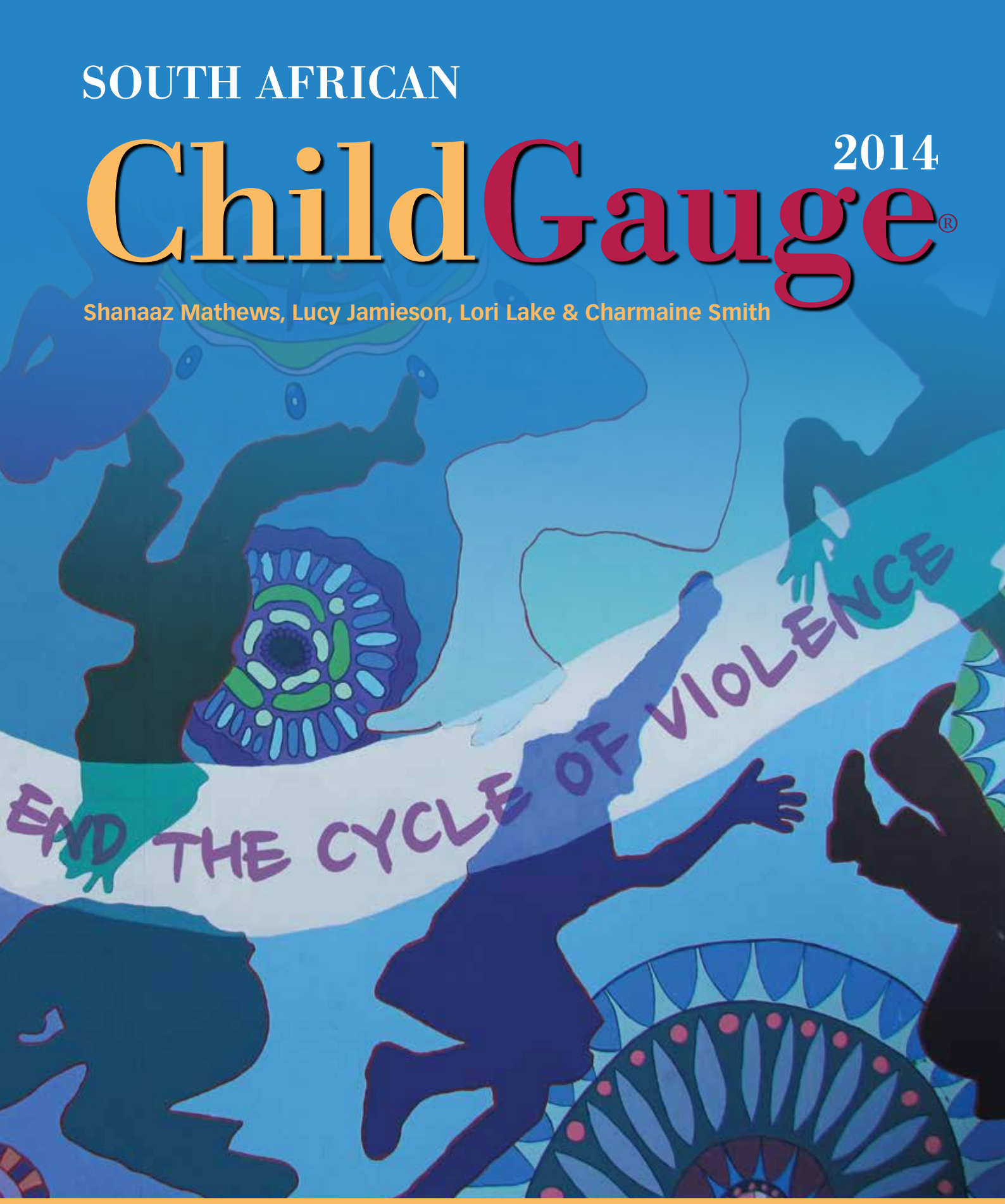
SOUTH AFRICAN

Child Gauge® 2014

Shanaaz Mathews, Lucy Jamieson, Lori Lake & Charmaine Smith



UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

children's institute
child rights in focus
Research • Advocacy • Education

Broad overview of the *South African Child Gauge 2014*

The *South African Child Gauge* is published annually by the Children's Institute, University of Cape Town, to monitor progress towards realising children's rights. This issue focuses attention on the prevention of violence against children.

PART ONE: Children and law reform

Part one outlines recent legislative developments affecting children. This issue comments on litigation, law reform and policy developments including Norms and Standards for School Infrastructure, a Constitutional Court ruling on school admissions policies, High Court judgments on school furniture and textbooks, the Traditional Courts Bill, Constitutional Court rulings on consensual sex between adolescents and children who commit sexual offences, an Amendment Act which provides for sexual offences courts; and proposed amendments to the Children's Act.
See pages 12 – 21.

PART TWO: Preventing violence against children – breaking the intergenerational cycle

Part two presents eight essays – the first essay describes the extent and primary drivers of violence against children, while the second provides a conceptual framework to inform the design and delivery of prevention programmes. The next two essays focus on the child protection system and address current design and resource challenges. A further three essays focus on violence prevention during three critical stages of children's development: early childhood, the primary school period and adolescence, while the conclusion considers what is needed to shift from policies and plans to implementation.
See pages 22 – 85.

PART THREE: Children Count – the numbers

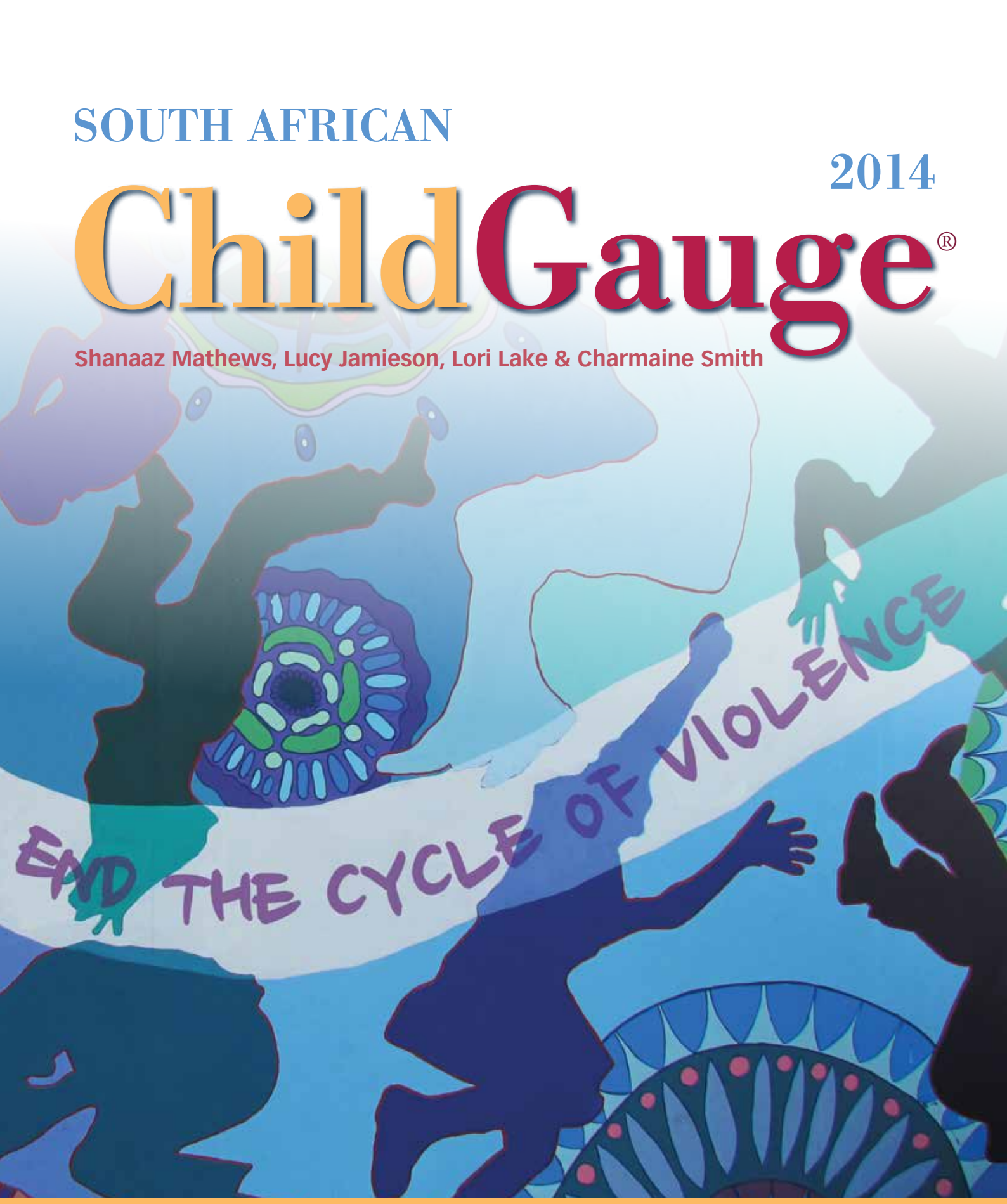
Part three updates a set of key indicators on children's socio-economic rights and provides commentary on the extent to which these rights have been realised. The indicators are a special subset selected from the website www.childrencount.ci.org.za.
See pages 86 – 116.

