOH, Stats SA, MRC & ICF.*
[29] Msemburi, Pillay-van Wyk, Dorrington, Neethling et al *Second National Burden of Disease Study for South Africa 1997-2012* (South Africa Medical Research Council, Cape Town 2016).
[30] Dorrington n27 above.

suggests that this may be nearly double this figure at 21 deaths/1000 live births[31]. There was a decline in the total number of neonatal deaths at facility level from 11 998 in 2014/15 to 10 925 in 2015/16.[32] Most deaths occur in the first seven days of life. The top three causes of neonatal deaths have remained perinatal asphyxia, preterm birth and infection.

76. **HIV and malnutrition** continue to be key underlying risks for death: 36.2% of deaths were associated with HIV in 2015, and 31.4% of young children who died in hospital were severely malnourished.[33] And there are concerns around the delayed diagnosis of TB due to poor history taking, contact tracing and case finding.

77. In addition, the role of **non-natural deaths** is under-recognised. These now account for 20% of deaths in the 1 – 4 year age group, and injuries (especially motor vehicle accidents) and violence are the leading cause of death in adolescence – peaking amongst adolescent boys.[34] Prevention of most of these deaths requires action outside the health sector, however there has been no obvious advocacy around non-natural deaths and child safety from the National Department of Health (NDoH).

78. High levels of **violence** remain a concern: 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 adolescent boys. Nearly half of child homicides are due to child abuse and neglect; with most of these are concentrated in the 0-4 year age group, and South Africa has among the highest reported infanticide rates globally, at 28.4/100 000 live births.[35] The child death review pilot confirmed that the number of neglect-related deaths in the under-5 age group is under-reported in current mortality estimates and that neglect-related deaths are often misclassified as natural causes.[36]

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[31] National Department of Health, Statistics South Africa, Medical Research Council and ICF *South African Demographic Health Survey 2016. Key Indicator Report* (2017).
[32] Data from the District Health Information System 2016.
[33] Child PIP 2015 data.
[34] *Statistics South Africa (2017) Mortality and causes of death in South Africa, 2015: Findings from death notification. Statistical Release P0309.3. Pretoria: Stats SA. P. 37.*
[35] Abrahams, Mathews, Martin, Lombard, Nannan and Jewkes "Gender differences in homicide of neonates, infants and under-five year olds in South Africa: Results from the 2009 national child homicide study" (2016) 13(4) *Plosmed* 1-15.
[36] Mathews and Martin "Developing an understanding of fatal child abuse and neglect: Results from the South African child death review pilot" (2016) 106(12) *The South African Medical Journal* 1160-1163.

79. **From survival to development:** Emphasis needs to shift beyond survival to optimal development. Poverty, violence, malnutrition, a lack of care and harsh discipline in the first 1000 days of life create "toxic stress" which has potentially lifelong consequences for children's health and schooling. Many chronic diseases have their roots in early childhood.[37] The health sector has a pivotal role to play in improving child outcomes starting in the antenatal period by identifying risk factors, promoting health and development, supporting mothers and caregivers, and providing a gateway to social grants, child protection and social services.[38] This requires a shift in focus, training, resources and the essential package of services if health is to fulfil its mandate as outlined in the 2015 National Integrated Early Childhood Development Policy. To date, the NDoH has played a secondary and marginal role in implementing changes required by the policy, and introduced no new initiatives.

Recommendations:

80. The recommendations in this regard are as follows:

Review child deaths to improve quality of care

81. Ongoing mortality reductions to reach the Sustainable Development Goals target requires a review of each child death. The Child Healthcare Problem Identification Programme (Child PIP programme) needs to be instituted at all hospitals in the country and data generated used more effectively at facility and district level to drive quality improvement. Better care on arrival in hospital, through more effective triage can be facilitated by supporting the rollout of the ETAT (Emergency Triage, Assessment and Treatment) or equivalent programmes. The perennial shortage of high- and intensive-care paediatric and neonatal facilities at hospitals should be prioritised.

[37] Morgan *Biological embedding of early childhood adversity: Toxic stress and the vicious cycle of poverty in South Africa. Research & Policy Brief series 2* (Ilifa Labantwana, Cape Town [in press]); Walker, Wachs, Meeks Gardner, Lozoff, Wasserman and Pollit "Child development: Risk factors for adverse outcomes in developing countries" (2007) 396 *The Lancet* 145-157.
[38] Slemming and Saloojee "Beyond survival: the role of health care in promoting ECD" in Berry, Biersteker, Dawes, Lake and Smith (eds) *South African Child Gauge 2013* (Children's Institute, University of Cape Town, Cape Town 2013).

Actively promote early childhood development

82. A shift in focus, training, resources and the essential package of services is demanded, if health is to fulfil its mandate as outlined in the 2015 National Integrated Early Childhood Development Policy. The Department of Health needs to initiate interventions to reduce stunting, including training community health workers (CHWs) to support breastfeeding, promote good complementary feeding practices and assist parents to care, stimulate and play with their young children. Health services need to be extended to ECD centres, such as nutritional support and catch-up immunisation, deworming and vitamin A supplementation. Support for pregnant women, including nutrition and mental health is also a health responsibility. Funding earmarked for ECD by National Treasury, some R813 million in the 2016 national budget, needs to be extracted for these purposes.

83. For more recommendations see part 6.3 on health and welfare.

4.5 RESPECT FOR THE VIEWS OF THE CHILD

84. Participation rights are included in a number of laws affecting children, providing a strong platform to promote participation and citizenship rights. Legislated participation rights are intended to provide children with decision-making powers in terms of obtaining their consent and expressing their views on matters affecting them. 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.

85. The Supreme Court of Appeal[39] has recently (2015) endorsed the importance of children's participation in cases about them, and expressly refers to South Africa' obligations under Article 12.

Recommendations

86. The recommendations in this regard are as follows:

a. GOSA should provide evidence that initiatives such as the Children's Parliament impact on policy and law development and systems of government.

[39] *Centre for Child Law v The Governing Body of Hoërskool Fochvile* 2016 (2) SA 121 (SCA).

b. GOSA must take steps to ensure that child participation is not an occasional occurrence, but a process that is essential and provided for in all matters that affect children in order to ensure that policies, laws, actions and procedures that affect children are informed by the views of children.

PART 5 CIVIL RIGHTS AND FREEDOMS

5.1 Name and Nationality

87. The Constitution of South Africa guarantees the right of every child to a name and a nationality from birth. The Charter (Art 6) and the UN Convention on the Rights of the Child (Art 7), both of which GOSA is a party to, recognise the right of every child to be registered and to acquire a nationality. However, due to birth registration barriers, the lack of an immigration status for unaccompanied children and the barriers to refugee and asylum-seeker documents, many children in South Africa are at risk of statelessness and do not have access to basic services, including basic education.

5.1.1 Barriers to birth registration

88. In 2016 the UN Committee on the Rights of the Child (UNCRC) made several recommendations to South Africa regarding barriers to birth registration. It recommended that the GOSA *"review and amend all legislation and regulations relevant to birth registration and nationality to ensure their full conformity with the Convention, including through the removal of requirements that may have punitive or discriminatory impacts on certain groups of children".*

89. The punitive measures referred to here are twofold. First, the regulations accompanying the new Births and Deaths Registration Act (BDRA) have introduced a fee for late registration of births. All births registered after 30 days of the birth are considered late. These fees are reportedly not being implemented yet, but the legislation already lays out the basis and this is concerning as it may create a barrier for those who cannot afford the fee. Secondly, the GOSA has issued a directive by which all children who are born to one foreign parent are required to produce proof of paternity in the form of a DNA test if the birth is registered after 30 days. The tests cost approximately R1 200 to R1 800 and applicants are expected to cover the cost. The test can only be done by one service provider, the National Health Laboratory Service

(NHLS) which can only be found in major cities. Where parents cannot afford to pay for the test or travel to a major city to have it done, births remain unregistered. There is currently no exception to this rule. Many children go unregistered, because of this expensive exclusionary practice.

90. With regards to discrimination, the BDRA (in regulation 3, 4 and 5) lists the requirements and documents, without which no application for birth registration will be accepted. These include, amongst others, a valid passport and permit of the parent; the fingerprints of the parents if alive; an affidavit by a South African citizen if the birth occurred outside a hospital; and the presence of the mother if the child is born out of wedlock. This means that the following children cannot be registered:

a. Children of undocumented parents (whether South African or foreign) or parents whose permits have expired;
b. Children who are in the care of next-of-kin where the parents are alive;
c. Children born at home where there was no witness or the only witness was a foreign national; and
d. Children in the care of single fathers where the mother has abandoned the child or is undocumented.

91. Around 10% of children in South Africa remain unregistered and hundreds of stateless children are identified each year.[40] Birth certificates and identity documents are crucial as the lack thereof can result in the denial of fundamental rights and the access to nationality, education, social grants and health care.

Recommendations

92. The recommendations in this regard are as follows:

a. The GOSA should review the BDRA regulations and remove the fee for late registration of birth.

[40]Lawyers for Human Rights "Childhood Statelessness in South Africa" available at http://www.lhr.org.za/sites/lhr.org.za/files/childhood_statelessness_in_south_africa.pdf; Sloth-Nielsen and Ackermann "Unaccompanied and Separated Foreign Children in the Care System in the Western Cape – A Socio-Legal Study" (2016) 19 *Potchefstroom Electronic Law Journal*.

b. The GOSA should cancel the directive requiring DNA tests to be done at late registration of birth. Where the GOSA requires DNA proof, if any, the GOSA should cover such costs and provide such services in all locations where they are required.

c. The GOSA should amend regulation 3, 4 and 5 of the BDRA to remove discriminatory requirements or to remove the absolute ban on acceptance of applications and allow such applications with the use of discretion by either the Department of Home Affairs or a Children's Court.

5.1.2 Unaccompanied children

93. In South African law, there is no dedicated mechanism to regularise the stay of unaccompanied migrant children who are not refugees. The Immigration Act provides status for children based on the status of their parents. As a result, abandoned and orphaned children have no option for a permit. This is concerning, because children without immigration permits are not allowed into school and when they reach the age of majority they are likely to be stateless, because of their long absence from their country of origin or the lost link to their parents.

94. The Immigration Act 13 of 2002 contains a provision which allows the Minister of Home Affairs to grant permanent residence to foreigners under special circumstances [section 31(2)(b) Immigration Act]. This provision should suit the needs of unaccompanied children in the care system, however the application fee is R1 350 which is unaffordable to unaccompanied children. The application takes at least 8 months to finalise and the outcomes are unpredictable. While the children wait for the completion of the application process, they cannot go to school. These applications are not treated with more urgency than adult applications.

95. Section 31(2)(b) of the Immigration Act allows the Minister to provide permanent residence to a "category of foreigners" under special circumstances. It is crucial that the GOSA identify unaccompanied foreign children in the care system as a special category in terms which indicate that they need urgent and special intervention in relation to their lack of immigration status. The UNCRC on the Rights of the Child recommended in 2016 that the GOSA "*systematically identify all undocumented children currently residing in child and youth care centres in all parts*

of the State party and ensure their access to a birth certificate and a nationality' and *'consider providing migrant, asylum-seeking and refugee children with an option of permanent settlement in the State party".*

96. Integration is often the most durable solution for children in such cases because they often do not have any ties to their countries of origin having arrived in South Africa at a young age and lived all their lives in South Africa.

Recommendations:

97. The recommendations in this regard are as follows:

a. The GOSA should identify unaccompanied migrant children as a "category" in terms of section 31(2)(b)[41] of the Immigration Act in order to allow all children who meet the definition to apply for and be granted permanent residence in South Africa.

b. The GOSA should waive all fees applicable to applications for immigration permits for unaccompanied children, fast track such applications and allow children to go to school while they await the outcome of their application.

5.1.3 Refugee and asylum seeker children

98. With regards to refugee and asylum-seeking children there are two main concerns. First, the Refugee Amendment Bill 2016, if passed, will limit the definition of a dependant of a refugee to biological children who are declared by the adult refugee upon arrival. Second, unaccompanied refugee children's access to Refugee Reception Offices is limited by the fact that these offices are only in three places in the country: Pretoria, Durban and Musina.

99. Under the current Refugees Act separated (migrant children who entered South Africa without a parent, or who entered with a parent or other relative, but who were subsequently abandoned) children qualify for refugee status if they are in the care of a refugee. They are included under the definition of a "dependant" making them

[41] Section 31(2)(b) & (c) of the Immigration Act: "(2) Upon application, the Minister may under terms and conditions determined by him or her- (b) grant a foreigner or a *category of foreigners* the rights of permanent residence for a specified or unspecified period when special circumstances exist which would justify such a decision… (c) for good cause, waive any prescribed requirement or form".

eligible for refugee status. The proposed Refugee Amendment Bill takes away this protection by limiting the definition of "dependant" to biological children only. This leaves children separated from biological parents unable to apply for asylum unless they can themselves qualify as a refugee, can remember and recount the events to an official.

100. The current Refugees Act in section 32 provides a referral mechanism to the Children's Court for unaccompanied children, but not for separated children. If the amendment is passed, separated children will have no pathway to documentation either through a care-giver or the court. Section 32 of the Refugees Act doesn't make it mandatory for a Children's Court to make an order regarding assistance of unaccompanied minors for applications for refugee status. The section uses the word "may" which means that such orders are often not made. The UNCRC on the Rights of the Child in 2016 recommended that the GOSA "*ensure that the Refugees Amendment Bill is fully consistent with the Convention".*

101. In addition to the stringent requirements of section 32 to access asylum, a further barrier to application for asylum by unaccompanied children, is the provincial nature of DSD. A refugee child in the care of a person other than a parent, or placed in a CYCC in any province other than Gauteng, Limpopo or KZN (locations of operational Refugee Reception Offices during the reporting period) – may access a social worker in the province where they reside, but designated social workers do not have the means to accompany refugee children to Refugee Reception Offices in other provinces. The result is that refugee children do not have access to documentation. Since the closure of the Cape Town Refugee Reception Office to new asylum applications in 2012, practice at the Cape Town Temporal Refugee Facility has been not to join children of refugees and asylum seekers to their parents' file – despite this being provided for in the law.

102. Para 137 of the GOSA report states that "The Refugees Act stipulates that unaccompanied children must be assisted by a legal guardian to apply for asylum. Once the children's court appoints a legal guardian, the [Department of Home Affairs] proceeds to assist the minors who are unaccompanied to apply for asylum." However, legal guardians are not systematically appointed to unaccompanied children. Unaccompanied and separated minors either reside in foster care, institutional care or

remains informally with relatives or other persons who take it upon themselves to raise such children. A foster care order does not confer legal guardianship. Similarly, a CYCC does not become the legal guardian of a child placed in care. Section 24 of the Children's Act deals with assignment of guardianship:

> "(1) Any person having an interest in the care, well-being and development of a child may apply to the High Court for an order granting guardianship of the child to the applicant."
>
> Section 25 of the Act goes on to say:
>
> "25. When an application is made in terms of Section 24 by a non-South African citizen for guardianship of a child, the application must be regarded as an inter-country adoption for the purposes of The Hague convention."

103. Asylum seekers or refugees who are informal caregivers of migrant children are not able to access the High Court due to financial implications. Furthermore, asylum seeker or refugees who are caring for migrant children are not able to meet the requirements for international adoptions – especially if they originate from countries where adoption registers are not kept, or International Social Services does not have a functional counterpart.

Recommendations:

104. The recommendations in this regard are as follows:

a. The GOSA should include separated children in the definition of "dependant" with relation to their primary care-givers in the Refugee Amendment Bill.

b. The GOSA should make provision for unaccompanied children to apply for and renew asylum seeker and refugee permits in the province where they live.

c. The GOSA should amend section 32 of the Refugees Act to make it mandatory for a Children's Court to order a social worker to assist such a child to make an application for asylum.

5.1.4 Stateless children

105. Section 2(2) of the South African Citizenship Act provides citizenship by birth to children who are born stateless in South Africa. Unfortunately, this section cites birth registration as a requirement for citizenship. This means that children will only be able to access nationality if their births are registered. Stateless children can often not be registered, because of the barriers discussed above, which then renders section 2(2) useless to them. Where stateless children do get birth certificates, there are cases in which the GOSA has refused to implement the section to the point that they have refused to comply with two court orders (one by the High Court of South Africa and one by the Supreme Court of Appeal) ordering the GOSA to register the child applicant as a South African citizen (DGLR v The Minister of Home Affairs). The child remains statelessness 8 years after her birth. There is also no regulation to accompany this section, which means there is no application form for this section. The two court orders also ordered the GOSA to make these regulations, but they have refused to do so.

106. Section 4(3) of the Citizenship Act allows children who were born in South Africa, have lived in South Africa until they turn 18 and whose births are registered in South Africa to apply for citizenship. Again, birth registration is vital in this section for children to be granted citizenship therefore section 4(3) does not provide much of an option for stateless children.

107. The UNCRC recommended in 2016 that the GOSA "*put in place regulations to grant nationality to all children under the jurisdiction of the State party who are stateless or are at risk of being stateless'* and to *'consider ratifying the Convention Relating to the Status of Stateless Persons of 1954 and the Convention on the Reduction of Statelessness of 1961"*.

