PART ONE:

Children and Law Reform

Part one examines recent policy and legislative developments that affect children in South Africa.

These include the:

- Green Paper on National Health Insurance
- Integrated School Health Policy
- High Court ruling on the Sexual Offences Act
- Schools' learner pregnancy policies
- Norms and standards for school infrastructure
- Policy for Social Service Practitioners

Legislative and policy developments 2012/2013

Paula Proudlock, Lori Lake, Lucy Jamieson (Children's Institute) and Lisa Draga (Equal Education Law Centre)

This review provides a description of and commentary on key legislative and policy developments affecting children over the past year. These include:

- Two new policies that promise improved health services for children – the Green Paper on National Health Insurance and the Integrated School Health Policy.
- Progress towards binding Minimum Norms and Standards on School Infrastructure which will contribute towards improvements in the quality of education.
- Direction from the Constitutional Court that schools' policies on pregnant learners should support pregnant learners to complete their schooling.
- A judgment by the High Court declaring the Sexual Offences Act unconstitutional for criminalising consensual sexual activity between adolescents.
- The finalisation of the Policy for Social Service Practitioners which aims to introduce a more equitable system for recognising and regulating the different categories of practitioners required to implement the Children's Act.

Green Paper on National Health Insurance

Globally, many countries are moving towards universal coverage in health care – this includes strengthening health systems to ensure equal access to quality services, and pooling financial risks so that health care costs do not put undue burden on poor and vulnerable households.[1]

In South Africa, the re-distribution of resources between the private and public health sector is key to achieving universal coverage. Private health insurance accounts for 44% of total health care expenditure, yet covers a relatively small proportion of middle- and high-income households concentrated in urban areas, while the under-resourced public health system is under pressure to deliver services to 85% of the population.[2] A further area of concern is the unequal distribution of health professionals between urban and rural areas. For example, only 12% of doctors work in the rural areas[3] which are home to 47% of the child population[4].

A Green Paper on National Health Insurance (NHI), outlining plans to ensure a more equitable distribution of financial and human resources, was released for public comment in 2011, and a White Paper is expected by the end of 2013.

The vision

The aim is to create a more equitable health system by:

- providing better access to quality health services for all South Africans;
- creating a single NHI fund to pool risks and resources;
- procuring services from accredited public and private providers on behalf of the whole population; and
- strengthening the performance of the public health system.

The Paper proposes a comprehensive, evidence-based, rights-based and cost-effective package of health services at all levels of care. Funds from the state fiscus, employers and individuals will be pooled in an NHI Fund to purchase health services on behalf of the population from accredited public and private health care providers.

The re-engineering of primary health care (PHC) is a core element of the plan and aims to revitalise the district health system. There is a strong emphasis on health promotion and prevention in addition to curative and rehabilitation services, and on community outreach to ensure that health care services reach those most in need. These PHC services will be delivered through three complementary streams:

1. District clinical specialist support teams will provide leadership at a district level with a focus on maternal and child health. The teams will provide training, mentoring and support to all health personnel to improve access to, and the quality of, services, and to ensure better health outcomes. These teams should comprise a principal obstetrician, gynaecologist, paediatrician, family physician, anaesthetist, midwife and PHC nurse. The Paper indicates that this composition is a starting point and districts can add to the team over time.
2. School health teams led by a professional nurse will do learner assessments, referrals, and health education with a focus on hygiene, nutrition, HIV and AIDS, abuse, mental health, and sexual and reproductive health.
3. Municipal ward-based outreach teams comprising community health workers, environmental health officers, health promotion practitioners and a professional nurse will extend the reach of health services.

Implementation

A phased implementation plan identifies the key systems needed to support the full transition by 2025. These include:

- setting national standards and quality assurance;
- investing in human resources;
- assessing and modernising health infrastructure and equipment;
- improving hospital management, administration and accountability;
- strengthening district health authorities;
- improving information management systems; and
- establishing pilot districts to cost and field test systems at district level.