SOUTH AFRICAN

2014

ChildGauge®

Shanaaz Mathews, Lucy Jamieson, Lori Lake & Charmaine Smith



Acknowledgements

The editors are grateful to all those who contributed to this ninth issue of the *South African Child Gauge*:

- The authors, whom without this publication wouldn't have been possible.
- For the *Reflections on preventing violence against children*, the Minister of Social Development, Bathabile Dlamini; and the Minister of Justice and Correctional Services, Mike Masutha.
- Marta Santos Pais, Special Representative of the United Nations Secretary-General on Violence against Children, for the *Foreword*.
- Patrizia Benvenuti, UNICEF; Mastoera Sadan, Programme to Support Pro-Poor Policy Development, The Presidency; Guy Lamb, UCT's Safety and Violence Initiative; Gertrude Chanda, World Vision South Africa; Joan van Niekerk, Childline South Africa; and Wessel van der Berg, Sonke Gender Justice, for their guidance as members of the editorial advisory committee.
- The peer-reviewers who so unselfishly gave their time to comment on the essays and recommend improvements: Carol Bower, Linali Consulting; Debbie Budlender, Debbie Budlender and Associates; Patrick Burton, Centre for Justice and Crime Prevention; Elizabeth Dartnell, Medical Research Council; Anik Gevers, Medical Research Council; Lisa Draga, Equal Education Law Centre; Chandre Gould, Institute for Security Studies; Lezanne Leoschut, Centre for Justice and Crime Prevention; Heidi Loening-Vosey, UNICEF South Africa; Jackie Loffell, Johannesburg Child Welfare; Robert Morrell, Programme for Enhancement of Research Capacity, University of Cape Town; Kelly Moult, Gender Health and Justice Research Unit; Divya Naidoo, Save the Children South Africa; Dean Peacock, Sonke Gender Justice; Bronwen Pithey, National Prosecuting Authority; Paula Proudlock, Children's Institute, University of Cape Town; Ann Skelton, Centre for Child Law, University of Pretoria; Catherine Ward, Department of Psychology, University of Cape Town; Samantha Waterhouse, Community Law Centre, University of the Western Cape.
- Frank Joubert Art Centre for the cover image which is drawn from a mural they developed as part of safe haven for pupils at Parkfields Primary in Hanover Park; and AMANDLA EduFootball, the National Association of Child Care Workers, The Parent Centre, Resources Aimed at the Prevention of Child Abuse and Neglect, and Sonke Gender Justice for the photographs in the book.
- Cassidy Williams, Tristan Forbes and Uzair Boyes from Norma Road Primary for the beautiful artwork used as section dividers.
- Children's Institute researchers and support staff who supported the editorial team in many ways.
- UNICEF South Africa, the Programme to Support Pro-Poor Policy Development in The Presidency; World Vision South Africa; the FNB Fund, and UCT's Safety and Violence Initiative for funding the production of the book, accompanying materials and the public launch.
- The ELMA Foundation for their support to the Children's Institute as a key donor over the past years, and the DG Murray Trust for their support to the Children Count – *Abantwana Babalulekile* project.
- Mandy Lake-Digby for the design and layout.

Opinions expressed and conclusions arrived at are those of the authors and are not necessarily attributed to any of the donors or reviewers.

Citation suggestion

Mathews S, Jamieson L, Lake L & Smith C (eds) (2014) *South African Child Gauge 2014*. Cape Town: Children's Institute, University of Cape Town.

ISBN: 978-0-7992-2514-3

46 Sawkins Road, Rondebosch, Cape Town, 7700, South Africa
Tel: +27 21 650 1473 Fax: +27 21 650 1460
E-mail: info@ci.org.za Web: www.ci.org.za

Contents

Acknowledgements 2

Contents 3

List of figures, tables and cases 4

Abbreviations 6

Foreword *Marta Santos Pais, Special Representative of the United Nations Secretary-General on Violence against Children* 7

Reflections on the prevention of violence against children 10

Ms Bathabile Dlamini, MP, Minister of Social Development 10

Mr Mike Masutha, MP, Minister of Justice and Correctional Services 11

PART ONE: CHILDREN AND LAW REFORM

Legislative and policy developments 2013/2014 *Lucy Jamieson, Nikki Stein and Samantha Waterhouse* 14

PART TWO: PREVENTING VIOLENCE AGAINST CHILDREN

Overview 24

Violence against children in South Africa: Developing a prevention agenda *Shanaaz Mathews and Patrizia Benvenuti* 26

The prevention of violence against children: Creating a common understanding *Joan van Niekerk and Mokhantšo Makoae* 35

Towards effective child protection: Adopting a systems approach *Cathy Chames and Dena Lomofsky* 43

Towards effective child protection: Ensuring adequate financial and human resources
Lucy Jamieson, Lorenzo Wakefield and Megan Briedé 51

Young children: Preventing physical abuse and corporal punishment *Carol Bower and Andrew Dawes* 58

Primary school children: Widening worlds and increasing risk of sexual abuse
Lucie Cluver, Franziska Meinck and Shaheeda Omar 65

Adolescents: Preventing interpersonal and gender-based violence *Pinky Mahlangu, Aník Gevers and Ariane De Lannoy* 73

Adopting a violence prevention approach: Shifting from policies and plans to implementation
Mastoera Sadan and Shanaaz Mathews 80

PART THREE: CHILDREN COUNT – THE NUMBERS

Introducing Children Count – *Abantwana Babalulekile* 88

Demography of South Africa's children *Katharine Hall, Helen Meintjes and Winnie Sambu* 90

Income poverty, unemployment and social grants *Katharine Hall and Winnie Sambu* 94

Child health and nutrition *Nadine Nannan, Katharine Hall and Winnie Sambu* 99

Children's access to education *Katharine Hall* 104

Children's access to housing *Katharine Hall* 110

Children's access to services *Katharine Hall* 113

Technical notes on the data sources 115

About the contributors 117

List of figures, tables and cases

PART ONE: LEGISLATIVE DEVELOPMENTS

Table 1: Deadlines for the upgrading of exisiting schools 14

PART TWO: PREVENTING VIOLENCE AGAINST CHILDREN

Cases

Case 1: Adverse family environments in the shaping of violent behaviour 27
Case 2: The intergenerational cycle of abuse 30
Case 3: Thula Sana – An intervention to enhance the mother–infant relationship and infant attachment 38
Case 4: Children are precious – A comprehensive approach to child protection at community level 40
Case 5: Poor collaboration between service providers 47
Case 6: Thuthuzela Care Centres 48
Case 7: Mapping child maltreatment at local level 49
Case 8: Community-based training of child and youth care workers 56
Case 9: The case for the legal prohibition of corporal punishment 62
Case 10: Building evidence for prevention – Parenting programmes 67
Case 11: Zero tolerance in Limpopo – A multi-level community-based intervention 67
Case 12: Preventing perpetrators from re-offending – The Support Programme for Abuse Reactive Children 70
Case 13: Stepping Stones – An intervention for addressing violence 76
Case 14: The PREPARE programme – Promoting sexual and reproductive health and reducing intimate partner violence and sexual violence among adolescents in the Western Cape 77
Case 15: AMANDLA EduFootball – Creating a safe hub and promoting fair play 78
Case 16: One Man Can – Mobilising men to end violence 81
Case 17: Isibindi safe parks – Creating safe spaces for children to play 83

Figures

Figure 1: Forms of violence through the life course of a child 29
Figure 2: The social-ecological model 30
Figure 3: How South African law gives effect to international rights 44
Figure 4: Key elements of the child protection system 45
Figure 5: The child protection and allied systems 46
Figure 6: Gradual shift from current emphasis on crisis response to ideal future where the need for crisis intervention has been reduced 52
Figure 7: Distribution of the children and families budget across sub-programmes, 2013/14 – 2016/17 53
Figure 8: Department of Social Development budget allocations to children and families, per child per province, 2014/15 54
Figure 9: Nested levels of influence 59
Figure 10: Social, economic and family vulnerabilities for child abuse 66

Tables

Table 1: Risk and protective factors for violence against children 31
Table 2: Mapping prevention and early intervention at each level of the social-ecological model 37
Table 3: Intervention strategies used by CAP 40
Table 4: Comparison of the share of resources allocated for Children's Act services with the share of the child population, 2013 54

Table 5: Key personnel required for Children's Act in year six of implementation 55
Table 6: Primary prevention – School- and community-based programmes 68
Table 7: Early intervention and protection services 69

PART THREE: CHILDREN COUNT – THE NUMBERS

Demography of South Africa's children

Table 1a: Distribution of households, adults and children in South Africa, by province, 2012 90
Figure 1a: Number and proportion of children living with their parents, by province, 2012 91
Figure 1b: Number and proportion of orphans, by province, 2012 92
Figure 1c: Number and proportion of children living in child-headed households, by province, 2002 & 2012 93

Income poverty, unemployment and social grants

Table 2a: Children receiving the Child Support Grant, by province, 2008 – 2014 96
Table 2b: Children receiving the Foster Child Grant, by province, 2014 97
Table 2c: Children receiving the Care Dependency Grant, by province, 2008 – 2014 98
Figure 2a: Children living in income poverty, by province, 2003 & 2012 94
Figure 2b: Children living in households without an employed adult, by province, 2003 & 2012 95
Figure 2c: Children receiving the Child Support Grant, by age, 2014 96
Figure 2d: Growth of the Foster Child Grant, 1998 – 2014 97

Child health

Table 3a: Child mortality indicators, 2009 – 2012 99
Figure 3a: HIV prevalence in pregnant women attending public antenatal clinics, by province, 2000 & 2012 100
Figure 3b: Children living far from their health facility, by province, 2002 & 2012 101
Figure 3c: Children living in households where there is reported child hunger, by province, 2002 & 2012 102

