SOUTH AFRICAN ALTERNATE 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

October 2015

This Alternate Report to the UN Committee on the Rights of the Child is a revision of the 2014 Complementary Report to the African Committee of Experts on the Rights and Welfare of the Child.

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Contributions to the content, strategic priorities and recommendations were received from people attending three workshops (24 and 25 January 2014, 09 December 2014 and 16 October 2015). For a full list of these see Annexure 2.

This Alternate Report is endorsed by 41 organisations and individuals.

See Annexure 1.

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Note: we use the acronym CPR to denote the South African Government's Combined Periodic Report.

1 INTRODUCTION

1. This Alternate Report to the Government of South Africa's (GOSA) Combined 2nd, 3rd and 4th Periodic Report to the UN Committee on the Rights of the Child (CROC) has been developed by an alliance of organisations in South Africa's children's sector, formed in 2013 to draft alternative reports to the African Committee of Experts on the Rights and Welfare of the Child and to the CROC. The content has been developed by 52 authors representing 42 institutions and organisations. Furthermore, the content, priorities and recommendations have been influenced by three workshops of sector organisations, including key national children's rights networks, between January 2014 and October 2015.

2. South Africa's periodic reporting on the UN Convention on the Rights of the Child (UNCRC) has been extremely delayed, with the 2nd, 3rd and 4th Periodic Reports being submitted together. We recognise the concerted effort of the Department of Women, Children and Persons with Disability (DWCPD) to prepare and submit the report; however this does not mitigate the seriousness of the delay. Furthermore, consultation with civil society on the preparation of the Combined Periodic Report (CPR) was limited. We urge the CROC to hold South Africa accountable for the late report, establish how this will be prevented in future and seek clarity on the process by which it was developed.

3. South Africa's child rights protection framework is relatively comprehensive. The Government of South Africa (GOSA) and civil society have invested significantly in its development since South Africa ratified the UNCRC in 1996. This includes amongst others, that the Constitution contains a section on the rights of children[1]; legislation such as the Children's Act as Amended (No. 38 of 2005) [hereinafter the Children's Act]; and Child Justice Act (No. 75 of 2008) which have entrenched the statutory protection of children's rights. We recognise the strong practice of public participation in the development of law and policy relating to children. Further, we commend the social assistance available to poor children and families, noting the positive impact on children's lives. Nevertheless 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, at the outset, set out our views on the context of these challenges.

2 OVERARCHING STRATEGIC ISSUES

2.1 Poverty and inequality

4. The CPR claims that poverty is declining create an inaccurate impression of the situation of poverty and inequality in South Africa. Nearly 56% of children live in poverty, and 32% of all children live in households where there is no employed adult;[2] 43% of female-headed households do not include a single employed person.[3]

5. The decrease in the proportion of children living in poverty over the past decade is attributed primarily to the availability of social grants, and not declining unemployment rates, which remain unacceptably high.

6. South Africa is a deeply unequal society; despite a decrease in absolute income poverty, income inequality has increased.[4] Although South Africa is a middle-income country, resources are unevenly distributed and while some children thrive, the majority face serious challenges. The country has one of the highest global Gini coefficients, at 0.68, and progress in addressing inequality has been weak.[5]

7. Inequality and inadequate income compromise children's health, quality education, and access to services, and frequently leaves them in situations where their physical safety is threatened.[6] In the context of our middle-income status, the high rates of malnutrition, children affected by HIV, child mortality and persistently weak performance in education are a national disgrace.[7]

2.2. Leadership and coordination

8. The Ministry and 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 the Department of Social Development (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.

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

10. The protection of children's rights has been strengthened by decisions of the courts, driven by civil society action. These cases are discussed throughout this Alternate Report. They include cases dealing with the best interest of the child principle; adolescent sexual autonomy rights; the rights of asylum seekers to access education; systemic failures that resulted in Foster Care Grants not being paid; the rights of child offenders; and automatic review, within 24 hours, of decisions to separate a child from his/her parents or caregivers amongst many others.

11. In line with the UN CROC General Comment 2, issued in 2002, and the 2014 Concluding Recommendations from the ACERWC to the GOSA, CSOs agree that South Africa requires an independent child's rights monitoring body.[8] The ideal form that this should take is not yet clear, some favour the creation of a Children's Ombud, while others argue the appointment of a dedicated Children's Rights Commissioner to the Human Rights Commission (HRC), with greater resources. This must be resolved through a consultative process with civil society. There is strong consensus that such a body must be properly capacitated and have the necessary authority.

Recommendation

12. Stronger political leadership, monitoring and coordination to realise children's rights; and establishing an independent child's rights monitoring body with the necessary resources, capacity and authority.

13. Civil society engagement, consultation and participation in governance, implementation and monitoring processes must be routine and funded.

2.3. Corruption, lack of capacity and a lack of accountability

14. Significant failures to implement the law and policy framework are evident across the spectrum of services to children and families. The positive framework is not having the intended effect, particularly on the lives of children who are marginalised due to their poverty, race, class, disability, sexuality and nationality. These are discussed throughout this Report. High levels of corruption, lack of capacity, and absence of accountability and transparency are a significant reason for this. However, these factors result from the weak political leadership. Significantly, this lack of political will leads to weak prioritisation of expenditure and resources to realise children's rights.

2.4. Budgeting and resourcing child services

15. Resources for child rights services should be identifiable in budgets for child protection, criminal justice, social security, health, early childhood development (ECD) and education amongst others. In addition, spending on housing, sanitation, infrastructure and many other areas is critical. Overall, the allocation of budgets to children's rights and services is problematic. For example, the costing and allocation of child care and protection services have been continuously under-funded since 2007/08.[9]

16. Under-resourcing is not the only issue; provinces' capacity to spend is a significant factor. The Financial and Fiscal Commission (FFC) reports: 'Total unspent funds by Social Development

Departments over the four-year period (2007/2008–2010/2011) amounted to R1.2 billion.'[10] The increase in allocation within child care and protection services for all provinces between 2012/13 and 2013/14 is welcome, but this increased allocation is primarily for the roll out of the Isibindi[11] programme and expansion of ECD programming, which we commend. The increase obscures the fact that allocations to other social development related services are 'near neglected' in some provinces.[12] These include funding for prevention and early intervention, the extremely under-resourced child protection services, and for child and youth care centres (CYCC).[13] Similarly, increases in the education budget are welcomed; however underfunding of poor schools a serious problem and overspending on nonessential areas and underspending on essential areas at provincial level contribute to the growing inequality in the education system.

17. The FFC report indicates that departments are failing to channel the funds allocated to CSOs that are delivering child welfare and protection services. All provinces rely heavily on CSOs to deliver the majority of child social welfare services, but on average transfer less than half of their total social welfare programme budgets to CSOs to deliver these services.[14]

18. Increased private sector interests and outsourcing of state mandated services to business is a concern. Claims of increased efficiency must be weighed against increased inequality in services to children and contradictions between private and human rights law. Problems with this are evident in the provision of social security, education and health.

Recommendation

19. GOSA must prepare and report on a national children's budget and provincial children's budgets. This must relate to the budgets of all government departments, not only those traditionally associated with realising children's rights. Further, GOSA must implement Human Rights Council Resolution 17/4 regarding the guiding principles on business and human rights.

2.5 Civil society's role and challenges

20. The political environment for South African civil society is positive, and civil society is relatively strong and independent. Emerging social movements linked to the children's sector are further strengthening the capacity and political impact of civil society to monitor and hold government to account. CSOs deliver services. The provision of prevention, ECD, protection and support services is significantly enhanced by CSOs. In the post-apartheid era, the funding scenario is fundamentally altered; the withdrawal of international donors from funding basic service delivery and government's reluctance to fully fund these services has placed many CSO services in a precarious position. The funding provided by government to CSO's falls far short of the actual cost of providing quality services and is less than the government's allocations to its own versions of those same services,[15] resulting in CSOs having to cut back on their services.

21. CSOs took a case to the Free State High Court arguing that government's subsidy for CSO service providers is unfair and unreasonable. The Court ruled in their favour and ordered government to revise its policy. After several iterations, the Court finally ruled that the government had brought its funding policy in line with the Constitution.[16] In 2013 the FFC tabled a report in Parliament about the funding crisis in services for children, Parliament has not yet engaged with it.[17]

2.6 Inadequate data collection, monitoring and evaluation systems

22. Comparatively speaking, GOSA has significant data on children. However much of the data needed to fully understand the realities facing children are not available, partly because of lack of disaggregation, and because systems for regular effective data collection are weak. Thus the data do not serve effective planning, budgeting, monitoring or evaluation. Despite the legislation, national plans of action and strategies that mandate monitoring and evaluation, it is frequently impossible. Evidence of the failures of data collection on services to children is addressed throughout this Report.

2.7 A culture of violence

23. South Africa has high levels of interpersonal, community and sexual violence, we believe that the 'normalisation' of violence against children (VAC) is a matter of extreme concern. Marginalised

children (e.g. children with disabilities and children in rural areas) are even more vulnerable to violence.[18] The relatively solid legal frameworks to address child protection and the criminal justice have not contributed to prevention or increased protections to children, and require urgent budget and programmatic interventions.

2.8 Marginalisation, discrimination and intersectionality

24. Social inequality is embedded; while the situation improves for some children, for others it worsens. Children who are particularly excluded, marginalised or discriminated against include: black children; children living in poverty; working class children; children with disabilities; migrant children; rural children; orphaned children; children living and working on the street; children in conflict with the law; and lesbian, gay, bisexual, transgender and intersex (LGBTI) children. Intersections between these compound the discriminations against certain children. For example, a poor child with a disability, living in a rural area faces multiple layers of exclusion and discrimination and their experience is very different from a child discriminated against on the basis of disability, but living in a middle class or wealthy, urban, context.

25. Throughout the report, we refer to the manner in which these different groups are affected. However it is important to provide a dedicated overview in respect of two groups of children before integrating our analysis of the way in which they are affected throughout the report. These are children with disabilities and migrant and refugee children.

2.8.1 Children with disabilities

26. There is no single piece of legislation governing disability. Provisions for children with disabilities are scattered across a range of policies. The *Integrated National Disability Strategy* is intended to guide all sector-specific legislation (we note that a new policy on disability rights is currently being drafted to replace this); and the significant provisions for children with disabilities in the Children's Act are welcomed.[19] 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.[20] The 2009 DSD draft *Strategy for the Integration of 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, the Strategy lacks coherence and is ineffective in guiding the development of co-ordinated and comprehensive services for children with disabilities.[21]

27. The Disabled Children's Action Group, a national membership organisation of parents of children with disabilities, argues that in spite of this framework, access to the full range of services for the majority of children with disabilities is compromised. They note that inter-departmental collaboration and integration of services is seldom evident and that it is essential that GOSA prioritise this. They emphasise the serious lack of services and support for children with disabilities in rural areas; they add that policies do not take a family-centred approach and thus fail to provide effective support to parents to the ultimate benefit of the child.

28. The absence of information disaggregated for children with disabilities renders them invisible and masks the disproportionate extent to which they are excluded from services. This 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.

29. The lack of access to health, ECD, education and social security rights for children with disabilities as well as the levels of violence committed against them is a serious concern.

2.8.2. Migrant children

30. African migrant children who are displaced in their countries of origin due to persecution, generalised violence or abject poverty are unquestionably a marginalised and excluded group. Refugee and asylum-seeking children, whether unaccompanied or accompanied by their parents or caregivers experience serious hardships in South Africa, primarily as a result of the poor

implementation by the Department of Home Affairs (DHA) of the Refugees Act of 1998 and the lack of equal access to basic services.

31. Although the Refugees Act is progressive in theory, it fails to adequately protect children in practice. The asylum system is woefully under-capacitated, corruption is rife, and there are lengthy delays.[22] Without a guardian to assist them, unaccompanied children face difficulties in making asylum claims.

32. The High Court has recently ruled that that 'separated children' who entered the country with asylum-seeker relatives should be included as dependents, but the DHA has lodged an application to appeal.[23] Recently, DHA has closed refugee reception offices in cities like Johannesburg and Cape Town, with the intent of relocating reception facilities along the country's northern borders.[24]

33. Many unaccompanied migrant children in South Africa do not have an asylum claim but are economic migrants, and often children in need of care and protection. They are currently dealt with under the Children's Act, but do not receive adequate services. They remain undocumented, but are protected from deportation if they have an order from the children's court. Many languish in shelters until they turn 18 and then face deportation.

Recommendations

34. Greater political leadership and commitment to realise the rights of children with disabilities is essential. These children have diverse needs that require an integrated approach and collaboration between the departments of health, social development, transport, police, justice and basic education.

35. GOSA should develop a single piece of legislation to specify, coordinate and govern services for children with disabilities and developmental delays.

36. The extreme marginalisation and discrimination against children with disabilities means that services to these children must be prioritised by government departments who must provide dedicated reporting on these services.

37. Increased focus on prevention and early intervention programmes in both the health and social development sectors is critical, as is a family oriented approach to services for children with disabilities.

38. International social services need to be strengthened and cross border mechanisms enhanced in order to find durable solutions for unaccompanied migrant children.

3 GENERAL MEASURES OF IMPLEMENTATION

39. Our comments relating to political leadership, failure to implement the positive legislative framework, resourcing and budgets are addressed in section 2 above.

40. South Africa has yet to sign or ratify the third Optional Protocol to the UN Convention on the Rights of the Child on Communications Procedures (2011) and the Optional Protocol on the Rights of Persons with Disabilities. The CPR provides no indication of the plan regarding these Optional Protocols. Furthermore, South Africa has failed to sponsor recent UN resolutions on children's rights.[25]

41. South Africa finally ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), but has a reservation relating to the immediate realisation of access to education. This reservation supports the progressive realisation of the right to basic education which is in conflict with the Constitution. The unqualified nature of this right has been endorsed by the Constitutional Court in the case of Juma Musjid.

42. Our serious concern regarding South Africa's weak track record on periodic reporting to the UNCRC is expressed in paragraph 2 of section 1 of this report.

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

43. There is a broad range of legislation and policy in South Africa which is protective and promotive of the rights of children. However, better planning and budgeting is essential to increase the benefits of the legislation for all children in South Africa.

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

(See section 7.7 below for an examination of harmful practice of customary traditions).