Recommendations:

108. The recommendations in this regard are as follows:

a. The GOSA should implement the two court orders regarding stateless children in terms of section 2(2) of the Citizenship Act, including the making of regulations to this section to allow for an application process.

b. The GOSA should ratify and implement the 1954 Convention Relating to the Status of Stateless Persons and the 1961 Convention on the Reduction of Statelessness in order to end childhood statelessness.

c. The GOSA should remove all requirements for birth registration from citizenship provisions. In the alternative GOSA should ensure that the process of getting birth registration less tedious.

5.1.5 Education of undocumented children

109. The GOSA currently views providing schooling to undocumented children to be a criminal offence in terms of the Immigration Act. This is because the Immigration Act prohibits learning institutions from providing instruction to "illegal foreigners". School Principles report having been told they will be fined or imprisoned if they admit undocumented children. This has resulted in an increase in children refused schooling in 2017. In the Eastern Cape, budgeting and provision of funds for schools have been limited to the number of documented children in the schools. As a result, these schools cannot afford to admit undocumented children. The Immigration Act allows the provision of services to illegal foreigners if they would be entitled to such services under the Constitution. However, the GOSA does not implement this section or does not it consider illegal foreigners to be entitled to a basic education under the Constitution. Section 29 of the Constitution says that "*everyone has the right to a basic education"*.

110. As discussed above many South African children remain undocumented and many refugee and asylum-seeking children face barriers in the renewal of their permits. Most unaccompanied foreign children have no documentation due to the reasons set out above. The children of irregular migrants are not responsible for their lack of documents and are rather victims of the situation which they find themselves in. These children's right to a basic education cannot be violated because of circumstances beyond their control.

Recommendations:

111. The recommendations in this regard are as follows:

a. The GOSA should immediately remove all barriers to education for undocumented children.

b. The GOSA should provide funding to schools based on the amount of both documented and undocumented children they have registered.

112. Many issues and central contentions with the South African law were addressed in the Concluding Recommendations of the ACERWC (recitals 30-33). The country report recognises and comments on all of these recommendations, but whilst important legal and organisational changes have been put in place, there has, unfortunately, been little tangible improvement regarding the existence and risk of statelessness amongst children. This is not only due to insufficiencies regarding the implementation of the law.

113. The GOSA must be commended for the implementation of its modernisation programme, Live Capture (a programme which creates electronic, unabridged birth certificates and the further allocation of funds for the registration of children, see para 127 of the GOSA report. We are, however, particularly concerned about the government's acceptance of the "pockets of unregistered children" (para. 130), as these are not only caused by the unwillingness of parents to register births or the difficulties in accounting for home births, but also by the discriminatory nature of the laws and procedures (barriers, requirements and burdens). These "pockets" have been growing since the amendment of the law in 2014.

114. Despite the improvements brought about by the South African Schools Act and the Birth Registration Strategy, as set out in para 134 of the GOSA report, GOSA also acknowledges that unaccompanied children or children with undocumented mothers run a high risk of becoming stateless (para. 136).

115. All of these gaps in the law, and resultant restrictions, are contrary to principles of non-discrimination and the best interests of the child, Article 28(1)(a) of the South African Constitution, Article 6 of the ACRWC and Article 7 of the CRC. They also undermine the protection against statelessness found in Section 2(2) of the Citizenship Act, perpetuate the cycle of lack of documentation and legal status (including nationality) and undermine the right to an identity of all children.

116. In addition to these and other gaps in the law, the biggest challenge is implementation.

5.2 Freedom of association and of peaceful assembly

117. Section 17 of the Constitution of South Africa provides that everyone has the right, peacefully and unarmed, to demonstrate, to picket and present petitions. Section 18 of the Constitution states that everyone has the right to freedom of association. GOSA acknowledges these two rights in its report at para 150. These rights impact children in two ways: children have the right to demonstrate and the right to freedom of association when they want to express grievances; and children are often negatively affected by violent and disruptive protest action.

118. Children have in several circumstances exercised their right to demonstrate and freedom of association in order to bring to the fore grievances and issues affecting their rights and well-being negatively. In recent months children have protested over the protection and appropriate implementation of their right to basic education and issues related to the exercise of this right. The challenges that have been the subject of protests include: overcrowded classrooms and teachers not being paid;[42] racism in a public school;[43] building of a new school;[44] poor conditions in a school, including overflowing sewage and blocked toilets.[45] This has allowed children to express their grievances and hopefully participate in how these grievances are resolved.

119. Children unfortunately also have had to bear the brunt of violent and disruptive services delivery protests. A report by the South African Human Rights Commission notes that a right tremendously affected is the right to basic education.[46] The

[42] Ground up "We are packed like sardines" say protesters at Gugulethu school" (27 February 2017) http://www.groundup.org.za/article/we-are-packed-sardines-say-protesters-gugulethu-school/.
[43] News 24 "Support for Pretoria High School for Girls Protest" (29 August 2017) http://www.news24.com/SouthAfrica/News/support-for-pretoria-high-school-for-girls-protest-20160829.
[44] Ground up "Philippi High students demand promised new school" (6 March 2017) http://www.groundup.org.za/article/philippi-high-students-demand-promised-new-school-be-built/; News 24 "Children study in middle of Eastern Cape road in protest" (15 February 2017) http://www.news24.com/SouthAfrica/News/children-study-in-middle-of-ecape-road-in-protest-20170215.
[45] iol news "Pupils boycott school as sewage spillage fills passages" (16 May 2017) http://www.iol.co.za/news/south-africa/gauteng/pupils-boycott-school-as-sewage-spillage-fills-passages-9158731.
[46] South African Human Rights Commission *National Investigative Hearing into the Impact of Protest-related Action on the Right to a Basic Education in South Africa* (September 2016).

Commission found that “learners are disadvantaged by certain protest-related action in that they are consequentially (a) physically barred or intimidated from attending school; and (b) infrastructure on which learners rely to access education is damaged or destroyed.”[47] Protestors and those involved in barring and/or intimidating children and damaging or destroying schools are violating the affected children’s right to basic education.[48]

Recommendations

120. The recommendations in this regard, as taken from the South African Human Rights Commission report, are as follows:

a. GOSA must ensure that a plan is in place to ensure that, where learners have been deprived of basic education due to protest action, the necessary catch up is achieved.
b. GOSA must ensure that different government departments have clear responsibilities where school infrastructure and buildings have been damaged or destroyed. This should be done to ensure that the learning environment is normalised as soon as possible and provision of education can continue.
c. Awareness should be created on the impact of public protests action on the right to basic education. This should include information on the right to protest and the role of the police and other government functionaries.

PART 6 ECONOMIC, SOCIAL AND CULTURAL RIGHTS

6.1 RIGHT TO EDUCATION

6.1.1 System Failure

121. The inequality within the South African education system, rather than being effectively addressed has been entrenched. Schools which have historically catered for black learners have invariably maintained their malfunctioned identity. An examination of the poorest 60% of schools in South Africa, reveals that these schools are unable to provide learners with the skills needed to read, write and calculate at the

[47] South African Human Rights Commission n46 above at 37.
[48] Ibid.

correct grade level. By grade 3, learners in these poorest schools lag behind by three years of learning as compared to their more affluent peers. Of these learners, those that manage to make it to grade 9 would suffer a learning gap of 5 years.[49]

122. The reasons for this include "weak teacher content knowledge and pedagogical skill", particularly in schools that serve poor communities, and there is a lack of district support, especially for teachers who teach below grade 10. A lack of accountability and support has resulted in system collapse.[50]

123. The disparities in the education system are even more pronounced when comparing rural – former homeland schools – with their urban counterparts. According to the Department of Basic Education's own statistics, 77% of schools nationally lack libraries whereas this figure rises to about 90% in respect of Limpopo schools. [51] Rural schools overwhelmingly bear the burden of the school infrastructure crisis.

124. An examination of the 2015 matric (last year of high school) pass rates tells a similar story. Inequalities between provinces are palpable. Largely urbanised provinces like the Western Cape and Gauteng consistently and significantly outperform rural provinces like KwaZulu-Natal and the Eastern Cape. The 2015 matric results showed that the Western Cape and Gauteng both received a just over 84% pass rate. By contrast, the Eastern Cape Province pass rate stood at a mere 57%.

125. Matric results do not, however, paint an adequate picture of the state of the public education system. Matric pass rates reflect the number of learners who reached matric and sat for exams, nothing is said of the many learners who dropped out of the system or of the disparities in the quality of passes. According to a report released by the Department of Basic Education in 2013, "*a responsible estimate of the proportion of youths that pass matric is about 40%.*"[52]

[49] Spaull, "Schooling in South Africa: How low-quality education becomes a poverty trap," in De Lannoy, Swartz, Lake & Smith (eds) *South African Child Gauge 2015* (Children's Institute, University of Cape Town, Cape Town 2015) 34-41.
[50] van den Berg, Spaull, Wills and Kotze *Identifying Binding Constraints in Education, Synthesis Report for the Programme to Support Pro-poor Policy Development (PSPPD)* (Research on Socio-economic Policy, Department of Economics (RESEP), University of Stellenbosch, Stellenbosch 2016).
[51] Department of Basic Education National Education Infrastructure Management System.
[52] Department of Basic Education *Macro Indicator Report* (2013) 43.

6.1.2 Quality of Teaching

126. Teachers continue to be distributed unequally across the education system. The current post provisioning model in terms of which teachers are allocated makes minuscule provision for poverty redress. In fact, the model exacerbates the unequal distribution of teachers by failing to take into account that privileged schools have the resources to simply "top up" through hiring additional teachers or that better suburban schools inevitably attract better qualified teachers who receive higher salaries. Ultimately, through the current post provisioning model, GOSA is in fact spending more per learner in better suburban schools than in poorer schools.

Recommendations

127. The current post provisioning model must be reviewed and revised so as to ensure that it is more pro-poor friendly.

6.1.3 Scholar Transport

128. Thousands of learners are forced to walk long distances to and from schools that they attend. For rural learners, the journey can be dangerous with children having to face, amongst other things, mountainous areas and flash floods as well as the constant risk of theft, rape or kidnapping.

129. The Department of Basic Education's own figures show that demand for scholar transport far outstrips supply with 516 886 learners in need and only 386 448 receiving assistance.[53] Whereas Western Cape Province is able to transport all qualifying learners, the KwaZulu-Natal province is only able to provide assistance to half of the learners that qualify to receive such assistance. A new funding approach to fund scholar transport is urgently needed.

Recommendations

130. The recommendations in this regard are as follows:

a. The introduction of a conditional grant for scholar transport.

[53] Department of Basic Education's 2015/2016 Annual Report.

b. The grant should take into account, amongst other things, the rural terrain of some provinces,

6.1.4 School Infrastructure

131. GOSA lauds its Accelerated School Infrastructure Delivery Initiative (ASIDI) programme and the school infrastructure backlogs grant as measures aimed at ensuring infrastructure delivery in compliance with the norms and standards for school infrastructure. However, recent reports to Parliament by the Department of Basic Education and National Treasury reveal severe underspending of the ASIDI grant. The Department of Basic Education's slow pace in spending the ASIDI grant, and the subsequent decrease in funds allocated to the grant by National Treasury do not bode well for successful implementation of the norms and standards. It demonstrates that proper planning and implementation across government departments is not taking place.

132. The School Infrastructure Norms and Standards requires each provincial Member of the Executive Council (MEC) for Education to submit annual implementation plans and progress report to the Minister of Basic Education. The MECs' latest reports lack the detail needed to ensure properly co-ordinated and successful school infrastructure delivery.

133. The Norms and Standards also have certain loopholes and deficiencies which the Minister has refused to address and which are currently the subject of litigation.

Recommendations

134. The recommendations in this regard are as follows:

a. GOSA must urgently address the deficits within the School Infrastructure Norms and Standards.
b. The Provincial MECs of Education must ensure that annual progress reports and implementation plans are thorough and cover all necessary aspects.
c. That the various government departments and agencies co-ordinate their activities in a way that proper planning and implementation can take place.

6.1.5 Violence in schools

135. Violence in schools remains rife. This includes physical and sexual assault by fellow learners and teachers. A culture of bullying is engrained. In areas where gang activity is endemic, there is a significant adverse effect on learning and teaching.

Recommendations

136. The recommendations in this regard are as follows:

a. GOSA must ensure anti-bullying policies and peer mediation structures are developed for and/or in schools. These should, in particular, focus on primary schools.
b. GOSA must commit resources to implement a national programme of training on positive discipline.

6.1.6 Learner Pregnancy

137. GOSA says that it continues to guarantee access to education for pregnant girls and is reviewing a draft policy on learner pregnancy. Once finalised this policy will replace the unconstitutional 2007 learner pregnancy measures which encourage lengthy exclusions of pregnant girls from school. Almost four years have lapsed since GOSA first acknowledged the unconstitutionality of the 2007 measures, in the wake of a constitutional court judgment[54], yet these measures remain in place and the learner pregnancy policy is yet to be finalised.

138. The lengthy delay in replacing the unconstitutional 2007 learner pregnancy measures has resulted in further rights violations. Discriminatory practices which frustrate pregnant learners' ability to access school remain rife. A learner pregnancy policy and clear guidelines which informs schools on how to properly support pregnant girls is urgently needed. The aim is to ensure that learners who fall pregnant will remain in the public education system.

[54] *Head of Department, Department of Education, Free State Province v Welkom High School and Another; Head of Department, Department of Education, Free State Province v Harmony High School and Another* 2014 (2) SA 228 (CC).

Recommendation

139. The national learner pregnancy policy that deals with how pregnant learners are to be accommodated and supported by schools be finalised urgently.

6.1.7 Learner teacher support material

140. The National Department of Basic Education has chosen a curriculum which by design relies heavily on learner teacher support material (LTSM) for implementation. This includes textbooks, workbooks, stationery and teacher guides. LTSM is supposed to be funded by the provincial department or, in the case of no-fee public schools, procured directly by the provincial department.

141. The new curriculum was phased in between 2012 and 2014. In 2014, the Department of Basic Education was taken to court by *Basic Education for All*, a voluntary organisation, after it received reports of tens of thousands of textbook shortages in Limpopo. The High Court found non-delivery to be a breach of the Constitution and ordered that each learner receive every textbook required prior to starting the part of the curriculum to which that textbook relates.[55] This judgment was confirmed on appeal.[56] Despite these court orders there are still thousands of textbook, workbook and stationery shortages reported to non-governmental organisations across the country.

142. There is an urgent need for regularisation of the ordering, procurement and delivery process to ensure that learners have the LTSM they require. Despite a draft policy being released for comment in 2014, there has been no further progress towards formalising a policy or regulations setting out the norms and standards for LTSM.

Recommendations

143. The recommendations include the following:

[55] *Basic Education For All and Others v Minister of Basic Education and Others* 2014 (4) SA 274 (GP); [2014] 3 All SA 56 (GP); 2014 (9) BCLR 1039 (GP).
[56] *Minister of Basic Education v Basic Education for All* [2016] 1 All SA 369 (SCA); 2016 (4) SA 63 (SCA).

- That a LTSM policy be finalised and corresponding norms and standards published.

6.1.8 Inclusive education and incorporation of special needs education

144. In 2001 the Department of Basic Education published White Paper 6 on Inclusive Education, this was done as part of a drive to eliminate barriers to access to education. The White Paper sets out a progressive framework for systemic changes required to establish a truly inclusive education system in South Africa. Unfortunately, the legal status of the White Paper is unclear and most of the steps set out in the White Paper have either not been implemented or have been inadequately implemented. As a result, the education system remains mostly inaccessible to learners with disabilities, and entirely untransformed to be truly inclusive. Brief descriptions of the barriers to access experienced by children with disabilities follow.

145. Children with disabilities experience discriminatory admission policies as they attempt to access ordinary schools and special schools. An Alternative Report to the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD)[57] notes that discriminatory admission policies and practices have the following effects: children who are incontinent are often excluded from schools; female learners are required to take contraceptives in order to be admitted into schools; learners with multiple disabilities are often excluded from schools as they do not fall within areas of specialisation offered by special schools. Special schools have long waiting lists of children applying for entry. Children can remain on these lists for more than 5 years without any alternatives made available to them. A strengthening and more focused implementation of the Screening, Identification, Assessment and Support Policy (SIAS), 2014 would go a long way in addressing a number of these challenges. SIAS seeks to provide assistance to learners who experience learning barriers by empowering educators, School Based Support Teams and District Based Support Teams to conduct assessments of learners who experience learning barriers and then provide multi-dimensional support for the learner. The implementation of the SIAS policy has been stagnated in certain areas; where educators have faced several

[57] Right to Education for Children with Disabilities Alliance *Alternative Report to the UN Committee on the Rights of Persons with Disabilities in response to South Africa's Baseline Country Report of March 2013 on the UN Convention on the Rights of Persons with Disabilities, with particular reference to the provisions of article 24* (January 2017).

difficulties in receiving support from the Education Department. In addition, the role of the parents in the assessment process has yet to be adequately clarified. The consequence is worst felt by those in rural areas where full-service schools are not readily available and where special needs schools are far in between.