Phase 1 (2011 – 2015) is currently underway:

- The National Core Standards for Health Care Establishments[5] provide a benchmark against which the quality of health establishments can be assessed, a national baseline audit of health care facilities[6] has been conducted, and an Office for Health Standards Compliance has been established to monitor standards.
- Eleven pilot districts, identified in 2012, are testing new interventions needed for the successful implementation of the NHI.[7]
- The National Human Resources for Health Strategy[8] has started to outline norms, staffing and training requirements and recognises the need to provide incentives to strengthen services in rural areas.

Commentary

The strong focus on primary health care, maternal and child health, and the proposed multidisciplinary composition of the various district health teams reflects the plan's emphasis on improving child and maternal health outcomes.

The adoption of a PHC approach gives effect to South Africa's obligations in terms of the child's right to health in the United Nations Convention on the Rights of the Child.[9] However, the lack of any reference to palliative health care services as part of the continuum of health care services under a PHC approach is of concern given South Africa's high HIV-prevalence rates.

Current shortages of health and allied professionals pose a major barrier to the implementation of the plan in all districts, especially in rural areas. The system will need to be flexible and innovative in addressing staff shortages and ensure a more equitable geographical spread of human resources.

Given the high rates of child abuse and neglect in South Africa and their impact on child health and development, it is important that the district health teams include or are expressly linked to child protection practitioners. This is a clear gap in the Green Paper that will hopefully be addressed in the White Paper. Due to chronic staff shortages in the child protection system, the categories of child protection practitioners that can serve on or support these teams need to include the full range of available social service practitioners.

Integrated School Health Policy

With nearly 11 million children attending school in 2011,[10] schools provide one of the most effective locations for providing health services to children. School health services aim to promote the physical, mental and social well-being of learners in order to maximise their learning capabilities. Health services at schools contribute therefore both to the realisation of children's rights to health and their rights to education.

A review[11] of South Africa's school health services notes large inequities between and within provinces, with low coverage at sub-district, school and child level. This stems in part from the challenges of integrating school health services into a new and still developing District Health System, where school health services are often put "on the back-burner" due to staff shortages and competing clinic-based demands.

> *In one of the rural research sites one of the nurses has 70 schools in her area, but she only managed to cover 20 since 2005. This coverage rate suggests that all 70 schools will be covered over a 12 year period only. This situation is especially prevalent in schools that are located far from clinics, many of these invariably being schools in the most disadvantaged areas.*[12]

A recent audit of health care facilities[13] reveals serious staff shortages at primary level and raises questions about health facilities' ability to respond to referrals from school health teams: 47% of clinics report no visit from doctors, whilst 52% of community health centres cannot offer proper dental services. Most facilities have no optometrists (89%), physiotherapists (72%), occupational therapists (74%), psychologists (82%), speech therapists (89%) or social workers (70%).

Acknowledging these challenges, the Departments of Health (DoH) and Basic Education (DBE) published the Integrated School Health Policy (ISHP)[14] in 2012. It aims to:

- *provide preventive and promotive services that address the health needs of school-going children and youth with regard to both their immediate and future health,*
- *support and facilitate learning through identifying and addressing health barriers to learning,*
- *facilitate access to health and other services where required, and*
- *support the school community in creating a safe and secure environment for teaching and learning.*

The policy aims to achieve broader provision and more equitable coverage of school health services. While implementation of the 2003 policy[15] focused primarily on screening for visual and hearing impairments of grade R and grade 1 learners, the new policy aims to introduce a comprehensive package of health care services for all learners from grade R to grade 12.

The package has a strong focus on health education and supplements the health education in DBE's life orientation

curriculum, with co-curricular activities to prevent risk behaviour; educate children about sexual and reproductive health, chronic illnesses and abuse; and promote good health and nutrition. These health education activities will be provided by health promoters, community health workers and/or non-governmental organisations.

While the 2003 policy focused on screening in the foundation phase, the new policy aims to assess each learner during each of the four education phases (grades R, 4, 8 and 10). Assessments include anthropometric[i] screening; assessments of oral health, vision, speech and basic hearing, fine and gross motor problems, chronic illness (including tuberculosis and HIV/AIDS); and psycho-social risk assessments.

Assessments in the foundation phase will focus on identifying barriers to learning, whilst mental health and sexual and reproductive health will be emphasised in high school including contraception, HIV counselling and testing for sexually-active learners either on site or at the nearest primary health care (PHC) clinic.