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

45. Prior to the enactment of the Children's Act, some provinces had embarked on developing legislation aimed at regulating initiation schools and circumcision, providing a range of different standards and restrictions which differ across provinces, and from those provided for in the Children's Act. The better regulation of initiation schools is welcomed but the number of deaths and maiming annually as a result of initiation practices is alarming and requires a stronger response from national government.[26]

46. The practice of ***ukuthwala*** (abduction and forced marriage)[27] is relatively common, in the Eastern Cape, Mpumalanga and KwaZulu Natal. It is not expressly prohibited in law; and it is concerning that the Commission for the Promotion and Protection of the Rights of Cultural, Religious, and Linguistic Communities advocates for recognising the practice when carried out on 'consenting' adult women.[28]

Recommendations

47. Provincial legislation on initiation schools and circumcision must be aligned with the Children's Act.

48. The State must develop minimum norms and standards and a national plan of action to address illegal initiation schools and harmful initiation practices, including the successful prosecution of persons responsible for harmful and illegal initiation practices.

4 GENERAL PRINCIPLES

4.1 The best interests of the child

49. 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. In its examination of the case law, the CPR has not included the internationally acclaimed developments regarding the best interest principle that have come about as a result. This positive development warrants attention. Justice Sachs's 2008 judgement constitutes a watershed moment in constitutional litigation regarding children's rights,[29] and has set the standard for how children should be dealt with and their rights considered in all cases where children are concerned:[30]

50. These principles have impacted on cases in several other fields of law, including assets forfeiture,[31] child offenders,[32] removal of children from their parent or care-giver,[33] inter-country adoption,[34] education of children with disabilities,[35] and treatment of child victims and witnesses[36]. These challenges to government by civil society have significantly informed the development of a child-centred approach in every matter concerning a child.

4.2 Respect for the views of the child

51. **Participation rights** are included in a number of laws affecting children, providing a strong platform to promote participation and citizenship rights. Although GOSA has argued that the annual Children's Parliament affords children the opportunity of participating in matters which affect them. Barriers and challenges often prevent access to participation rights and gaps remain between provisions and implementation.

52. 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.[37] For an example of the disjuncture between legislation and practice, see annexure 5.

53. Regarding children's **participation in court matters** affecting them, the CPR only refers to preliminary inquiries—which fall under the Child Justice Act and involve only children in conflict with the law. Figures regarding the Children's Court decisions regarding care and protection matters, are not reflected. In addition, statistics where children are victims and witnesses in cases are not provided. Attention is drawn to the Concluding Recommendations from the ACERWC which require that a record be kept of all children involved in justice processes (especially victims and witnesses) to enable proper assessment of children's participation in matters that concern them.[38] In a case brought by the Centre for Child Law, the Supreme Court of Appeal has recently (2015) endorsed the importance of children's participation in cases about them, and expressly refers to South Africa' obligations under Article 12.[39]

Recommendations

54. The GOSA should be requested to report to the UN CROC on the issue of children's courts, child witnesses and victims and children in conflict with the law.

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

5 DEFINITION OF A CHILD

5.1 Concerns regarding the age for different capacities

5.1.1. Consent to medical treatment

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

57. Despite these consent provisions, there are no clear guidelines for health professionals to assess children's mental capacity; this is left to their discretion. The consent provisions must be explicitly integrated into pre- and in-service education of health professionals as well as professional codes of conduct so that health professionals are aware of their obligation to provide information in child-friendly formats and to actively involve children in health care decision-making.

58. 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 stipulate 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".

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

5.1.2. Age of sexual consent

60. The age of sexual consent is 16 years, determined by the Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007) [the Sexual Offences Act]. Sections 15 and 16 criminalise consensual sexual acts with adolescents below the age of 16. In addition they criminalised adolescents between the ages of 12 and 16 who commit sexual acts with each other. Stating that both children must be prosecuted if the NPA decided to charge them with rape or sexual assault, i.e. both children were treated as both victims and perpetrators.

61. The constitutionality of these provisions was challenged in the courts by CSOs and these sections were declared unconstitutional by the Constitutional Court in the matter of *Teddy Bear Clinic and RAPCAN v The Minister of Justice and Constitutional Development and another* in 2014.[40] The Court found that the criminalisation of adolescent sexual experimentation violated children's constitutional rights to dignity, privacy and to have their best interests considered paramount. The court ordered parliament to redraft the provisions. The amended sections of the Sexual Offences Act that decriminalise consensual sexual activities between adolescents became law on 3 July 2015. We welcome this development.

5.1.3. Minimum age of marriage

62. 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. Section 12(2) of the Children's Act prohibits the marriage or engagement of any child below the minimum age set by law, i.e. 12 for girls and 14 for boys.

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

64. The Civil Union Act (No. 17 of 2006) does not allow children to enter into civil unions at all. Thus children are allowed to enter into civil and customary marriages but are prevented from entering into same sex marriages in terms of the Civil Union Act. It is therefore not true to claim that "children under the age of 18 may marry" without qualifying that this excludes civil unions and thus LGBTI children. These inconsistencies in the marriage laws violate various constitutional provisions including the right to equality.[41]

5.2 Age of criminal capacity

65. The Child Justice Act sets the minimum age of criminal capacity at 10, with a *doli incapax* presumption from 10 – 14 years. This falls short of CROC General Comment 10. As government concedes, it also does not address concluding observation 17. The Child Justice Act requires government to review the minimum age of criminal capacity by April 2015, but this has not occurred. The Department of Justice has consulted with civil society and indicated that government is considering raising the minimum age to 12. Civil society is concerned that, on its own, this may reduce protection for 12 and 13 year olds (currently *doli incapax*) and also that it may affect the minimum age of imprisonment, which is currently 14 years.

5.3 Ages impacting on customary law

66. This Children's Act sets the age for consent to virginity testing and circumcision at 16. Harmful cultural and traditional practices are discussed further in section 3.2 above and 7.7 below.

Recommendations

67. GOSA must ensure that all policies relating to children's right to consent to medical treatment and access to sexual and reproductive health rights services are aligned with the Children's Act which sets the age of consent at 12.

68. GOSA must remove any discrimination between boys and girls and set a uniform age of marriage. The State must consider raising the minimum age of marriage to 18, irrespective of parental consent, to bring it in line with international standards.

69. GOSA must recommend raising the age of criminal capacity to Parliament as soon as possible, that it be raised to 14 years, and that the *doli incapax* presumption must be removed; failing this, the rights 12- and 13-year-olds currently enjoy must not be eroded.

6 CIVIL RIGHTS AND FREEDOMS

6.1 Name, nationality, identity and registration at birth

70. Birth certificates and identity documents are critical the South African context as denial of these essential documents can result in a denial of a range of other rights, such as education, social grants and health care. The UN CROC has made clear that children should not be denied access to services on the grounds of the absence of a birth certificate.[42] However this occurs in practice in South Africa and results in the exclusion of marginalised children from a range of services including social grants, social insurance, health care, education, protection and alternative care.[43]

71. It is not possible to accurately determine how many children in South Africa are born each year versus how many are registered. Two self-reporting surveys reveal a significant number of unregistered births. Analysis of the 2008 National Income Dynamics Study revealed that 11% of children in South Africa under 3 did not have a birth certificate.[44] Analysis of the 2011 General Household Survey produced similar results.[45]

72. South Africa has made progress in improving children's access to birth certificates and their parents' access to identity documents, mainly in ensuring increasingly good rates of birth registration within 1 year of the child's birth. However 50% of children are only registered after the prescribed period of 30 days—with the percentage being higher in the more rural provinces. For example, in Mpumalanga, only 37% of registrations occurred within 30 days.[46] Despite this, in March 2014, South Africa put into effect an Amendment to the Births and Deaths Registration Act (No. 18 of 2010) that makes birth registrations after 30 days more difficult to access by imposing additional requirements (in the form of an affidavit) and the payment of a prescribed fee.[47] Children who experience higher levels of social exclusion will be further disadvantaged by these stricter requirements, particularly children in rural areas, and orphaned and abandoned children.

73. Over 4 million children in South Africa are living with extended family members rather than their biological parents. The vast majority (3 million) have living parents who are residing elsewhere. However, according to the 2014 Amendment Act, a relative can only register a child if both parents are deceased.[48] Again orphaned and abandoned children are most likely to be discriminated against due to difficulties for relatives to register births.

6.1.1. Orphaned and abandoned children

74. Orphaned and abandoned children and other categories of children in need of care and protection must go through a Children's Court inquiry before they can be placed in alternative care. To finalise the process, the child's birth certificate is needed. However it is challenging to register the birth of a child without his or her parents' identity documents, this delays finalising the protection and care decisions, which delays permanency planning for the child's care. Furthermore, the courts are requesting unabridged copies of birth certificates, resulting in long processing delays at DHA (often beyond 6 months) and consequently longer delays in the finalisation of alternative care placements for children, an unacceptable violation of their rights.

6.1.2. Children living in rural areas

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

6.1.3. Foreign migrant children

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

77. However children born to undocumented migrant women are at serious risk of becoming stateless. In addition, when unaccompanied foreign children (without asylum claims and who cannot be reunited with family or returned to their country of origin) who lack identification documents, reach the age of majority and must exit the South African child protection system, they risk remaining undocumented. Without the ability to prove or access a nationality, they will be unable to access basic rights such as education, health care, employment, equality, liberty and security of the person.

78. The 2014 Births and Deaths Registration Amendment Act and its regulations introduce a new requirement that a foreign parent wishing to obtain a birth certificate for their child must provide proof of legal residence in South Africa and a copy of their passport. This has been strongly criticised by Lawyers for Human Rights (LHR). There are many migrants in South Africa without proof of legal residence. There are also many refugees without passports who will be unable to obtain them from their country of origin. The result of the imposition of this requirement will be that many children born in South Africa to migrant parents will be unregistered and are likely to grow up stateless, be denied access to a range of socio-economic services and denied their internationally and constitutionally protected rights.

Recommendations

79. The state must not implement the stricter requirements of proof and fees for birth registration from 30 days to 1 year.

80. The cost of obtaining birth certificates and copies for purposes of Children's Court inquiries (child protection cases) should be waived by the DHA.

81. All applications for birth certificates and copies required for Children's Court processes should be processed within a period of 30 days by DHA.

82. The new requirement in law that foreigners can only get a birth certificate for their child born in South Africa if they have a passport and proof of legal residence, should be repealed. Birth registration should not be conflated with enforcing immigration laws.

83. Government should reconsider its position and sign the Statelessness Convention as it has previously pledged in order to develop a legal framework and mechanisms to assess, prevent and reduce statelessness.

7 VIOLENCE AGAINST CHILDREN

7.1. The South African Child Protection System

84. The GOSA has invested in a strong legal framework to give effect to the constitutional provisions for the protection of children from maltreatment and the right to be free from violence. However the need child protection and criminal justice services far outweigh the state's capacity to respond timeously.[49] The Sexual Offences Act makes provision for special protective mechanisms in court for child victims and witnesses; however most courts are not child-friendly and therapeutic support is seldom available, disadvantaging court outcomes.[50]

7.2 Sexual violence

85. The country has extremely high levels of **rape and sexual assault**. The 2015 Optimus national prevalence study established that 20% of children report an experience of sexual abuse before the age of 18.[51] This is supported by South African Police Services (SAPS) data, which reported 53,617 sexual offences between April 2014 and March 2015, in excess of 147 a day. Approximately 40% of these reports involve child victims; these figures are most likely an

underestimate as only one in nine cases are reported to the police.[52] **Rape homicide**, the most extreme form of sexual violence is of concern; it was reported in 102 child murders in 2009, mostly girls. Children with disabilities are at increased risk of sexual abuse and neglect in Gauteng and it is likely to be similar in all parts of the country.[53]

86. The improved legal framework has not translated to increased access to justice or convictions. A conviction rate study in 2000 found a conviction rate of 7%,[54] compared with analysis of more recent data provided by the SAPS and the National Prosecuting Authority reveals that the conviction rate in 2013 was unchanged at 7%.[55]

87. The failure to release disaggregated statistics on crimes against children in the 2014/2015 crime statistics is unacceptable.

7.3 Physical violence

88. While reported rates of domestic violence are high, high underreporting makes it difficult to estimate incidence and prevalence. The World Health Organisation (WHO) estimated in 2012 that around sixty thousand women and children in South Africa were victims of domestic violence every month—the highest rate in the world.[56] Children exposed to domestic violence learn that violence is normative and violence increases the risk for boys to become perpetrators of violence as they grow older.[57]

89. In 2011/2012 (the most recent figures available), SAPS reported that over 23,000 children were **physically assaulted** with almost half of them suffering grievous bodily harm.[58] In the same period, nearly 800 children were **murdered** in South Africa. Nearly half (44%) of children murdered are killed in the context of fatal child abuse; children under the age of five most likely to be killed at home.[59]

7.4 Corporal punishment in the home

90. The 2007 Children's Act failed to prohibit **parental corporal punishment**. A 2005 study found that 57% of parents smacked or beat their children, with 33% reporting that they used sticks or implements.[60] Service providers report that the majority of serious physical abuse cases that come to their attention relate to 'discipline gone wrong' or 'getting out of hand'.[61]

91. A further amendment to the Children's Act, containing a prohibition on parental corporal punishment, is scheduled for the first half of 2016. A recent Human Rights Commission (HRC) Report regarding a complaint against a local charismatic Christian Church[62] has recommended that within 12 months of the date of the report "Cabinet resolve to direct DSD to initiate amendments to the Children's Act, or initiate such other legislation as may be necessary in order to:

a. Give effect to the statutory prohibition of corporal punishment in the private sphere;
b. Provide child-friendly mechanisms and procedures to enable children to access justice;
c. Provide for appropriate remedies; and
d. Provide for appropriate penalties to be meted out to offenders."[63]

7.5. Neglect and emotional violence

92. Emotional violence and neglect are of great concern, especially relating to children not living with their biological parents.

93. Childline South Africa received 4,091 reports of **emotional violence** between 1st April 2014 to 31st March 2015; the Optimus Study on Child Abuse,[64] found that 16.1% of young people (aged 15-17 years) reported experiencing emotional violence, with girls reporting higher rates than boys. Childline SA received 1,104 reports of **neglect** for the 2014/2015 period; the Optimus Study found that one fifth of respondents reported experiencing neglect, with girls again reporting higher rates than boys.