146. The differentials in the available data make a proper statistical analysis impossible, but it is clear that thousands of learners with disabilities are out of school because schools are unable to adequately cater for their needs or parents are not aware that their children are educable. Once learners are in school, there is insufficient funding provided for learners because a proper budgetary framework for special and full-service schools is yet to be established. A conditional grant envisioned by the White Paper to provide ring-fenced funding for non-personnel expenditure has never been established. There are also no special schools that have been categorised as "no fee-paying schools", therefore learners with disabilities that attend special schools do not have access to free basic education. Poor families are able to apply for fee exemptions but either do not know about this or struggle with the procedures.

147. The provision of school transport does not account for the needs of learners with physical disabilities and the heightened risks and difficulties associated with these learners getting to school. Transport is provided to learners in unsafe, inappropriate vehicles that have not been adapted to meet the needs of the learners concerned. In addition, funding norms and standards comprehensively addressing the transport needs of learners with disabilities have not been adopted yet.

148. These challenges are partially aimed to be addressed in the White Paper on the Rights of Persons with Disabilities and the Draft Policy on the Provision of Quality Education and Support for Children with Severe to Profound Intellectual Disability (October, 2016).

149. Braille workbooks are being provided to learners with visual impairments in special schools, but there is no programme for provision of braille textbooks, which are considered by the DBE to be an essential component of the curriculum.

Recommendations

150. Recommendations include:

a. The amendment of the SIAS policy to allow for a more streamlined school placement procedure of children currently not in the education system (see the report by the *Right to Education for Children with Disabilities Alliance*).
b. GOSA must adopt comprehensive norms and standards that guide the provision of transport to learners with disabilities (see the report by the *Right to Education for Children with Disabilities Alliance*).
c. The development of a comprehensive, costed programme for provision of LTSM to learners with disabilities, in particular blind learners, that respond to those learners' needs in special schools, full service schools and public ordinary schools.
d. Fund and resource; implement; monitor and evaluate GOSA's inclusive education policies and guidelines to address learner diversity and provide appropriate support to teachers and learners to achieve quality learning outcomes.
e. Focus on the early identification of barriers to learning and intervene with appropriate support in the earlier years.
f. That the conditional grant envisaged in Education White Paper 6 for non-personnel expenditure in special schools be budgeted for and allocated.

6.2 LEISURE, RECREATION AND CULTURAL ACTIVITIES

151. The ACRWC recognises, in article 12, the child's right to rest and leisure and engage in play and recreational activities. In South Africa, the right to play in particular is yet to have a framework for the measurement and assessment of whether adequate, meaningful play is happening or not. This state of affairs needs to be remedied because, in addition to being an end in itself, play "is also a very important means to an end. Play is an instrument of learning and development; children develop and learn through play . . . [play contributes to the building of] social, emotional, cognitive, language and physical foundations skills, competencies and capacities necessary for children to develop to their full potential".[58]

152. It is questionable whether play is currently considered a serious activity, particularly since there is yet to be a common understanding of what play means. In

[58] A Chance to Play Southern Africa *A Child's Right to Play: A Policy Brief for South Africa* (May 2017) 4-5.

addition to this, play also involves sectors and duty bearers that are not typically child-centred in their functions.

Recommendation

153. GOSA must pull key duty bearers in several sectors, government and civil society, together to define and advocate for play more broadly than just within schools.

6.3 HEALTH AND WELFARE

Measures taken to reduce infant and child mortality

154. The **Child Healthcare Problem Identification Programme's** (Child PIP) audit of hospital deaths has helped identify modifiable factors at hospital, clinic and community levels – including transfers between facilities.[59] This has helped inform planning at national level, and reduced mortality and morbidity at implementing hospitals, but the programme has yet to be implemented countrywide, and Child PIP data needs to be used more effectively at facility and district level for corrective actions to drive quality improvement.

155. **The majority of in-facility deaths are preventable**. Preventable factors in the home include: delay in seeking care, not recognising danger signs/severity of illness, and inadequate nutrition. Failures at primary level include: failure to identify or respond to growth problems, inadequate assessment of HIV (IMCI not used), and danger signs missed, and these problems are compounded by a lack of high care facilities for children, failure to identify and respond to new danger signs, and inadequate note taking and investigations in ambulatory and emergency care.[60]

156. **Case fatality rates** for diarrhoea and pneumonia are decreasing (and less so, severe acute malnutrition), which may reflect improved care for those children accessing the health sector. However more than half of child deaths occur outside hospitals. Lower respiratory tract infections are the leading cause of these outside

[59] See: www.childpip.org.za.
[60] Stephen *Saving Children 2012-2013: An eighth survey of child healthcare in South Africa* (Tshepesa Press, Pretoria 2016).

facility deaths – with almost half associated with preterm birth, and many occurring soon after discharge from hospital.[61]

- Early entry to the health sector and better care on presentation is critical. A third of deaths in hospital (32%) occur within 24 hours of admission[62]. This reflects late presentation, delayed referral, absent triage, poor initial care and lack of adequate early review once in hospital. This requires a response at the household level, improved use of IMCI or an alternative "triage" system at primary health care, and better care on arrival in hospital. The rollout of the ETAT (Emergency Triage, Assessment and Treatment) programme or equivalent needs to be supported.

- In addition, the role of community health workers needs to be extended to include not only prevention, but also treatment for diarrhoea and pneumonia. (see para 95). This is provided for in the National Development Plan but cannot happen without changes to the legislation/regulations around the prescribing, dispensing and storage of drugs.

157. We note with concern that over half of all reported **child deaths occur outside health care facilities** (52% in 2014).[63] To some extent this is a reflection of poor access to health care services, but is more likely a reflection of the quality of care and communication provided within the health sector – as patients either do not want to return or are not informed of when they should return. In addition, data from the 2016 Community Survey[64] suggest that 17% of child deaths are not reported.

158. Key recommendations from the Ministerial Committee on Morbidity and Mortality in Children under 5 years (CoMMiC) include:

- More effective use of the Road to Health Book to improve quality and continuity of care;

[61] Mathews, Martin, Scott, Coetzee and Lake *Every child counts: Lessons learned from the South African Child Death Review pilot* (Children's Institute, University of Cape Town, Cape Town 2015).
[62] Child PIP data.
[63] Committee on Mortality and Morbidity in Children under 5 years, personal communication, Neil McKerrow.
[64] Statistics South Africa *2016 Community Survey* (2016).

- Strengthening the role of the Health Department in promoting early childhood development with a specific focus on the 1st 1000 days;
- Non -rotation of staff on paediatric wards;
- Outreach programmes to mentor and supervise frontline workers including observation of case management; and
- The development of an **Essential Package of Care** for children and norms and minimum standards for child health services — as it is vital to specify staffing, resources and clear targets in order to ensure that child health services are adequately resourced and to hold government accountable.[65]

159. Preterm birth is the leading cause of **neonatal death**, and 60% of these deaths occur in infants weighing less than 1000g. Therefore, upstream factors in obstetric care need to be addressed. However, 85% of asphyxial deaths are in babies weighing > 2000g whose mothers have had a normal antenatal course – and more than half (53%) of these deaths are preventable.[66] Roll out of three neonatal interventions targeting early neonatal deaths – Helping Babies Breathe, management of the small and sick neonate, and the implementation of non-invasive ventilation to address respiratory distress in preterm neonates – is ongoing, but provinces are struggling to achieve adequate coverage as they have no funds to take these interventions to scale.

160. Key recommendations of the National Perinatal Mortality and Morbidity Committee (NaPeMMCo) include: a) focusing on the modifiable causes of asphyxia to reduce early neonatal deaths; b) reducing late neonatal deaths by allowing community worker management of pneumonia; c) rolling out basic antenatal care plus (which includes two extra visits during the third trimester and has been shown to reduce stillbirths); and d) allowing the District Clinical Support Teams (DCSTs) to lead and track the quality of neonatal care at district level (as the quality of neonatal care in districts where the paediatric dyad is complete, has improved by up to 30%)[67]. The WHO recommendation to extend antenatal care to eight routine antenatal visits has been adopted by the country. A further recommendation is to institute postnatal home

[65] Department of Health. *Interim Report of the Committee on Morbidity and Mortality in Children Under 5 Years (CoMMiC) 2011-2014* (2016).
[66] Data extracted from Perinatal Problem Identification Programme 2015 – 2016.
[67] Data extracted from Perinatal Problem Identification Programme 2013 – 2016.

visits by community health workers to all neonates within one week of delivery for early identification of sick newborns and to reinforce mothers' recognition of danger signs.

Good programmes, poor implementation and accountability

161. The National Department of Health (NDoH) has adopted well-recognised child survival programmes which are appropriate and relevant for the South African setting and its burden of disease. However, implementation is flawed with no sense of accountability, and provinces and districts are not held accountable for poor implementation: for example, only two provinces have appointed provincial paediatricians, despite numerous National Health Council resolutions recommending this.

Maternal mortality

162. The Institutional Maternal Mortality Ratio (iMMR) decreased from 176.22 per 100,000 live births in 2008-2010 to an iMMR of 154.06 per 100,000 live births in 2011-2013 driven mostly by a decrease in deaths due to non-pregnancy related infections such as TB and pneumonia[68]; and the 2015 Interim Saving Mothers report has shown a further reduction of iMMR to 126.75 deaths/100 000 live births. These rates are below the population rates of 154 death/100 000 live births in 2014,[69] and more needs to be done to improve quality of care during the antenatal, intrapartum and postnatal periods.

163. Further reductions in maternal mortality require focused attention on the 5 Hs (HIV, haemorrhage, hypertension, health worker training and health system strengthening) and specifically the 5Cs (caesarean section safety, contraception, care quality, coverage, and community responsiveness). In particular, the updated HIV-testing and treatment strategy and the Essential Steps in the Management of Obstetric Emergencies training programme have both made major contributions to reducing iMMR.

68 Department of Health Saving Mothers 2011-2013: Sixth Report on the Confidential Enquiries into Maternal Deaths in South Africa (not dated).
69 Dorrington, Bradshaw, Laubscher and Nannan *Rapid mortality surveillance report 2015* South African Medical Research Council, Cape Town 2016).

Measures taken to eradicate malnutrition

164. This complementary report speaks to ongoing concerns about **household food security** in the context of drought and high unemployment – with an expanded unemployment rate of 36%[70] likely to increase following the recent downgrading of the country to junk investment status. According to the 2016 Community Survey, 20% of households had run out of money to buy food in the previous 12 months, with two provinces the Eastern and Northern Cape worst affected (with over 25% households food insecure)[71]. The 2016 DHS report confirmed that 23% of children 6 to 23 months received a minimum acceptable diet.

165. In this context it is not surprising that **malnutrition** remains a key driver of under-five mortality, with 31% of young children who died in hospital in 2015 being classified as severely malnourished – a figure that has remained stubbornly unchanged over the reporting period.[72] As noted in our previous report, one in four children (27%) aged 0 - 3 years is stunted, a figure which has not reduced in the past decade, indicating chronic food insecurity and failure to thrive with long-term implications for schooling and cognitive development, while overweight (15%) and obesity (6%) are also a concern.[73] While the National School Nutrition and School Deworming programmes are protective for older children, efforts to prevent malnutrition need to focus far on the preschool years – and particularly the under two's, starting with adequate maternal nutrition during the antenatal period. While good strides have been made in delivering these two programmes, delivery of the National School Nutrition programme faces periodic setbacks due to poor governance and oversight, leaving school-children at risk of poor quality food and hunger[74].

166. While we welcome the expansion of the Mother-and-Baby-Friendly Hospital Initiative which helps mothers initiate **breastfeeding**, this has still not reached full national coverage. Breastfeeding rates remain low, with only 25 of infants 0-5 months exclusively breastfed (DHS). Whilst this is a significant improvement from 8% reported

70 Statistics South Africa *P0211 - Quarterly Labour Force Survey, 4th Quarter 2016* (2017).
[71] Statistics South Africa *Community Survey 2016. Statistical Release PO301* (2016).
[72] Unpublished data from the Child Health Problem Identification Programme that audits hospital deaths at 75% of facilities countrywide.
[73] Shisana et al *South African National Health and Nutrition Examination Survey(SANHANES-1)* (Human Sciences Research Council, Cape Town 2016)
[74] Department of Basic Education *Annual report 2015-2016* (2016)

in 2003, the high levels of stunting and inadequate diets of children point to much greater efforts required to improve child nutrition[75] Greater commitment and investment in community-based breastfeeding support is needed[76] as is support for working mothers to ensure breastfeeding as outlined in the Code of Good Practice on the Protection of Employees during Pregnancy and after the Birth of a Child to ensure breastfeeding is sustained. Despite these commitments being propagated in the 2011 Tshwane Declaration on Breastfeeding, little subsequent action has followed.

167. We welcome the publication of **Regulation 991** (R991) that regulates the marketing of breastmilk substitutes, yet note with concern widespread ignorance and apathy amongst health professionals, and continued violations by industry, and therefore call on government to strengthen efforts to promote, monitor and enforce R991. GOSA also needs to regulate the aggressive marketing of unhealthy foods to address the rise in obesity in children. We welcome moves to introduce a tax on sugary beverages. Consideration should also be given to ring-fencing the revenues from this tax to subsidise basic, healthy foods such as milk and placing taxes on ultra-processed foods whose consumption is driving the obesity epidemic.[77] Finally, liberalisation of trade and foreign direct investment is contributing to rapid and negative changes in the food environment which is impacting negatively on children, especially the poor.

168. We acknowledge recent progress in reducing **Severe Acute Malnutrition** (SAM) case fatality rates from 11.3% in 2013/14 to 8.9% in 2015/16,[78] yet note that these remain nearly double the WHO target of 5%. While acknowledging the contribution of HIV to this high toll, the 1380 child SAM deaths in 2015/16 is unacceptably high. The inadequate commitment to the community-based management of SAM contributes to the high case-fatality. A failure to recognise SAM in the home and community (by community health workers) prevents earlier responses to SAM, resulting in seriously ill children being admitted.

[75] The District Health Information Software presented at the World Breastfeeding Conference on 13 December 2016 during the Department of Health session.
[76] Tylleskär et al "Exclusive breastfeeding promotion by peer counsellors in sub-Saharan Africa (PROMISE-EBF): a cluster-randomised trial" (2011) 378(9789) *The Lancet* 420- 427.
[77] Monteiro, Cannon, Moubarac, Levy, Louzada and Jaime "The UN Decade of Nutrition, the NOVA food classification and the trouble with ultra-processing" (2017) *Public Health Nutrition* 1-13.
[78] Massyn et al *District Health Barometer 2015/16* (Health Systems Trust, Durban 2017).

169. In addition, it is vital to identify and support at-risk children whose growth is faltering before they need to be hospitalised. This includes monitoring of the Road-to-Health booklet to ensure effective growth monitoring and promotion, as failure of clinics and out-patient units to identify and timeously refer children with impaired growth (including moderate and severe malnutrition) has been identified as a key modifiable factor in preventing child deaths.[79] **Growth promoting activities** also need to extend beyond simple weighing and plotting of children, to include a systematic effort to ensure that hungry or malnourished children are linked to food provision, community health services and social assistance. The dedicated allocation for nutrition in all provinces combined amounts to only 0.5% of the primary health care budget throughout the period 2013/14 to 2018/19.[80]

170. Children in poor households continue to be adversely affected by **rising food costs**. While the Child Support Grant (CSG) was valued at R350 in 2016 and reached just under 12 million children. The grant has been associated with improved nutrition outcomes,[81] but its value falls below the food poverty line (valued at R415 in 2015). It is also failing to keep pace with food inflation. While the cost of a basic food basket increased by 15% between September 2015 and 2016, and essential foods such as maize meal increased by 32%[82], the value of the CSG increased by only 6% over the same period - from R330 in 2015/16 to R350 in 2016/17.[83] Additional measures to ensure food security through improved employment, social assistance and land and agrarian reform in combination with regulation of prices of healthy foods are therefore essential.

Measures to improve access to health and health care services

171. The South African health system continues to be characterised by **marked inequities** between rural and urban areas as well as the private and public sectors. 52% of health care spending and the majority of SA's health professionals are focused

[79] Recommendation of COMMIC drawing list of modifiable factors identified in Child PIP.
[80] The United Nations Children's Fund and the International Budget Partnership *Children and South Africa's Health Budget* (2016).
[81] Delany, Jehoma and Lake L *South African Child Gauge 2016* (Children's Institute, University of Cape Town, Cape Town 2016).
[82] Pietermaritzburg Agency for Community Social Action 2016 *PACSA Food Price Barometer Annual Report* (Peitermaritzburg Agency for Community Social Action, Pietermaritzburg 2016)
[83] National Treasury and South African Revenue Service *2016 Budget: People's Guide* (2016).

on the richest 16% of the population who can afford private health care.[84] This leaves the majority of South Africans dependent on the public health system where resources are thinly stretched: only 32% of medical practitioners work in the public sector, and specialists remain concentrated in the wealthier and more urban provinces of the Western Cape and Gauteng.[85] While rural areas house 44% of South Africa's children,[86] rural provinces continue to experience significant shortages of nurses and medical practitioners[87] – which are likely to increase in the context of posts being frozen due to austerity measures.[88] With increasing urbanisation, significant peri-urban poverty on fringes of all cities also exists, and this has implications for children's health and access to health services.