The ISHP outlines both departments' responsibilities at national, provincial, district, primary health care facility and school levels and recognises that strong partnerships between schools, communities and service providers are essential.

The policy describes how school health teams (as outlined in the National Health Insurance Green Paper) will be based in PHC clinics and led by a professional nurse, and may be assisted by an enrolled nurse or nursing auxiliary, with one nurse for every 2,000 learners. The professional nurse will coordinate the delivery of school health services, do learner assessments and provide on-site services, while health education will be delivered by health promoters or community health workers.

The policy includes a section on children's consent to school health services and states that:

> *Learners below the age of 18 years should only be provided with school health services with written consent of their parent or caregiver. However learners who are older than 14 years may consent to their own treatment, although they should be advised to inform and discuss their treatment with their parent or caregiver.*[16]

Commentary

It is vital to address potential barriers to the successful implementation of the ISHP. These include staff shortages; a lack of transport; insufficient basic equipment such as scales to weigh children; a lack of privacy at schools; inadequate referral systems;[17] and insufficient public sector physiotherapists, occupational therapists and psychologists to provide follow-up services at health facilities.[18] Possibly in recognition of these barriers, the ISHP provides for a progressive, phased implementation starting with younger learners in the most disadvantaged schools and extending services upward and outwards to reach all learners.

A mapping exercise will be needed to identify schools and districts with poor child health and education indicators, schools where health care services are non-existent, and districts where school health care nurses have unmanageable case loads. Provincial Health Departments are ultimately responsible for ensuring that the most disadvantaged districts receive the necessary capacity development and financial and human resources to implement the ISHP effectively.

For some unexplained reason, the ISHP's provisions on children's right to consent to treatment is based on the 1983 Child Care Act[19] which enabled children to consent to medical treatment from the age of 14. However, this Act's provisions were repealed on 1 April 2010 and replaced by new provisions in the Children's Act.[20] The new Act reduced the age of consent to medical treatment to 12, provided the child is mature enough to understand the risks, benefits and other implications of treatment. The Act also stipulates that the health status of children is confidential and health professionals may only breach confidentiality if it is in the child's best interests (as in the case of abuse).

The ISHP's stipulation of 14 as the age at which children can consent to health care services is also out of sync with another recently published DoH policy – the National Contraception and Fertility Planning Policy and Service Delivery Guidelines[21] which correctly follows the Children's Act and stipulates the age of consent as 12 years.

Sexual Offences Act: High Court rules criminalisation of consensual sex between adolescents unconstitutional

The primary intention of the Sexual Offences Act[22] is to protect children from abuse and exploitation by adults by setting the age of consent to sexual activity at 16. However, the Act also makes it a sexual offence for children aged 12 – 16 to engage in consensual sexual activities (ranging from kissing to penetration). The Act obliges adults to report a known sexual offence to the police – even if those involved are consenting adolescents. The constitutionality of these provisions was challenged by the Teddy Bear Clinic and Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) in the North Gauteng High Court on the grounds that they do not serve the best interest of children. The Minister of Justice and Constitutional Development opposed the application.

In the judgment, the court noted that all the parties to the case, including the Minister (even though he had opposed the application), agreed that "it is a common and normal part of sexual development for children to explore and experiment in sexual behaviours with their peers".[23] The court further noted that the duty to report sexually active adolescents limits the ability of adults to provide education, guidance and support to children in their sexual development.

The court found that the Act constitutes an "unjustified intrusion of control into the intimate and private sphere of children's relationships in a manner that will cause severe harm"[24]

i Measuring children's weight and height to assess their nutritional status.

and declared that the criminalisation of consensual teenage sexual activity, and consequent reporting to the police, violate a number of constitutional rights. These include the best interests' principle, dignity, bodily and psychological integrity, and privacy. In finding the provisions unconstitutional, the court concluded that "[t]he use of damaging and draconian criminal law offences to attempt to persuade adolescents to behave responsibly is a disproportionate and ineffective method which is not suited to its purpose".[25]