94. Other forms of violence against *young people* measured in the Optimus Study included: 23.1% reported exposure to **family violence**; 19.7% reported persistent **bullying**; 19.2% had been **attacked without a weapon**; and 15.9% had been **attacked with a weapon**.

7.6 Child protection

95. The child protection system is in crisis; service providers report that large numbers of children referred for formal child protection services such as risk assessment and removal, don't receive support or intervention from child protection services. This is one outcome of foster care cases clogging the child protection system (see also section 10).

100. There are very few specialised services to support children's recovery from abuse and neglect, where available, services are inadequate and under-resourced. A study exploring psychosocial adjustment post sexual assault revealed that children face numerous barriers to access services and overall levels of psychological distress remain high among child victims.[65]

7.7. Harmful cultural and traditional practices

101. Deaths and mutilations due to **botched circumcisions** devastate the lives of boys and their families. Despite the Application of Health Standards in Traditional Circumcision Act of 2001, 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.[66] A 2014 report revealed that despite the high number of deaths and injuries, only 11 people had been convicted.[67] The SAPS indicate that they do not keep case-specific crime conviction data so they are not able to confirm this number of people convicted.[68]

102. **Virginity testing** is mainly supported in Eastern Cape and KwaZulu-Natal Provinces. Children identified as non-virgins are exposed to physical and emotional danger. Anecdotal evidence suggests that girls under the age of 16 are subjected to virginity testing in contravention of the Children's Act. Additionally, children who have been sexually abused and identified as non-virgins face increased risks. Some traditional leaders have openly stated their opposition to the provisions on virginity testing.[69] Recently a man who owns an initiation school for girls was convicted of rape and assault and sentenced to 17 life imprisonments.[70] Although these cases are rare, the sentence should serve as a deterrent to those who conduct violent acts against girls under the guise of cultural practices.

103. ***Ukuthwala*** (forced marriage) is predominantly reported in the Eastern Cape, Mpumalanga and KwaZulu-Natal. The exact numbers of girls affected is unknown. The practice compels girls and young women into marriage against their will, with anecdotal reports of sexual assault perpetrated as part of the kidnapping. In S v Jezile the Western Cape High Court dismissed the accused's defence of ukuthwala as a customary practice against charges of rape, abduction and assault where the victim was a 14 year old girl.[71] The South African Law Reform Commission has produced a Discussion Paper with recommendations on addressing ukuthwala.[72]

7.8 Trafficking

104. The extent of trafficking in children in South Africa is unknown. This is due to the lack of research, coordination, reporting, monitoring and an effective national data collection and analysis system. Often cases go undetected as they are not identified and recorded by police.

105. A recent media monitoring report, indicates that at least 93 people were trafficked into and within South Africa from January to December 2014, of which 17 (17.3%) were children.[73]

106. Most cases involved the trafficking of children for sexual exploitation.[74] Cases involving labour exploitation through domestic work and farm labour, as well as forced marriages or sex slavery, body parts and using the 'excuse' of the practice of 'ukuthwala' were also reported.[75]

Recommendations

Violence prevention

107. GOSA has a duty to prioritise and resource programmes to prevent violence.

108. GOSA has to commit in law and through resourcing, to an increase in protection and therapeutic services for children.

109. Specialised policing and court services for child victims must be adequately resourced and implemented as a matter of urgency.

110. There is duty to bring the South Africa law in line with the international obligations to prohibit corporal punishment.

111. Large scale programmes to support positive non-violent parenting are required.

Harmful cultural and traditional practices

112. The GOSA must take steps to ensure that initiation schools comply with the Children's Act. Furthermore, health and safety initiatives to eradicate incidences of deaths and injuries are a priority.

113. Prosecution of those who are responsible for deaths and injuries of initiates must be prioritised and statistics in relation to these prosecutions must be disaggregated.

114. The State Party must ensure that virginity testing is practiced in accordance with the Children's Act age of consent at 16 years and does not allow for marking girls as virgins.

115. The GOSA must implement the South African Law Reform Commission recommendations:[76] define "forced marriage", "child marriage", and "ukuthwala", criminalise all persons involved in forcing a person into marriage; include an aggravated offence in relation to a person under the age of 18 years and undertake education, and awareness-raising among professionals, urban and rural communities and with traditional leaders to address the root causes and consequences of ukuthwala.

Trafficking

116. GOSA must commit to programmes to increase awareness, education and training for all service providers, particularly front-line SAPS personnel who must be trained to identify and manage trafficking.

8 CHILDREN IN CONFLICT WITH THE LAW AND CHILD JUSTICE

117. The 2010 Child Justice Act is strongly welcomed as a significant improvement, however, a lack of reliable statistical information about the system is a serious concern.[77] Government's reports on children in the child justice system (CJS) show that the number of children coming into the system had dropped significantly since the commencement of the Act. The reasons for this are unclear.[78] Although fewer children in the CJS appears to be positive, there is concern that children are not receiving services.

118. The CPR appears to confuse diversion and sentencing, the law is clear that diversion can occur prior to trial, at the trial or before sentencing, although it is predicated upon 'an acknowledgment of responsibility'. Diversion by placing children in child and youth care centres is intended only for the most serious of cases. There is concern that this option is being over-utilised, possibly due to the lack of community diversion options and treatment, linked to insufficient funding for these programmes.

119. The number of **children sentenced to imprisonment** has been remarkably reduced. However, it is unclear whether this is linked to a rise in the number of children held in secure care facilities. This information is not in the public domain. A positive feature is that almost all sentences of children in magistrates' court are automatically reviewed by the High Court, providing an important monitoring mechanism.

120. Concerns regarding the automatic placement of convicted child sex offenders on the Sexual Offenders Register – in some cases for life have been addressed through a recent Constitutional Court ruling that this is unconstitutional. Parliament has amended the law to reflect this. However the amended law does not require the state to proactively remove the names of children who were automatically placed on the register between 2007 and 2015.

Recommendations

121. Improved data and publication of statistics regarding secure care placements.

122. Diversion programme availability must be enhanced.

9 FAMILY ENVIRONMENT AND ALTERNATIVE CARE

9.1 Family environment

123. The CPR has not acknowledged that the family is difficult to define and, in the South African context, and must not be assumed to be nuclear. Over 4.2 million children (23%) do not live with their biological parents but are in the care of extended family members (kin).[79] This is an established feature of childhoods in South Africa, related to factors including historic population controls, labour migration, poverty, housing and educational opportunities, low marriage rates and cultural practice. While it is common for relatives to play a substantial role in child-rearing, kinship care is not formally recognised or adequately supported.

124. Children living in households without adults require particular support. The CPR notes that the proportion **child-only households** is small and is not increasing (see Annexure 6).[80]

125. The CPR states that the Social Assistance Act (No. 13 of 2004) makes provision for Child Headed Households (CHH) by allowing for children of 16 years and older to access social grants on behalf of themselves and their younger siblings. However in reality children heading households cannot access a grant for themselves and their siblings at the same time, because the SOCPEN[81] system will not allow the child to be both a primary caregiver and a child beneficiary. Children younger than 16 who head households are not able to obtain grants for themselves or their younger siblings. (see section 10).

126. There is a dearth of support programmes available to parents and care-givers, those that exist are provided by CSOs rather than the government. The lack of support to adolescent parents is of particular concern. Parenting programmes alone cannot address underlying problems such as poverty and structural unemployment.

127. The number of **children living and working on the streets** is unknown, but this is considered to be a significant problem. This highlights the need for family support, prevention and early intervention programmes.

Recommendations

128. Parenting programmes must be made available and, if provided by CSOs, be fully funded by government.

129. The care giving role of extended family (kin) should be legally recognised and adequately supported.

130. Law and practice must be reformed to enable social assistance to children heading households for themselves and the siblings they are caring for.

131. Prevention and early intervention programmes must be broadly budgeted for and rolled out, they should be developed in unison with responses addressing external stressors, such as inequality, poverty and structural unemployment.

9.2 Family reunification and alternative care

9.2.1. Alternative care

132. Data needed to inform policy and increase family reunification and placement in permanent families through kinship care, foster care and adoption are not available. These gaps in information about children's living arrangements would be addressed by the following information on an annual basis:

a) The number of children removed from their families due to neglect or abuse for the first time in a given year in relation to the most recent census figures for the same year;
b) The cumulative number of children living in CYCC's;
c) The cumulative number of children in foster care;
d) The number of children placed in foster care for the first time;

e) The cumulative number of children in corrective facilities;
f) The cumulative number of children in foster group homes;
g) The cumulative number of children in adoptive homes;
h) The number of local and international adoptions; and
i) The cumulative number of children living permanently with relatives (kinship care).

133. The range of alternative care options in the Children's Act includes '**cluster foster care**'. However, the Act and the Regulations define how these should operate nor establish norms and standards; as a result there are concerns that such schemes will operate as unregistered CYCCs without having to meet the norms and standards required for CYCCs.[82] Whilst the Children's Act and its Regulations state that children must be placed in the programme "best suited" to their specific needs, and that all children in formal care should have care plans and independent development plans (IDPs), only 59% of the children in CYCCs had IDPs, and only 47% had both.[83]

134. Undocumented migrant children are often excluded from accessing alternative care due to their immigration status. Refugees are often excluded as foster parents and should be able to foster unaccompanied or separated children if this is in the best interest of the child.

9.2.2. Family reunification and review of placement in CYCCs

135. The Children's Act requires that a child be placed in alternative care for as short a period as possible and that effort is made for the reunification of the child and parent or caregiver. CSOs expressed concern that designated social workers do not have sufficient time to provide family re-integration services, due to high case-loads. As a result, children remain in CYCCs for long periods.

136. Placement in alternative care is done via a Children's Court for a maximum period of two years, where after it must be reviewed. However, in 2012, 56% of children in unregistered centres, and 16% of children in registered centres did not have a court order placing them in care.[84] In 2010, 43% of children in registered CYCCs had court orders or extensions that were dated 2008 or earlier i.e. over the two-year maximum, and 9% had a date of 2003 or earlier, meaning that those children's placement had not been reviewed in over seven years.[85]

137. The foster care system is in crisis because applications for foster care placements have increased dramatically. Overburdening of social workers with high numbers of applications for foster care placements by extended family caring for orphans results in failures to give effect to the legal requirements for reunification and review of placement in CYCCs. This **crisis in the foster care system** is discussed more fully in section 10.2 below. We note it here due to the impact of the sheer volume of these applications on other critical social welfare services. Addressing the crisis in the foster care system would thus impact on capacity to render reunification services and ensure that children do not remain in alternative care longer than necessary.

138. In respect of migrant children, cross-border family tracing and reunification mechanisms are weak or non-existent. These need to be strengthened to prevent migrant children from losing links to their countries of origin and spending lengthy periods in care.

9.3. Adoption

139. There is uncertainty regarding the **Register for Adoptable Children and Adoptive Parents** (RACAP) procedures. The purpose of the register is to facilitate matching available adoptable children with prospective adoptive parents.[86] It is not clear whether every adoptable child and adoptive parent must be placed on RACAP or only if they cannot be matched. Whether placement on RACAP is mandatory is significant as the time periods prescribed for children placed on RACAP may significantly delay the conclusion of an adoption.[87] Only South African citizens or permanent residents may be placed on RACAP as prospective adoptive parents.[88] This prevents foreign citizens who are working in South Africa on valid permits from adopting children.

140. The statistics provided in Table 26 of the CPR are outdated and do not reflect the sudden decrease in adoptions that occurred in 2010 when the Children's Act came into operation. This drop in adoptions between 2010 and 2012 and the low adoption rates in subsequent years (see Annexure 7.) are concerning given the high number of orphans (approximately 3.36 million in 2013).[89] The

DSD data fail to specify what category of adoption has been registered. CSOs are concerned that DSD's difficult bureaucratic requirements for adoption have led to the substantial decrease in the number of adoptions.[90] Administrative delays on the part of DSD result in some children waiting up to six months in alternative care before being placed in a family environment, raising concerns around early attachment.

141. The CPR notes that customary law adoptions are public events that confer parental responsibilities and rights within a specific culture. While these adoptions are considered informal and not regulated by the Children's Act or any other law, the South African courts have recognised these forms of adoptions to the benefit and protection of the adopted child.[91]

9.4 Maintenance

142. Despite a strong legal framework for maintenance, the system is plagued by implementation challenges. Evidence shows that custodian parents struggle to access maintenance due to inefficiencies in the system, lack of adequate resources and capacity.[92]

143. The greatest challenge is human capacity and despite the stipulations in the Maintenance Act (No. 99 of 1998), appointments of maintenance officers or maintenance investigators are insufficient[93] resulting in too few maintenance court officials.[94] In cases where there have been appointments, it appears that some courts do not have legally qualified maintenance officers and investigators.

144. Linked to capacity is the issue of access. Some areas do not have dedicated maintenance courts and general or criminal courts are used for maintenance matters.[95]

145. In 2002 the Constitutional Court pointed out that some of the legislative remedies of the maintenance court were ineffective to protect the rights and the best interests of children.[96] For example, some employers do not cooperate with emolument attachment orders and this frustrates the purposes of having such remedies.

146. The commonest remedy is laying criminal charges against the defaulter. However, the criminal justice system is slow and the matter takes many months to finalise. The Maintenance Amendment Act, which was signed by the President in September 2015, will be unable to solve these problems because it does not address implementation challenges.

Recommendations

147. Data collection should be improved to inform policy and increase family reunification and placement in permanent families through kinship care, foster care and adoption

148. Government and service providers must improve reunification services to ensure that children do not remain in alternative care longer than necessary.

149. Innovative alternative care options including 'cluster foster care' must be operationalised through the establishment of regulations or norms and standards.

150. The DSD policy regarding the Register for Adoptable Children and Prospective Adoptive parents should be clarified in law.

151. Bureaucratic processes that delay adoptions must be streamlined.

152. Maintenance courts must be established and equipped with necessary court officials, particularly appropriately trained maintenance officers and investigators.