172. It is currently not possible to disaggregate the **budget** for child health, and there is no programme or sub-programme in provincial department budgets that explicitly refers to maternal and/or child health. A recent child-centred analysis noted that despite increased spending on primary health care it accounts for less than a third (29%) of provincial health budgets.[89] If all children under 5 years of age without medical aid made four visits to clinics and all pregnant women made four antenatal visits, this would account for 39% of the total primary health care budget, excluding funds for HIV and AIDS, raising questions around whether children receive a fair share of resources. Also of concern is the relative small allocation to nutrition for all age groups (R245 million), which is equivalent to only 4% of the Department of Education's funding for the National School Nutrition Programme, which is worrying given the Department of Health's responsibility for nutrition in preschool children, when the effects of undernutrition are most severe.

173. South Africa has made progress in improving children's **access to health care** over the reporting period; however, in 2014 one in five children still travelled more than

[84] McIntyre Doherty and Ataguba *Universal Health Coverage Assessment: South Africa* (Global Network for Health Equity, 2014).
[85] Gray and Vawda "Health Policy and Legislation" in Padarath, King, Mackie and Casciola (eds) *South African Health Review 2016* (Health Systems Trust, Durban 2016).
[86] Hall and Sambu "Housing and Services—Urban-rural Distribution: Child centred analysis of GHS 2014 data" (2015) available at https://www.childrencount.org.za/indicator.php?id=3&indicator=13.
[87] Rural Health Advocacy Project *Rural Health Fact Sheet 2015* (not dated).
[88] Gonzalez "Health-e News: The Big Chill: Health post freeze threatens services" (1 February 2016), available at http://www.rhap.org.za/health-e-raises-alarm-on-frozen-posts-following-rhap-investigation/
[89] The United Nations Children's Fund and the International Budget Partnership n80 above.

30 minutes to reach a health facility[90] – and transport costs and safety concerns continue to cause life-threatening delays in accessing treatment.

174. Quality of care remains a concern. In 2011, the NDoH introduced **National Standards for Health Care Facilities** which offer a potentially powerful mechanism for driving quality improvement processes. Similarly, we welcome the vision of an **ideal clinic** which "opens on time", "is very clean", and "treats people with dignity" yet there appears to be little focus on children and adolescent's specific needs and what is needed to develop child and family-friendly services at clinics and community health centres and hospitals. It is therefore vital that the Norms and Standards for Health Care Establishments, Ideal Clinics and other guidelines such as the proposed "comprehensive package of health services" and "essential drug list" explicitly factor in children's needs and articulate with, and give effect to, the proposed essential package of care for children and adolescents. In particular adolescent-friendly sexual and reproductive health services are not adequately considered, which has significant implications for teenage pregnancy and growing adolescent HIV-rates.[91]

175. "What we fail to measure, we fail to act on", therefore the WHO recommends incorporating a focus on adolescents into all health policies, strategies and programmes.[92] Yet the word "adolescent" appears only once in the 2015/6 Annual Inspection Report of the OHSC. It is particularly important to track adolescents' experience of positive and caring attitudes, waiting times and availability of medicines and supplies. As adolescents are at high risk of HIV and other adverse sexual and reproductive health outcomes, and are more likely than adults to have difficulties accessing sexual and reproductive health services.

176. The **Office of Health Standards Compliance** was established in an effort to strengthen the public health service and improve accountability and quality of care (including ministerial priorities areas such as cleanliness, waiting times, positive and caring attitudes and availability of medicines). Yet the majority of the 500+ clinics

[90] Child centred analysis of 2014 General Household Survey. Viewed on 22 April 2016 at: www.childrencount.uct.ac.za

[91] Mathews et al "Reaching the hard to reach: longitudinal investigation of adolescents' attendance at an after-school sexual and reproductive health programme in Western Cape, South Africa" (2015) 15 *BMC Public Health* 608.

[92] Dick and Ferguson "Health for the World's Adolescents: A second chance in the second decade" (2015) 56 *Journal of Adolescent Health* 3-5.

audited in the 2015/2016[93] scored less than 50%, with only a handful of the 50+ hospitals scoring above 70% across all domains (with 80% set as the minimum standard). Critical and systemic challenges identified in the report include budgetary constraints, vacant posts and shortages of medical supplies and equipment, poor leadership, governance and quality of care.

177. **Stock-outs** and shortages of ARV or TB treatment (in the last three months) increased from 21% in 2013 to 36% in 2015, while vaccine stock-outs and shortages decreased slightly from 15% to 11% over the same period[94]. These shortages are of particular concern given that over 2.4 million people rely on the regular supply of ARVs, and the rise of multidrug-resistant and extreme drug-resistant TB. Vaccine unavailability may be life-threatening and is difficult to justify, but remains pervasive: For example, a recent study in OR Tambo district found that only 48% of children were up to date with immunisations at 3 months and that the main reason for incomplete immunisations was stock outs (56%).[95] Significant shortages of vaccines, particularly of newer vaccines were identified in a better resourced district in Gauteng.[96] Many of these stock-outs were of long duration; over a fortnight in the majority of clinics. Identified causes for the stock-outs included poor stock management at clinic and district depot level, unreliable deliveries, lack of pharmacy assistants and limited fridge capacity.

National Health Insurance and Primary Health Care Reengineering

178. **National Health Insurance** (NHI) aims to promote universal health coverage, a more equitable distribution of resources between public and private sectors, and financial risk protection for the poor. This will require a massive reorganisation of the current healthcare system, and it is therefore of concern that there appears to have been little or no monitoring and evaluation of the NHI pilot districts in order to build on successes and respond to emerging challenges before taking the model to scale. In addition, further effort and resources are required to ensure that public health facilities

[93] Office of Health Standards Compliance *2015/2016 Annual Inspection Report* (2017).

[94] Stop Stock Outs Project *2015 Stockouts National Survey: The continuing crisis* (2015).

[95] Le Roux et al "Immunisation coverage in the rural Eastern Cape – are we getting the basics of primary care right? Results from a longitudinal prospective cohort study" (2016) 107(1) South African Medical Journal.

[96] Ngcobo and Kamupira "The status of vaccine availability and associated factors in Tshwane government clinics" (2017) 107(6) South African Medical Journal.

serving poor and rural areas are able to meet the criteria and become accredited providers. If not, then NHI may serve to further entrench the divisions between public and private, rural and urban health care.

179. The **re-engineering primary health care** (PHC-R) and associated Ward-based Outreach Teams, Integrated School Health Programme and District Clinical Specialist Teams – have the potential to improve the reach and quality of maternal and child health services provided they are adequately staffed and implemented with fidelity.

180. The **District Clinical Specialist Teams** are intended to improve clinical governance, enhance quality of care, and drive intersectoral collaboration in response to the local burden of disease. While there are examples of promising practice, many teams are understaffed and struggling to establish an identity, too often undertaking administrative tasks (such as clinic audits), or addressing gaps in the district management team, rather than improving quality of care. For example, in September 2016, only 40% of DCSTs had appointed a paediatrician.[97] The Department of Health should as a matter of urgency ensure that all DCSTs have their full staff complement. In addition, the department should appoint provincial lead clinicians to improve provincial co-ordination, define clearer clinical governance roles for DCSTs, and imbue the teams with sufficient authority to be able to demand accountability for clinical activities.

181. The Ward-based PHC outreach teams have the potential to extend the reach of health care services to vulnerable children and families. Yet the selection, training, supervision and remuneration of **community health workers** in South Africa remains uneven. In addition, the proposed ratio of 1 CHW: 250 households is simply not sufficient to enable regular home visits and follow-up care[98]. We also note that the Policy Framework and Strategy for Ward-based PHC Outreach Teams passed by the National Health Council in 2016, outlines a narrow role for CHWs – focusing on

[97] Personal communication. Neil McKerrow.

[98] Leon et al "The role of 'hidden' community volunteers in community-based health service delivery platforms: examples from sub-Saharan Africa" (2015) 8 *Global Health Action* 27214.
White and Mason *Assessing the impact on child nutrition of the Ethiopia community-based nutrition programme* (Tulane University, New Orleans 2012).
World Health Organisation *Essential Nutrition Actions: Improving maternal-new born-infant and young child child health and nutrition* (2013).

prevention and health promotion, despite evidence that CHWs can treat infectious childhood diseases as effectively as nurses at PHC clinics, for example, through the early recognition and treatment of pneumonia with antibiotics[99]. It is therefore essential to expand both the numbers of CHWs and their scope of practice to ensure meaningful gains for child health, and to amend Medicines Control Council and Pharmacy Council regulations to enable CHWs to dispense these simple preventative medicines. In addition, the CHW programme remains uncoordinated and underfunded, and this remains a huge impediment that limits children's access to preventative and primary health care.

182. The emphasis on **school health services** since 2012 is a welcome move by the Ministry of Health, as this is a previously neglected age-group of children and adolescents. However, the successful implementation of the school health service remains a challenge, with national coverage cited as no more than 23% for quintile 1 and 2 schools in the 2014/15 National Department of Health Annual report.[100] In particular, the health needs of school-going adolescents remain neglected, with the sexual and reproductive health (SRH) services being absent, or plagued by many implementation challenges[101]. In particular, the stance of the DBE to only allow provision of contraceptives by permission of individual school governing bodies, remains a significant potential barrier to SRH services. On a positive note, the recent introduction of the HPV vaccine for school-aged girls, which has over 90% coverage to date, is a positive intervention in the fight against cervical cancer, which is a common cause of cancer death in South African women. The shortage of school nurses, social workers and allied health professionals compromises screening and referrals, and limits the range of services delivered on the ground. As such, the huge potential of the Integrated School Health Policy (ISHP) remains untapped and more attention is required to ensure an acceptable level of performance. A focus on the

[99] Sazawal and Black "Effect of pneumonia case management on mortality in neonates, infants, and preschool children: a meta-analysis of community-based trials" (2003) 3(9) *Lancet Infect Dis* 547-56. Dawson et al "From research to national expansion: 20 years' experience of community-based management of childhood pneumonia in Nepal" (2008) 86(5) *Bull World Health Organisation* 339-43; Lassi, Haider and Bhutta "Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes" (2010) 11 *Cochrane Database of Systemic Reviews* 2010 CD007754.

[100] Department of Health *Annual Report 2014/15* (2015).

[101] Shung-King, Orgill and Slemming "School Health in South Africa: reflections on the past and prospects for the new Integrated School Health Policy" in Padarath and English (eds). *South African Health Review 2013/14* (Health Systems Trust, Durban 2014).

concept of school health teams, where the nurse leads a team of less skilled individuals who can competently undertake screening and health promotion tasks, allowing the nurse to assume organisational, supervisory and more demanding clinical responsibilities seems to be a logical way forward. Another challenge of the ISHP is that screening is recommended, yet no packages of care or onward referral pathways exist – in particular for child and adolescent mental health. It is therefore meaningless to identify children and adolescents at risk without treatment plans.

Access to Primary Health Care

183. Primary health care (PHC) is free, as is health care for pregnant and nursing mothers, children under the age of 6, and social grant beneficiaries. There are, however, significant barriers to access, and the persistent inequities between provinces and districts remains a concern.

184. For example, routine **immunization** coverage has reportedly improved from 84% in 2013/14 to 89% in 2015/16[102], but national figures mark stark inequalities between districts with coverage ranging from 61% to 123%, and remaining below the national target of 90% in all but 14 of 52 districts. In truth, true coverage rates are unknown as there is uncertainty around the size of the infant population and deficiencies in the monitoring system are well-recognised. This has raised concerns that true immunisation rates may be well below those reported, as confirmed by the 2016 Demographic Health Survey which showed that only 42% of children 24 -35 months have received all age appropriate vaccines.

185. Delivery of other preventive strategies such as **early antenatal care** (61%), and **vitamin A supplementation** between 12 – 59 months (57%), has improved significantly over the reporting period. But further effort is required to build on this foundation and improve coverage.

186. Integrated Management of Childhood Illnesses (**IMCI**) strategy has not been widely adopted as standard practice despite considerable investment in training. IMCI trained staff do not practice IMCI for a variety of reasons including delayed

[102] Massyn et al *District Health Barometer 2015/16* (Health Systems Trust, Durban 2016).

accreditation, failure to deploy trained staff to areas where they can utilize their skills, staff rotation and inadequate supervision and mentoring to enable staff to apply their new knowledge, and a lack of easy tools to apply the case management algorithms. Furthermore, CHWs need to be trained in home and community based IMCI in order to help caregivers prevent and treat illnesses at home, and respond to danger signs. The NDoH needs to re-evaluate the delivery of the strategy, including whether it is meeting the needs of sick children as currently implemented, and provide a clear indication of its preferred strategy for the care of sick children at primary level. The Ideal Clinic project has failed to address this critical need.

Emergency and intensive care

187. In 2015, the SA Human Rights Commission released a **damning report on emergency medical services** (EMS) in the Eastern Cape noting how poor management, shortages of qualified staff, ambulances and medical supplies, and an inability to navigate long distances and difficult terrain, resulted in often fatal delays and/or forced poor families to shoulder the high costs of public or private transport, and driving them deeper into poverty[103].

188. We also note with concern that ambulance crews have extremely limited training in the **management of paediatric emergencies** and most EMS services do not carry the necessary equipment to manage the resuscitation and safe transport of children. It is therefore vital to scale up training in paediatric emergency care and triage, and to ensure that paediatric staff and equipment is specified in the national standards.

189. Many hospitals continue to turn away children due to a shortage of beds in **intensive care**. It is therefore important to prioritise the development of paediatric facilities and address the shortage of paediatric and neonatal staff.

Early childhood development

190. Government's report focuses exclusively on child survival, yet health has a unique opportunity and responsibility to promote children's optimal development,

[103] South African Human Rights Commission *Hearing report of the South African Human Rights Commission into Access to Emergency Medical Services in the Eastern Cape* (2015)

particularly in the critical “first 1000 days” - a uniquely sensitive period for early brain and organ development which lays the foundation and sets the trajectory for health and wellbeing throughout the child's life course[104]. Recognition of this role is evident in the mandate outlined for the health sector in the 2015 National Integrated ECD Policy[105] but this needs to be matched by a **commitment** to provide adequate resources to implement new services (such as perinatal mental health screening, parenting support and active efforts to involve fathers in antenatal and postnatal care), as well as the strengthening of existing services (such as kangaroo mother care and the surveillance of infant growth and development, with appropriate responses to any abnormality or delay detected).

- The ECD programme is being led by the Department of Social Development, and to date, there is little evidence that the health department has developed a clear plan as to its implementing role in providing the expanded set of health services required by the ECD policy. Specifically, these would require additional nutritional support and mental health services for pregnant women and targeted support for their offspring, stronger efforts at anthropometric monitoring (including stunting) with deliberate efforts to promote breastfeeding and reduce stunting rates, home stimulation programmes (including play support) for infants and young children and improved utilisation of ECD centres to provide essential health promotion and prevention.

191. Whilst some gains have been made **at facility level** (for example, providing lodger facilities for mothers of new born babies admitted to hospitals, and promoting breastfeeding through Mother and Baby Friendly Hospitals) this has been patchy. ECD services extend beyond facilities, and role of community based health workers in supporting pregnant women and caregivers of young children in **home and community settings** must be prioritized and matched by commitment to invest in adequate training, remuneration and support to fulfil this essential preventive and promotion ECD role. There is no evidence that this role of the CHW is happening at scale in any district.

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[104] *The* Lancet *Early Childhood Development Series: Advancing Early Childhood Development: from science to scale* (2016) 389(10064) The Lancet.
[105] Department of Social Development *National Integrated Early Childhood Development Policy* (2015)

192. ECD services need to be prioritized, monitored and protected, given the demands to provide curative and chronic disease related care services. **Indicators** of early childhood development (such as levels of stunting) should therefore be tracked regularly as part of the core national indicator set.

193. Health also has a critical **advocacy role** to play in addressing the social determinants of health that affect child development before and after birth such as parental leave policies, cash and care support grants to support exclusive breastfeeding, and health services for children attending ECD centres.

194. Finally, it is important to expand the use of the IMCI Care for Development module at community level (clinic and home), and strengthening early identification and referral systems to ensure continuity of care for children and families in need of additional support.[106]

HIV and TB, adolescent health and risk behaviour

195. 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 family members and caregivers.[107] 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.

[106] Jacklin "The future is in our hands" in Stephen and Bamford (eds) *Saving Children 2010-2011 A seventh survey of child health care in South Africa* (Tshepesa Press, Pretoria 2013).
[107] Slemming and Saloojee "Beyond survival: the role of health care in promoting ECD" in Berry, Biersteker, Dawes, Lake and Smith (eds) *South African Child Gauge 2013* (Children's Institute, University of Cape Town, Cape Town 2013).

196. In South Africa there is a high burden of TB in children, but it is often overlooked as it is difficult to diagnose.[108] **Childhood TB** is still not addressed in the 2017 – 2022 National TB Plan.[109] TB is thought to be a major contributor to under-five mortality in South Africa, however, children dying from TB are often incorrectly classified as pneumonia, meningitis, HIV or malnutrition deaths.[110] Poor integration of the TB and MCWH programme contributes to this problem.[111] Although active case-finding and contact tracing is essential, these services have seldom functioned optimally and presently are being cut-back, and are currently not included in community caregivers scope of practice. As the drug-resistant TB burden in the country increases, there are increasing numbers of children with drug-resistant TB. These children are treated with adult drugs not tested in children, as children-friendly formulations have not been developed.[112] Furthermore, they are often hospitalized for many months.[113] TB prevalence is also reportedly increasing in adolescence.