As the case concerns a declaration of unconstitutionality of an Act of national Parliament, it has to be confirmed by the Constitutional Court, which heard the case on 30 May 2013.[26] The Department of Justice and Constitutional Development (DoJ&CD) is opposing the application for confirmation by the Teddy Bear Clinic and RAPCAN. Based on the assumption that the law acts as a deterrent, the DoJ&CD claims that the prohibition protects "the bodily and psychological integrity of adolescents by delaying their choice on matters which may have a harmful consequence"[27] and that "parents, guardians and other responsible adults will be empowered to drive the message of risks of early sexual intimacy through these prohibitions"[28]. The department further argues that "there are no other less restrictive means to achieve the purpose of the prohibitions".[29]

The Constitutional Court will consider all the arguments before making a ruling.

Commentary

Sexual experimentation by adolescents is a normal part of growing up. However, adolescents' health and well-being may be at risk if they engage in sexual activity without the necessary knowledge about contraception, sexually-transmitted infections (STIs) and HIV, and before they are mature enough to understand and handle the emotional and health consequences. Everyone agrees that it is in the best interests of children to minimise these risks; the debate is about the most reasonable and effective way to do this.

Research has shown that while a mandatory reporting and abstinence-only approach is not an effective deterrent, "comprehensive sex education programmes have shown an increased likelihood in delaying sexual initiation and reduced likelihood of teen pregnancy".[30] Using an evidence-based approach, all adolescents should therefore be offered appropriate education and guidance on sexual and reproductive health from their parents and caregivers and at school and health care facilities.

Criminalising adolescents for engaging in developmentally normal behaviour is an extreme measure that not only violates their rights but may also prevent them from approaching their parents, educators, social workers, nurses and other support people for guidance, information, contraception, treatment of STIs and HIV, and advice on options and services if they fall pregnant. The DoH has explicitly recognised these risks in its 2012 Contraception Policy and therefore advises health professionals to enable adolescents to have access to counselling, contraception and health care services rather than follow a rigid approach to the reporting obligations:

> *The overarching public health imperative to prevent teenage pregnancy and prevent HIV and STIs needs to guide the provision of quality health services for young people. Every effort should therefore be made to provide accessible sexual and reproductive health services that take into account young people's vulnerability, psychosocial needs and their right to confidentiality. All initiatives should focus on prevention and, where this fails, to provide safe, quality youth-friendly services. This needs to be the overriding ethos, and should be counter-balanced with the rigid implementation of the reporting obligations.*[31]

The Child Justice Act[32] and Sexual Offences Act give discretion to police officers and prosecutors on whether or not to arrest and prosecute adolescents for consensual sexual activity. Would it not be more appropriate for health and social professionals – who are better qualified to assess the psychological and other risks to the child – to assess what is in each child's best interests? Parents and social and health professionals should have the freedom to determine their actions based on the best interests of the child; however, the Sexual Offences Act compels them to report even healthy sexual experimentation. The decriminalisation of consensual sexual activities between adolescents would allow parents and professionals to balance children's rights to protection, access to health services and confidentiality.

South African Schools Act: Schools should support pregnant learners

In March this year the Constitutional Court heard argument concerning the learner pregnancy policies of two Free State schools: Welkom and Harmony High. The schools' pregnancy polices excluded pregnant learners from school for a period of up to one year while pregnant and after giving birth.

Based on their policies the schools excluded two learners from school due their pregnancies. The head of the Free State Department of Education (HoD) instructed the schools to re-admit the learners. While the schools' principals eventually agreed to re-admit the learners, their school governing bodies (SGBs) launched a High Court application to prevent the HoD from interfering with the implementation of school policies on the basis that the HoD had no authority to override SGB policies in terms of the South African Schools Act (Schools Act). The HoD argued that the policies were unconstitutional and that he was obliged to intervene to protect the learners' rights. The SGBs succeeded in both the High Court and the Supreme Court of Appeal, so the HoD appealed to the Constitutional Court. Equal Education (EE) and the Centre for Child Law (CCL), University of Pretoria, acted as *amici curiae* (friends of the court).