10 SOCIAL SECURITY

10.1. Child Support Grant (CSG)

153. The CPR provides a clear overview of the origins, expansion and impacts of the Child Support Grant (CSG). Para 256 cites the DSD-commissioned evaluation of the CSG, which together with independent studies, shows a compelling array of positive outcomes associated with the CSG. We share GOSA's concern regarding low take-up of the CSG for infants aged 0-1. One reason for this is

lack of access to documents (birth certificates and parents' identity documents). Lack of documentation also prevents older children (including orphaned children and refugees) accessing the CSGs.[97] Government's interventions to overcome access barriers have not been successful.[98] Furthermore, the South African Social Security Agency (SASSA) is not making adequate use of regulation 11(1) of the Social Assistance Act which allows for alternative documents to prove identity when formal birth certificates or IDs are non-existent, pending or lost.[99]

154. Another concern regarding the CSG is its low value (in 2015 the value is R330 per month, less than $25). Given that there is no social assistance for unemployed adults between 19 and 59 years, many families' only income is the small CSG.

10.2. Orphans in South Africa, foster care and the Foster Care Grant

155. Government has taken a policy decision to use the ***Foster Care Grant*** (FCG) for orphans in the care of extended family members. Given South Africa's uniquely large number of orphans, using the child protection system to administer FCG applications has detrimental effects. The FCG is failing to reach over two thirds of orphans in need. There are approximately 1.4 million orphans in the care of relatives who qualify for the FCG.[100] However fewer than 500 000 are receiving it. Evidence shows that it will take another 20 years or more to reach the 1 million orphans not yet reached. By then most of these children would have grown up without an adequate social grant. The significant decrease in FCGs payment over the past three years is concerning and shows that DSD is not making progress in reaching the other 1 million orphans:

a) 31 March 2010 = 510,760 FCGs in payment (increase of 36,001 FCGs)
b) 31 March 2011 = 512,874 FCGs in payment (increase of 2114 FCGs)
c) 31 March 2012 = 536,747 FCGs in payment (increase of 23,873 FCGs)
d) 31 March 2013 = 532,159 FCGs in payment (decrease of 4,588 FCGs)
e) 31 March 2014 = 512,055 FCGs in payment (decrease of 20,104 FCGs)
f) 31 March 2015 = 499,774 FCGs in payment (decrease of 12,281 FCGs)
(source: SASSA's SOCPEN database)

156. Using the child protection system for the administration of a grant to orphans is also problematic for abused and neglected children. Their well-being and, at times, survival depends on the availability of state protection services; yet the system is overwhelmed by foster care applications. In the current system, ongoing support to placements is minimal. This links to issues already raised in Section 7.

157. When the first warning signs of increasing deaths of parents due to HIV and increasing numbers of orphans became apparent in 1996, CSOs began calling for an accessible kinship care and grant system that could provide family members caring for orphans with an easily accessed adequate social grant, support to obtain guardianship, and good quality support services, without the family having to go through time consuming and intensive social work or court process. This would ensure the majority of orphans would be reached with a grant and services, and free up social worker and court time to focus on quality child protection services.

158. DSD removed the South African Law Commission (SALC) recommendation to introduce kinship care grants from the draft Children's Bill before it was tabled in Parliament. In 2007, after public submissions on the Bill highlighted the crisis in the foster care system and called for recognition of kinship care as distinct from foster care, Parliament instructed DSD to review the foster care system and propose a solution.[101] To date the Department has not complied with Parliament's instruction.

159. In 2011, DSD was taken to court by civil society because approximately 120,000 FCGs had stopped being paid to children[102] due to the high numbers preventing the system from keeping up with extending foster care court orders. DSD agreed in a court ordered settlement to re-instate the lapsed grants. The court order placed a temporary moratorium on further lapsing of grants and ordered DSD to design a comprehensive legal solution by December 2014. However in December 2014 an urgent application was made for an extension of the court order because a comprehensive solution was still not in place, and a further 300,000 FCGs were about to lapse. The court granted

the extension and DSD is now under obligation to design a comprehensive legal solution by December 2017. To meet this deadline, both the Social Assistance Act and Children's Act would need to be amended by Parliament by mid-2017.

160. To date bills to amend the Social Assistance Act and the Children's Act in this regard have not been published for public comment. While the DSD continues to delay putting an effective solution in place, over a million orphans live in poverty, hundreds of thousands of abused and neglected children receive inadequate child protection services and children who could be reunited with their families languish in alternative care.

10.3. Care Dependency Grant

161. The CPR fails to mention that despite the consistent increase in access to the Care Dependency Grant (CDG) for disabled children, substantial numbers of eligible children are not receiving the CDG. The problem is caused by inconsistencies between the Social Assistance Act and its regulations as well as the implementation of the law.[103] One 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, DSD has not yet developed a form to guide assessment based on the new criteria.[104] 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.[105] 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.[106]

10.4. Contributory social insurance

162. The CPR neglects to point out that South Africa has one of the highest unemployment rates in the world, with formal unemployment around 25% and a 'real' unemployment rate (including discouraged work-seekers) well in the 30%s.[107] Unemployment rates are high in marginalised areas, which is where children (and orphans) are over-represented. **Contributory social insurance**, mainly in the form of the Unemployment Insurance Fund (UIF), can benefit children by reducing the financial shock of job-loss among adults in the household. It is highly relevant in a context of labour market instability brought about by recession, and in the context of HIV and high adult morbidity and mortality. There is no social security for the vast population of unemployed adults.

163. While UIF, pension and provident schemes provide *some* income security for *some* children, a large proportion of the child population is unlikely to derive benefits because they reside in households where no adults are employed (in 2012, over a third of children lived in "unemployed households"). The CPR incorrectly states that unemployment insurance and workers' compensation schemes provide a death benefit to the children of the member as beneficiaries are nominated by the member. The challenges of accessing death benefits are compounded by the fact that many South Africans die intestate.

10.5. Deductions from grant beneficiaries bank accounts

164. The Black Sash, through it's Hands off our Grants (HOOG) Campaign, identified that the service provider appointed by SASSA has structured the system in a way that facilitates the access of secondary financial services to the bank accounts of social security beneficiaries.[108] These are making deductions from beneficiaries' accounts that often unlawful and sometimes fraudulent, this is considered immoral. The HOOG resulted in the establishment of a Ministerial Task Team, the Minister of Social Development has accepted the Task Team finding and taken steps to address the practice.[109]

Recommendations

165. The value of the CSG should be increased above the basic inflation rate to increase its already positive benefits.

166. SASSA should use regulation 11(a) of the Social Assistance Act to its maximum potential to enable children without birth certificates or lost birth certificates, to access grants.

167. DSD should design and implement a comprehensive legal solution to the foster care crisis by December 2017 as required by the High Court order. Such solution should (a) adequately recognise and support kinship carers looking after orphaned children and (b) free up the scarce resources of social workers and courts to provide quality protection services to children who have been abused and neglected.

168. DSD must review the inconsistencies between the Social Assistance Act and its regulations regarding the CDG.

169. DSD should develop an appropriate form for assessing children's eligibility for the CDG.

170. The implementation of the recently introduced system to stop illegal deductions from beneficiaries' accounts must be accellarated and better communicated to the public.

11 BASIC HEALTH AND WELFARE AND DISABILITY

11.1 The right to life, survival and development

171. The right to life, survival and development for children in South Africa is entrenched in some good legislation, but is constantly undermined by the many challenges outlined in this report. Estimates of **child mortality** varied widely over the reporting period, growing consensus is that under-five mortality rose from the early 1990s to an estimated peak of 70 — 80 deaths per 1,000 births in 2003 — 2005, driven primarily by the HIV pandemic.[110] Remarkable gains followed between 2006 and 2011, but mortality rates stagnated in 2012-13. The decrease is likely attributable to the reduction in new HIV infections through improved prevention of mother-to-child transmission (PMTCT), increased antiretroviral therapy (ART) access, the introduction of pneumococcal and rotavirus vaccines (reducing pneumonia and diarrhoeal deaths respectively) and improved access to water and sanitation. The reduction in HIV-related and diarrhoeal deaths appears to be key.[111] There is less evidence of reduction in pneumonia deaths.[112] Despite these gains South Africa failed to reach the MDG4 target and the latest (2013) under-five, infant and neonatal mortality rates are 41, 29 and 11 deaths per 1000 livebirths respectively.[113]

172. Despite modest decreases in diarrhoea and pneumonia case fatality, and reduction in severe acute malnutrition fatality, in-hospital case fatality rates for children under 5 in public hospitals between 2011 and 2014 have not decreased.[114] Infant case fatality is particularly problematic. This situation reflects failure to improve quality of care overall, and probably reflects significant numbers of HIV-infected children who are not on ART and arrive seriously ill at hospital.

173. The 2010 burden of disease report identified HIV/AIDS (27.8%) as the leading cause of **under-five mortality** followed by diarrhoeal diseases (18.4%), lower respiratory infections (10.8%) preterm birth complications (10.6%) and birth asphyxia (5.2%); injury deaths account for a rising share (4.5%) of young deaths.[115] **Violence** is a concern with a child homicide rate of 5.5/100 000 - more than double the global rate.[116] Nearly half these homicides were associated with child abuse and neglect of predominantly children under five. Many are likely to be misclassified as natural deaths in the absence of a post mortem exam.[117]

174. The **Child Healthcare Problem Identification Programme (ChildPIP)**[118] and the **Perinatal Problem Identification Programme (PPIP)**[119] audit child deaths at 42% and 75% of public hospitals respectively, they are a powerful mechanism to identify modifiable factors and improve quality of care at hospital, clinic and community levels. These should be mandatory and extended to all facilities to address avoidable causes of child and neonatal deaths. Ideally these should be complemented by child death reviews which are effective in investigating the circumstances surrounding out-of-facility deaths and improving intersectoral collaboration across health, social development and the criminal justice system.[120]

175. **Most child deaths are preventable**. Factors at home include inadequate nutrition, failure to recognise the severity of illness and delays in seeking care. Failures at primary level include failure to adhere to the Integrated Management of Childhood Illness (IMCI) guidelines and failure to identify and respond to growth faltering.[121] More than half (55%) of deaths occur outside the health

sector.[122] Data suggests most children have sought care during their last illness but are **discouraged from returning** by poor quality of care and poor communication – especially from doctors.[123]

176. Neonatal **mortality rates** (NMR) have shown a slow but steady decline from 2009/10 to 2012/13 (14.6 to 12.3 per 1,000 live births respectively).[124] This is attributable to interventions targeting better quality of neonatal care. Analysis of avoidable factors in the PPIP[125] indicates that it is vital to improve training in antenatal and labour management, neonatal resuscitation, kangaroo mother care, and breastfeeding support. Improvement of quality of care at district hospitals and access to early antenatal care (ANC) are essential.

177. The National Perinatal Mortality and Morbidity Committee (NaPeMMCo) recommends focus on the three major causes of neonatal deaths: prematurity, asphyxia and infections. The 3 targeted interventions: Helping Babies Breathe, Management of the Small and Sick and Continuous Positive Airway Pressure at district hospitals, require DH to ensure that 80% coverage target must be reached to reduce the neonatal mortality.

178. Maternal **mortality** increased significantly over the past two decades, driven primarily by HIV, however it has recently started to decline, dropping from 176.2 deaths per 100,000 live births in 2008 — 2010 to 154.7 in 2011-13.[126] This is associated with a 25% reduction in deaths due to non-pregnancy related infections including HIV. Other causes of maternal mortality include hypertension and haemorrhage associated with caesarean section. These deaths reflect serious problems with the functioning of the health system and the competencies of health providers; the abuse of patients in maternity settings remains cause for concern.[127]

179. The National Committee for Confidential Enquiry into Maternal Deaths recommended focus on priority districts and problem areas including HIV, hypertension and haemorrhage.[128] Systems improvements introduced in the Free State including emergency obstetric skill training, onsite ambulances for emergency obstetric transport have proved effective. Many of the recommended strategies for improving maternal health should help prevent stillbirths and new-born deaths and be integrated for midwives and doctors providing care.

180. We note with concern the failure of the DH to adequately respond to the recommendations made by the ministerial committees on child, neonatal and maternal morbidity and mortality.

11.2 Health and health services

181. The decline in mortality seems to have been driven by technological interventions (antiretroviral therapy and vaccines) rather than fundamental improvements in the social determinants of health or more equitable access. It is therefore important to identify and address the **underlying social determinants of health** (see Annexure 8). Child health continues to be compromised by poverty, food insecurity, inadequate housing, water and sanitation. While the National Development Plan recognises these and sets targets for 2030, a clear multi-sectoral implementation plan with interim targets and a monitoring and reporting system that foreground child wellbeing is required.

182. The marked **inequalities** between public and private sectors and rural and urban areas compound poor access to healthcare. Private health insurance accounts for 44% of total health care spending in South Africa, supporting primarily urban and hospital-based services serving only 15% of the population.[129] The majority of South Africans are dependent on the underresourced public health system: only 53% of medical practitioners and 36% of specialists work in the public sector.[130] 47% of South Africa's children live in rural areas,[131] yet rural provinces experience significant shortages of nurses and medical practitioners.[132]

183. The provision of free primary health care (PHC) and expanding network of primary health facilities, improved children's **access to health care** significantly since 2002, however nearly a quarter of children still travel more than 30 minutes to reach a health facility,[133] and transport costs can lead to life-threatening delays.[134]

184. Children with disabilities, pregnant teenagers and foreign children experience **discrimination** in accessing health care. Despite the National Health Act and Uniform Patient Fee schedule confirming refugees and asylum seekers right to access basic health care services and anti-retroviral therapy, providers frequently obstruct their access to health services.[135] Positively, a national circular confirmed all children's rights to the Road to Health booklet and associated services.

185. The delivery of public health services are a provincial competency with considerable variation across provinces. Most provinces, including the Eastern Cape, are plagued by corruption, mismanagement, and shortages of staff, essential drugs, equipment and emergency medical services.[136]

186. Power is overly centralised at provincial level, while districts' ability to manage services and budgets is marginalised. Strong leadership is required at district level to drive intersectoral collaboration and address local determinants of child health. KwaZulu-Natal's Operation Sukuma Sakhe "war on poverty" and child-centred "war rooms" and District Clinical Specialist teams are potential mechanisms for this.