Children's access to education

Figure 4a: School-age children attending an educational institution, by province, 2002 & 2012 104
Figure 4b: Reported attendance at an educational institution, by age and sex, 2012 105
Figure 4c: School or ECD facility attendance among children aged 5 – 6 years only, by province, 2002 & 2012 106
Figure 4d: School-aged children living far from school, by province, 2012 107
Figure 4e: Children aged 10 – 11 years who have passed grade 3, by province, 2002 & 2012 108
Figure 4f: Children aged 16 – 17 who have passed grade 9, by province, 2002 & 2012 109

Children's access to housing

Figure 5a: Children living in urban areas, by province, 2002 & 2012 110
Figure 5b: Children living in formal, informal and traditional housing, by province, 2012 111
Figure 5c: Children living in crowded households, 2002 & 2012 112

Children's access to services

Figure 1a: Children living in households with water on site, by province, 2002 & 2012 113
Figure 1b: Children living in households with basic sanitation, by province, 2002 & 2012 114

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASSA	Actuarial Society of South Africa
BEFA	Basic Education for All
CAP	Children Are Precious
CCTV	Close-Circuit Television
CDG	Care Dependency Grant
CSG	Child Support Grant
CYCWs	Child and Youth Care Workers
DBE	Department of Basic Education
DSD	Department of Social Development
EC	Eastern Cape
FCG	Foster Child Grant
FETC	Further Education and Training Certificate
FS	Free State
GHS	General Household Survey
GT	Gauteng
HIV	Human Immunodeficiency Syndrome
ICD10	International Statistical Classification of Diseases and Related Health Problems
IMR	Infant Mortality Rate
IMC	Inter-Ministerial Committee
KZN	KwaZulu-Natal
LP	Limpopo
MDG	Millennium Development Goal
MP	Mpumalanga
MST	Multi-Systemic Therapy
MTSF	Medium-Term Strategic Framework
NACCW	National Association of Child Care Workers
National Strategic Plan	Comprehensive National Strategy Aimed at the Provision of Prevention and Early Intervention Programmes to Families, Parents, Caregivers and Children Across South Africa
NC	Northern Cape
NCPR	National Child Protection Register
NDP	National Development Plan
NFP	Nurse Family Partnership
NGOs	Non-Governmental Organisations
NMR	Neonatal Mortality Rate
NPA	National Prosecuting Authority
NPOs	Non-Profit Organisations
NRSO	National Register for Sex Offenders
NSP	National Strategic Plan
NW	North West
OMC	One Man Can
POA	Integrated Programme of Action for 2013 – 2017
PMTCT	Prevention of Mother-To-Child Transmission
PSUs	Primary Sampling Units
QLFS	Quarterly Labour Force Survey
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RMS	Rapid Mortality Surveillance
SA	South Africa
SACSSP	South African Council for Social Service Professions
SAHRC	South African Human Rights Commission
SASSA	South African Social Security Agency
Situational Analysis	Situational Analysis Report of the Social Service Workforce Serving Children
SOA	Sexual Offences Act
SOCPEN	Social Pensions
Stats SA	Statistics South Africa
STIs	Sexually-Transmitted Diseases
TCCs	Thuthuzela Care Centres
TVEP	Thohoyandou Victim Empowerment Programme
U5MR	Under-5 Mortality Rate
UCT	University of Cape Town
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Emergency Children's Fund
WC	Western Cape
White Paper	White Paper on Social Welfare

Foreword

Marta Santos Pais

Special Representative of the United Nations Secretary-General on Violence against Children

This issue of the *South African Child Gauge* marks a very special year for children – the 25th anniversary of the adoption of the United Nations Convention on the Rights of the Child. Upon ratification of this international charter of children's rights, 193 states parties have made a solemn pledge to safeguard the rights of all girls and boys, everywhere and at all times.

Under the Convention on the Rights of the Child, children are not simply passive beneficiaries of actions, services or charity. They are subjects of rights and agents of change. Governments are required to take children seriously and to promote children's rights as a distinct priority: in laws and policies, in budget decisions and in daily actions across all levels of administration. One key dimension of this agenda is the imperative to safeguard the right of the child to freedom from violence.

The right of the child to freedom from violence lies at the heart of the Convention. It is inherent to the human dignity of the child and it stands as a crucial indicator of how genuine the commitment of any nation is to safeguarding children's human rights.

Violence is a human rights violation that compromises children's rights and hinders social progress. Fear and pain continue to haunt the lives of millions of children around the world. The 2006 UN Secretary-General's study on violence against children[1] represented the first attempt to document this sad reality. The study set forth 12 overarching recommendations to accelerate progress toward the prevention and elimination of violence against children, in all its forms and in all settings. To assess progress in the implementation of these recommendations, in 2013 my office conducted a global survey[2] which was informed by reports received from over 100 national governments.

The global survey highlights positive developments and provides strategic guidance on what needs to be done to give every child the opportunity of enjoying a childhood free from violence. Our understanding of how and why children are exposed to violence in the home, in schools, on the streets, in the workplace, in care institutions and in detention centres has deepened and strategic actions are underway in a number of countries to translate this knowledge into effective protection.

The global survey found that many governments have strengthened national implementation efforts through the adoption of public policies and legal reforms, and have launched information campaigns to rally public support and overcome social norms and attitudes condoning violence against children. Children and young people are actively joining these efforts, including through advocacy and peer education.

Despite this positive trend, progress has been too slow, too uneven and too fragmented to bring violence against boys and girls

1 Pinheiro PS (2006) *World Report on Violence against Children*. New York: UN.
2 Office of the Special Representative of the United Nations Secretary-General on Violence against Children (2013) *Toward a World Free from Violence: Global Survey on Violence against Children*. New York: UN.

to an end. Violence remains a pervasive phenomenon that blights the life of countless children around the world and is associated with serious human, social and financial costs.

The global survey calls upon governments to develop and promote a national, child-centered, integrated, multi-disciplinary and time-bound strategy for violence prevention and children's protection there from. Explicit legal bans on all manifestations of violence against children should be enacted as a matter of urgency, accompanied by detailed measures for effective enforcement and by greater efforts to address the social acceptance of this phenomenon. Governments must work to enhance the meaningful participation of children and to ensure the social inclusion of girls and boys who are particularly vulnerable. A stronger focus should be placed on the factors that influence levels of violence and the resilience of children, their families and communities. The crucial importance of collecting and effectively using disaggregated data on violence against children should be recognised and matched with adequate support and resources. Moreover, to further advance nations' development and the protection of children's rights, violence against children should be made a priority concern in the post-2015 development agenda.

This issue of the *South African Child Gauge* supports global efforts to prevent and eliminate violence against children. It provides a sound contribution to our understanding of the challenges faced by children in South Africa and encourages action to strengthen violence prevention and response efforts and accelerate progress in the implementation of the Children's Act and with the Bill of Rights in the Constitution.

The report highlights that while much has been achieved, the violence is pervasive in South Africa, as it is around the world. It points to the extent and depth of the violence that is committed against children and, importantly, what needs to be done from a legal, policy and programmatic perspective to more effectively secure children's protection.

The *South African Child Gauge 2014* is particularly timely, as South Africa commemorates 20 years of the advent of democracy. This is a uniquely auspicious time to mark the start of an era where all boys and girls enjoy a childhood free from violence.

As Special Representative of the Secretary-General on Violence against Children, I warmly welcome this important report and look forward to joining hands with the South African government and its partners to ensure that children's right to freedom from violence is a reality everywhere and at all times.

New York, 1 August 2014

Isibindi child and youth care workers: Work in the life space of children providing developmental care and support

Reflections on the prevention of violence against children

Ms Bathabile Dlamini, MP

Minister of Social Development

It is with pleasure that I submit my contribution to the 2014 *South African Child Gauge*, a valuable publication that gives a detailed account of the status of children in our country. The publication of this report comes at an opportune time as we celebrate 20 years of freedom and democracy in South Africa.

The celebration of this significant milestone will not be complete without us taking a collective reflection on the progress we have made in protecting our children. The *Child Gauge 2014* gives us a unique opportunity to consider the breadth and depth of actions taken by the many contributors to this effort, and also to begin to document the areas of common endeavour that will translate the promise of a better life, including child protection especially for many vulnerable children in South Africa, into a living reality.

Twenty years ago, under the leadership of our first democratically elected President, Mr Nelson Mandela, we set about creating a caring society and a South Africa fit for children. This commitment is reflected in a number of progressive pieces of legislation that our ANC government ratified since coming into office. The achievements of our government as reflected in the *Twenty Year Review* report reflect our enduring commitment to achieving this goal, and also highlight the remarkable progress we have made since the dawn of democracy.

Through government's pro-poor policies and programmes such as school nutrition, social assistance, no-fee schools and other initiatives, we have witnessed improvement in girls' enrolment and attendance in school and also increased access to basic services at the household level, resulting in positive outcomes for children and families.

Despite this remarkable progress, much more still needs to be done to address high levels of violence against women and children. The urgency of addressing this issue is underlined by the recent spate of terrible violence and sexual offences against children in Gauteng province and other parts of our country. This violence – unjustifiable and largely preventable – is a major barrier to the full realisation of the human rights of children as enshrined in our Constitution.

It is against this background that, in 2012, Cabinet established the Inter-Ministerial Committee (IMC) made up of the Ministers of Social Development; Justice and Correctional Services; Women; Home Affairs; Police; and Basic Education to look into the root causes of violence against women and children.