The case was primarily concerned with the balance of power between HoDs who, through principals, are responsible for the management of schools (including implementing school policies), and SGBs, who are given certain defined powers under the Schools

Act to govern schools (including the power to craft school policies). The Court therefore had to consider whether the HoD had the authority under the Constitution and the Schools Act to instruct the principals to act against policies adopted by the SGB. The second issue which the Court was asked to rule on was whether the schools' policies on pregnant learners were constitutional from a content perspective.

EE argued that HoDs do have the power to intervene because they are obliged by the Constitution to respect, protect and fulfil pregnant learners' rights to human dignity, to receive a basic education, and not to be subjected to unfair discrimination. EE also contended that the pregnancy policies constitute unfair and double discrimination on the basis of both gender and pregnancy. It was submitted that the discrimination on the basis of gender in the pregnancy context is even more reprehensible when viewed in light of the societal dynamics that lead to young girls falling pregnant, which include skewed power relations, lack of organised sexual counselling in schools, non-availability of condoms and, sometimes, impregnation by teachers.[33]

The CCL made similar arguments concerning the content of the policies and also brought to the Court's attention that the policies were contrary to the state's obligations in terms of the African Charter on the Rights and Welfare of the Child, which requires states' to adopt policies and practices that encourage pregnant learners to return to school.[34]

As the High Court case was framed on the scope of the HoD's powers under the Schools Act, and not as a constitutional challenge to the content of the policies, the majority of the Constitutional Court judges did not make a definitive pronouncement on the constitutionality of the policies. Instead the Court stated that, on face value, the policies violated pregnant learners' rights to basic education, dignity, privacy and equality.[35] The Court ordered the two SGBs to revisit their pregnancy policies in consultation with the HoD and to furnish the Court with the revised policies.

Commentary

While the Court did say that pregnancy policies which punish pregnant girls are unacceptable and that learner pregnancy policies should be aimed at supporting pregnant learners, and while the Court ordered the two schools involved in the case to revise their policies, the judgment does not provide a systemic solution to the on-going exclusion of pregnant pupils from schools across the country.[36]

The kind of discriminatory practices evident in these two schools has been caused in part by unclear national policy on the rights of pregnant learners. The Department of Education's 2007 Measures for the Prevention and the Management of Learner Pregnancy[37] – while aiming to address discriminatory practices – also champion the view that a pregnant learner may be required to take a leave of absence of up to two years to "exercise full responsibility for parenting". In addition, it states that pregnant learners will not be allowed to return to school in the same year that they took time off to give birth. As a result many schools tailored pregnancy policies that compel pregnant learners to leave schools for extended periods of time. Notwithstanding a 2009 letter by the Director-General to all HoDs stating that "the measures have caused significant confusion",[38] they have not been clearly revoked or amended and schools are still excluding pregnant learners.

The Minister can remedy this by unequivocally revoking the 2007 policy and publishing a new national policy on pregnant learners based on the direction provided by the Constitutional Court. This would provide the necessary clarity to schools across the country.

South African Schools Act: The need for binding norms and standards on school infrastructure

Most public schools in South Africa lack the necessary resources and facilities to provide learners with quality education. Of the 24,793 public schools in the country, 14% of schools have no electricity, 46% use pit-latrine toilets and 95% have no science laboratories.[39]

Parliament added section 5A to the Schools Act in 2007 to empower the Minister of Basic Education to adopt regulations prescribing national minimum norms and standards for school infrastructure. When promulgated, these standards will set the basic level of infrastructure that every school must meet to function properly. The National Development Plan also recognises that it is only through minimum standards carrying the force of law that the Minister (and provincial ministers) can ensure that officials involved in planning, constructing and improving school infrastructure do not deliberately ignore these standards.[40] However there has been a long delay in finalising the regulations.