11.3 Quality of care

187. The **National Standards for Health Care Facilities** are a potentially powerful mechanism to drive quality improvement, yet children's needs are rarely addressed beyond the confines of paediatric and neonatal wards. Paediatric equipment, staff and child-friendly standards must be specified across the entire health care system. [137] The **National Audit of Health Care Establishments** noted poor compliance with ministerial priority areas such as adequacy of waiting times (68%), cleanliness (50%), patient safety (34%) and positive and caring attitudes (30%).[138] Measures for accountability of support staff, health professionals, managers and administrators are desperately needed. Prevalent uncaring attitudes must be addressed as part of the quality improvement process and integrated into performance appraisal systems.

188. The Ministerial Committee on Morbidity and Mortality in Children under 5 years (CoMMiC) called for the development of an **Essential Package of Care** for children[139] this urgently needs to be defined and adopted by government. This should function within a defined set of norms and standards across the continuum of care - from neonatal care to adolescent and youth friendly services. This framework should drive quality improvement, enhance accountability and ensure that adequate human and financial resources are allocated to child health services. In addition, **budgets** for child health need to be disaggregated in line with the Committee's General Comment 15 on the Right to Health. Annual national, provincial and district health plans must include child health targets and budgets.

11.4 National Health Insurance (NHI) and Primary Health Care (PHC)

189. Without a white paper it is impossible to assess to what extent the needs of children have been accommodated in the NHI. The Essential Package of Care is the overarching framework that should guide delivery and ensure reasonable standards of health care for children. Public health facilities serving poor and rural areas require additional support to avoid further entrenching inequalities.

190. We welcome the **reengineering of PHC's** strong focus on maternal and child health. This includes District-based Clinical Specialist Teams (DCSTs) driving population-based planning, quality improvement and inter-sectoral collaboration to address the broader social determinants of health, and school health and ward-based outreach teams (WBOTs) providing community-based services. The responsibilities of these teams in the provision of Child Health services need to be more clearly defined, and greater numbers of health workers will be needed, including reorientation and training to enable staff to play a broader advocacy/leadership role.

191. While **home- and community-based services** have the potential to improve the reach of PHC, the designated ratio of households to community health workers (CHWs) of 250:1 is problematic. Greater efforts are needed to develop and support the functioning of a cohort of maternal and child health workers at community level. This requires inter alia improvements to their

training, mentoring, support and conditions of service. CHWs' scope of practice needs to be widened.[140]

192. As child mortality falls, emphasis must shift beyond survival to promote optimal development as outlined in the ECD policy gazetted in April 2015. The **first 1,000 days** (conception to the second birthday) is particularly important. Poverty, malnutrition, a lack of care and harsh discipline create 'toxic stress' which has potentially lifelong consequences for children's health and schooling.[141] In terms of ECD, the health sector is critical to identifying risk factors, promoting optimal health and development, supporting mothers and caregivers, and providing a gateway to social grants, and child protection services.[142]

193. We call on government to accelerate implementation of these ECD programmes in accordance with the policy's short- and medium-terms goals to ensure that delays do not compromise young children's health and development.

11.5 Access to PHC

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

195. **Early antenatal care** (ANC) is a critical opportunity to promote healthy pregnancies, identify mothers and babies at risk, and provide mental health screening and referrals. While almost all pregnant women (89%) attended at least one antenatal visit in 2013, only 50% had their first visit before 20 weeks.[143] It is critical to address barriers such as attitudes of nursing staff reflected in the data of the Saving Babies Report [144] and opening hours to make it easier for school girls and working women to access services, given that youth attendance is particularly poor and teenage girls account for 1 in 3 maternal deaths in South Africa.[145]

196. The expanded **Road-to-Health booklet** can potentially strengthen growth monitoring, developmental screening, early intervention and IMCI home and community-based practices, but it is not clear how the tool is being used in practice. We recommend that the DH monitors both coverage and quality of these essential services to ensure that health workers and caregivers can use the booklet effectively to track children's health, nutrition and development. Given the high levels of child poverty, eligibility and access to social grants should be included.

197. On average, children under-5 visited PHC facilities 4.3 times in 2013 (including scheduled well-child visits and unscheduled visits when ill) which falls below the national target. While estimated national immunisation coverage at 1 year is fair (85%),[146] Vitamin A coverage from 12 — 60 months is low (45%)[147] indicating a drop in attendance in the second year. Greater effort is needed to improve **immunisation coverage** at district level, and a national survey is needed to determine true immunisation coverage.

198. **Integrated Management of Childhood Illness training** needs to be supplemented with effective supervision and support, and regular audits to ensure quality of care.

199. The **Integrated School Health Policy** provides for an ambitious range of services for older children, but it is not clear how staff, transport and equipment shortages that hampered implementation of the previous policy will be addressed.[148] Screening for developmental delays and disabilities in schools is important, yet follow-up care is likely to be severely comprised, given current shortages of physiotherapists, occupational therapists, social workers and psychologists.[149]

11.6 Child medicines

200. The **paediatric Essential Drug List** (EDL) went out of print in 2011/12, and the latest version was only released in February 2014. This reflects a trend lengthy delays between the development of policies, strategies and programmes for children and their adoption. **Procurement of medicine** nationally focuses on adults and often fails to consider children's needs (e.g. palatable and easy to swallow). Pharmacists therefore manipulate adult medicines and this unlicensed usage may put children at risk.

201. A separate paediatric EDL committee with a separate budget allocation may prove more effective in addressing children's health care needs. A pharmacopeia providing clear guidance on how to adapt adult medicines for children is needed.

11.7 Emergency and intensive care:

202. In addition to district and primary health care, efforts to ensure access to emergency and intensive care are important. Ambulance crews have limited training in the management of children and neonates, paediatric emergencies or life support; and most do not carry the necessary equipment to manage the resuscitation and safe transport of children and neonates.[150]

203. There is a shortage of beds for children in intensive care with only 20% of Intensive Care Unit (ICU) beds dedicated to children and neonates—and only 4% of these for children.[151] An acute shortage of ICU trained nurses—who are prone to burnout and low morale – compounds this.[152] Future plans should consider preferential development of paediatric facilities and address the shortage of nurses and doctors trained in paediatric and neonatal care.

11.8 Malnutrition

204. **Malnutrition** is a key driver of under-five mortality. 31% of young children who died in hospital in 2013 were severely malnourished and a further 30% were underweight for age.[153] One in four children (26%) aged 0—3 years is stunted[154] and Vitamin A deficiency remains high at 44%. Overweight (15%) and obesity (6%) are also a concern, especially in urban areas.[155] Prevention of malnutrition in the first 1,000 days is key, starting with adequate maternal nutrition during the antenatal period.

205. The Tshwane Declaration in support of exclusive breastfeeding is welcomed given the previous lack of clarity around breastfeeding and HIV, yet only 45% of infants were exclusively breastfed at 14 weeks.[156] We commend the establishment of human milk banks to ensure the most vulnerable babies in hospital have access to breastmilk.[157] While the Mother-and-Baby-Friendly Hospital Initiative helps mothers initiate breastfeeding, it is not required nationally. Greater investment is needed in community-based breastfeeding support (peer and expert) and support for working mothers to ensure breastfeeding is maintained.

206. Given high levels of child poverty and malnutrition, it is vital to identify and support at-risk children whose growth is faltering. This includes monitoring the implementation of the new Road-to-Health booklet to ensure effective growth monitoring and promotion, and effective clinic, community-based and in-patient management of **severe acute malnutrition** (SAM).

207. Children in poor households and rural areas are adversely affected by **rising food costs**. The cost of a basic food basket increased by 6.4% from 2012 to 2013,[158] and at a cost of R457 equates to 40% of the total monthly income of the poorest 30% of households.[159] Of particular concern is the higher cost of basic food stuffs in rural areas.[160] Regular government monitoring is needed to ensure bread flour and maize meal are fortified in line with statutory requirements.[161]

208. Consumption of fast foods, sweets and confectionary has risen sharply, and carbonated drinks are one of the top three food/drink items consumed by young urban South Africans.[162] Greater effort is needed to regulate "**Big Food**" and marketing unhealthy food to children.[163]

11.9 Efforts to address HIV/AIDS and TB

209. HIV and TB have exacted a heavy toll on South African children, whether infected or affected.[164] Although various interventions have been implemented to prevent transmission of HIV to children multiple challenges remain.

210. The marginalisation of the children's sector in the South African National AIDS Council (SANAC) is of concern. Following restructuring in 2012, the involvement of the children's sector's is limited to the civil society forum, diluting the voice of the sector, and making it harder to ensure that children's specific needs are addressed.

211. The National Strategic Plan (NSP) on HIV, STIs and TB 2012-2016 aims to reduce mother to child transmission (MTCT) to less than 2% at six weeks after birth and less than 5% at 18 months by 2016. While transmission rates have declined to 2.7%,[165] 39% of child deaths in hospital 2013 were associated with HIV.[166] Further strides in reducing MTCT require strengthening the management, leadership and coordination of the PMTCT programme and ensuring integration with maternal and child health programmes. Mechanisms must be established to more readily identify the estimated 40% of infants who are HIV-infected but not on ART. The identification of undiagnosed children older than 18 months needs prioritisation.

212. Condom distribution in schools remains an important HIV prevention measure.

213. Medicine **stock-outs** plague the health care system - 25% of health care facilities reported a stock-out or shortage of ARVs or TB medication in 2014.[167] Another major challenge is access to effective, tolerable TB regimens for adults and children and treatments for drug resistant TB have poor success rates.

214. Poor management of **information systems** at facility level hampers early identification of HIV and TB and adherence to treatment. Information-gathering is vital both for individual patient care and for data collection at national level to inform policy-making and prioritisation.[168]

215. Despite significant gains in **early infant diagnosis and ART**, challenges remain in ensuring that children are initiated on ART as early as possible and in systems for tracking progress. Follow-up support for ART by community health workers, adherence supporters and child and youth care workers needs to be recognised, remunerated, supported and effectively integrated into the health care system.

216. Lack of reliable national data makes it impossible to evaluate the extent to which children have access to **post exposure prophylaxis**, psychosocial support and ARVs following sexual assault.

11.10 Reproductive health rights and measures to promote a healthy lifestyle

217. Despite the moral panic around **teenage pregnancy**, teen childbearing appears to have declined since 1996,[169] and the proportion of teenagers aged 15 – 19 attending antenatal clinics has not increased.[170] The greatest barrier to clinical services remains the attitude of healthcare providers, many of whom regard it their duty to scold young people who are either thinking of having sex for the first time, or who are already sexually active.[171] Dumped foetuses are also a problem highlighting the need to improve access to abortion and contraceptive services and ensure a supportive rather than punitive response to pregnant teenagers.[172] Despite the DH taking steps to establish youth-friendly clinics, adolescents continue to report negative experiences,[173] even at accredited clinics.[174]

218. Evidence around **condom use** among young people is unclear. A LoveLife study in 2012 confirmed the trend of earlier HSRC studies which showed increasing condom use among young people. But the national Seroprevalence and Behaviour Survey suggests that condom use among young people is on the decline, and that other risky behaviours are on the increase.[175]

219. **New HIV infections** among young females are of particular concern. Approximately a quarter of all new infections (113,000) occurred among girls and young women 15-24 years, and female youth were four times more likely to be newly infected than their male counterparts (2.5% vs. 0.6%).[176] Young people who do not see a clear future for themselves, are most likely to take risks with their health and more likely to have multiple concurrent partners, and adolescent pregnancy.[177]

220. It is essential to provide young people with **discreet and easy access** to sexual and reproductive health (SRH) services including condoms, emergency contraception, PEP, medical circumcision, HIV tests, ARVs and treatment for sexually transmitted infections (STIs). At the same time SRH education must address gender and sexual identity and enable young people to manage relationships, negotiate safe sex and challenge the norms that legitimate gender-based violence.

Work with health workers, teachers, and parents is needed to address paternalistic and judgemental attitudes to teenage sex.

11.11 Substance abuse and mental health

221. We welcome government's efforts to prevent **smoking,** including increased taxes and an advertising ban which is associated with an overall decline in smoking rates among high school students from 23% in 1999 to 17% in 2011. However smaller reductions amongst girls and black learners and a slight increase in the 2008 – 2011 period[178] suggest that additional efforts are needed.

222. **Alcohol use** is a leading risk factor for death and disability in sub-Saharan Africa for person's aged 15 to 19 years. In a national survey of grade 8 to 11 learners: 37% of males and 28% of females reported drinking in the past 30 days, 30% of male and 20% of females reported binge drinking.[179] Alcohol is associated with rape, interpersonal violence, absenteeism, school failure, unwanted pregnancies, sexually transmitted infections, HIV, and foetal alcohol spectrum disorders.[180] Recommendations include ensuring: the price of alcohol remains high; restrictions on advertising/marketing; products aimed at enticing young people to start drinking are disallowed; underage drinking regulations are enforced; and novice drivers are not permitted to test positive for alcohol in the first 3 years after acquiring a driving license.[181]

223. While alcohol is the substance of choice, high school learners are also experimenting with cannabis (12.7%) methamphetamines, heroin, cocaine and mandrax (11.5%).[182] Treatment demand for youth **substance abuse and addiction** has increased over the past two decades.[183] Violence, discrimination and the absence of positive parenting increase substance abuse risk.[184] These environmental stressors are associated with depression, low self-esteem.[185] This highlights the need for better access to drug rehabilitation services, as well as stronger linkages between alcohol and drug rehabilitation and mental health sector programmes. Mental health screening among youth should be prioritised in school-based health services.[186]

11.12 Children with disabilities

(Section 2.8.1. provides the overview on children with disabilities. This section refers specifically to health-sector related issues).

224. The National Health Act provides for PHC, embracing the continuum of services. Various policies including *Free Health Care*, the *National Rehabilitation Policy* and the *Standardisation of Provision of Assistive Devices* seek to improve access and quality of health services for children with disabilities. Despite this, finances, lack of transport, inaccessible health facilities,[187] shortage of staff and lack of access to medicines restrict access to health services for children with disabilities.[188]

225. The implementation of the IMCI delivery strategy for under 5 year olds varies widely within provinces and districts. Child health care delivery is idiosyncratic with no prioritised system or model, and is focused on curative care. Scant attention has been paid to the development of quality rehabilitative care for children with permanent impairments. Developmental screening and early intervention across the health, social development and education sectors is limited; the inclusion of a more detailed table of developmental milestones in the new *Road to Health* booklet is thus welcomed but it is not sufficient.