The membership of this committee clearly shows that protecting children is a shared societal responsibly that cannot be left to government alone. For this reason, the Integrated Programme of Action (POA) for 2013 – 2017 highlights the need to work together across government and with all sectors of our society to prevent and respond to violence against children. The POA is a five-year plan which underlines our national effort to put the safety, health and well-being of children at the centre of government's work. It represents an integrated approach to protecting children and drives new partnerships in achieving a common goal. Furthermore, the POA notes the need to pay special attention to cross-cutting strategies aimed at promoting and protecting the rights of children with disabilities. Social Development, as a lead government department and a key member of the Justice, Crime Prevention and Security Cluster, will co-ordinate the implementation of the POA in collaboration with all stakeholders.

The proposed interventions and programmes in the POA outline an extensive range of existing and new measures that are aimed at stepping up our national efforts to combat violence against children. One such initiative is the annual national Child Protection Week campaign, which provides a key platform for accelerating violence prevention and response efforts at all levels of our society.

For over 20 years we have been running an annual multimedia Child Protection Week campaign to increase awareness and understanding of the importance of primary prevention to reduce child abuse, neglect and exploitation in South Africa. The main aim of the campaign is to embed primary prevention by supporting the work of community-based organisations and other initiatives to act on the core message, "protecting children is everyone's business".

I have no doubt that, if we mobilise and empower communities to take action at local level, we will succeed in bringing a solution to one of the most intractable challenges of our times – violence against women and children.

Working together, I am confident that we can, indeed, ensure that all children in South Africa are and feel safe.

Mr Mike Masutha, MP

Minister of Justice and Correctional Services

The protection of children's rights is a collective responsibility.

By their very nature, children are susceptible to violence, abuse and exploitation. It's always horrifying to read stories of gross violence, neglect and abuse perpetrated against defenceless children. Some of these horrible acts of criminality are perpetrated by immediate family members, who should be leading in the protection of children's rights.

This situation requires collective effort from all concerned parties and community members. Children have a special role in the future of the country and carry the responsibility to advance the country's democracy. Over the past 20 years, the Department of Justice and Constitutional Development has placed at the heart of its initiatives the need to protect and promote the rights of children.

In pursuit of a safer society for the children and all who live in the country, the department is guided by the Constitution and lately the National Development Plan (NDP), which is the country's vision until 2030. The Constitution, which is one of the defining heritage symbols of the country's democracy, is unequivocal in its dictate for all to prioritise the rights of children.

The Constitution clearly states that every child has the right to basic nutrition, shelter, basic health care services and social services. It further states that every child has the right to be protected from maltreatment, neglect, abuse or degradation. The NDP has adopted this instruction as one of the country's apex priorities and envisions a society where children will be able to walk freely in our streets without fear of violation.

This vision is supported by various pieces of legislation which specifically aim to protect and promote the rights of children. Amongst these is the Criminal Law Amendment Act (otherwise known as the Sexual Offences Act) which expands the definition of rape to include all forms of sexual penetration without consent, irrespective of gender and age. The Act also introduces the National Register for Sex Offenders which contains the names of people convicted of sexual offences perpetrated against children and people with mental disabilities. The register ensures that people convicted of sexual violence do not work in institutions dealing with children.

The department has also promoted the ascent of the Children's Act (Act 38 of 2005) to create a platform for children in need of care and protection, and makes decisions about those who are abandoned and neglected. In terms of this Act, all magistrate's courts are considered children courts, which essentially brings access to justice for children closer to their communities.

Last year the President signed into law the Prevention and Combating of Trafficking in Persons Act, which adds yet another measure in the protection of children against abuse and violation. While, previously, perpetrators of trafficking persons would be charged under different and fragmented statutes, this Act provides a clear guidance in dealing with this heinous crime.

The Maintenance Act has been passed to deal with the socio-economic abuse of children through neglect by parents and responsible guardians. The Maintenance Act places a responsibility on the parents to support the child financially and to ensure that they have basic nutrition and shelter. The department is currently improving its systems and processes to speed up the application and payment of maintenance money to the rightful beneficiaries.

One of the key focus areas of this administration is to drastically reduce the number of children in correctional facilities. The intension is to encourage the use of diversion programmes in dealing with children who are in conflict with the law. In doing this the department is guided by the Child Justice Act, which creates a separate and less adversarial criminal justice system for children in conflict with the law.

The department has also undertaken to re-establish a new model of sexual offences courts to provide special supporting services for victims of sexual violence. This requires a separate, conducive room fitted with the necessary equipment to support the testimonies of children in sexual offence-related matters.

All these initiatives, amongst others, require that community members consciously work with the criminal justice system to protect children. Children live in our communities. Let us not look away. Instead let us say: "not under my watch" and report any act of violation. The country's future is as secure as the future of the children.

Chel
Go my
boy

PART ONE:
Children and Law Reform

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

These include:

- Norms and standards for school infrastructure;
- A Constitutional Court decision on school admissions policies;
- High Court judgments on school furniture and textbooks;
- The Traditional Courts Bill;
- Constitutional Court rulings on consensual sex between adolescents; and children who commit sexual offences;
- An Amendment Act that provides for sexual offences courts; and
- Proposed amendments to the Children's Act.

Legislative Developments 2013/ 2014

Lucy Jamieson (Children's Institute, University of Cape Town), Nikki Stein (SECTION27), and Samantha Waterhouse (Community Law Centre, University of the Western Cape)

This review summarises and comments on a range of developments between July 2013 to July 2014, focusing on education, justice and social services for children. These include:

- New regulations that set minimum norms and standards for public school infrastructure.
- A Constitutional Court decision on the balance of power between provincial Education Departments and school governing bodies in determining school admissions policies.
- High Court judgments on the obligation on the state to provide school furniture and textbooks.
- The Traditional Courts Bill which seeks to recognise and enhance traditional justice systems and provide for structure and functioning of traditional courts.
- Constitutional Court rulings on appropriate ways of dealing with consensual sexual acts between adolescents, and children who commit sexual offences.
- An Amendment Act that provides for the establishment of sexual offences courts.
- Two new Bills that propose to amend the Children's Act.

South African Schools Act: Minimum norms and standards for public school infrastructure

On 29 November 2013, the Minister of Basic Education published regulations[1] that provide for minimum norms and standards to which all public school infrastructure must comply. The norms and standards are necessary to ensure improvements are made to the poor and often unsafe state of schools across the country, particularly in rural areas. Adequate school infrastructure is necessary to protect the safety and dignity of learners and is key to their basic education.[2]

Data collected by the Department of Basic Education (DBE) in 2011 show there were over 400 mud schools, and of the 24,793 public ordinary schools:[3]

- 3,544 schools do not have electricity;
- 2,402 schools have no water supply;
- 913 do not have any ablution facilities and 11,450 schools still use pit latrines;
- 22,938 schools do not have stocked libraries;
- 21,021 schools do not have any laboratory facilities;
- 2,703 schools have no fencing; and
- 19,037 schools do not have a computer centre.

The norms and standards set out in detail the minimum that must be done to ensure appropriate learning environments for children. They specify, for example, classroom sizes, school toilets, and water and electricity provision.

All new schools, and schools renovated after the norms and standards came into effect, must adhere to the norms and standards in full. Table 1 presents deadlines that were set for the upgrading of existing schools, following a phased approach and starting with the most pressing needs as identified by the Minister. The provincial Education Departments must submit implementation plans to the Minister by 29 November 2014, and are required to report annually on their compliance with the plans.

The finalisation of the minimum norms and standards is just the beginning of the process of ensuring that learning and teaching

Table 1: Deadlines for the upgrading of existing schools

Norms and standards to be met	Implementation deadline
Schools built from mud, asbestos, wood and metal are to be replaced.	29 November 2016
Schools that do not have access to any form of power supply, water supply or sanitation are to be provided with these amenities.	29 November 2016
The standards relating to classrooms, electricity, sanitation, water, electronic connectivity and perimeter security are to be implemented in all other schools.	29 November 2020
The norms and standards for libraries and laboratories for science, technology and life science are to be implemented in all schools.	29 November 2023
All other norms and standards for school infrastructure such as computer laboratories, sports facilities and school nutrition centres as well as accommodation of learners with physical disabilities are to be implemented.	31 December 2030

take place in safe and appropriate environments. Effective implementation of the norms and standards is key. This requires, among other things, allocation of sufficient funds to meet the infrastructure needs of all schools, and oversight to ensure the proper and efficient expenditure of these funds. It is also possible that while there are now clear timeframes for implementation, emergencies may arise that threaten the health and safety of learners and teachers to such an extent that urgent intervention is required.

A recent analysis[4] of budgeting and spending of the school infrastructure budget has revealed that the process of eliminating "inappropriate structures", such as mud schools, is far behind schedule. If this process is not sped up considerably, the target set by the minimum norms and standards will not be achieved.

South African Schools Act: Admissions policies

On 3 October 2013 the Constitutional Court handed down judgment in *MEC for Education in Gauteng v The Governing Body of Rivonia Primary School*,[5] which involved the relative powers of school governing bodies and provincial Education Departments in determining a school's capacity to accommodate learners. In this case, the Head of the Gauteng Department of Education instructed the school governing body of Rivonia Primary School to admit a learner, even though the school was full in terms of its own admissions policy. The school governing body challenged this, arguing that the provincial department did not have the power to issue such an instruction.

The Court ruled that provincial Education Departments can override school admissions policies, but they must do so in a way that is procedurally fair and in accordance with their powers under the South African Schools Act[6] and any other relevant laws. The Court emphasised the importance of meaningful engagement between all role-players in education to ensure that the best interests of learners are promoted at all times.

This case was the third in a set of Constitutional Court judgments regarding the interaction of powers between provincial Education Departments and school governing bodies.[7] All three judgments have emphasised the need for consultation and co-operation to ensure full realisation of all learners' right to basic education.