197. To reduce childhood TB in South Africa, all efforts must be made to: a) provide BCG to all newborn children (with functional PMTCT programmes), b) ensure provision of preventive TB therapy to all vulnerable young children exposed to an infectious source case, c) increase training, awareness and linkages between MCH and TB services to improve diagnosis of childhood TB, d) develop child-friendly TB formulations, and e) enable access to MDR-TB prevention and treatment when appropriate.

- Children have benefited enormously from the rollout of **antiretroviral therapy** (ART) **and prevention of mother-to-child transmission** (PMTCT). The most recent evaluation of the PMTCT programme shows that transmission rates

[108] Beyers et al "Delay in the diagnosis, notification and initiation of treatment and compliance in children with tuberculosis" (1994) 75 *Tubercle and Lung Disease* 260–265.
[109] TB Think Tank *South Africa National Department of Health National Tuberculosis Programme Strategic Plan: 2017-2021* (Unpublished draft 2017).
[110] Graham, Sismanidis and Menzies "Importance of tuberculosis to address child survival" (2014) 383 *Lancet* 1605–1607.
[111] Marais "Improving access to tuberculosis preventive therapy and treatment for children" (2017) 56 *International Journal of Infectious Diseases* 122-125.
[112] Seddon et al "Caring for Children with Drug-Resistant Tuberculosis" (2012) 186 *American Journal of Respiratory and Critical Care* Medicine 953-964.
[113] Loveday et al "Household context and social impact of childhood MDR-TB in KwaZulu-Natal, South Africa" (*In print* 2017).

have declined to 2.6%,[114] yet less than 50% of young HIV-positive individuals are on treatment.[115] To date, evaluations of HIV care programmes report sub-optimal levels of treatment acceptance, poor ART adherence and low retention in HIV care among HIV-positive children and adolescents, including high levels of co-morbidities (HIV and tuberculosis (TB)), premature disability and mortality.[116] There is an urgent need to prioritise children and adolescents in HIV budgetary allocations. Effective and cost-effective models of HIV care targeting key economic (distance, transport) and health system (drug stock outs, lack of counsellors, clinic waiting times) barriers must be identified and scaled-up to improve HIV treatment outcomes among this vulnerable group.[117] Moreover, innovative community-based HIV counselling and testing models must be scaled-up to reach undiagnosed HIV-positive children and adolescents in need of ART.[118]

- **HIV prevalence** among women 15 to 19 years attending antenatal clinics remains high, with no appreciable declines (2009: 13.7%, 2013: 12.7%)[119] and estimates based on the 2012 national survey indicate that young women aged

[114] Goga, Dinh and Jackson *Early (4 - 8 weeks postpartum) Population-level Effectiveness of WHO PMTCT Option A, South Africa, 2012 – 2013.* South African Medical Research Council, Department of Health of South Africa and PEPFAR/US Centers for Disease Control and Prevention.
[115] World Health Organization. Global HIV/AIDS Response Geneva, Switzerland: WHO; 2011 [cited 2014 15 September]. Available from: http://www.who.int/hiv/pub/progress_report2011/en/.
[116] Nglazi MD, Kranzer K, Holele P, Kaplan R, Mark D, Jaspan H, et al. Treatment outcomes in HIV-infected adolescents attending a community-based antiretroviral therapy clinic in South Africa. BMC Infect Dis. 2012;12:21;Evans et al "Treatment outcomes of HIV-infected adolescents attending public-sector HIV clinics across Gauteng and Mpumalanga, South Africa" (2013 29(6) *AIDS research and human retroviruses* 2013 892-900; Nachega et al "Antiretroviral therapy adherence, virologic and immunologic outcomes in adolescents compared with adults in southern Africa" 2009;51(1) *JAIDS Journal of Acquired Immune Deficiency Syndromes* 65-71; Maskew et al "Insights into Adherence among a Cohort of Adolescents Aged 12–20 Years in South Africa: Reported Barriers to Antiretroviral Treatment" (2016) *AIDS Research and Treatment*.; Wachira et al "Factors underlying taking a child to HIV care: implications for reducing loss to follow-up among HIV-infected and -exposed children" (2012) 9(1) *Journal of Social Aspects of HIV/AIDS Research Alliance* 20-9.
[117] Yeap et al "Factors influencing uptake of HIV care and treatment among children in South Africa - a qualitative study of caregivers and clinic staff" (2010) 22(9) *AIDS Care* 1101-7.; Woldesenbet et al "Missed Opportunities for Early Infant HIV Diagnosis: Results of A National Study in South Africa" (2015) 68(3) *Journal of Acquired Immune Deficiency Syndromes* e26-e32.
[118] Ferrand et al "AIDS among older children and adolescents in Southern Africa: projecting the time course and magnitude of the epidemic" (2009) 23(15) *AIDS* 2039.; Govindasamy et al "Uptake and yield of HIV testing and counselling among children and adolescents in sub-Saharan Africa: a systematic review" (2015) 18(1) *Journal of the International AIDS Society*.
[119] Department of Health *The 2013 National Antenatal Sentinel HIV Prevalence Survey South Africa* (2015).

15 - 24 years are at highest risk of incident HIV infection - higher than men and higher than women in any other age group[120].

- While we acknowledge the renewed focus on adolescent health and the development accreditation standards for **Adolescent and Youth Friendly Services**. We note that the draft National Adolescent and Youth Policy 2012-2013 still needs to be finalized and endorsed; and that adolescents continue to express dissatisfaction with public health services, including their interactions with health service staff, their perceptions of the quality of care, and long waiting times.[121]

- Despite provisions in the ISHP, the government has yet to provide a package of **school-based sexual and reproductive health services**. This should ideally include evidence-based behavioural interventions, HIV testing, TB and STI screening, pregnancy tests, condoms and other contraceptives, and referrals for HIV/TB services. And despite condoms being one of the most effective biomedical HIV prevention technologies, these are not made available in South African schools. The discordance between the Health and Education departments on key elements of a school-based sexual and reproductive health services package requires prompt resolution at the highest level.

- South Africa has an excellent **National Strategic Plan for HIV, STIs and TB 2017-2022**, but it fails to provide clear guidelines or specify the funds, human resources and indicators needed to ensure effective implementation and track progress raising concerns about implementation and capacity to hold provincial and district health departments accountable.[122]

- Globally, the greatest burden of disease children and adolescents between the ages of 10-20 years is attributable to **mental health** disorders: 80% of all mental health problems start in the first 18 years of life, and an estimated 17%

[120] Human Sciences Research Council *South African National HIV Prevalence, Incidence and Behaviour* (2014).
[121] Schriver et al "Young people's perceptions of youth-oriented health services in urban Soweto, South Africa: A qualitative investigation" (2014) 14 *BMC Health Services Research* 625–630.; Mokomane et al "Availability and accessibility of public health services for adolescents and young people in South Africa" (2017) 74 *Children and Youth Services Review* 125-132.
[122] www.tbonline.info/posts/2017/4/4/TAC-and-Section27-we-cannot-endorse-hiv-and-tb-plan/

of young South African's will have a diagnosable and treatable mental health disorder[123]. Early identification and early evidence-based treatments are effective and cost-effective and can prevent many of the secondary deficits associated with mental health problems including burden on families, school drop-out, poor academic and occupational achievement, crime and substance abuse. However, in spite these obvious needs, there are fewer than 50 child & adolescent psychiatrists in South Africa, of those only 15 in state-funded posts. Most provinces do not have child and adolescent psychiatrists or in-patient paediatric facilities. Training capacity in child & adolescent psychiatry is highly limited given that it is perceived as a 'sub-specialty' rather than an essential specialty (which is should be). Nationally there are only five funded training posts. Red Cross has just lost one of those posts, thus reducing national training capacity in child & adolescent psychiatry by 20%. There is grave concern that child & adolescent mental health is rapidly becoming a forgotten service, despite the high burden of disease data.

198. There is an urgent need to develop an evidence-base that focuses attention on mental health problems and identify what works in local (often adverse) contexts.[124]

199. While the promotion of adolescent mental health and wellbeing is a key priority in the Department of Health's Adolescent and Youth Health Policy, there is no mention of treatment services, [125] and school- and community-based prevention and promotion programmes and technologies will need to be developed and tested at scale.

Measures to address the social determinants of health

200. It is also essential to address the underlying social determinants of health. There has been little change in child poverty which stood at 64% in 2014, and only marginal decreases in the proportions of children living in unemployed households (30%), households with inadequate water (30%), sanitation (26%), electricity (21%), and overcrowded households (18%).[126] Stark racial and spatial inequalities persist,

[123] Kleintjes et al "The prevalence of mental disorders among children, adolescents and adults in the western Cape, South Africa" (2009) 9 *South African Psychiatry Review* 157–60.
[124] Petersen et al *Promoting mental health in scarce-resource contexts. Emerging evidence and practice* Human Sciences Research Council, Cape Town 2010).
[125] Department of Health *Policy guidelines for youth and adolescence health* (2001).
[126] Child centred analysis of 2014 General Household Survey, available at www.childrencount.uct.ac.za.

with African children in rural areas experiencing multiple deprivations. These living conditions have an adverse impact on children's health, safety, survival and development, and it is vital that the NDoH plays a leadership role in driving intersectoral action at both national and district level. There is sparse evidence of significant intersectoral collaboration at any level.

201. A key social determinant is the impact of **alcohol**: Drinking during pregnancy can damage the unborn child, and rates of foetal alcohol spectrum disorder have been found to be among the highest in the world (at 14% and 21% for grade 1 learners in certain mainly rural communities of the Western Cape).[127] Drinking amongst high school learners remains prevalent with 37% of males and 28% of females reported drinking in the past 30 days, and an alarming 30% of male and 20% of female learners reporting binge drinking during the same period.[128] Drinking amongst children and adolescents is associated with sexual and interpersonal violence, absenteeism, school failure, unwanted pregnancies, sexually transmitted infections, HIV, and FASD.[129]

202. 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. Progress has been slow in instituting any of these changes, ostensibly because of disputes within government departments about the consequences of these actions. 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 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

[127] May et al "Approaching the prevalence of the full spectrum of fetal alcohol spectrum disorders in a South African population-based study" (2013) 37 *Alcoholism: Clinical & Experimental Research* 818-830.
[128] Reddy et al *Umthente Uhlaba Usamila – The 3rd South African National Youth Risk Behaviour Survey 2011* (South African Medical Research Council, Cape Town 2013).
[129] Morojele et al "Alcohol and drug use" in van Niekerk, Suffla and Seedat (eds), *Crime, violence and injury in South Africa: 21st century solutions for child* safety (MRC-University of South Africa Safety and Peace Promotion Research Unit, Tygerberg 2012) 195-213.

prevention programmes to improve quality; and ensuring that there are appropriate and quality treatment programmes available for young persons who need such an intervention.[130]

Measures to prevent violence against children

203. Violence is rooted in early childhood – where exposure to domestic violence, neglect, abuse, substance abuse and mental illness result in toxic stress - causing neurological and psychological damage.[131] This early exposure to violence increases the risk of violence later in life: with girls at increased risk of sexual assault and intimate partner violence, and boys more likely to become perpetrators.[132] It is therefore essential to intervene early before patterns of violence become entrenched.

204. Health professionals need to play a more proactive role in preventing violence against children by looking out for - and responding to - signs of maternal depression, substance abuse and domestic violence; promoting warm and responsive caregiving, involving fathers in antenatal and postnatal care, and ensuring that mothers and caregivers of young children have adequate material and social support. The provision of adolescent-friendly health services – including information that promotes healthy relationships, self-esteem, gender equality is also essential.

205. In cases where abuse has occurred, further training is needed to ensure health professionals uphold their **reporting obligations under the Children's Act and Sexual Offences Amendment Act.** In addition to completing a J88 to trigger a criminal justice investigation, it is essential that they submit a Form 22 to the Department of Social Development or designated child protection organisation to ensure children's safety and access to therapeutic and mental health services.

Recommendations

[130] Morojele, Parry and Brook *Substance Abuse and the Young: Taking Action* (Research Brief) Medical Research Council, Pretoria: 2003).
[131] Center on the Developing Child *The Impact of Early Adversity on Child Development (InBrief)* (2007).
[132] Dunkle et al "Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa" (2004) 160(3) *American Journal of Epidemiology* 230-239; Mathews, Jewkes and Abrahams "'I had a hard life': Exploring childhood adversity in the shaping of masculinities among men who killed an intimate partner in South Africa" (2011) 51(6) *British Journal of Criminology* 960-977.

206. The recommendations in this regard include the following:

- **Define an Essential Package of Care and set minimum norms and standards for child health**

The development of an Essential Package of Care for children and norms and minimum standards for child health services needs fast-tracking. It is vital for the health department to specify staffing, resources and clear targets to ensure that child health services are adequately resourced. This essential package needs to be integrated with existing accountability and quality improvement mechanisms such as the National Core Standards and Office of Health Standards Compliance. Active civil society and community participation in clinic committees and hospital boards should also improve accountability at local level, while use of the courts and Chapter 9 institutions have also proven effective.

- **Strengthen maternal and child health at district level**

The community health worker (CHW) programme remains uncoordinated and underfunded, and this remains a major impediment that limits children's access to preventative and primary health care. The role of CHWs in the provision of maternal and child services needs to be clearly articulated, and better supported. Their role should be extended to include not only prevention, but also treatment for diarrhoea and pneumonia. This is provided for in the National Development Plan but cannot happen without changes to the legislation/regulations around the prescribing, dispensing and storage of drugs.

The Department of Health needs to ensure that all District Clinical Specialist Teams have their full staff complement. In addition, the Department should appoint provincial paediatricians to improve provincial co-ordination, define clearer clinical governance roles for DCSTs, and imbue the teams with sufficient authority to be able to demand accountability for clinical activities.

A focus on the concept of school health teams, where the nurse leads a team of less skilled individuals who can competently undertake screening and health promotion tasks, allowing the nurse to assume organisational, supervisory and more demanding clinical responsibilities seems to be a logical way forward. Packages of care or onward

referral pathways need to be developed to manage disabilities or problems identified in screened children.

The NDoH needs to re-evaluate the delivery of the IMCI strategy and provide a clear indication of its preferred strategy for the care of sick children at primary level. The Ideal Clinic project has failed to address this critical need. If IMCI is confirmed as still being appropriate, the implementation of the strategy needs revitalisation.

- **Intensify efforts to address stunting**

Malnutrition can result in permanently stunted growth and development, undermining children's school performance and employment prospects, and driving a growing burden of obesity and non-communicable diseases in adulthood. Efforts to prevent malnutrition need to focus on the infant and pre-school years. Greater commitment and investment in community-based breastfeeding support is needed as is support for working breastfeeding mothers. Efforts need to extend beyond growth monitoring and include a systematic effort to ensure that hungry or malnourished children are linked to food provision, community health services and social assistance. The management of severe acute malnutrition at a community level needs to be strengthened, with the availability and provision of ready-to-use-therapeutic food at all health centres being a critical and rate-limiting immediate intervention.

- **Prioritise children in HIV and TB prevention and treatment**

To reduce childhood TB in South Africa requires greater effort to ensure the provision of preventive TB therapy to all young children exposed to an infectious source, increased training, awareness and linkages between MCH and TB services to improve diagnosis of childhood TB, child-friendly TB formulations and access to MDR-TB prevention and treatment when appropriate. Children and adolescents need to be prioritised in HIV budgetary allocations. Effective and cost-effective models of HIV care targeting key economic (distance, transport) and health system (drug stock outs, lack of counsellors, clinic waiting times) barriers must be identified and scaled-up to

improve HIV treatment outcomes. Moreover, innovative community-based HIV counselling and testing models must be scaled-up to reach undiagnosed HIV-positive children and adolescents in need of ART.

- **Invest in adolescent health**

The discordance between the Health and Education departments on key elements of a school-based sexual and reproductive health services package requires prompt resolution at the highest level. The implementation of a new policy on adolescent and youth health requires adequate resource allocation. Given high levels of poverty and violence, mental health needs to be prioritised including scaling up treatment services, and designing effective school- and community-based prevention and promotion programmes.

For further recommendations see section 4.3 on survival and development.

PART 7 FAMILY ENVIRONMENT AND ALTERNATIVE CARE

7.1 Protection of the family and support for parental responsibilities

207. GOSA provides data on: (1) Children living in child- or youth-headed households according to the electronic child-headed households (CHH) register; (2) number of children in need of care and protection placed in funded child and youth care centres; (3) total number of children in foster care; and (4) average number of sentenced children in correctional facilities.

208. We note with concern that the data provided is not disaggregated. Furthermore, the data provided does not provide the full picture of the situation of children in family care and or alternative care: (1) The data provided by GOSA on the number of children living in child headed households in table 40 of their report (3082) is way below the statistics available in the General Household Survey (54 000 in mid-2014). (2) There is no data provided on the number of children living on the street. (3) There is no data provided on the number of children placed in foster care for the first time in a given year (The number provided by GOSA is for the total cumulative number of Foster Child Grants in payment in 2016). Data on first time foster care would be useful as this could help determine the cause of the decline in foster care numbers over the past five years. (4) There is no data provided on the number of children removed from their families

due to neglect or abuse for the first time in a given year. (5) There is no data provided on the number of children in CYCCs who have been reunified with their families in a given year. (6) There is no data provided on the total number of children in correctional facilities.