226. The DH has recently drawn up the *Strategy for Re-engineering Primary Health Care*.[189] The discussion document that guides this process includes community based rehabilitation (CBR) - described as 'PHC for people with disabilities' - as an essential part of PHC. Given the absence of a national strategy for CBR it is hoped that this renewed emphasis will ensure that barriers to access and quality are addressed.[190]

227. We welcome the new child and adolescent mental health (CAMH) policy, however it has yet to be implemented. Capacity to deliver **mental health care** services remains poor—especially for children and adolescents. One in five children will have a diagnosable and treatable mental health disorder;[191] 50-80% of mental health problems start before the age of 18 and account for 60-70% of

the burden of disease in young adults. In spite of the known impact of mental health problems on development, education and future productivity, there are only ~40 subspecialists in child and adolescent psychiatry in the country; less than half are in the state sector. The majority of funding goes to adult mental health problems. It is therefore essential to invest in development of CAMH services across all levels.

Recommendations

228. We note the failure of the DH to adequately respond to the recommendations made by the ministerial committees on child, neonatal and maternal morbidity and mortality, and call on government to take action and implement these.

229. An essential package of care for children needs to be defined and adopted by government. The package should function within a defined set of norms and standards across the continuum of care - from neonatal care to adolescent and youth friendly services. These demand that adequate human and financial resources are allocated to child health services, should drive quality improvement and address accountability.

230. The lack of caring attitudes amongst health care providers must be explicitly addressed and integrated into performance appraisal systems to improve quality.

231. Child health continues to be compromised by poverty, food insecurity, inadequate housing, water and sanitation. A clear multi-sectoral implementation plan with interim targets and a monitoring and reporting system is required.

232. Power is overly centralised at provincial level, districts' power to manage services and budgets is marginalised. Strong leadership is required at district level to drive intersectoral collaboration and address local determinants of child health.

233. Community health workers: While the re-engineering of PHC envisages an expanded role for CHWs, greater efforts are needed to develop and support the functioning of a cohort of community level maternal and child health workers. Including improvements to their curriculum and conditions of service, expanding their scope of practice and their integration into the health care system, mentoring and support.

234. Policy, programmes and other initiatives to address the right to health of children with disabilities must be integrated into a holistic government programme for realising the rights of children with disabilities, including promoting optimal development, preventing developmental delay, and providing services for children with disabilities that optimise their health, development and participation, across the life course.

235. Adolescents require discreet and easy access to a range of SRH services including condoms, emergency contraception, post-exposure prophylaxis (PEP), medical circumcision, HIV tests, ARVs and treatment for STIs. SRH education must address questions of gender and sexual identity, enable young people to manage relationships, negotiate safe sex and challenge the norms that legitimate gender-based violence. It is important to engage with health workers, teachers and parents to address paternalistic and judgemental attitudes to teenage sex that prevent the information, support and services needed.

236. Substance abuse is a key driver of the adolescent burden of disease. Recommendations include keeping alcohol and cigarette prices high, limiting marketing to youth and enforcing sanctions to limit underage use. Given the links between substance abuse, depression and poor self-esteem, increased investment in adolescent mental health promotion, screening and treatment services is needed.

237. The Road to Health booklet is intended as an entry point to a package of services that extend beyond growth monitoring and immunisation to include development– and should serve as an effective patient-held record of treatment. It is therefore recommended that both health workers and mothers are empowered to use the booklet effectively.

238. Data collection and evaluation systems need to be strengthened. In particular, Child PIP and PPIP must be mandatory and extended to all facilities to identify and address avoidable causes of child and neonatal deaths in the health care system. This should be complemented by the introduction of child death reviews.

12 EARLY CHILDHOOD DEVELOPMENT (ECD)

239. **ECD programmes** are delivered predominantly by NGOs and the private sector, with a per child government subsidy for poor children attending ECD centres. However, large numbers of children are not accessing the subsidy (only 16% of the poorest children were estimated to receive it in the 2013/2014 financial year).[192]

240. The CPR acknowledges that ECD is a form of childcare service; however, it is vague on the findings of an ECD Diagnostic Review conducted by the Department of Performance Monitoring and Evaluation within the Presidency, which showed a positive trend in the roll-out of ECD services. This positive development should not be overlooked.

241. The prioritisation of the provision of ECD services to children with disabilities and chronic illness in the 2007 Children's Act is welcomed. However the 2015 ECD policy pays limited attention to children with disabilities, indicating that this group requires its own, deliberate set of policies expanded beyond just the ECD realm.

242. Inclusive ECD is not stipulated in the framework. The Right to Education for Children with Disabilities (R2E CWD) Campaign argues that there are a number of difficulties that undermine access to quality ECD services for children with disabilities, notably, in spite of the provisions of the Children's Act, there is no dedicated national programme to target ECD at children with disabilities and the concept of 'inclusive ECD' has not been embraced.[193]

243. The R2E CWD highlights that ECD centres are not always willing and able to admit children with disabilities. Personnel are concerned about their lack of training and their perceived inability to support the special needs of such children. There is no provision for additional DSD funding to support inclusion."[194] Additional challenges to ensuring accessible ECD services include lack of funding and fragmentation of services across departments.[195]

Recommendations

244. GOSA must accelerate implementation of ECD programmes in accordance with the new ECD policy's goals.

245. Dedicated programmes to ensure access to ECD services for children with disabilities, particularly in rural contexts, must be put in place.

13 EDUCATION

13.1. Budgets and expenditure – entrenched and deepening inequality in schools

146. The steady and substantial increase in the education budget over the last decade has not necessarily translated into corresponding expenditure. The continued increase remains necessary, however considered against actual expenditure, and the comments of the Auditor General,[196] the significance of the increase seems much less praiseworthy. Both national and some provincial departments consistently overspend in some less critical areas, and underspend in areas where effective and full spending is absolutely necessary. For example, one immediate challenge is the inability of the state to spend the large amount of funds allocated for the improvement of school infrastructure.[197] In the 2011/2012 financial year only R76 million of the R700 million under the direct control of the Department of Basic Education (DBE) was spent. At the end of the third quarter of 2012/2013 financial year, only R476 million of the 2.3 billion allocated had been spent.[198]

247. Effective expenditure would necessitate equitable and pro-poor expenditure. Whilst pro-poor funding policies linked to 'schools in the poorest income quintiles' are referenced in the CPR as a measure designed to aid marginalised learners, their impact is curtailed by the limited focus on non-personnel expenditure which constitutes less than 10% of education spending. An education

economist concluded that: "every South African datasheet of educational achievement shows that there are in effect two different public education systems in South Africa. The smaller, better performing system accommodates the wealthiest 20-25 percent of pupils who achieve much higher scores than the larger system which caters to the poorest 75-80% of learners."[199]

248. The unequal distribution of teachers has not been addressed on a pro-poor basis. Measures, financial incentives and funding to provide more equitable provision of more highly qualified teachers to schools catering for poor learners remains absent. The allocation of teachers to schools in provinces takes place in accordance with a post provisioning model. Although the current model states that the "head of a provincial department must set aside a certain percentage of its available posts for poverty redress based on the department's relative level of internal inequality"[200] this is subject to the Minister of BE exercising statutorily conferred discretionary power to "set the maximum percentage that provincial departments may use for this purpose". The Minister has set this maximum limit at a meagre 5%.

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

250. There are increasing concerns about the growing profit-driven school privatisation movement moving into South Africa. Western Cape and Gauteng are enthusiastic about this and don't seem to appreciate how this trend will entrench segregation based on economic class.

251. Sustainable and substantial progress in the education system will only be achieved with increased allocation to basic education budgets and with the efficient and effective expenditure of the allocated budgets.

Recommendations

252. Continued increase of allocation to BE budget, based on pro-poor budgeting and expenditure priorities.

253. President to sign a proclamation in terms of Act 74 of 1996 conferring authority on the Special Investigation Unit to investigate both nationally and provincially (a) maladministration (b) unlawful appropriation or expenditure of public funds (c) intentional or negligent loss of public money (d) the need for criminal or civil proceedings (e) the need for institution of disciplinary proceedings against employees.

254. Introduce legal reform to replace the existing teacher provisioning model with a pro poor model that addresses the disparities within the public education system.

255. Strengthen the legal framework around privatization and create strict monitoring reporting obligations, particularly regarding reporting on their financial affairs.

13.2. School infrastructure, norms and standards and accountability

256. The policy and legal regulatory gains in school infrastructure over the last four years are directly attributable to the sustained pressure which a social movement of youth and parents, along with civil society organisations have exerted upon the State through advocacy and litigation.[201] The Minister of BE until recently remained recalcitrant regarding the need to enact regulations containing the basic standards for school infrastructure. The 2012 guidelines on school infrastructure were introduced in an unsuccessful last minute attempt to appease civil society demands for legally binding school infrastructure standards.

257. The National Education Infrastructure Management System [NEIMS] Report 2014, noted that: 1 131 schools had no electricity supply; 7 438 schools still use pit latrine toilets and 474 schools had no ablution facilities. There were 604 schools with no water supply (down by 1,798 from the 2,402 such schools in the 2011 NEIMS figures).[202] However in this same period, the number of schools with unreliable water supply increased exponentially by 2,070 over the 2011 figure, to 4,681 in 2014. The

same trend can be seen elsewhere in the NEIMS data suggesting that schools may have simply been reclassified rather than the infrastructural issues addressed.

258. In November 2013 the Minister published regulations on basic school infrastructure. Aspects of the regulations remain worrying. They fail to provide for urgent action in relation to unsafe schools built partially from inappropriate material (asbestos, metal and wood) and fail to establish a binding norm for schools built, budgeted or planned for within the 2013/14; 2014/15 and 2015/16 Medium Term Expenditure framework periods. The legally binding nature of the norms is wholly undermined by a clause that allows the Minister to escape liability for achieving the norms by the due dates, making delivery subject to the resources and co-operation of other government agencies/entities.

259. The regulations require that the MECs for Education in each province submit a plan indicating how they intend to achieve the norms. Accompanying these are infrastructure project lists which schools ought to be able to look to, to determine whether they stand to benefit, they type of infrastructure measure they can expect to receive and by when. The plans and project lists have been drawn up haphazardly with several disregarding the deadlines imposed by the regulations and many are grounded on unreliable information. This has led to confused planning and also makes it difficult for parents, learners, teachers and the public to hold the state to account.

13.3. Quality education, learner retention and drop out

260. The CPR makes important admissions with regard to the challenges and symptoms of poor quality and unequal provision of education in South Africa.

261. Despite the improvement in retention rates, learner drop-out rates are concerning. A 2013 DBE report recognises the "high levels of drop-outs [which] begin after the age of 16. Attainment of matric is still unequal across race groups, with white and Indian youths more likely to attain matric than black and coloured youths."[203] While there has been a moderate increase in the number of learners who attain matric, a study of learners born between 1985—1987, found that 17.5% of learners who achieve grade 10, and a further 28.3% of learners who achieve grade 11, received no further education. Drop-out rates are closely related to high repetition rates in grades 10—12. Analysis of Community Survey data found children with disabilities to be disproportionally represented among school drop-outs. The data indicate that children with disabilities have a lower school attendance rate than other children, as 22.5% (38,000) were out of school.[204]

262. The touted improvements in the matric pass rate must be directly considered against high drop-out rates. Almost half of all learners who enter the schooling system do not reach matric (grade 12). In total, of 24 136 public schools there were 1,407 schools in the 2013 academic year with a pass rate below 60%, the standard used by the DBE to identify "underperforming schools". 86% (1,209) of these schools are in Quintile 1, 2 and 3. These are the poorest and most under-resourced schools in the country. In comparison, only 36 schools in Quintile 5 had a pass rate below 60%.[205]

Recommendation

263. Increased policy attention on learner retention and the quality of learning

13.4. Access to contraception in schools and learner pregnancy

264. DBE has recently released a draft national policy on TB, STIs and HIV/Aids in schools, which makes provision for the distribution of condoms in schools. In its current form, the policy is vague about how and to which learners the condoms will be distributed.

265. The CPR makes a vague reference to measures that the State has taken to "prevent early pregnancies and provide support to ensure the return of girls who become pregnant". The reality is that the 2007 National Pregnancy Prevention Measures introduced by the State to combat learner pregnancy and ensure support for pregnant learners not only failed to deliver on its intended purpose but actually exacerbated the discrimination faced by pregnant learners. These measures explicitly endorsed a punitive policy which encouraged schools to exclude pregnant learners for a period of up to two years. The DBE finally acknowledged the unconstitutionality of the measures after the Constitutional Court handed down judgment in a case where two pregnant learners had been

excluded from their schools.[206] The judgment places beyond any legal doubt that the 2007 measures are unacceptable and need to be replaced as a matter of urgency.

Recommendations

266. Access to contraception in schools should be considered a basic human right. The GOSA must through the proposed policy and its implementation ensure unqualified, easy and discreet access to condoms.

267. DBE to urgently replace the unconstitutional 2007 school pregnancy policy and ensure the new policy is brought to the attention of provincial and district officials and the public.

13.5. Education for foreign migrant children

268. Foreign migrant children in South Africa have the right to basic education; this is enabled through the Constitution, Children's Act of 2005, South African Schools Act of 1996, and the Refugees Act of 1998. However, these children face serious barriers to access education. Reasons include being unable to afford school fees - although a care-giver can apply for an exemption, based on a means test, there are recorded cases of care-givers being denied access to fee exemptions through school policies that expressly prevent refugees and foreign migrants from applying for a fee exemption at their school; being without or holding expired documents; being unable to afford transport, uniforms or books for school; language difficulties; and, finding the local schools full.[207] Admission to school is conditional on the parent/caregiver being in the process of applying for documentation to remain in the country which may take over a year to complete.

269. As a direct result of the case of Mubake and 7 others v Minister of Home Affairs,[208] the DBE is required to amend its Admissions Policy for Ordinary Public Schools to specify that asylum-seeker and refugee children must be allowed to register in public schools, without South African birth certificates or study permits. The court order was made on 30 April 2015 but has not been complied with.