After many years of dialogue and advocacy without results, Equal Education (EE) filed an application in the Bhisho High Court. EE argued that the Minister's failure to promulgate the regulations was a violation of learners' rights to a basic education, dignity and equality, and a breach of obligations under the Schools Act. Twenty-four affidavits from principals, teachers and parents from public schools across the country detailed the poor conditions of school infrastructure and the negative impact of inadequate school facilities on teaching and learning. The poor conditions highlighted included unhygienic and non-functioning toilets; leaking roofs; decaying walls and floors; overcrowded classrooms; and the lack of running water, electricity, libraries and computer and science laboratories. The Minister's court papers acknowledged the "serious inadequacies and shortcomings in relation to infrastructure at many schools … across the country".[41]

In November 2012, just before the court case was to be heard, the Minister entered into a settlement agreement with EE in which she committed to publish draft regulations for comment by January 2013, and promulgate final regulations by May 2013. However the draft regulations published in January failed to set minimum standards and lacked detail on a number of crucial areas.

When the May deadline passed and the Minister had not introduced the regulations, EE turned back to the court for assistance. In July the High Court made an "order by consent" that the Minister should publish amended draft regulations for

© Equal Education

Mud schools in the Eastern Cape highlight the need for norms and standards.

comment by 12 September 2013, and final regualtions by 30 November 2013. The regulations must also contain timeframes for the provincial departments to comply with the minimum norms and standards.

Commentary

The key virtue of binding minimum norms and standards coupled with tangible deadlines is that they will introduce better planning and greater accountability into the education system. This includes top-down accountability of the Minister over provinces who are not delivering, by HoDs over principals who are not delivering, and most importantly accountability bottom-up from communities, parents and children themselves.

Policy for Social Service Practitioners

The Children's Act allocates tasks to "social service professionals", whom it defines as a "probation officer, development worker, child and youth care worker, youth worker, social auxiliary worker and social security worker".[42] However, the Act provides that only professionals who are registered under the Social Service Professions Act[43] may perform these functions.

Currently the only social service professionals that can register with the South African Council for Social Service Professionals (SACSSP) are social workers, social auxiliary workers and student social workers. While child and youth care workers have been performing child care and support services for more than three decades, they have faced many obstacles in gaining professional recognition. The recently inaugurated Professional Board for Child and Youth Care Workers has drafted regulations and a code of ethics that will allow child and youth care workers to register; however, these regulations have not yet been approved by the SACSSP.

The purpose of regulating professions is firstly to ensure that services are delivered by appropriately trained and skilled people who are bound by a code of conduct and ethics. Secondly, it is to ensure that professionals are supported by standardising education and training, and by developing career paths. In this way, people are attracted to the profession allowing numbers to grow and services to reach more children.

The Social Service Professions Act treats social workers differently to other social service professionals, for example, social workers are overrepresented on the SACSSP and elect six representatives, whilst other professions elect only three. This has made it difficult for new professions to gain recognition. For these and other reasons there is a need for new policy and legislation to regulate the different professions and to provide a more equitable regulatory framework. This will enable professions to grow and will assist the creation of a truly multidisciplinary workforce to implement the Children's Act effectively.

After stakeholder consultation, the Department of Social Development (DSD) published the Policy for Social Service Practitioners in January 2013[44] which seeks to address the obstacles to the expansion of the social service workforce by:

- recognising all practitioners in the field;
- creating mechanisms for planning the workforce;
- acknowledging the right to self-determination of existing practitioner groups such as child and youth care workers and community development practitioners; and
- improving education and training initiatives.

Commentary

The finalisation of the policy paves the way for the completion of a new law to recognise and regulate all social service practitioners. There is some urgency in this to enable recognition, career paths and regulation for the 10,000 child and youth care workers that will be trained and deployed to reach vulnerable children over the next five years as part of the Isibindi[ii] roll-out. The DSD has committed to finalise the new law in 2014/15.[45]

Conclusion

The developments outlined above promise improved health care services, education, and care and protection for children. However, the realisation of these improvements is heavily dependent on coherence across the various policies and laws and on the various departments ensuring that they plan and implement together. Such a coordinated approach will not only ensure improved access to quality services for children but would also enable the various sectors to pool resources and therefore deliver services more cost effectively.

The partnership approach followed by the national Department of Health (DoH) and the Department of Basic Education (DBE) in developing and publishing the Integrated School Health Policy (ISHP) bodes well for partnership at the provincial level of implementation. While the national Department of Social Development (DSD) was unfortunately not a formal partner in the development and publication of the ISHP, the policy does refer to a commitment by the DoH and the DBE to closer collaboration with the DSD.