High Court ruling on furniture shortages in the Eastern Cape

On 20 February 2014, the Eastern Cape High Court delivered judgment[8] in an urgent application brought against the national and provincial Education Departments to compel the delivery of desks and chairs to schools across the province. The Education Departments argued that the allocation of resources, procurement and delivery of furniture could only happen after an independent audit of furniture shortages across all schools in the Eastern Cape was completed later that month. The Court rejected this argument, holding that such an open-ended approach amounted to a continued breach of the right to basic education, which requires that learners have desks and chairs. The Court recognised that the national and provincial Education Departments had been aware of the furniture shortages for a long time, and therefore ordered them to deliver the furniture by 31 May 2014, but specified that they could apply for an extension if they were unable to meet this deadline.

This judgment emphasised that the right to basic education must be realised with immediate effect. While it is important for state departments to plan and budget for services, they cannot use their internal processes to justify delays in taking action when they are aware of a violation of the right to basic education.

Unfortunately, the deadline of 31 May 2014 was not met. The Education Departments applied for an extension of the deadline. This application, which was opposed, has not yet been heard. There are currently an estimated 200,000 learners without school furniture in the Eastern Cape.[9]

Litigation to compel the delivery of textbooks to schools in Limpopo

Textbook shortages in Limpopo schools were first brought to the attention of the courts in 2012.[10] In that year, Judge Kollapen granted three court orders against the national and provincial Education Departments, compelling full textbook delivery to schools in Limpopo, among other things.

Although the DBE has committed in its policy documents to ensuring that every learner has access to his or her own textbook for every learning area, and despite the three court orders in 2012 compelling full textbook delivery, textbook delivery to schools in Limpopo was not completed in 2013 and 2014. Indeed, the South African Human Rights Commission (SAHRC), after investigating the delivery of learning and teaching support materials across South Africa, has reported that textbook delivery is a problem across many provinces, and has put forward recommendations to address these.[11]

On 27 March 2014, the community-based organisation Basic Education for All (BEFA) and 18 Limpopo schools approached the North Gauteng High Court for an order compelling full textbook delivery to all schools in Limpopo.[12] They argued that independent monitoring was necessary to ensure that all learners received their textbooks, and asked that the SAHRC take on this role.

In their answering affidavit, the national and provincial Education Departments acknowledged that approximately 800,000 books had not been delivered to Limpopo schools by the start of the 2014 academic year. They cited two reason for this: that they did not have enough funds to order the outstanding textbooks; and that school principals did not follow the prescribed procedures to report textbook shortages.

On 6 May 2014, Judge Tuchten declared that for as long as there is one child who does not have all their prescribed textbooks, there is a violation of learners' rights to basic education, dignity and equality.[13] However, he declined to prescribe deadlines for full textbook delivery, or to direct the SAHRC to monitor delivery. Continued monitoring by BEFA and the SAHRC found that the DBE failed to meet its own deadlines for textbook delivery, and that there remained significant textbooks shortages after these deadlines had passed.[14]

Norms and standards to put in place: Adequate school infrastructure for children's safety, dignity and basic education

Judge Tuchten also ordered the national and provincial Education Departments to give detailed information to the Court and to the applicants on the funds requested and made available for textbook procurement in 2015.

The national and provincial Education Departments applied for leave to appeal to the Constitutional Court against the judgment and order of Judge Tuchten, and also filed a conditional application in the North Gauteng High Court to appeal to the Supreme Court of Appeal (which would take effect if leave to appeal was refused by the Constitutional Court). In both applications, the departments argued that the right to basic education does not require that every child receives every prescribed textbook, as this would impose a standard of perfection that they cannot meet. They also applied for leave to appeal the order requiring them to provide information on the funds requested and allocated for textbooks for 2015.

BEFA and the applicant schools opposed this approach, arguing that the right to basic education is absolute and that the state must do everything possible to realise the right in full and immediately. They argued that the national and provincial Education Departments should not be allowed to appeal the judgment of Judge Tuchten, as they had failed to appeal the previous orders granted by Judge Kollapen in 2012 (which also called on the national and provincial Education Departments to comply with their obligation to deliver textbooks in full).

BEFA and the applicant schools have also applied for leave to cross-appeal the failure of Judge Tuchten to order independent monitoring of textbook delivery, as well as his failure to find that the national and provincial Education Departments did not comply with the court orders handed down by Judge Kollapen in 2012. The SAHRC also emphasised in its affidavit the need for the court to supervise the implementation of the order to ensure the full delivery of textbooks.

On 20 August 2014, the Constitutional Court dismissed the application for leave to appeal, reminding the parties of their right to approach other competent courts. The application to the North Gauteng High Court for leave to appeal to the Supreme Court of Appeal has not yet been heard.

Traditional Courts Bill

The re-introduction of the controversial Traditional Courts Bill[15] in Parliament early in 2012 resulted in a strong and unified civil society calling for it to be scrapped because the consultation process was flawed; the Bill was unconstitutional; and it failed to address regulation and accountability in customary courts.[i] The Bill was once again withdrawn in Parliament in early 2014 after an intensive campaign led by the Alliance for Rural Democracy. However, the Department of Justice and Correctional Services has indicated that the Bill will return, although it is unclear when, or to what extent it will be revised to address civil society's concerns.

The Bill contained clauses that undermined the right to equal protection and benefit of the law by essentially creating two separate legal systems: one for people living in urban areas, and

i A large number of submissions to the National Council of Provinces Select Committee on Security and Constitutional Development, as well as corresponding committees in provincial legislatures, took this position. A portion of these can be found at: www.lrg.uct.ac.za/research/focus/tcb/

one for people living in the former apartheid homelands with lower standards for legal representation, appeals and sentencing. It also made no reference to children's rights in the Constitution, the Children's Act or the Child Justice Act, and lowered some of the standards set by this legal framework for children living in rural areas.

Although the Bill excluded important decisions relating to custody and guardianship of children from being dealt with in traditional courts, the civil matters which could be dealt with were not defined. Therefore, except for those issues expressly excluded, the Bill left room for matters such as the property and living arrangements of children who are orphaned to be decided at this level, without any provision for legal representation or support to the children. This may result in substantial injustice and violate children's constitutional right to legal representation.[16] The Bill specifically defined the criminal matters that could be heard by these courts, including theft, malicious damage to property, assault where no grievous bodily harm is inflicted and *crimen injuria*. Because no specific direction was provided in the Bill regarding matters where the accused or complainant is a child, it left space for a range of children's matters to be heard by these courts. This included the potential for forms of child abuse (assault where no grievous bodily harm is inflicted); harmful religious and cultural practices such as virginity testing and circumcision; and child labour to be heard in traditional courts.

Undoubtedly the traditional courts are required to work within the framework created by the Constitution and specific laws relating to children. However, these courts' capacity to protect, promote and respect children's rights adequately is questionable. Customary courts are reportedly[17] dealing with matters that are currently not within their jurisdiction (eg some sexual abuse cases, including rape, and forced marriages of young girls, known as *ukuthwala*). The Bill's provisions for accountability were limited to appeals on some (not all) of the sentences of the courts but the decisions of the court could not be appealed. Further, by vesting greater power in the traditional leader alone, the Bill undermined the customary role of the traditional councils, which, when functioning well, can provide a forum for accountability. Given the absence of checks and balances on traditional leaders' decisions and a lack of clear direction on which cases must be referred to the formal criminal justice system, the Bill fails to put in place adequate safeguards to protect children's rights within traditional courts.

One of the greatest areas of concern was the Bill's potential ramifications for children accused of crimes. As with the Child Justice Act, the Bill included a strong principle of promoting restorative justice and reconciliation. While the Child Justice Act recognises the vulnerability of children in conflict with the law and introduces mechanisms to improve the protection of children's rights and the functioning of the criminal justice system in this regard, the Bill provided no similar measures. It did not refer to the Child Justice Act provisions, nor did it require that matters involving children be referred to the formal justice system.

Only one organisation made a submission on the impact of the Bill on children, and suggested bringing customary practices into the formal justice system where possible, and incorporating child rights standards and training into the Bill to strengthen the capacity and obligation of traditional courts to give effect to children's rights.[18]

Given current social norms that disregard children's rights and the profound violation of children's rights across the country, there is a need for vigilance and strong accountability systems to ensure that the people tasked with protecting children do not abuse their position of power. Irrespective of the status or passage of this Bill, it is essential that children's rights are better understood and protected within customary law.

Sexual Offences Act: Consensual sexual activities

In January 2013, the North Gauteng High Court ruled that sections 15 and 16 of the Sexual Offences Act,[19] which criminalise consenting sexual activity between children aged 12 – 15 years (inclusive), were unconstitutional.[20] The Constitutional Court subsequently also found that these provisions are unconstitutional and declared them invalid.[21] It is important to emphasise that the court rulings only deal with matters where both children consented. Cases where one or both children do not consent to a sexual act are still considered offences and are not affected by this judgment. Furthermore, committing a sexual act with a child under the age of 12 remains an offence, whether the child consented or not.

While recognising the need to deter early consensual sexual activity, the Constitutional Court agreed with the applicants that the provisions which criminalise consenting sexual activity increase adolescents' risks by limiting their access to communication, education and health care that can help them to make emotionally, socially and physically healthy sexual decisions.[22] The Court also found that the criminalisation of these behaviours "punishes" "developmentally normal" forms of sexual expression, was degrading, and "inflicts a state of disgrace on adolescents".[23] Hence, the Court found that criminalisation was not the best protection of children.