209. In South Africa, a large proportion of children (22%) do not live with their biological parents. The majority of these children are being cared for by extended family members (kin).[133] GOSA should be encouraged to collect data on both informal and formal kinship care and to ensure that all departments and laws recognise and support this family form and do not discriminate against them. Data that would be useful include:

- the total number of children living in kinship care;
- the total number of children living in informal kinship care; and
- the total number of children living in formal kinship care (court ordered kinship care via foster care or parenting rights court orders).

210. In terms of strengthening families, GOSA refers to government strategies and programmes to address absent fathers, teenage parents, parenting of teenagers and family reunification (para 229). However, no detailed information is provided on these strategies and programmes or on how many families and children these programmes are reaching. In reality, there is a dearth of support programmes for parents and care-givers and existing programmes are largely provided by CSOs which lack adequate funding from government. Government's Report on the review of Welfare White Paper provides a budgetary analysis of **social services** to families.[134] It shows gross under funding and sharp disparities between the different provinces, with the Eastern Cape showing up as having the lowest allocation. It is concerning that the GOSA report provides vague information where more accurate information is available which should be guiding allocation of funding of social services.

211. While government's ECD policy and roll-out is to be commended, the Report on the Welfare White Paper Review (at page 78) points to concerning disparities in

[133] Hall and Sambu "Demography of South Africa's Children" in Delany, Jehoma and Lake (eds) *South African Child Gauge 2016* (Children's Institute, University of Cape Town, Cape Town 2016). The data can also be accessed here: http://www.childrencount.org.za/indicator.php?id=1&indicator=2.
[134] Department of Social Development *Comprehensive Report on the Review of the White Paper for Social Welfare, 1997* (2016) 150.

spending. For ECD and partial care, the Western Cape Province is the top performer at R1 369 per poor child aged 0-4, followed by the Free State Province and Gauteng Province. The Eastern Cape Province is the poorest performer with only R 345 per poor child aged 0-4.

7.2 Social Security

7.2.1 Irregular tenders, unlawful deductions and possible corruption

212. "One of the signature achievements of our constitutional democracy is the establishment of an inclusive and effective programme of social assistance. It has had a material impact in reducing poverty and inequality and in mitigating the consequences of high levels of unemployment. In so doing it has given some content to the core constitutional values of dignity, equality and freedom. This judgment is, however, not an occasion to celebrate this achievement. To the contrary, it is necessitated by the extraordinary conduct of the Minister of Social Development (Minister) and of the South African Social Security Agency (SASSA) that have placed that achievement in jeopardy. How has this come about?"[135]

213. These were the opening words of a recent judgement of the Constitutional Court.[136] The case relates to a tender process found to be irregular by the Court in 2012. In 2012 the South Africa Social Security Agency (SASSA) signed a contract with Cash Payment Masters (CPS) to manage the payment of social grants to 15 million beneficiaries, including 11 million children. The contract was worth R10 billion and would involve processing grant payments totalling approximately R500 billion over the 5-year contract period. An aggrieved bidder, Allpay, alleging irregularities in the tender process, challenged its lawfulness in court. The Constitutional Court found the tender process irregular and declared the contract between the state and CPS invalid but suspended the invalidity to ensure the payment of grants was not interrupted while the state re-ran the tender process and developed in-house capacity to take over the payment of grants. It also imposed reporting obligations on the state to enable the court to monitor progress.

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[135] *Black Sash Trust v Minister of Social Development and Others Case* [2017] ZACC 08 at para 1 *[*Hereafter *'Black Sash 2017']*.

[136] '*Black Sash 2017*'.

214. In November 2015 SASSA filed a report with the Constitutional Court, stating that it had decided not to award a new tender, and intended to in-source the payment function of social grants from 1 April 2017. Accepting SASSA's assertions, the Court ended its supervision over SASSA.

215. However, during 2016 it became apparent from briefings in Parliament that SASSA was not in a position to take over the payment of grants and that the Minister of Social Development intended to extend the invalid contract with CPS without following a competitive tender process. There was also evidence of unlawful deductions being made from people's grants by subsidiary companies of CPS for airtime, loans and funeral policies. The Black Sash Trust, a human rights civil society organisation, therefore asked the Constitutional Court to resume its supervisory power over the Minister and SASSA with regards to the CPS contract.

216. After a high stakes legal battle, the Court decided to suspend the initial declaration of invalidity for a 12-month period from 1 April 2017 to 31 March 2018 and set out a detailed court order[137] aimed at ensuring people's rights to social assistance were protected amidst apparent inability by the Ministry and SASSA to do so within the prescripts of the rule of law. The Court re-imposed oversight over the payment of social grants by requiring the Minister and SASSA to file reports with the Court every 3 months, setting out their plan and progress according to that plan for ensuring the payment of social grants after the expiry of the 12-month period. The Court also required the creation of an independent committee to review the reports and submit their opinion to the court. Either a new tender process needs to be initiated and completed or SASSA's in-sourcing capacity established by 1 April 2018. However, with the Minister of Social Development and the CEO of SASSA being estranged due to arguing conflicting versions of events before the Court, there are concerns that the Ministry and SASSA are not in a position to make progress.

217. Given that the Minister was ultimately accountable yet had failed to give adequate reasons to the Court as to why she had allowed the grant payment system to reach a crisis point, the Court requested the Minister to give reasons why she should

[137] '*Black Sash 2017*'. Order paras 4 – 14

not be ordered to pay the costs of the application in her personal capacity.[138] This is an extra-ordinary approach by the Court which indicates the level of negligence it imputes to the Minister.

218. While CPS has ensured that beneficiaries receive their grants timeously and through improved payment methods, there continue to be complaints from beneficiaries that subsidiary companies of CPS are making unlawful deductions from the beneficiaries' bank accounts that have been set up by CPS and Grindrod bank[139]. The result is that many beneficiaries, children's caregivers included, receive severely reduced amounts every month and are struggling to provide their children with food, clothing, housing, transport and education related costs. The Court order imposes terms and conditions on CPS and the state aimed at protecting beneficiaries' personal information and preventing direct marketing to beneficiaries so as to prevent future unlawful deductions from beneficiaries' grants. However, ensuring that this aspect of the order is implemented is very hard to monitor and has been left up to civil society to do.

7.2.2 Child Support Grant

219. In the Concluding Recommendations addressed to the South African government at the end of 2015, the Committee expressed concern at the prevalence of poverty and inequality in South Africa[140] and advised the State to address income inequality "in particular through more effective pro-poor policies and child rights sensitive budgeting and expenditure"[141]. Observing that the Child Support Grant (CSG) value does not match the actual cost of feeding and caring for a child, the Committee recommended that its value should be progressively increased.[142]

220. However, in mid-2017 the CSG remains by far the lowest social grant in South Africa and its value remains below the lowest poverty line (the food poverty line). Table

[138] At the date of publication of this report the Minister had filed her affidavit as directed by the court but the matter of costs had not yet been decided.
[139] See the Hands off our Grant Campaign available at https://www.blacksash.org.za/index.php/sash-in-action/campaigns/hands-off-our-grants.

[140] African Committee of Experts on the Rights and Welfare of the Child (ACERWC) *Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of South Africa Initial Report on the Status of Implementation of the African Charter on the Rights and Welfare of the Child* (2015) para 6.
[141] ACERWC n140 above para 9.
[142] ACERWC n140 above para 41.

1 in **Annexure 2** compares the CSG amount to other relevant values and illustrates its inadequacy.

221. Furthermore, the annual "inflation related" increases to the value of the CSG over the past few years have only just kept pace with headline inflation rates and have not kept up with food price inflation rates. GOSA has therefore not heeded the committee's recommendation to progressively increase the value of the grant.

222. The GOSA Report reports on the increases to the social security budget over the period 2006/7 to 2014/2015 (para 57), without contextualising that these increases are as a result of expanding the age threshold of the grant and are not related to any increases to the value of the grant that would amount to progressively increasing its value.

223. Instead of reporting on plans to increase the CSG value, GOSA expands on a number of food security initiatives aimed at addressing food poverty (paras 54 and 56 of the GOSA report), including vitamin A supplementation programme, food fortification programmes, breastfeeding promotion, the National School Nutrition Programme, the National Nutrition Security Development Programme and the Food Security Policy for South Africa. GOSA fails to mention that these interventions have had little impact in reducing underweight and wasting, as will be discussed below. Furthermore, a *Diagnostic Evaluation* of nutrition interventions for children in four provinces (Western Cape; Eastern Cape; Free State; KwaZulu Natal) found that none of these interventions are delivered optimally.[143] The evidence shows that with the exception of the school feeding scheme, none of these food security programmes mentioned by GOSA are being implemented at the scale necessary to make any notable difference to the 5.5 million children living below the food poverty line. GOSA should be asked what measures have been taken in response to the detailed recommendations included in the 2014 *Diagnostic Evaluation*.

[143] Department of Health, Department of Social Development and Department of Planning, Monitoring and Evaluation *Diagnostic/Implementation Evaluation of Nutrition Interventions for Children from Conception to Age 5: Summary evaluation report*. (2014).

224. The Country Report does not mention that almost 1.8 million eligible children (18%) are excluded from accessing the grant due to implementation challenges.[144] Many of these are infants, a particularly vulnerable group for whom early exclusion has a negative long-term developmental impact. Barriers preventing caregivers from enrolling infants at birth include problems accessing birth certificates,[145] social and cultural practices, and limited baby friendly facilities at SASSA service points.[146] Lack of access to identity documentation also prevents older children, especially orphaned children and refugees from accessing the CSGs.[147] Government's interventions to overcome these access barriers have not yet been successful.[148] Furthermore, the South African Social Security Agency (SASSA) is not making adequate use of regulation 11(1) of the Social Assistance Act which allows officials to accept alternative documents for proof of identity when formal birth certificates or IDs are non-existent, pending or lost.[149] See section 5.1 above on birth registration and the challenges being experienced by particularly vulnerable groups of children.

7.2.3 Foster Child Grant

225. GOSA reports that the total number of children receiving the FCG was 500 366 on 31 August 2016 (para 241). However, they fail to elaborate that the number of children on the FCG has been declining over the past 5 years. Furthermore, they have chosen the month of August to draw their statistics instead of the start of the financial year (end of March) which is the month used in all official government documents. We present the statistics in the next paragraph showing the full picture and trends.

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[144] Department of Social Development, South Africa Social Security Agency and the United Nations Children's Fund *Removing Barriers to Accessing Child Grants: Progress in Reducing Exclusion from South Africa's Child Support Grant. Summary* (2016).

[145] Zembe-Mkabile et al "Why do families still not receive the Child Support Grant in South Africa? A longitudinal analysis of a cohort of families across South Africa" *BMC International Health and Human Rights* 12 (2012):24. See also Proudlock and Martin "Children's rights to birth registration: A review of South Africa's law" in Proudlock P (ed) *South Africa's Progress in Realising Children's Rights: a Law Review* (Children's Institute, University of Cape Town, Cape Town 2014) 7 for more detail on the barriers to birth certificates.

[146] Martin "Children's rights to social assistance: A review of the Child Support Grant" in Proudlock (ed) *South Africa's Progress in Realising Children's Rights: a Law Review* (Children's Institute, University of Cape Town, Cape Town 2014) 69.

[147] Alliance for Children's Entitlement to Social Security (ACESS) *Barriers to Accessing Comprehensive Social Security in Vulnerable Rural Areas in South Africa* (2009); Department of Social Development, South African Social Security Agency and the United Nations Children's Fund *Child Support Grant Evaluation 2010: Qualitative Research Report* (2010)

[148] Martin n146 above 66.

[149] Martin n146 above 67.

226. At the end of March 2017, 420 000 children (under 21 years) were accessing the Foster Child Grant (FCG)[150] of R860.[151] While the number of children accessing the FCG increased from 50 000 in 1998 to 550 000 in 2012, there has been a steady decline since 2012.[152] The increase was attributed to government's decision in 2002 to promote the use of the FCG (instead of the CSG) as the preferred grant for orphans living with relatives.[153] The decline since 2012 is attributed to the inability of the child protection system to place South Africa's uniquely high number of orphans into foster care. Table 2 below shows the declining numbers.

Table 2 – Number of children accessing the Foster Child Grant

Year	Number of FCGs in payment	Decline
31 March 2012	536 747	+23 873
31 March 2013	532 159	-4588
31 March 2014	512 055	-20 104
31 March 2015	499 774	-12 281
31 March 2016	470 015	-29 759
31 March 2017	440 000	-30 015

Source: SOCPEN (Governments social grants and pension database) data analysed by K Hall, Children's Institute, UCT.

227. Evidence of the failures of the system was brought to the High Court's attention in 2010 by the Centre for Child Law (CCL) after receiving complaints from a number of CSOs. Between 2009 and 2011 over 120 000 children stopped receiving their FCGs

[150] Source: SOCPEN (Governments social grants and pension database) data analysed by K Hall, Children's Institute, UCT.
[151] As of 1 April 2017 it is R890.
[152] Hall et al 'Social assistance for orphaned children living with family in Delany et al (eds) *South African Child Gauge 2016.* Children's Institute, University of Cape Town at 70
[153] Hall et al above at 69

because social workers and courts had not extended the required foster care court orders in time. Many more stood to lose their grants if a solution was not found. The Department acknowledged that they did not have the social worker capacity to extend all lapsed court orders as required by the Children's Act and the parties agreed to work out a settlement. In terms of the court ordered settlement, the Department of Social Development was given temporary authority to extend most foster care orders administratively (without having to go to the Children's Court) until December 2014 by which time a comprehensive legal solution to the challenge must be implemented.[154] This meant that, contrary to section 159 of the Children's Act which requires foster care orders to be reviewed and extended by the Children's Court every 2 years, the provincial departments of social development would be temporarily allowed to ignore the law and extend court orders themselves.

228. In December 2014, the Department approached the Court with an urgent application to extend the court ordered settlement. They presented evidence that a further 300 000 foster care court orders had expired and if the Department was not allowed to continue to extend court orders themselves, these grants would stop being paid in January 2015.[155] The court granted the Department an extension to December 2017 but ordered that progress reports be submitted to the applicant (Centre for Child Law) every 6 months.[156] The progress reports submitted so far focus on the Department's efforts at addressing the backlog of expired court orders but do not provide adequate information on progress towards a systemic solution. A systemic solution would require that both the Social Assistance Act and the Children's Act are amended by December 2017.

229. In November 2016 there was some progress towards a solution with the gazetting of a draft Social Assistance Amendment Bill to enable orphaned children living with relatives to access a larger Child Support Grant [colloquially know as a

[154] *Centre for Child Law v Minister of Social Development and Others* (North Gauteng High Court) Case number 21726/11. Order of 10 May 2011a. Reported in Government Gazette No. 34303. Notice 441. 20 May 2011.
[155] Department of Social Development (2014) Annexure in *Centre for Child Law v Minister of Social Development and others* (North Gauteng High Court) unreported case no. 21726 (12 December 2014).
[156] *Centre for Child Law v Minister of Social Development and others* (North Gauteng High Court) unreported case no. 21726 (12 December 2014) available at http://www.centreforchildlaw.co.za/images/files/ourcases/2014Foster_Care_Order.pdf.

"CSG Top-Up"] instead of the FCG.[157] The other piece of the puzzle to meet the requirement of "a comprehensive legal solution" is an amendment to section 150(1)(a) of the Children's Act to ensure that all new applications by orphans are referred to the CSG Top-Up instead of the FCG. Without this amendment, there will continue to be inequality across the country with the majority of orphans on the CSG Top-Up and some on the FCG.[158] As of May 2017 a draft Children's Amendment Bill had not yet been made public, yet there is not much time left before the court order expires in December 2017.

230. The Committee recommended to the state in 2015 that the state should "urgently" come up with a "durable policy solution" to the challenges in the foster care system.[159] However, despite being given 6 years by the High Court to come up with a solution, the Department is clearly not prioritising this reform. In the absence of a clear indication of systemic reform initiatives, CSOs intend to oppose any attempts by the Department to extend the court order any further.

231. It should be noted that while the GOSA report, at para 232, makes reference to the report of the Minister's Committee on Foster Care (which has not been made public at the time of writing), it is surprising that no mention is made of the Report on the Review of the Welfare White Paper – the product of another Ministerial Committee. That Report found that "[t]he strain on the foster care system results in children who are abandoned, abused or neglected not receiving the level of service they require, as a great deal of social workers' time is spent on dealing with the administrative and court processes relating to foster care".[160] The report supports the larger CSG for orphans in the care of relatives, and recommends the fast-tracking of amendments to section 150 of the Children's Act, the effect of which will be to ensure that orphans living with relatives will benefit from an increased grant and will only be referred to a social worker if he or she has care and protection needs.

7.2.4 Care dependency grant

[157] Social Assistance Amendment Draft Bill, B – 2016 published in GG 40391, GN 1362 dated 1 November 2016.
[158] Proudlock "Weighing up the policy proposals: Some considerations" in Delany et al (eds) *South African Child Gauge 2016* (Children's Institute, University of Cape Town, Cape Town 2016) 97.
[159] ACERWC n140 above para 44.
[160] Department of Social Development *Comprehensive Report on the Review of the White Paper for Social Welfare, 1997* (March 2016) 364.