270. Xenophobic attacks, such as those that took place across South Africa in 2008 and 2015, create additional obstacles to children's access to education due to, among other things, parents' fears of allowing their children back into unstable communities and the cost of transport for those sheltered far from their original schools.[209] Non-national children in schools report being regularly subjected to xenophobic comments by teachers or other students.[210]

Recommendation

271. The policy must stipulate that refugee and foreign migrant children cannot be discriminated against in school policies related to admissions such as fee exemption policies.

13.6. Inclusive education

272. In 2001, White Paper 6: Towards an Inclusive Education and Training System was finalised, containing a 20-year implementation plan. South Africa's progress in implementing this policy has been inexcusably slow. By April 2013, 12 years into its implementation, the Department of Basic Education had only made limited progress in supporting special schools to become resource centres and identifying certain primary schools to be equipped as full service schools.[211] Research indicates that significant numbers of children with barriers to learning, and in particular children with disabilities are not participating meaningfully in education. The lack of provision of support in both special schools and ordinary or full service schools fails to meet diverse learning needs. Poor curriculum delivery, unskilled educators, inflexible curriculum and the lack of commitment to inclusive education has resulted in children not reaching their full potential. The DBE's focus on provision of Braille textbooks and SASL teaching is necessary, but this is delivered in isolation of the goals of inclusive education.

273. The DBE reported in May 2015 that 597,953 children with disabilities were out of school, an alarming increase from the estimated 280,000 out of school learners reported in 2001[212] and is evidence of the poor implementation of inclusive education in South Africa. These children are being denied their right to basic education.

274. Several barriers to accessing education persist. These include lack of appropriate physical infrastructure in both special and ordinary schools; insufficient skilled teachers, transport difficulties and associated high costs of travel; poor admission procedures and policies at special and ordinary schools; the high secondary costs associated with schooling, including uniforms, stationery, transport, hostel fees, etc.

275. There is a serious gap in education for children with serious and multiple disabilities as special schools seldom cater for this, a Deaf and autistic child, for example, falls through the cracks.

276. Civil society organisations condemn the lack of political will, translated into budgets and implementation plans, which has resulted in the inexcusable delays in realising this right.

Recommendations

277. Transformation of White Paper 6 into legislation in line with the UNCRPD. Without undermining the standards and system for inclusive education contained in White Paper 6, the mechanisms to implement the policy and timeframes must be reviewed through a transparent process.

278. The urgent prioritisation of the implantation of inclusive education including costing, budgeting and planning. The GOSA must avoid responding to the provision of inclusive education in a piecemeal fashion which exacerbates the lack of inclusion in mainstream schools of learners with barriers to learning.

279. Collation of information regarding the names, ages and entrance grade required of children with disabilities on

a) Mainstream schools' admissions waiting lists.
b) Special schools' admissions waiting lists
c) Disabled Children who are not in the education system

This information to be updated and made publically accessible on a consistent basis.

13.7. Violence in schools

280. Corporal punishment in the education system was prohibited in 1996; nevertheless 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".[213]

281. The DBE indicate that their efforts are hampered by parents and communities' overall acceptance that corporal punishment is an effective way to discipline children.[214]

282. Schools have high levels of several forms of violence, including physical and sexual assault, perpetrated by both fellow pupils and by teachers. The ongoing violence in school contributes to the acceptance of a culture of bullying, fear and anxiety in an environment that should be safe and nurturing. Bullying is linked to vulnerability for more serious criminal victimisation. Gang violence and activities have an extremely negative impact on schooling in areas where gangs are prevalent.

Recommendations

283 The DBE must ensure anti-bullying policies and peer mediation structures in schools that are resourced.

284 DBE must commit resources to implement a national programme of training on positive discipline.

285 DBE must encourage the establishment of school-level committees including learners and teachers to identify and respond to violence in schools.

ANNEXURES

Annexure 1 List of endorsing partners

1. Action in Autism
2. The Black Sash Foundation
3. Centre for Child Law, University of Pretoria
4. Children's Institute, University of Cape Town
5. Children In Distress Network (CINDI)
6. CHILDS~ Children In Legal DisputeS
7. Childline South Africa
8. Child Welfare South Africa
9. Disabled Children's Action Group (DICAG)
10. Disability Studies Division, Faculty of Health Sciences, University of Cape Town
11. Dullah Omar Institute, University of the Western Cape
12. Equal Education
13. Equal Education Law Centre
14. Families South Africa Western Cape (FAMSA WC)
15. Inclusive Education South Africa
16. The Institute of Family Mediators
17. Isabel Magaya
18. Jo'burg Child Welfare
19. JWay Children's Ministry
20. Letitia Brummer
21. LINALI – protecting children's rights
22. LoveLife
23. Molo Songololo
24. The National Institute for Crime Prevention and the Reintegration of Offenders
25. NACOSA (Networking AIDS Community of Southern Africa)
26. Quaker Peace Centre – (with recommendations to address violence in schools)
27. Resources Aimed at the Prevention of Child Abuse and Neglect
28. Rural Women's Movement
29. Save the Children South Africa
30. Scalabrini Centre of Cape Town
31. Shukumisa Campaign
32. Sonke Gender Justice
33. SOS Children's Villages Association of South Africa
34. Teddy Bear Clinic
35. Thohoyandou Victim Empowerment Programme
36. Ubuntu Centre
37. Umtata Child Abuse Resource Centre (UCARC),
38. Western Cape Forum for Intellectual Disability
39. Women And Men Against Child Abuse
40. Women on Farms Project
41. World Vision

Annexure 2 List of workshop participants

Civil Society Consultative Workshop - Alternative Report to UN CROC 24-25 January 2014, Cape Town	
Organisation	Name of participant
Anex CDW	Doreen Gaura; Matipa Mwamuka
Centre for Child Law, University of Pretoria	Carina Du Toit; Karabo Ozah
Children's Institute – University of Cape Town	Lori Lake; Paula Proudlock
Connect Network	Deborah Handcox; Erica Greathead
Deafblind South Africa	Philip Dobson
Disability Research Action	Sue Philpott
Disabled People South Africa	Gillian Moses
Dullah Omar Institute, University of the Western Cape	Maria Assim; Samantha Waterhouse
Homestead/Western Cape Street Children's Forum	Charmaine Germishuys; Paul Hooper
Human Sciences Research Council	Isabel Magaya
JWay Children's Ministry	Charmaine Manuel; Donovan Manuel
LINALI Consulting	Carol Bower
Oasis Association	Lourika Rossouw; Siddeeqa Stevens
Parliament of South Africa Research Unit	Lorenzo Wakefield; Kashiefa Abrahams
Refugee Centre, University of Cape Town	Tal Schreier
Save the Children Sweden, South Africa	Divya Naidoo; Richard Montsho
Scalabrini Centre	Charlotte Manicom; Marilize Ackermann
Sign Language Education and Development	Renee Rossouw; Zoliswa Flekisi
Social Workers Veterans	Pumla Mncayi
South African National Council for the Blind	Phandle Phandle
Teddy Bear Clinic	Shaheda Omar
Thinktwice	Moussa Muzamba
ThisABILITY	Simon Manda
Ubuntu Centre	Annie Robb

Civil Society Consultative Workshop - Alternative Report to UN CROC 9 December 2014, Cape Town	
Organisation	Name of participant
Anex CDW	Doreen Gaura; Matipa Mwamuka
Catholic Parliamentary Liaison Office	Lois Law
Centre for Child Law, University of Pretoria	Karabo Ozah

Centre for Justice and Crime Prevention/ African Policing Civilian Oversight Forum	Lorenzo Wakefield
Childline South Africa	Dumisile Nala
Children In Distress Network	Tracey Sibisi
Children's Institute – University of Cape Town	Paula Proudlock
Community Paediatrics, University of the Witwatersrand	Haroon Saloojee
Dullah Omar Institute, University of the Western Cape	Aquinaldo Mandlate; Maria Assim; Samantha Waterhouse
Human Sciences Research Council	Isabel Magaya
LINALI Consulting	Carol Bower
Molo Songololo	Patric Solomons
Networking HIV,AIDS Community Of South Africa/Yezingane Network	Menaka Jayakody
Save the Children Sweden, South Africa	Divya Naidoo; Richard Montsho
Sign Language Education and Development	Renee Rossouw
SOS Children's Villages South Africa	Mosa Moremi
Teddy Bear Clinic	Shaheda Omar

Civil Society Consultative Workshop - Alternative Report to UN CROC 16 October 2015, Cape Town 17 organisations; 23 participants	
Organisation	Name of participant
Catholic Parliamentary Liaison Office	Lois Law
Centre for Child Law, University of Pretoria	Anne Skelton
Childline South Africa	Dumisile Nala
Children In Distress Network	Suzanne Clulow
Childrens Institute – University of Cape Town	Lori Lake; Paula Proudlock; Shanaaz Mathews; Stefanie Röhrs
Community Paediatrics, University of the Witwatersrand	Haroon Saloojee
Disabled Children's Action Group	Sandra Ambrose
Dullah Omar Institute, University of the Western Cape	Samantha Waterhouse; Vivienne Mentor-Lalu
Equal Education Law Centre	Lisa Draga; Nurina Ally
LINALI Consulting	Carol Bower
Molo Songololo	Patric Solomons; Ronnie Ngalo
Resources Aimed at the Prevention of Child Abuse and Neglect	Tarisai Mchuchu

Save the Children Sweden, South Africa	Richard Montsho
Scalabrini Centre	Emma Ford
The Children's Radio Foundation	Themba Tshabalala
Umtata Child Abuse Resource Centre	Nomzamo Mdubeki
Yezingane Network	Joan van Niekerk

Annexure 3 List of Acronyms

Aids	Acquired immunodeficiency syndrome
ANC	Ante-natal care
ART	Antiretroviral treatment
ARV	Antiretroviral
CAMH	Child and adolescent mental health
CBO	Community-based organisation
CDG	Care Dependency Grant
CHH	Child-headed household
ChildPIP	Child Healthcare Problem Identification Programme
CHW	Community Health Worker
CJS	Criminal Justice System
CPR	Combined Periodic Report
CROC	Committee on the Rights of the Child
CSE	Child sexual exploitation
CSG	Child Support Grant
CSO	Civil society organisation
CYCC	Child and Youth Care Centre
DBE	Department of Basic Education
DCST	District-based Clinical Specialist Team
DHA	Department of Home Affairs
DH	Department of Health
DWCPD	Department of Women, Children and People with Disabilities
ECD	Early childhood development
EDL	Essential Drug List
EE	Equal Education
FCG	Foster Care Grant
FFC	Fiscal and Finance Committee
GOSA	Government of South Africa
HCT	Hematocrit
HIV	Human immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICU	Intensive care unit
ID	Identity document
IMCI	Integrated Management of Childhood Illnesses

ISHP Integrated School Health Policy

LGBTI Lesbian, gay, bisexual, transgender and intersex

LHR Lawyers for Human Rights

MDG Millennium Development Goal

MTCT Mother-to-child transmission

NEIMS National Education Infrastructure Management System

NHI National Health Insurance

NMR Neonatal Mortality Rate

NSP National Strategic Plan

PCR Polymerase chain reaction

PEP Post-exposure prophylaxis

PHC Primary Health Care

PMTCT Prevention of mother-to-child transmission

PPIP Perinatal Problem Identification Programme

R2E CWD Right to Education for Children with Disabilities

RACAP Register of Adoptable Children and Adoptive Parents

SALC South African Law Commission

SAM Severe acute malnutrition

SANAC South African National Aids Council

SAPS South African Police Service

SASSA South African Social Security Agency

SRH Sexual and reproductive health

StatsSA Statistics South Africa

STI Sexually transmitted infection

TIP Trafficking in persons

TB Tuberculosis

UIF Unemployment Insurance Fund

UNCRC United Nations Convention on the Rights of the Child

VAC Violence against children

WBOT Ward-based

WHO World Health Organisation

Annexure 4 Consolidated recommendations

(Note that each heading in the Alternate Report which has recommendations attached is reflected in the Consolidated Recommendations with the same heading numbering)

2 OVERARCHING STRATEGIC ISSUES

2.2. Leadership and coordination:

1. We call for stronger political leadership, monitoring and coordination for the realisation of children's rights; establishing an independent child's rights monitoring body with the necessary resources, capacity and authority should be considered.

2. Furthermore, civil society engagement, consultation and participation in governance, implementation and monitoring processes must be routine and funded.

2.4. Budgeting for and resourcing of services for children

3. GOSA must be encouraged to prepare and report on a national children's budget and provincial children's budgets. This must relate to the budgets of all government departments, not only those that are traditionally associated with realising children's rights.

2.8.2. Migrant children

4. Greater political leadership and commitment to realising the rights of children with disabilities is essential. These children have diverse needs that require an integrated approach and collaboration between the departments of health, social development, transport, police, justice and basic education in order to be addressed holistically.

5. GOSA should develop a single piece of legislation to specify, coordinate and govern services for children with disabilities and developmental delays.

6. The extreme marginalisation and discrimination against children with disabilities means that services to these children must be prioritised by government departments who must provide dedicated reporting on these services.

7. An increased focus on prevention and early intervention programmes in both the health and social development sectors is critical, as is a family oriented approach to providing services to children with disabilities.

8. International social services need to be strengthened and cross border mechanisms must be enhanced in order to find durable solutions for unaccompanied migrant children.

3 GENERAL MEASURES OF IMPLEMENTATION

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

9. The national and provincial legislation must be aligned and provincial legislation brought in line with the Children's Act.

10. The State must develop minimum norms and standards and a national plan of action to address illegal initiation schools and harmful initiation practices, including the successful prosecution of persons who are responsible for harmful and illegal initiation practices leading to injury and death of initiates.

4 GENERAL PRINCIPLES

4.2 Respect for the views of the child

11. The UNCROC should ask the Government of South Africa to report on the issue of children's courts, child witnesses and victims and children in conflict with the law.

12. Government should provide evidence that initiatives such as the Children's Parliament have a real effect on policy and law development and systems of government.

5 DEFINITION OF A CHILD

5.3 Ages impacting on customary law

13. GOSA must ensure that all policies relating to children's right to consent to medical treatment and access to sexual and reproductive health rights services are aligned with the Children's Act which sets the age of consent at 12.

14. GOSA must remove any discrimination between boys and girls and set a uniform age of marriage. The State must consider raising the minimum age of marriage to 18, irrespective of parental consent, to bring it in line with international standards.