The Court has ordered that Parliament correct the law by 3 April 2015. Until then, a moratorium has been placed on reporting, investigation, arresting, prosecuting and initiating any criminal and additional proceedings against children under 16 years for engaging in consensual sexual activity.[24]

Sexual Offences Act: National Register of Sex Offenders

In May 2014, the Constitutional Court declared section 50(2)(a) of the Sexual Offences Act[25] unconstitutional.[26] This section specifies that any person convicted of a sexual offence against a child or person who is mentally disabled (regardless of whether the offender is a child or an adult) must automatically be included on the National Register for Sex Offenders (NRSO). People whose names appear on the NRSO are deemed unfit to work with children and can not apply for a licence for certain facilities and ventures.

The Court ruled that the obligation to include a child offender's name on the NRSO infringes the child's rights to have his or her

best interests considered of paramount importance, as determined by the Constitution and international law.[27] Although, the purpose of the NRSO is to protect all children from sexual abuse, the rights of potential victims have to be balanced with the rights of the child offender. The Act assumes that it is always acceptable to limit the rights of a child offender, and the courts thus have no discretion to order that a child offender's name be recorded in the NRSO or not. Consequently, there is no opportunity for child offenders to make representations, and the court cannot consider the best interests of the child offender.

The Child Justice Act states that the objectives of sentencing include "promot[ing] an individualized response which strikes a balance between the circumstances of the child, the nature of the offence and the interests of society".[28] Evidence shows that not all children who commit sexual offences against other children reoffend or pose a risk to children in adulthood[29] and that child offenders are more responsive to treatment than adult offenders[30]. Experts have argued that proper assessment and treatment of child sex offenders – and not automatic placing their names on the NRSO – will yield optimal results for the safety of child victims.[31]

The Court found that it is not justifiable to limit the rights of child sex offenders and that their best interests must be considered of paramount importance. The Court's declaration of constitutional invalidity was restricted to child offenders; hence adults who commit sexual offences against children and persons with mental disabilities must still be added to the NRSO. The Court suspended the declaration of invalidity for 15 months to give Parliament an opportunity to correct the constitutional defect.

Stop press

In October 2014 the Department of Justice and Correctional Services published the Criminal Law (Sexual Offences and Related Matter) Amendment Amendment Bill [B- 2014].[32] The definitions of statutory rape and statutory sexual assault now exclude consenting adolescents where the gap in their ages is less than two years. Previously there was a close-in-age defence for adolescents consenting to non-penetrative sexual acts. The new formulation will protect children from the early stages of criminal processes.

Where a child commits a sexual offence against another child or a disabled person the court will have the discretion to add the child's details to the NRSO but must consider the report of a registered psychologist or psychiatrist and hear representations from the child before deciding.

Judicial Matters Second Amendment Act: Sexual offences courts

The Judicial Matters Second Amendment Act[33] was passed in January 2014 and amends the Sexual Offences Act to provide a legal framework for the establishment of sexual offences courts. These courts specialise in the prosecution of sexual offences. The Bill was introduced by the (then) parliamentary Portfolio Committee on Justice and Constitutional Development after a national alliance of 52 organisations (who are promoting the implementation of sexual offences legislation) involved the committee in their campaign to improve the legal framework and resourcing of courts to deal specifically with sexual offences.[34]

The existence of these courts has been precarious. First established in 1993, they were rolled out until 2005, when a moratorium was placed on creating new sexual offences courts. Thereafter, many of the gains made in infrastructure and court practice were lost.[35] Under the previous framework, each court was required to appoint two prosecutors, victim assistants, court preparation officials and dedicated magistrates; and maintain infrastructure, such as separate waiting rooms and closed-circuit television equipment, to protect complainants.

The new legislation safeguards the ongoing provision of specialised sexual offences courts. However, the Act is weak from an implementation perspective in spite of civil society submissions and the findings and recommendations of the Ministerial Task Team on the Adjudication of Sexual Offence, set up in 2012.[36] It is framed very broadly and fails to place a duty on the Minister of Justice and Correctional Services to establish these courts. It does not provide direction on the pace of implementation of the courts; does not require the department to provide resources for the courts; and it sets no standards in terms of infrastructure, staffing or support services to victims. Without these, there is no guarantee that sexual offences courts will reduce secondary victimisation and improve conviction rates. This is of concern, given the inconsistent standards that plagued these courts in the past.[37]

Children's Act: Amendment Bills

The Department of Social Development has published two draft Bills for public comment in November 2013: the Children's Amendment Bill[38] and the Children's Second Amendment Bill[39]. Both propose to amend the Children's Act.[40] The reason for two Bills relates to the Constitution's prescribed processes for passing legislation. When the national Parliament deals with a Bill that will be implemented by national government departments, the National Assembly and the National Council of Provinces are the only bodies that deal with the Bill. However, when a Bill deals with matters that the provinces must implement, then the provincial legislatures have a right to participate in the process of developing the legislation alongside the national bodies. The Children's Act contains competencies that must be implemented by both national and provincial departments; therefore the Amendment Bill – just like the original Act – was split into two parts. Although they will be processed separately, the two Amendment Bills should be read together. For the sake of simplicity, we refer here to the "Amendment Bill", although in some cases the provisions are found in both Bills.

The definition of child in need of care and protection

Controversially, the Amendment Bill seeks to change the definition of a child in need of care and protection. The Act states that a child who has been orphaned or abandoned and "is without visible means of support" is a child in need of care and protection.[41] This section is interpreted by some magistrates to mean that children

in the care of relatives are not in need of care and protection, whilst other magistrates are finding them to be in need of care and protection, and place them in foster care.

Two cases concerning these interpretations came before the South Gauteng High Court. In the first, the Court ruled that orphans living with a caregiver "who does not have a common law duty of support towards such child"[42] may be placed in foster care if the child does not have the means to support him/herself (i.e. does not have his/her own inheritance) and does not have an enforceable claim of support against a caregiver and "the means of support is not readily evident, obvious or apparent".[43] In the second case the Court considered what should happen in the case of orphans living with relatives such as grandparents and siblings who do have a common law duty of support. It ruled if the child did not have an inheritance or other income (such as an insurance policy) that the Foster Child Grant (FCG) means test should be applied to the relative caring for the child. Where the relative did not have sufficient means to care for the child, that the duty of care was not enforceable on the relative and therefore the child could be placed with them in foster care, meaning the family could claim the FCG.[44]

The Amendment Bill proposes to change the definition of a child in need of care and protection so that it includes any child who has been orphaned or abandoned, and who "does not have the ability to support himself or herself and such inability is readily evident, obvious or apparent".[45] The new phrasing aims to clarify that relatives caring for orphaned and abandoned children can become foster parents.

There are several problems with the proposed amendment.

Section 1 of the Children's Act defines an orphan as a child who has no surviving parent caring for him/her. Most children who have lost their fathers live with their mothers[46] and therefore do not fall under the definition of "orphan" for purposes of the Children's Act. However, over 1.4 million children have lost both parents or are maternal orphans living with relatives[47] and could be considered in need of care and protection according to the proposed new definition. The amendment would mean that all these children and their relatives would have to be assessed by a social worker, go through a children's court inquiry which would include a means test, and be declared in need of care and protection in order to access the FCG.

In March 2014, 512,055 children received the FCG,[48] with the majority being orphans. It took almost 10 years to increase the number of children in foster care from 50,000 to 500,000.[49] Reaching 1.4 million is likely to take much longer.

The child protection system is ill equipped to deal with the current number of cases, including abused and neglected children, and any expansion in demand threatens to increase the time that it takes for children and families to get support, and can reduce the quality of the service. As the majority of children in need are not able to access the system, legal experts have argued that the foster care system fails the reasonable measures test.[50]

Furthermore, using the child protection system as the delivery mechanism impacts on a number of other children and violates their rights to social services and equality:

Child Witness Project: Uses court support workers to minimise secondary trauma for child witnesses

1. Children who have been abused or neglected are waiting for extended periods to receive social work services, which violate their right to protection from maltreatment, abuse, neglect and degradation.[51]
2. Almost a third (29%) of children live with relatives and there is little difference between the wealth of those whose parents are still alive and those who are orphaned.[52] So it is not clear on what basis children living in the same financial circumstances should receive different amounts of financial aid from the government.
3. The phrase "does not have the ability to support himself or herself and such inability is readily evident, obvious or apparent" is ambiguous; therefore, it is likely that some orphans will be placed in alternative care whilst other will not, again violating the right to equality.

Judicial review of emergency removals

In January 2012, the Constitutional Court declared sections 151 and 152 of the Children's Act unconstitutional.[53] The Court ordered that two new subsections be added, stating that a judicial review is required when a child is removed from the care of his/her family and placed in temporary safe care. Regardless of whether the removal was done with or without a court order, the children's court must review the decision before the end of the next court day. Prior to this order, the parents or the child had to wait until the children's court hearing to contest the removal. The Act requires that a children's court inquiry must be held within 90 days of the removal, but in reality it can take much longer. Although, social workers have been obliged to follow the procedures outlined by the Court since 2012,[54] the new subsections do not appear in the Act. The Amendment Bill aligns the Children's Act with the court order. This amendment gives effect to the child's right to participate, and to the general principles of the Act to give the child's family a chance of expressing their views (if in the child's interest), and to avoid delaying action and decisions on the well-being of child.[55] The children's court review also allows an independent arbitrator to balance the child's rights to family care with the right to protection from abuse.

Persons unsuitable to work with children

At present the Children's Act states that people convicted of certain offences must be deemed unsuitable to work with children and their names must be entered automatically into the National Child Protection Register.[56] However, there are some critical omissions in the list of offences, such as attempted rape. A proposed change to the Act will ensure that a person convicted of any sexual offence against a child under the Sexual Offences Act is deemed unsuitable to work with children.