232. In terms of the Care Dependency Grant (CDG) for children with disabilities, which the GOSA report mentions as a poverty alleviation strategy (see para 52), government fails to acknowledge the challenges that children with disabilities and their families experience when trying to access the grant. One problem lies in the inconsistencies between the Social Assistance Act and its Regulations. Whereas the CDG used to be only available to children with a severe disability requiring home care of the child, this was changed in 2004 when the Social Assistance Act was expanded to apply to children with disabilities who require support services, regardless of the nature or severity of their disabilities. However, the Regulations under the Social Assistance Act, which are meant to guide the implementation of the law, do not reflect these changes and information on the CDG provided on government websites also uses the outdated terminology of "severe" disability and "full-time and special care".[161] This leads to an inconsistent application of the law and prevents children with mild and moderate disabilities and children who require support services from accessing the CDG.[162]

233. Another major problem is the medical assessment of the child to determine whether he or she is disabled. Although new assessment criteria were introduced in 2004 and 2008 via amendments to the law and regulations, the Department has not yet developed a form to guide assessment based on the new criteria.[163] Doctors therefore either use the assessment form based on the repealed eligibility criteria or a form designed by SASSA for assessing adults' eligibility for the Disability Grant.[164] Both of these are framed in a medical rather than social model of disability and SASSA's form focuses on employability. Neither is a viable tool for assessing children's functional abilities or their care or support service needs.

7.3 Child and youth care centres (CYCCs)

[161] South African Government "Care Dependency Grant" (not dated), available ate http://www.gov.za/services/services-residents/parenting/child-care/care-dependency-grant.
[162] Martin, Proudlock and Berry "The Rights of Children With Disabilities to Social Assistance: A review of South Africa's Care Dependency Grant" in Proudlock (ed) South Africa's Progress in Realising Children's Rights: A Law Review (Children's Institute, University of Cape Town, Cape Town 2014) 91-2.
[163] Martin n162 above 92.
[164] Martin n162 above 92.

234. Section 192 of the Children's Act requires the Minister of Social Development to include in the departmental strategy, "a comprehensive national strategy aimed at ensuring an appropriate spread of child and youth care centres throughout the Republic providing the required range of residential care programmes in the various regions…". This is then meant to be matched at provincial level, with the Ministerial counterparts of the provinces publishing a similar strategy for each province. The National Minister has failed to produce such a strategy, despite the fact that the Act has been in operation since 2010. The importance of this plan and concern that it has not been produced was noted by the High Court of South Africa, Western Cape Division, Cape Town, which ordered the Department of Social Development to produce such plan.[165]

235. The GOSA report, at para 251, is vague about registration of facilities, beyond the development of guidelines. GOSA should be asked for more information about the total number of registered facilities per province, and how many unregistered facilities were conditionally or unconditionally registered in each province in the years 2013-2016.

236. The GOSA report is vague about the developmental quality assurance (DQA) processes for CYCCs. GOSA should be asked for more detail on whether the legal requirement (Section 211 of the Children's Act, read with regulation 89) that there should be a quality assurance process for each CYCC every two years is in fact being carried out. How many DQA's were carried out in the years 2013-2016?

237. It should be noted that DQA's have been carried out at two government-run CYCCs after NGOs brought applications to court for those DQA's to be carried out. In both instances, the results of the DQAs have been highly concerning. In one instance, the Court requested that her judgment about the conditions in the Bhisho Secure Care Facility should be brought to the attention of the provincial MEC for Social Development. [166] GOSA should be asked what steps have been taken to solve the

[165] *Justice Alliance of South Africa and Another v Minister of Social Development, Western Cape and Others* [2015] 4 All SA 467 (WCC) para 40 and 44. This part of the order was not overturned by the Supreme Court of Appeal, even though other parts were: *MEC for Social Development, Western Cape and Others v Justice Alliance of South Africa and Another* [2016] ZASCA 88.
[166] *SJ and Others v S*, unreported judgment of the High Court of South Africa, Eastern Cape Division, Grahamstown, Case No CA&R 202/16 (18 August 2016).

problems identified in these two court-ordered DQAs. See **Annexure 3** for excerpts from the *Bhisho* judgment.

238. GOSA is not currently monitoring the number of children in CYCCs who are reunified or reintegrated with their family. Due to a lack of reunification services and no monitoring system, children are essentially left 'forgotten' in CYCCs even though they have biological families they could return to.

7.4 Adoption

Measures taken to encourage national and international adoption

239. It is unclear why GOSA makes reference here to unaccompanied migrant children in para 259 of its report. This is not relevant to the issue of adoption or inter-country adoption. The report says that "many children have been reunited successfully with their parents". In a report by Save the Children,[167] it is clear that reunification of unaccompanied minors is rare and GOSA should be asked to provide concrete data in this regard.

240. It should be noted that inter-country adoption in South Africa is carried out in terms of the relevant Hague Convention, and the Central Authority is the Director General for Social Development, represented by the Registrar of Adoptions.

241. It is clear that the number of both domestic and international adoptions have dropped significantly since the Children's Act came into operation. The 2016 Welfare White Paper Review Report observes (at page 152) that although government policy aims to increase adoptions, in reality "the number of adoptions has fallen sharply over the past ten years, from 2840 in 2004 to 1448 in 2014". DSD's annual report for 2014/2015[168] states that 1651 adoptions were registered during the reporting period of which 1402 were national adoptions.

242. Therefore, it is clear that although the heading of this section of the report is "steps taken to encourage adoption", GOSA has simply failed to do so, and that something is wrong in the adoption system. GOSA should be urged to identify the

[167] Save the Children *In Search of a Better Future: Experiences of Unaccompanied Migrant Children in Limpopo and Mpumalanga in South Africa* (2016) 23.
[168] Department of Social Development *Annual Report 2014/201*5 (2015).

systemic problems that are blocking adoption and put in place measures to alleviate them.

243. Systemic problems in the system are causing long delays with the result that adoptable children spend unnecessarily long periods of time in institutions or with temporary foster parents when they could rather be forming attachment bonds with their adoptive parents. The damage done to children's ability to attach is profound.

Recommendations

244. The recommendations in this regard are as follows:

Protection of the family and parental responsibilities and rights

- GOSA to identify and describe in more detail the strategies and programmes it is implementing to strengthen families, and provide data on the families and children being reached with these programmes.
- GOSA to provide information on how many CSO programmes they are funding and how many children these programmes reach compared to the number of children in need.
- GOSA to explain whether it has plans to assist CSOs presenting programmes on its behalf to prevent further reductions in CSO programmes, especially in the Eastern Cape.
- GOSA should increase budget allocations for social services especially prevention and early intervention programmes provided by CSOs, protection services and CYCCs.
- GOSA should increase and standardise the subsidies it pays to CSOs across the provinces in line with an objective measure of the costs of caring for a child (ECD, CYCCs, Social Worker salaries, and programme funding)
- GOSA should provide the specific data requested by the Committee in its 2015 concluding comments and the data recommended in this shadow report (see section 7.1)

Social security

- GOSA to report on its plans for the payment of social grants from 1 March 2018 onwards and how this plan will protect the personal data of beneficiaries from unethical marketing practices by private financial companies.
- GOSA to report on how it intends to progressively increase the value of the Child Support Grant to ensure it at least covers the basic nutritional needs of a child.
- GOSA to report on what measures have been taken in response to the recommendations in the 2014 Diagnostic Evaluation of nutrition interventions for children.
- GOSA to provide an explanation as to why the FCG numbers are declining and to provide data on the number of new FCGs per year.
- GOSA to explain its plans and timeframes for implementing a durable and comprehensive legal solution to the foster care crisis, given that the Court deadline for said solution is December 2017.
- GOSA to amend the regulations on the CDG to be in line with the 2004 amendments to the Social Assistance Act
- GOSA to explain its plans and timeframes for introducing a new assessment tool for the CDG that recognises the 2004 amendments to the Social Assistance Act which introduced a social model for assessing disability (instead of a medical model based on type and severity of disability).

Child and Youth Care Centres (CYCCs)

- GOSA to explain why it has not yet published its comprehensive national strategy on CYCCs as required by section 192 of the Children's Act, and its plans and timeframes to do so.
- GOSA to provide statistics on total number of registered and unregistered CYCCs in the country and per province, and their capacity. GOSA to also specify the total number of CYCCs that have been conditionally registered over the period 2013 - 2016.
- GOSA to provide information as to how many DQAs were conducted in the years 2013 – 2016.

- GOSA to provide information on the steps it has taken to solve the problems identified in two court-ordered DQAs involving two state run CYCCs.
- GOSA to provide data on the number of children in CYCCs who were reunified or reintegrated with their family in a given year.

Adoption

- GOSA to explain why the number of adoptions are declining and to identify and describe the systemic barriers that are discouraging and delaying adoptions.
- GOSA to explain what steps are being taken to address the systemic barriers discouraging and delaying adoptions.

- GOSA must indicate how they intend to promote adoptions in a child-centred manner that will ensure that children do not unnecessarily remain in residential care.

PART 8 PROTECTION OF CHILDREN IN MOST VULNERABLE SITUATIONS

245. In its last concluding recommendations addressed to GOSA the Committee expressed concern at the high rate of violence against children and recommended that GOSA put in place all the necessary measures in all settings to protect children from violence. It is concerning to note that South Africa still has high levels of interpersonal, community and sexual violence, to the extent that violence against children has been "normalised". The 2015 Optimus National Prevalence Study established that between 16.8% and 35.4% of children report having been sexually abused before the age of 18.[169] A national study on child homicide shows conclusively that children under 5 years are at increased risk of being killed in the home due to fatal child abuse. Marginalised children (such as children with disabilities and children in rural areas) are even more vulnerable to violence.[170]

246. A recent study by the Children's Institute at the University of Cape Town found that, despite a comprehensive legal and policy framework, the child protection system is failing children. Implementation is poor, and large numbers of children remain at risk

[169] Centre for Justice and Crime Prevention *The Optimus Study on Child Abuse, Violence and Neglect in South Africa* (2015) 2
[170] Hesselink-Louw, Booysens and Neethling "Disabled children as invisible and forgotten victims of crime" (2003) 16(2) *Acta Criminologica* 165-80.

of continued abuse, with few families accessing prevention and early intervention programmes and most children do not receive appropriate therapeutic interventions.[171]

- Reasons identified for the ongoing vulnerability of children include: Physical abuse is not taken seriously by the designated departments and services which are supposed to protect children and respond when they suffer violence and abuse;
- The needs of children with disabilities are not even recognised, let alone met;
- The lack of therapeutic services risks increases the continued impact of trauma;
- Poor record-keeping and inadequate data-collection prohibit evidence-based planning;
- Poor case management and inadequate supervision lead to children being lost in the system;
- Children suffer because professionals are not working collaboratively.

247. The failure to legislate the prohibition of corporal punishment in the home exacerbates the vulnerability of all children to violence, but especially marginalised children, including children with disabilities and poor children.

248. In paras 153, 155, 157 and 158 of its Report, GOSA refers to progress in enacting prohibition of corporal punishment in the home and refers to it as "still a very sensitive issue." It is our view that GOSA is not treating the issue with the necessary urgency. This goes against Concluding Recommendations made by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) in its 2014 examination of South Africa, the Concluding Observations of the United Nations Committee on the Rights of the Child in its 2016 examination of South Africa, the 2016 instruction from the South African Human Rights Commission, and South Africa's own multiple stated commitments to prohibition of corporal punishment in the home (for example, after the 2012 Universal Periodic Review). As recently as the 2017 Universal Periodic Review, South Africa was again urged to "(a)dopt legislation to prohibit all forms of corporal punishment in the private sphere" (Israel) and "(e)xpedite the

[171] Jamieson, Sambu and Mathews *Out of harm's way? Tracking child abuse cases through the child protection system in five selected sites in South Africa* (Children's Institute, University of Cape Town, Cape Town 2017).

adoption of legislation to prohibit all forms of corporal punishment in the home, including 'reasonable chastisement' and ensure that those who perpetrate corporal punishment are held accountable" (Lichtenstein).[172]

249. GOSA refers to the Child Protection register (CPR), at para 47 of the country report, claiming an increase in the use of both Part A (reported cases of child abuse) and Part B (persons found unsuitable to work with children). Given the scale of the problem, and the level of under-reporting, we remain concerned about the limited usage of the CPR, in terms of both the accuracy and quality of recorded information. This is especially true for government employees working with children, and causes long delays in screening those who care for children. A Child Abuse Tracking study has shown that social workers rarely used the prescribed forms—only 13% of the files reviewed contained a Form 22.[173]

250. We remain concerned regarding the appropriateness of investing in two poorly functioning resource-intensive registers, the CPR and the National Register for Sex Offenders (NRSO), mandated in the Criminal Procedures (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007).

251. Since our last Alternative Report to the ACERWC, we have seen no improvement in the capacity of the child protection and criminal justice services in terms of maintaining the two registers, and no movement towards the development of an electronic system which could potentially streamline both systems.

252. Despite the emphasis on prevention and early intervention in the Children's Act, the Child Abuse Tracking Study highlights the multiple failures in implementing such programmes, and concludes that "[t]he child protection system is failing children"[174]

253. This is exacerbated by the lack of coordination among all role-players when violence has already occurred. The Child Abuse Tracking Study found that, although the Children's Act is based on a cooperative implementation model and obliges social workers and police offices to cross-refer cases, only 8% of all cases of reported abuse

[172] Human Rights Council *Draft report of the Working Group on the Universal Periodic Review, South Africa* (May 2017) 18.
[173] Jamieson n171 above 18.
[174] Ibid.

were cross-referred, and none were jointly managed.[175] Limited inter-sectoral collaboration was also found between other key departments. This results in schools and teachers not being involved in the management of children post abuse.[176]

254. Claims made by GOSA, in paras 116 and 180, of its Report regarding crime-prevention in schools are also not supported by the reality on the ground. There exist high levels of violence in schools which are related to:

- **Gang activity**. For example, in 2013, education officials in the Western Cape province temporarily closed 16 schools, affecting 12,000 students, in Manenberg, an area near Cape Town, because of a spike in gang violence that left teachers too afraid to go to work.
- **Violence between pupils**. As just one of many examples, a 12-year-old was stabbed to death by a fellow pupil in 2014, at a school in the Gauteng province.
- **Violence perpetrated by teachers**. Corporal punishment in schools, despite being prohibited since 1996, is rife. 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". As recently as June 2016, the principal of a Primary School in Mhluzi near Middleburg (in the Mpumalanga province), beat a 15-year-old child so severely that he became paralysed after the incident and was wheelchair-bound.

255. 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. In addition, 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 fear and anxiety

[175] Jamieson n171 above page 55.
[176] Ibid.

which has lasting psychological consequences in an environment that should be safe and nurturing.

256. In para 376, the GOSA report highlights crime-awareness and child protection campaigns, including Child Protection week (in para 152). This has been shown to be an ineffective strategy to reduce violence. The recent Optimus Study on Child Abuse, Violence and Neglect in South Africa, the first community based prevalence study in the country, involving over 10,000 participants aged 15-17 years does not confirm that current strategies are reducing levels of violence against children. Its findings include:

- One in five young people reported having experienced some form of sexual abuse in their lifetimes, and this was true of both boys and girls;
- One in three respondents reported being hit, beaten or kicked by an adult caregiver;
- A total of 16.1% of young people reported experiencing emotional abuse, with girls reporting higher rates than boys. This is an under-reported form of abuse as it has received very little publicity and awareness raising.

257. Other forms of violent victimisation reported included:

- 23.1% of young people reported exposure to family violence (violence perpetrated by an adult caregiver against a sibling or against another adult in the household);
- 44.5% of respondents had experienced theft;
- 26.2% of respondents had been robbed;
- 19.7% of young people reported persistent bullying;
- 21.4% of respondents reported having been threatened with violence;
- 19.2% of young people had been attacked without a weapon; and
- 15.9% had been attacked with a weapon.

258. Levels of community violence in South Africa are also high, and increasing with the rise in service delivery protests and gang activities in areas such as the Cape Flats in Cape Town. Dissatisfaction with poor and inadequate service provision, exacerbated by criminal gang-related activity put children at risk daily.

259. On average, there were 6 “unrest-related incidents” in South Africa every day for the 2014/15 period.[177] Children are invariably involved in and affected by community violence. The 2012 survey on violence in schools[178] found that levels of violence in the home, the school and the community are inter-linked and impact on each other. Crime and violence were widespread in the communities in which study participants lived.

- The average age at which they first witness violence in their community is 14 years (which suggests that a great number of young people have already been subjected to some form of violence by the time they enter high school).

- There was widespread exposure to adults and other young people in communities who are involved in drug-related and other illegal activities in their neighbourhoods, and family criminality is common.

- Alcohol (64.7%), drugs (27.6%), firearms (17.2%) and other weapons such as knives (50.5%) were easily accessible in the areas in which the participants live.

- Children and young people frequently do not leave their homes because of the risk of violence.

260. In its Concluding Observations to South Africa’s previous Country Report, the Committee noted the high levels of violence against children and the lack of evidence-based strategies to reduce violence. The Committee recommended the expansion of police child protection units across provinces to mitigate long term effects.