At a national and provincial level, the three departments need to plan and implement together to be able to respond appropriately to the social and health needs of the high numbers of abused, neglected, orphaned and otherwise vulnerable children that will be identified in the school health assessments. Given that civil society organisations deliver the majority of child care and protection services in the provinces, the participation of civil society service providers in planning and implementing the National Health Insurance (NHI) and ISHP is also essential.

The lack of coherence between the Sexual Offences Act, Children's Act, the ISHP and the National Contraception Policy in relation to the provision of sexual and reproductive health and social services to adolescents is concerning. The preference of Department of Justice and Constitutional Development (DoJ&CD), as set out in the Sexual Offences Act and demonstrated by their arguments in court, is for adolescents between the ages of 12 and 16 who engage in consensual sexual activity to be dealt with via the criminal justice system. The Children's Act however guarantees children's right to development and therefore enables children's access to contraception and to make decisions about medical treatment from age 12. The ISHP, published jointly by the DoH and DBE, confuses matters by stipulating 14 as the age at which children can consent to health services despite being bound by the Children's Act to stipulate the age of 12. On the other hand, the Contraception Policy, also issued by the DoH, adheres to the Children's Act's prescribed age of 12 and encourages health professionals to focus on preventing HIV, sexually-transmitted infections, and teenage pregnancy by providing accessible and sensitive adolescent reproductive and sexual health services rather than following a rigid approach to the reporting requirements set out in the Sexual Offences Act.

The result of these contradictory policies and laws is confusion amongst the various officials and professionals tasked with serving children's best interests. To address this lack of coherence and ensure accessible health care services for adolescents, both the Sexual Offences Act and the ISHP and all future policies, including the national learner pregnancy policy, should be brought in line with the provisions of the Constitution and the Children's Act.

The successful implementation of each of these laws and policies is dependent on the successful implementation of the others. For example, the ISHP and PHC re-engineering with their strong focus on child health, are dependent on schools having the necessary infrastructure to ensure children have access to clean water and adequate sanitation. The ability of district-based health teams and school nurses to assist abused and neglected children is dependent on the DSD ensuring that there are sufficient numbers of appropriately trained social service practitioners to provide a timeous and caring protective and therapeutic response for traumatised children. Making sexual and reproductive education and health services accessible to adolescents will help reduce learner pregnancy while a national policy that supports pregnant learners to finish their schooling will improve young mothers education outcomes and the health, development and education outcomes of their children.

The successful implementation of both the NHI and ISHP is hampered by a critical shortage of health and allied professionals as well as social service professionals, particularly in rural areas. While there are plans to increase the numbers of professionals available and to incentivise work in rural areas, the shortages are so bad that more inventive approaches are needed to see improvements in the short to medium term. If the three departments involved could pool their existing human resources – particularly community health workers and child and youth care workers – to work in an integrated manner and align their selection of districts most in need, we could see major improvements in child health and well-being.

ii Isibindi is a support programme for orphaned and vulnerable children developed by the National Association of Child Care Workers (NACCW) and implemented by a range of non-governmental organisations in all the provinces.