The Amendment Bill also empowers provincial Heads of Social Development to transfer children between different forms of alternative care; and amend or insert new definitions to:

- ensure that young people can stay in alternative care until they complete their education (including high school, further education and training, and higher education); and
- allow departmental social workers to process adoptions.

Conclusion

Crafting a legislative framework that fully respects children's rights is a process, one that is no doubt taking longer than was initially envisaged. While South Africa has incorporated many international rights into the Constitution and has passed pioneering laws for children, the process of ensuring these laws are designed and implemented in accordance with children's rights and best interests is far from complete.

Over the past two decades civil society organisations working together, through formal participation processes such as public hearings and informal protest, have drawn on children's rights in the Constitution to shape legislation in Parliament, or even to persuade parliamentarians to dismiss some, as with the Traditional Courts Bill. When laws have violated children's rights, civil society organisations have challenged them in the courts. In some cases the Constitutional Court has interpreted ambiguous provisions, amended legislation or sent it back to Parliament for review. The government has also consulted with organs of state and civil society on their experiences of implementing the legislation to identify improvements to laws, as with the Children's Act.

Civil society has also actively monitored the implementation of these laws and where the government has not committed sufficient resources to implement the legislation, they have dialogued, protested or litigated. In the textbook and school furniture cases the courts have interpreted the right to education broadly and refused to excuse inadequate planning or budgeting.

These developments show how child law is progressing and how South Africa's democracy is consolidating as all spheres of government and civil society are steadily building and strengthening the legal framework to realise children's rights.

References

1 Department of Basic Education (2013) South African Schools Act 84/1996: Regulations relating to minimum uniform norms and standards for public school infrastructure. *Government Gazette* 37081, regulation 10067, 29 November 2013.
2 See for example: Department of Basic Education (2011) *Action Plan to 2014. Towards the Realisation of Schooling 2025*. Pretoria: DBE;
Department of Basic Education (2010) The National Policy for an Equitable Provision of an Enabling School Physical Teaching and Learning Environment. *Government Gazette* 33283, Notice 515, 11 June 2010.
3 Department of Basic Education (2011) *NEIMS (National Education Infrastructure Management System) Report*. Pretoria: DBE.
4 Abdoll C & Barberton C (2014) *Mud to Bricks: A Review of School Infrastructure Spending and Delivery*. Pretoria: Pretoria University Law Press.
5 *MEC for Education, Gauteng and Others v Governing Body of the Rivonia Primary School and Others* 2013 (6) SA 582 (CC).
6 South African Schools Act 84 of 1996.
7 See also: *Head of Department, Department of Education, Free State Province v Welkom High School and Another; Head of Department, Department of Education, Free State Province v Harmony High School and Another*, 2014 (2) SA 228 (CC);
Head of Department: Mpumalanga Department of Education and Another v Hoërskool Ermelo and Another, 2010 (2) SA 415 (CC).
8 *Madzodzo and Others v Minister of Basic Education and Others* 2014 (3) SA 441 (ECM).
9 Personal communication, Cameron McConnachie, Legal Resources Centre (Grahamstown), October 2014.
10 *Section 27 and Others v Minister of Basic Education and Another*, 2013 (2) SA 40 (GNP);
Section 27 and Others v Minister of Basic Education and Others. Unreported judgment of the North Gauteng High Court, case no. 24565/2012, 4 October 2012.
11 South African Human Rights Commission (2014) *Report: Delivery of Primary Learning Materials to Schools.* Johannesburg: SAHRC.
12 *Basic Education for All and Others v Minister of Basic Education and Others*, 2014 (4) SA 274 (GP).
13 See no. 12 above. Para 52.
14 SECTION27 participated in the BEFA-SAHRC monitoring visits to applicant schools, May and June 2014.
15 Traditional Courts Bill [B1–2012].
16 Constitution of the Republic of South Africa, 1996.
17 Personal communication, National Association of Child and Youth Care Workers staff member, February 2012;
Personal communication, S Ngubani, Rural Women's Movement, April 2013.
18 Community Law Centre, University of the Western Cape (2013) *Submission to the National Council of Provinces Select Committee on Security and Constitutional Development: The Traditional Courts Bill (Bill 1 2012) and its Impact on Children's Rights*. Cape Town: UWC.
19 Criminal Law [Sexual Offences and Related Matters] Amendment Act 32 of 2007.
20 *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.
21 *Teddy Bear Clinic for Abused Children and Others v Minister of Justice and Constitutional Development and Others*. Case CCT 12/13 [2013] ZACC 35. Para 117.
22 See no. 21 above. Para 87.
23 See no. 21 above. Para 55.
24 See no. 21 above. Para 111.
25 See no. 19 above.
26 *J v National Director of Public Prosecutions and Another* (CCT 114/13) [2014] ZACC 13.
27 See no. 26 above.
28 Child Justice Act 75 of 2008. Section 69(1)(b).
29 Written submissions of the *amici curiae* in: *National Director of Public Prosecutions and Others v Childline South Africa and Others*, 2014 (2) SACR 1 CC. Paras 44 – 50.
30 See no. 29 above. Para 60.3.
31 See no. 29 above.
32 www.justice.gov.za/legislation/bills/2014-Hd4SOAmm14.pdf
33 Judicial Matters Second Amendment Act 43 of 2013.
34 Shukumisa Campaign (2013) *Submission to the Portfolio Committee on Justice and Constitutional Development on the Strategic Plans and Budget of the Department of Justice and Constitutional Development and the National Prosecuting Authority.* Submitted 13 April 2013.
35 Townsend L, Waterhouse S & Nomdo C (2014) Court support workers speak out: Upholding children's rights in the criminal justice system. *South African Crime Quarterly*, 48: 75-88.
36 See no. 34 above.
37 See no. 35 above.
38 Children's Amendment Bill, 2013. *Government Gazette* 37014, Notice 1106, 15 November 2013.
39 Children's Second Amendment Bill, 2013. *Government Gazette* 37014, Notice 1105, 15 November 2013.
40 Children's Act 38 of 2005.
41 See no. 40 above. Section 150(1)(a).
42 *SS v Presiding Officer of the Children's Court, District Krugersdorp and Others*, 2012 (6) SA 45 (GSJ).
43 See no. 42 above. Para 31.
44 *MN v Presiding Officer of the Children's Court, District Krugersdorp and Others*, 2013 (4) SA 379 (GSJ).
45 See no. 38 above. Section 3(b).
46 Hall K & Meintjes H (2014) Demography – Orphanhood. *Children Count website*, Children's Institute, UCT. Accessed September 2014: www.childrencount.ci.org.za
47 See no. 46 above.
48 K Hall analysis of SOCPEN database 2014, Children's Institute, UCT.
49 Hall K & Proudlock P (2011) *Orphaning and the Foster Child Grant: A Return to the 'Care or Cash' Debate*. Cape Town: Children's Institute, University of Cape Town. P. 2.
50 Proudlock P & Tilley A (2013) *Children's Institute Submission on the Second Children's Amendment Bill*. Cape Town: Children's Institute, UCT.
51 Proudlock P, Mathews S & Jamieson L (2014) Children's rights to be protected from violence: A review of South Africa's laws and policies. In: Proudlock P (ed) *South Africa's Progress in Realising Children's Rights: A Law Review*. Cape Town: Children's Institute, UCT & Save the Children South Africa.
52 See no. 49 above. P. 5.
53 *C and Others v Department of Health and Social Development, Gauteng, and Others*, 2012 (2) SA 208 (CC).
54 Department Social Development (2012) Children's Act (38/2005): Constitutional Court Judgment. *Government Gazette* 35246, Notice 301, 13 April 2012.
55 See no. 40 above. Sections 6(3) and (4).
56 See no. 40 above. Section 120(4).


ENERGY
me

PART TWO:

Preventing Violence against children

Part two presents a series of eight essays that motivate for greater investment in violence prevention programmes, and outline effective strategies to help break the intergenerational cycle of violence in South Africa.

The essays motivate for:

- a deeper understanding of violence against children;
- a common conceptual framework for violence prevention to guide programme design;
- a systems approach to child protection programmes and services;
- the allocation of adequate financial and human resources;
- the prevention of the use of physical abuse and corporal punishment against young children;
- the prevention of sexual abuse of primary school children;
- the prevention of interpersonal and gender-based violence amongst adolescents; and
- a shift from policies and plans to implementation.

Overview

Isibindi safe parks: Draw children together under the supervision of child and youth care workers

Part 2 motivates for strengthening of the evidence base and increasing investment in prevention services to reduce both the immediate and intergenerational costs of violence against children. This collection of short essays stresses the cumulative impact of violence across the life course and the need to intervene early before violence takes place. It highlights the need for intersectoral collaboration to address a complex interplay of risk and protective factors across different settings; and it identifies critical points for intervention across the life course: from early childhood, through the primary school years, into adolescence.

Violence against children in South Africa: Developing a prevention agenda

(pages 26 – 34)

South Africa lacks systematic research on the nature and extent of violence against children. This essay reviews the current evidence-base and calls for the strengthening of surveillance systems and research on determinants of violence to target prevention programmes better. It highlights how patterns of violence shift across the life course and their immediate and long-term effects, and it adopts a social-ecological approach to identify key risk and protective factors across different settings.

The prevention of violence against children: Creating a common understanding

(pages 35 – 42)

It is it more effective to prevent violence, than it is to mitigate the effects of violence once it has occurred. Drawing on a public health approach to violence prevention, the essay outlines the key concepts that should inform the design and planning of effective prevention programmes. It emphasises the need to mitigate risks and strengthen protective factors, and assesses the current status of prevention and early intervention programming in South Africa.