15. GOSA must recommend raising the age of criminal capacity to Parliament as soon as possible, that it be raised to 14 years, and that the *doli incapax* presumption must be removed; failing this, the rights 12- and 13-year-olds currently enjoy must not be eroded.

6 CIVIL RIGHTS AND FREEDOMS

6.1.3. Foreign migrant children

16. The state should not implement stricter requirements of proof and fees for the period of 30 days to 1 year as currently, this is when the majority of caregivers register their children.

17. The cost of obtaining birth certificates and copies for purposes of Children's Court inquiries (child protection cases) should be waived by the DHA.

18. All applications for birth certificates and copies required for Children's Court processes should be processed within a period of 30 days by DHA.

19. The new requirement in law that foreigners can only get a birth certificate for their child born in South Africa if they have a passport and proof of legal residence, should be repealed. Birth registration should not conflated with enforcing immigration laws.

20. Government should reconsider its position and sign the Statelessness Convention as it has previously pledged, in order to develop a legal framework and mechanisms to assess, prevent and reduce statelessness.

7 VIOLENCE AGAINST CHILDREN

21. GOSA has a duty to prioritise and resource programmes to prevent violence.

22. GOSA has to commit in law and through resourcing, to an increase in protection and therapeutic services for children to break the cycle of violence

23. Specialised policing and court services for child victims must be adequatly resourced and implemented as a matter of urgency.

24. There is duty to bring the South Africa law in line with the international obligations to prohibit corporal punishment.

25. Large scale programmes to support positive non-violent parenting are required.

7.7 Harmful cultural and traditional practices

26. The GOSA must take steps to ensure that initiation schools comply with the Children's Act, which provides for the age of consent to such practice at 16. Furthermore, the health and safety of initiatives to eradicate incidences of deaths and injuries are a priority.

27. Prosecution of those who are responsible for deaths and injuries of initiates must be prioritised and statistics in relation to these prosecutions must be disaggregated.

28. The State Party must ensure that virginity testing is practiced in accordance with the Children's Act which provides for the age of consent at 16 years and does not allow for any marking of girls as virgins.

29. The GOSA must implement the South African Law Reform Commission recommendations: define "forced marriage", "child marriage", and "ukuthwala", criminalise all persons involved in forcing a person into marriage, including attempts; include an aggravated offence in relation to a person under the age of 18 years and undertake education, and awareness-raising among professionals, urban and rural communities and with traditional leaders must be taken to address the root causes and consequences of Ukuthwala.

30. GOSA must commit to programmes to increase awareness, education and training for all service providers; font-line police service personnel must be trained to identify and manage trafficking.

8 CHILDREN IN CONFLICT WITH THE LAW AND CHILD JUSTICE

31. Improved data and publication of statistics regarding secure care placements.

32. Diversion programme availability must be enhanced.

9 FAMILY ENVIRONMENT AND ALTERNATIVE CARE

9.1 Family environment

34. Parenting programmes must be made available and, if provided by CSOs, be fully funded by government.

35. The care giving role played by extended family (kin) should be legally recognised and adequately supported.

36. Law and practice must be reformed to enable social assistance to children heading households for themselves and the siblings they are caring for.

37. Prevention and early intervention programmes must be more broadly budgeted for and rolled out, they should be developed in unison with responses addressing external socio-economic stressors, such as inequality, poverty and structural unemployment.

38. Data collection should be improved to inform policy and increase family reunification and placement in permanent families through kinship care, foster care and adoption

39. The government and service providers must improve reunification services to ensure that children do not remain in alternative care longer than necessary.

40. Innovative alternative care options including 'cluster foster care' must be operationalised through the establishment of regulations or norms and standards.

41. The DSD policy regarding the Register for Adoptable Children and Prospective Adoptive parents should be clarified in law.

42. Bureaucratic processes that delay adoptions must be streamlined.

43. Maintenance courts must be established and equipped with necessary court officials, particularly appropriately trained maintenance officers and maintenance investigators.

10 SOCIAL SECURITY

44. The value of the CSG should be increased above the basic inflation rate in order to increase its already positive benefits.

45. SASSA should use regulation 11(a) of the Social Assistance Act to its maximum potential to enable children without birth certificates or lost birth certificates, to access the CSG and other children's grants.

46. DSD should design and implement a comprehensive legal solution to the foster care crisis by December 2017 as required by the High Court order. Such solution should (a) adequately recognise and support kinship carers looking after orphaned children and (b) free up the scarce resources of social workers and courts to provide quality protection services to children who have been abused and neglected.

47. DSD needs to review the legal inconsistencies between the Social Assistance Act and its regulations regarding the Child Dependency Grant.

48. DSD should develop an appropriate assessment form for medical officers to use when assessing children's eligibility for the CDG and address the legal inconsistencies between the Social Assistance Act and its regulations.

11 BASIC HEALTH AND WELFARE AND DISABILITY

49. We note the failure of the DH to adequately respond to the recommendations made by the ministerial committees on child, neonatal and maternal morbidity and mortality, and call on government to take action and implement these recommendations.

50. An essential package of care for children needs to be defined and adopted by government. The package should function within a defined set of norms and standards across the continuum of care - from neonatal care to adolescent and youth friendly services. These demand that adequate human and financial resources are allocated to child health services and should drive quality improvement and address accountability.

51. The lack of caring attitudes amongst health care providers must be explicitly addressed to improve quality, it must be integrated into performance appraisal systems.

52. Child health continues to be compromised by poverty, food insecurity, inadequate housing, water and sanitation. A clear multi-sectoral implementation plan with interim targets and an effective monitoring and reporting system is required.

53. Power is overly centralised at provincial level, districts' power to manage services and budgets is marginalised. Strong leadership is required at district level to drive intersectoral collaboration and address local determinants of child health. Child-centred health councils ("war rooms") and District Clinical Specialist teams or potential mechanisms for this.

54. Community health workers: While the re-engineering of PHC envisages an expanded role for CHWs, greater efforts are needed to develop and support the functioning of a cohort of maternal and child health workers at community level. This requires inter alia improvements to their curriculum and conditions of service, expanding their scope of practice and their integration into the health care system, mentoring and support.

55. Policy, programmes and other initiatives by DH at all levels to address the right to health of children with disabilities must be integrated into a coordinated and holistic government programme for realising the rights of children with disabilities, including promoting optimal development, preventing developmental delay, and providing services for children with disabilities that optimise their health, development and participation, across the life course.

56. Adolescents require discreet and easy access to a range of SRH services including condoms, emergency contraception, post-exposure prophylaxis (PEP), medical circumcision, HIV tests, ARVs and treatment for STIs. SRH education must address questions of gender and sexual identity, enable young people to manage relationships, negotiate safe sex and challenge the norms that legitimate gender-based violence. It is important to engage with health workers, teachers and parents to address paternalistic and judgemental attitudes to teenage sex that prevent the information, support and services needed.

57. Substance abuse is a key driver of the adolescent burden of disease. Key recommendations include keeping alcohol and cigarette prices high, limiting marketing to youth and enforcing sanctions to limit underage use. Given the links between substance abuse, depression and poor self-esteem, it is important to increase investment in adolescent mental health promotion, screening and treatment services.

58. The Road to Health booklet is intended as an entry point to a package of services that extend beyond growth monitoring and immunisation to include development– and should serve as an effective patient-held record of treatment. It is therefore recommended that both health workers and mothers are empowered to use the booklet effectively.

59. Data collection and evaluation systems need to be strengthened. In particular Child PIP and PPIP need to be mandatory and extended to all facilities to identify and address avoidable causes of child and neonatal deaths in the health care system. This should ideally be complemented by the introduction of child death reviews. These have proven effective in investigating the circumstances surrounding out-of-facility deaths and improving intersectoral collaboration across health, social development and the criminal justice system.[215]

12 EARLY CHILDHOOD DEVELOPMENT (ECD)

60. GOSA accelerate implementation of ECD programmes in accordance with the new ECD policy's goals.

61. Dedicated programmes to ensure access to ECD services for children with disabilities, particularly in rural contexts, must be put in place.

13 EDUCATION

13.1. Budgets and expenditure – entrenched and deepening inequality in schools

62. Continued increase of allocation to BE budget, based on pro-poor budgeting and expenditure priorities.

63. President to sign a proclamation in terms of Act 74 of 1996 conferring authority on the Special Investigation Unit to investigate both nationally and provincially (a) maladministration (b) unlawful appropriation or expenditure of public funds (c) intentional or negligent loss of public money (d) the need for criminal or civil proceedings to be brought (e) the need for institution of disciplinary proceedings against employees.

64. Introduce legal reform through replacing the existing teacher provisioning model with a pro poor model that appropriately addresses the disparities within the public education system.

65. Strengthen the legal framework around privatization and create strict monitoring reporting obligations for private providers so that they are obliged to report on their financial

13.3. Quality education, learner retention and drop out

65. Increased policy attention on learner retention and the quality of learning.

66. Access to contraception in schools should be considered a basic human right. The GOSA must through the proposed policy and its implementation ensure unqualified, easy and discreet access to condoms.

67. DBE to urgently replace the unconstitutional 2007 school pregnancy policy. DBE to take steps to ensure that the new policy is brought to the attention of provincial and district officials and the public.

13.5. Education for foreign migrant children

68. The policy must stipulate that refugee and foreign migrant children cannot be discriminated against in school policies related to admissions such as fee exemption policies.

13.6. Inclusive education

69. Transformation of White Paper 6 into legislation in line with the UNCRPD. Without undermining the standards and system for inclusive education contained in White Paper 6, the mechanisms to implement the policy and timeframes must be reviewed through a transparent process.

70. The urgent prioritisation of the implantation of inclusive education including costing, budgeting and planning. The GOSA must avoid responding to the provision of inclusive education in a piecemeal fashion which exacerbates the lack of inclusion in mainstream schools of learners with barriers to learning who should be learning in those environments.

71. Collation of information regarding the names, ages and entrance grade required of children with disabilities on

a) Mainstream schools' admissions waiting lists.
b) Special schools' admissions waiting lists
c) Disabled Children who are not in the education system

This information to be updated and made publically accessible on a consistent basis.

Annexure 5 Respect for the views of the Child

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

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Annexure 6 Child-headed households in South Africa

The table below presents the numbers of child-headed households (CHHs) per year according to the Country Report (Table 47) and compares these with the numbers calculated by the Children's Institute (www.childrencount.ci.org.za). Although the same data source is used, the numbers presented in the Country Report are higher and in fact closer to the individual-level totals (i.e. the number of children, not households, living in CHH). The first line shows the numbers provided in Table 47 of the Combined Periodic Report. The second line shows the Children Count calculations by the Children's Institute in respect of children (individual level) and the third line shows the Children's Institute calculations at household level. It is unclear why the numbers presented in the Combined Periodic Report find an upward trend in the number of CHHs, whereas the Children Count data suggest a slight decline.

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

*All figures given in 000s

The Combined Periodic Report refers to the Children's Act's provisions for children living in CHHs. However the definition of "child-headed household" in the Children's Act is slightly different to the definition of "child-only household" for which statistics have been provided in the preceding paragraph. The latter is defined as a household in which all resident members are under the age of 18. The definition contained in section 137 of the Children's Act includes a household in which a child over the age of 16 has assumed the role of care-giver even if there is an adult living in the household who, for instance, is terminally ill. The definition of such CHHs is dependent on their identification by welfare services and a discretionary decision by the provincial head of social development that it is in the best interest of the children in the household for it to be defined as a child-headed household. This construction of 'child-headed household' is therefore conferred administratively; it is not a household form that can be quantified through national survey data and should not be conflated with the statistical estimates.

In paragraph 144 the Combined Periodic Report states that almost two-thirds of CHHs are living in formal dwellings concluding that this "supports the finding that many CHHs are created for a limited period of time only and often continue to be supported by an adult family member". However, the majority of the child population in general (nearly three-quarters) lives in formal housing. Given the distribution of children in different housing types, it would be more accurate to claim that children in CHHs are disproportionately represented in 'less adequate' forms of housing.

Annexure 7 The number of child adoptions in South Africa per financial year

Year	Local Adoption	International Adoption	Total
2009/2010	2605	293	2898
2010/2011	2236	200	2436
2011/2012	1426	194	1620
2012/2013	1522	177	1699
2013/2014	1236	212	1448

Source: Department of Social Development: Adoption register

Annexure 8 Snapshot of child health: social determinants, access to health services and outcomes 2013

Social determinants	
Poverty	54%
Reported child hunger	14%
Rural	45%
Informal housing	11%
Overcrowded households	20%
Inadequate access to water	32%
Inadequate access to sanitation	28%
Access to services	
Early access to antenatal care	50%#
Immunisation (< 1 year)	84.4% #
Vitamin A coverage (children 12 – 59 months)	44.6%
Early Infant Diagnosis	88.3%
Far from clinic (more than 30 min)	23%
Outcomes	
Under-five mortality rates (deaths/1,000 live births)	41*
Neonatal mortality (deaths/1,000 live births)	11+
Stunting (0 – 3 years)	26%^
HIV/AIDS	27.8%
Diarrhoea	18.4%
Lower respiratory	10.8%
Preterm birth complications and birth asphyxia	10.6% + 5.25%)

^ = SANHANES[vi] -1 (2013); # = DHIS[vii] 2013/14; * = RMS[viii] 2013; + = DHIS 2013

$ = Second national burden of disease study[ix]; all other indicators are drawn from GHS[x] 2013

[vi] SANHANES -South African National Health and Nutrition Examination Survey
[vii] DHIS – District Health Information System
[viii] RMS = Rapid Mortality Surveillance
[ix] Msemburi W, Pillay-van Wyk V, Dorrington RE, Neethling I, Nannan N, Groenewald P, Laubscher R, Joubert J, Matzopoulos R, Nicol E, Nojilana B, Prinsloo M, Sithole N, Somdyala N and Bradshaw D. 2014. *Second national burden of disease study for South Africa: Cause-of-death profile for South Africa, 1997–2010.* Cape Town: Medical Research Council
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ENDNOTES

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[9] Budlender D & P Proudlock analysed the budget for children's social services every year since the Children's Act was enacted in 2007, until 2014. The series can be downloaded at: http://ci.org.za/index.php?option=com_content&view=article&id=493&Itemid=185
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