261. In paras 313 and 314, GOSA refers to the high rates of violence against children in general, and sexual violence in particular. GOSA’s response outlines the expansion of the Family Violence, Child Protection and Sexual Offences Investigation (FCS) units across the provinces and protecting vulnerable children through the direct relationship with Child and Youth Care Centres (CYCCs).

[177] Bhardwaj “Are there 30 service delivery protests a day in South Africa?” (8 June 2016), available at https://africacheck.org/reports/are-there-30-service-delivery-protests-a-day-in-south-africa-2/.
[178] Centre for Justice and Crime Prevention *School Violence in SA: Results of the 2012 National School Violence Study* (2012).

262. GOSA's claims of dealing with the situation are not supported by experience on the ground. South Africa remains a country characterised by very high levels of interpersonal, family, community and sexual violence. Marginalised children, including children with disabilities, are particularly vulnerable to violence. Children with disabilities who experience abuse find access to justice a challenge.

263. Since 2008, the police have not reported the number of child rape cases separately in their annual report. Instead, incidents of child rape are lumped together under the sexual offences category that includes rape and sexual assault of all genders and ages, prostitution and acts such as flashing. We are therefore unable to track the reported incidence of child rape over time.

264. Although there has been a decrease in the reported rape figures, South Africa continues to experience very high rates of sexual violence. Between April 2015 and March 2016, a total of 51,895 sexual offences were recorded by the South African Police Service (SAPS), with 42,596 of these being rape—more than 116 a day. This decrease is not viewed by civil society organisations working in the field as a positive sign, which find the decrease in the reported rate deeply concerning as child protection organisations still receive reports of children being turned away from police stations when they attempt to report.

265. A child abuse tracking study shows that child sexual abuse is primarily reported to SAPS and less than one in three cases are referred by SAPS to social services for therapeutic services to reduce long-term effects. Inter-sectoral collaboration in the management of child abuse cases is absent with limited evidence that children are accessing temporary safe care. Inter-sector protocols on the coordinated management of child abuse are outdated and unused. In addition, research suggests that social service professionals lack the capacity to adequately manage cases of sexual abuse and most children remain at continued risk with perpetrators still around.

266. South Africa has some of the highest incidences of child and infant rape in the world. The 2015/2016 crime statistics report 15,790 child victims of rape, representing 37% out of a total of 42,596 such cases in that period. In 1/3 of cases, the perpetrator is a family member or close relative. Child welfare groups estimate that the number of unreported incidents could be up to 10 times the reported figure.

267. The Child Death Review (CDR) initiated by the Children's Institute, at the University of Cape Town, reviewed the deaths of 711 children for the period 1st January to 31st December 2014. It found that 43% of these deaths were due to non-natural causes. In 110 cases of child murders that were reviewed by the CDR teams, the biggest drivers of child murders were interpersonal violence among older boy children mainly related to gangs, and deaths due to fatal child abuse, mostly affecting children under 5 years of age in their home.

268. 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 South African Medical Research Council (SAMRC) found that 40% of men reported having ever assault their partners.[179] A 2016 study demonstrated that conflict in the household increases the risk for becoming a victim of violence and later a perpetrator.[180] . The co-morbidity between domestic violence and child abuse has been found to be close to 40%.

269. Not only are children in violent homes at greater risk for physical abuse, they are also at greater risk for violence direct against them when they get "caught in the crossfire of adult violence"[181]

270. The GOSA country report does not deal in any way with child pornography – and the exposure of children to adult pornography, this is quite concerning due to the fact that advances in technology have increased children's exposure to adult pornography and adult use of child pornography. This makes the provision of therapeutic and support services to children affected by child and adult pornography imperative, but these services are lacking.

271. South Africa's legislation has not kept up with these changes, although exposing children to any form of pornography and the making, distribution and viewing of child pornography has been criminalised. The GOSA has established, through the

[179] Jewkes et al Preventing Rape and Violence in South Africa: Call for Leadership in a New Agenda for Action (Medical Research Council, Pretoria 2009).
[180] Safety and Violence Initiative *Towards a More Comprehensive Understanding of the Direct and Indirect Determinants of Violence against Women and Children in South Africa with a View to Enhancing Violence Prevention* (2016).
[181] Van As 2012. Cited in: Department of Social Development, Department of Women, Children and Persons with Disabilities and United Nations Children's Fund *Violence Against Children in South Africa* (2012).

SA Law Reform Commission (SALRC), a project committee of experts and researchers on child pornography in order to review existing legislation and propose reforms. The work of this committee is slow due to the under-resourcing of the SALRC. However draft legislation will be workshopped around the country in early 2018.

Recommendations

272. The recommendations in this regard are as follows:

- GOSA has a duty to prioritise and resource programmes to prevent violence, and should implement a coordinated, resourced and evidence-based violence-prevention strategy.
- GOSA has a duty to bring South Africa law in line with the international obligations by amending the Children's Act to include prohibiting corporal punishment in the home.
- Support to parents and building their capacity to use positive discipline strategies in raising their children, as is provided for in the Children's Act, must be implemented widely across the country.
- Teachers must be held accountable when they break the law.
- Specialised policing and court services for child victims must be adequately resourced and implemented as a matter of urgency.
- The work of the SA Law Reform Commission on the reviewing of legislation and proposing law reform on child pornography must be treated with urgency.
- Steps should be taken to ensure better management of the Child Protection Register and the National Register for Sex Offenders.

PART 9 HARMFUL PRACTICES

9.1 Measures taken to discourage harmful social and cultural practices

273. The South African Law Reform Commission (SALRC) Discussion Paper on *ukuthwala* notes that in 2009 there were numerous reports that the age-old tradition

of *ukuthwala*, which had apparently died out, was re-emerging in certain parts of the country.[182] Some of the reports noted that:

- About 20 girls a month were being forced to drop out of school because of the forced marriage resulting from *ukuthwala*;
- A disturbing dimension had arisen where girls as young as 12 years were being forced to marry men old enough to be their parents, some of whom were HIV positive;
- Some of the abductions were sanctioned by the parents/guardians of the abducted girls who in some instances were influenced by the lobolo offered by the prospective husband due to their dire economic situation;
- Parents/guardians of the abducted girls rarely reported the abductions to the police for fear of reprisals, ridicule or being *shunned by community members;* for those who reported, police often told them that there was not much to be done because *ukuthwala* is/was a cultural issue;
- Immediately after the abductions, most girls were verbally, sexually and physically abused by their "husbands" and their families.[183]

274. *Ukuthwala* is an irregular method for commencing negotiations between the families of the intended bride and bridegroom directed at the conclusion of a customary marriage.[184] It is not a marriage in itself. In the evidence that the Legal Resources Centre put before the High Court in the *Jezile*[185] matter there are two contrasting understandings of the content of *ukuthwala*. On the one hand, there is the traditional conception of *ukuthwala* that requires consent, and is used primarily to further marriage negotiations; on the other hand, there is the aberration of the traditional conception, which permits rape and abduction. The "bastardised" version of *ukuthwala* is the lived experience of large numbers of women and children, and is a blatant abuse of fundamental constitutional rights.

275. Many men who abduct girls in the name of *ukuthwala* like the Appellant in the *Jezile* matter conceive of *ukuthwala* as a form of marriage. However, that is contrary

[182] South African Law Reform Commission (SALRC) *Revised Discussion Paper 138: Project 148 The Practice of Ukuthwala* (January 2016) page 18.
[183] SALRC n182 above 19
[184] *Jezile v S and Others* 2016 (2) SA 62 (WCC) at para 72.
[185] *Jezile* at para 74-6.

to the provisions of the Recognition of Customary Marriages Act 130 of 1998. Since *ukuthwala* is a portal to commencing marriage negotiations, the minimum requirements for a valid customary marriage must apply. This proposition finds its authority in the wording of section 211(3) of the Constitution which states that the practice of custom is subject to any applicable legislation that specifically deals with customary law.

276. Section 3 of the Recognition of Customary Marriages Act stipulates two requirements for a valid customary marriage to exist (i) that both parties consent to the marriage; and (ii) that both parties be at least 18 years old or have parental consent.

277. Additionally, there is an exemption clause in the Recognition of Customary Marriages Act which gives parents and guardians the authority to give consent for their minor children to be married in terms of this Act. This is detrimental to the rights of the girl children forced into these circumstances.

278. A number of cases have been reported where girls as young as 12 years were *thwala'd* by men old enough to be their fathers in some cases. Many of these girls have had to drop out of school because they fall pregnant and/or are required to stay home to take of household chores, placing them in perpetual poverty and dependency on their male counterparts. A digression from constitutional precepts that value and protect children as a vulnerable group in society. Many girls/women have had difficult, and in some cases fatal experiences, with child birth as they are too young to be delivering babies. We believe that this is a very serious concern that must be borne in mind in considering this legislation.

279. We submit that any customary practices that allows women and children to be married without their consent is an unjustifiable violation of their right to equality, dignity, freedom and security of the person and privacy. Such a custom would need to be developed in order to ensure that it complies with the prescripts of the Bill of Rights.

9.2 Death and mutilation of boys because of botched circumcision and virginity testing of girls

280. There continue to be numerous reports of violence against children perpetuated through the practice of certain harmful customary practices. Anecdotal evidence

suggests that girls and boys, in some instances as young as 12 years, are subjected to practices that include illegal male circumcision and virginity testing without their consent. In the five and a half years from June 2001 to December 2006, one provincial Health Department recorded 208 deaths and 115 mutilations, out of 2,262 hospital, admissions due to initiation practices relating to male circumcision.[186] A 2014 report revealed that despite the high number of deaths and injuries, only 11 people had been convicted.[187]

281. In 2016 the Kwazulu Natal Province's uThukela District Municipality caused an uproar when it promoted a study bursary for girls using virginity testing as a qualifying factor.[188] Girls wanting to be considered for the bursary have to produce a certificate certifying their virginity status and should their application succeed then during the course of their studies they have to undergo inspections and produce regular confirmation of their virginity status in order to hold on to the bursary. News of the bursary scheme caused the Commission for Gender Equality to investigate the terms of the bursary and it subsequently found the virginity testing requirement to be unconstitutional. It found that the terms of the bursary creates gender inequality especially seeing that the municipality offers a similar bursary to boys but they are not required to undergo virginity testing in order to qualify for the bursary. It held that "any funding by an organ of state based on a women's sexuality perpetuates patriarchy inequality in South Africa". [189]

Recommendations

282. The recommendations include the following:

- GOSA must implement the concluding recommendations from the Committee on the Rights of the Child that both the Marriage Act and Recognition of

[186] Eastern Cape Department of Health *Health Statistics: Circumcision Statistics Since June 2001* (not dated), available at www.ecdoh.gov.za/uploads/files/120707095947.pdf.
[187] Nqaba Bhanga "119 initiation deaths reported over past two years" (20 August 2014), available at http://www.politicsweb.co.za/politics/119-initiation-deaths-reported-over-past-two-years.
[188] Georgina Guedes "Maiden's Bursary Awards must be scrapped" Politicsweb (16 January 2016), available at https://www.enca.com/opinion/maidens-bursary-awards-must-be-scrapped; Amanda Khoza "Girls be warned: Lose your virginity, you lose your bursary" News24 (January 2016) available at http://www.news24.com/SouthAfrica/News/municipality-warns-maidens-lose-your-virginity-lose-your-bursary-20160122.
[189] Commission for Gender Equality *Supplementary Investigative Report: The Maiden Bursary Investigative Report* (24 June 2016) 22.

Customary Marriages Act be amended to ensure that the minimum age for all marriages is 18. Any sections that allows for parental consent to be given in order for a minor child to be married must be removed from all legislations relating to marriage. We propose that the position in the Civil Unions Act 17 of 2006 where the minimum age for a person to consent to a marriage is 18, be uniformly applied to all marriages without any exemptions in order to comply with international obligations that have abolished child marriages. [190]

- We encourage GOSA to enact legislation that would define and criminalise forced marriages in any context.
- It is necessary for GOSA to review, and where necessary amend, provincial legislation that may give defences for *ukuthwala*.
- GOSA must strengthen the legal framework and implementation thereof to ensure the protection of children against illegal circumcision and virginity testing.
- GOSA must discourage practices that perpetuate patriarchy and gender inequality under the guise of cultural practice and State funds must not be used for such actions such as the "Maiden Bursary".

PART 10 CHILD JUSTICE

283. The Child Justice Act 75 of 2008 (CJA) has been in force for close to 7 years. The CJA creates a separate system in which children in conflict with the law are dealt with. As acknowledged by the State's country report, the lack of reliable statistical information on the system is a serious concern. GOSA's reports, in paras 359 to 361**,** on children in the child justice system show that the number of children coming into the system has dropped significantly since the commencement of the CJA.[191] At first glance having fewer children in the child justice system could be positive, however there is the concern that children are not receiving the necessary services.[192] In order

[190] The Civil Unions Act recognises the union between couples of the same sex and allows for them to enter into a civil union. The age of consent to enter into such a union is 18 years and no exception provision is allowed for. The Act also regulates unions between couples of different sex who do not wish to enter into a marriage in terms of the Marriages Act. In order for this union to be legally recognised it must be registered with the Department of Home Affairs and a certificate issued.
[191] South African Alternative Report Coalition *Alternate report to the UN Committee on the Rights of the Child in response to South Africa's Combined 2nd, 3rd and 4th Periodic Country Report on the UN Convention on the Rights of the Child* (2015) 17.
[192] As above.

for the impact of the new child justice system to be successfully measured reports must indicate whether the State has accepted the responsibility placed on it to adequately protect children in conflict with the law.[193]

284. As noted by GOSA's country report, in para 364, the number of children sentenced to imprisonment has decreased. Contrary to GOSA's positive outlook on this decrease we are of the view that it is not clear whether this decrease is as a result of a rise in the number of children sentenced to secure care facilities. This information has not been made public.[194] What is positive however is the existence of an important monitoring mechanism namely that almost all sentences of children in magistrates' courts are automatically review by High Courts.[195]

285. In 2014, the Constitutional Court found that the automatic placement of convicted child sex offenders on the National Sexual Offenders Register was unconstitutional.[196] In 2015 the Sexual Offences Act was amended to reflect this finding.[197] Sadly the judgment and the amended law do not require the State to proactively remove the names of children who were automatically placed on the register between 2007 and 2015. Therefore, more proactive steps need to be taken to ensure the removal of children from the register.

286. In order to provide "for a wide range of appropriate sentencing options specifically suited to the needs of children" the CJA makes it possible for a child convicted of an offence to be sentenced to compulsory residence in a child and youth care centre (managed by the Department of Social Development) instead of imprisonment.[198] This alternative to imprisonment is a praiseworthy attempt at complying with international law and constitutional law principles on treatment of child offenders. However, the challenge arising from this sentencing option is the fact that the legislative scheme is vague on the possibility of early release of children sentenced

[193] Civil society submission to the Portfolio Committee on Justice and Correctional Services on the Judicial Matters Amendment Bill [B-2015] relating to amendments to the sexual offences and child justice legislation (2015) 26.
[194] South African Alternative Report Coalition n191 above 17.
[195] South African Alternative Report Coalition n191 above 17.
[196] *J v National Director of Public Prosecutions and Another* [2014] ZACC 13; 2014 (2) SACR 1 (CC); 2014 (7) BCLR 764 (CC).
[197] Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act 5 of 2015.
[198] See the preamble and section 76 of the Child Justice Act 75 of 2008.

to these centres.[199] Namely early release that is akin to the parole of those sentenced to imprisonment. This results in differentiation in the manner in which children serving under the two sentences are treated.[200] Children in imprisonment have the option of being paroled as a way of promoting reintegration and rehabilitation. Children in child and youth care centres do not have this option and therefore do not feel motivated to make the most of programmes and assistance provided to them while in the centres.

287. The CJA introduced a hybrid sentencing option in which a child convicted of an offence is sentenced to a term of compulsory residence in a child and youth care centre and thereafter a period of imprisonment (section 76(3) sentence).[201] The period of imprisonment is served after completion of the time in the child and youth care centre. This only happens if it is found that the child concerned has not been sufficiently rehabilitated. The role of the child and youth care centres is important in that they have the responsibility of ensuring that the children receive appropriate therapeutic interventions in order to be rehabilitated and reintegrated. In addition, they assist the courts in determining whether or not the children concerned should serve further periods of imprisonment. It is therefore concerning that it has emerged that child and youth care centres do not understand what constitutes this sentence.[202]

Recommendations

288. The recommendations include the following:

- Fast track the implementation and finalisation of research to determine the cause of the decline; research on the impact of the Child Justice Act; and the reviewing of the current data collection system.
- Improved data and publication of statistics on secure care placements of children.
- Create clarity on the legislative framework on the early release of children sentenced to compulsory residence in child and youth care centres.

[199] Centre for Child Law *The early release of child offenders sentenced to child and youth care centres* (2016) 17.
[200] As above 14-5.
[201] See section 76(3) of the Child Justice Act 75 of 2008 and Centre for Child "Working for rehabilitation? An account of the implementation of section 76(3) of the Child Justice Act 75 of 2008 by child and youth care centres" (2016) 1.
[202] Centre for Child Law n199 above 5 and 7-9.

- A concerted effort to ensure an increase in knowledge of the effects section 76(3) sentence amongst practitioners that work in child and youth care centres that child offenders are sentenced to compulsory residence in.