References

1 Frenk J & de Ferranti D (2012) Universal health coverage: Good health, good economics. *The Lancet*, 380(9845): 862-864.
2 McIntyre D (2010) *Private Sector Involvement in Funding and Providing Health Services in South Africa: Implications for Equity and Access to Health Care*. Equinet discussion paper no. 84. Health Economics Unit, UCT & Institute for Social and Economic Research, Rhodes University.
3 Department of Health (2011) *Human Resources for Health South Africa. HRH Strategy for the Health Sector: 2012/13 – 2016/17*. Pretoria: DoH.
4 Hall K (2013) Housing and services – urban-rural distribution. *Children Count – Abantwana Babalulekile* website, Children's Institute, UCT. Accessed 8 June 2013: www.childrencount.ci.org.za.
5 Department of Health (2011) *National Core Standards for Health Establishments in South Africa*. Pretoria: DoH.
6 Health Systems Trust (2012) *National Health Care Facilities Baseline Audit: Summary Report*. Durban: HST.
7 Matsotso MP & Fryatt R (2013) National Health Insurance: The first 18 months. In: Padarath A & English R (eds) *South African Health Review 2012/13*. Durban: Health Systems Trust.
8 See no. 3 above.
9 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN Assembly resolution 44/25*. Geneva: United Nations. Articles 24(2)(b) and (c).
10 Hall K (2013) Education – School attendance. *Children Count – Abantwana Babalulekile* website, Children's Institute, UCT. Accessed 8 June 2013: www.childrencount.ci.org.za.
11 Shung King M (2009) *Reviewer Report: Implementing the National School Health Policy in South Africa, 2003 – 2009. Executive Summary*. Oxford: Oxford University.
12 See no. 11 above.
13 See no. 6 above.
14 Departments of Health and Basic Education (2012) *Integrated School Health Policy and Implementation Guidelines*. Pretoria: DoH & DBE.
15 Department of Health (2003) *National School Health Policy and Implementation Guidelines*. Pretoria: DoH.
16 See no. 14 above, pp.16 – 17.
17 See no. 11 above.
18 See no. 6 above.
19 Child Care Act 74 of 1983.
20 Children's Act 38 of 2005.
21 Department of Health (2012) *National Contraception and Fertility Planning Policy and Service Delivery Guidelines*. Pretoria: DoH.
22 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
23 *Teddy Bear Clinic for Abused Children and Others v Minister of Justice and Constitutional Development and Others*. Case no. 73300/10, North Gauteng High Court, 14 January 2013. Para 100.
24 See no. 23 above, para 74.
25 See no. 23 above, para 112.
26 *Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another.* CCT 12/13.
27 Minister of Justice and Constitutional Development (2013) *Respondent's Heads of Argument in the matter Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another*. CCT 12/13. Para 44.
28 See no. 27 above, para 91.3.
29 See no. 27 above, para 94.
30 Gevers A, Mathews C, Cupp P, Russell M& Jewkes R (2013) Illegal yet developmentally normative: A descriptive analysis of young, urban adolescents' dating and sexual behaviour in Cape Town, South Africa. *BMC International Health and Human Rights,* 13:31.
31 See no. 21 above, p. 45.
32 Child Justice Act 75 of 2008.
33 Equal Education (2012) Equal Education's written submissions in the matter between *Head of Department, Department of Education Free State Province v Welkom High School and Others (Equal Education and Centre for Child Law intervening as Amici)*. CCT 103/12 [2013] ZACC 25.
34 Centre for Child Law (2012) Written submissions by the Centre for Child Law in the matter between *Head of Department, Department of Education Free State Province v Welkom High School and Others (Equal Education and Centre for Child Law intervening as Amici)*. CCT 103/12 [2013] ZACC 25.
35 *Head of Department, Department of Education Free State Province v Welkom High School and Others (Equal Education and Centre for Child Law intervening as Amici)*. CCT 103/12 [2013] ZACC 25.
36 Veriava F (2013) Don't rely on courts: Fix the policy. *Mail & Guardian Online*, 15 August 2013.
37 Department of Education (2007) *Measures for the Prevention and Management of Learner Pregnancy: Choose to Wait for a Brighter Future.* Pretoria: DoE.
38 Soobrayan B (2009) Learner Pregnancy. Letter to provincial HoDs for Basic Education signed by the Acting Director-General of the national DBE, Mr Soobrayan, 28 November 2009. Copy on file with Equal Education.
39 Department of Basic Education (2011) *NEIMS (National Education Infrastructure Management System) Report, May 2011*. Pretoria: DBE.
40 National Planning Commission (2012) *National Development Plan 2030. Our future – make it work:* Pretoria: The Presidency. P. 313.
41 Minister of Basic Education (2012) *Answering Affidavit in the matter Equal Education v Minister of Basic Education*. Bhisho High Court case no. 81/2012. Para 15.
42 See no. 20 above, section 1.
43 Social Services Professions Act 110 of 1978.
44 Department of Social Development (2013) *Policy for Social Service Practitioners*. Pretoria: DSD.
45 Department of Social Development (2013) *Annual Performance Plan*. Pretoria: DSD.