Towards effective child protection: Adopting a systems approach

(pages 43 – 50)

While South Africa has put in place laws and policies to protect children from violence, they continue to experience violence in their homes, schools and communities. This essay outlines the key elements of an effective and well co-ordinated child protection system, identifies key challenges, and makes recommendations towards systems strengthening.

Towards effective child protection: Ensuring adequate financial and human resources

(pages 51 – 57)

While the previous essay focused on the design of the child protection system, this essay discusses delivery. It questions whether sufficient financial and human resources have been allocated to implement prevention and early intervention services, and if these resources are equitably and appropriately targeted.

Young children: Preventing physical abuse and corporal punishment

(pages 58 – 64)

Physical abuse and corporal punishment have long-term adverse effects on children's psycho-social and cognitive development. It is therefore vital to intervene in the early years and to provide support to parents and caregivers. This essay identifies a number of critical points for intervention from mental health screening of pregnant women, through to parenting programmes and the prohibition of corporal punishment in the home.

Primary school children: Widening worlds and increasing risk of sexual abuse

(pages 65 – 72)

Children are exposed to violence not just at home but also in the wider community as they start moving out of the house to attend school. This essay focuses on sexual abuse and stresses the need for early intervention and therapeutic services to minimise the risk of re-victimisation and perpetration. It lists promising programmes, and promotes a comprehensive approach that includes prevention, response and work with offenders.

Adolescents: Preventing interpersonal and gender-based violence

(pages 73 – 79)

Young people are most likely to be both the victims and perpetrators of violence. This essay explores how gender norms, poverty and inequality intersect to shape violent masculinities. It highlights the need to address the structural drivers of violence by improving young people's access to quality education and employment, and the need to strengthen young people's interpersonal communication, problem-solving and conflict resolution skills with as focus on gender transformation as a foundation for more respectful and equitable relationships.

Adopting a violence prevention approach: Shifting from policies and plans to implementation

(pages 80 – 85)

This essay draws together some of the key arguments raised in the preceding essays and reflects on what is needed to translate policy into practice and enable a sustained approach to violence prevention.

Violence against children in South Africa: Developing a prevention agenda

Shanaaz Mathews (Children's Institute, University of Cape Town) and Patrizia Benvenuti (UNICEF South Africa)

Violence against children is widespread, affecting the health, social and psychological well-being of large numbers of children in South Africa.[1] This impacts on children's ability to realise their full potential throughout their life course. It has far-reaching intergenerational consequences, with substantial economic and social costs, emphasising the need for prevention.

Violence violates children's rights to be protected from maltreatment, neglect, abuse or degradation as enshrined in the Constitution, the African Charter on the Rights and Welfare of the Child, and the United Nations Convention on the Rights of the Child (UNCRC).[2] These rights place a duty on the state to take proactive steps to prevent violence against children, and to prevent further harm when a child has experienced violence. Unfortunately, South Africa lacks both national empirical data on the exact magnitude of the problem, and a limited research base on the causes and effects of violence against children in the local context. The limited evidence restricts an understanding of the problem, the effective design and targeting of services, as well as an ability to use evidence-based strategies for prevention.

This essay reviews the latest research to address the following critical questions:

- How is violence against children best defined?
- What is known about the extent of violence against children in South Africa?
- What are the patterns of violence against children across the life course?
- What are the immediate and long-term effects of violence against children?
- What are the risk and protective factors?
- What are the recommendations?

It is not possible to write about violence against children without reflecting on South Africa's high levels of violence and crime. The underlying causes of violence are complex. It is thought to be rooted in the colonial past and the legacy of apartheid that normalised and created widespread social acceptance of violence.[3] Widespread poverty, inequality and high levels of unemployment combined with a weak culture of law enforcement, rapid urbanisation, inadequate housing and poor education outcomes all contribute to social dynamics that fuel violence.[4]

In addition, apartheid has had a profound effect on family life. The migrant labour system created an environment where large numbers of fathers were largely absent in the lives of their children.[5] Racial oppression and the grossly unequal power and economic opportunities accentuated gendered inequalities.[6] Gender norms dictate child-rearing practices, which are widely perceived a women's domain.[7] Men are predominantly viewed as providers and report being excluded from the lives of their children if they are unable to meet this expectation.[8] Single-parent families are widespread and the associated stresses may result in harsh and inconsistent parenting practices.[9]

The medical, social welfare, criminal justice and lost productivity costs of violence against children have not been estimated for South Africa. Research from developed settings suggests that responding to violence costs governments billions of dollars yearly; yet it does not take into account the lifetime economic costs of lost productivity and negative human capital costs.[10] The burden from violence is substantial; thus investing in prevention is imperative to break this vicious intergenerational cycle (see the next essay).

How is violence against children best defined?

Violence against children is a multi-faceted and complex problem. This has resulted in multiple definitions which make it particularly challenging to monitor the incidence of violence, analyse trends and guide actions for prevention and response. The *World Report on Violence and Health*[11] defines violence "as the intentional use of physical force or power, threatened or actual, that results or is likely to result in injury, death, psychological harm, mal-development or deprivation". The UNCRC recognises the complexities of violence against children, and defines violence against children as "all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse".[12] The World Health Organisation extends this definition to include "the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity".[13]

The above definitions outline the core components of violence against children and highlight how violence extends beyond physical injuries to include emotional and psychological dimensions, and can occur across a range of settings and relationships. Violence against children can spread from the home to the community and vice versa. For the child this experience is multi-layered and inter-related. For example: a child witnesses his mother being abused by her partner. He is also exposed to harsh parenting, with corporal punishment used as a means of discipline. He seeks affirmation outside the home and gets lured into petty crime by the local gang, and drops out of school (see case 1).

The Children's Act[14] provides definitions for abuse, exploitation and neglect and outlines specific measures for their prevention, early detection and response. Section 1 of the Act defines abuse as bullying, exploitation, physical, sexual, emotional or psychological harm. Section 1 also defines neglect as "a failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs" of the child.

The Act describes sexual abuse as sexual molestation, using a child for sexual gratification, deliberately exposing a child to sexual activity or pornography, or the commercial sexual exploitation of a child.[15] However there are inconsistencies between the Children's Act and the Sexual Offences Act (SOA)[16] with respect to age and the definition of rape and sexual assault. The Children's Act defines a child as anyone under the age of 18, therefore sexual activity between consenting 16- and 17-year-olds would constitute sexual abuse, as the Act does not define consensual sexual activity between children. In addition, the definition in the Children's Act does not cover rape, while the SOA also defines sexual assault.

The lack of common or shared definitions hinders intersectoral collaboration and the provision of services. Teenagers often get blamed by services for being raped because perpetrators are most likely known to them and for getting lured into situations where they are unable to protect themselves.[17]

Another key component of violence against children is child maltreatment. This term is widely used in international literature and is often used interchangeably with child abuse. The term refers to situations where the parent or caregiver either commits an act of violence or fails to provide care, resulting in harm, potential harm or threat of harm to the child.[18]

Maltreatment encompasses physical abuse, sexual abuse, psychological or emotional abuse, neglect and exploitation.[19] The term "child maltreatment" is used in section 28(1)(c) of the Constitution but is not defined in the Children's Act. In this issue of the *South African Child Gauge* we use the term "child abuse" for consistency, while we use "violence against children" as an umbrella term for a range of physical, emotional and sexual abuse, neglect and negligent treatment, as well as the exploitation of children across a range of settings.

What is known about the extent of violence against children in South Africa?

South Africa lacks systematic research on the extent and range of violence experienced by children. A national study on violence against children is currently in the field and this research will provide the first national prevalence estimates by 2015.[i] However, population-based prevalence studies have shown that the most common forms of violence against children reported in South Africa are physical and sexual violence in the home and community.[20] Dedicated school-based and youth victimisation surveys provide important insights but are generally weak at measuring experiences of a sensitive nature and tend to under-report sexual violence and physical violence in the home or in intimate relationships.[21]

Crime statistics also indicate the extent of violence against children in South Africa. But a limitation is the lack of routinely disaggregated data by age, and that some categories such as neglect and ill treatment have not been reported since 2009/2010. Furthermore, although certain categories such as homicide and sexual assault are routinely reported, sexual assault was not disaggregated for children in 2012/2013. These figures are likely to underestimate the scale of the problem because under-reporting is widespread. Despite these limitations, crime statistics are a useful surveillance tool to monitor violence against children; therefore efforts to provide a child-centred analysis need to be strengthened. The National Child Protection Register, maintained by the Department of Social Development, also has the potential to fulfil an important surveillance function, but needs to be well maintained and routinely analysed.

Sexual violence

The 2011/2012 crime statistics report nearly 26,000 child victims, which account for 40% of all sexual offences.[22] These figures are likely to be an underestimate, as only one in nine cases of sexual assault is reported to the police.[23] A community-based survey in the Eastern Cape, which questioned young adults about their experience of sexual violence before the age of 18, found that 38% of women and 17% of young men reported sexual abuse.[24] These rates are similar to those reported by a national Tanzanian study[25] (which found 30% of girls and 13.4% of boys reported sexual abuse), and by a Zimbabwean national study[26] (which found 33% of the girls, and 9% of boys, reported sexual violence before 18 years). Rape homicide, the most extreme form and consequence

Case 1: Adverse family environments in the shaping of violent behaviour

Themba (not his real name) was raised by his father after his parents separated when he was 18-months old. The family lived in a peri-urban town in the Western Cape, where his father was a community leader. His mother, although living in the same community, did not have regular contact with him during his early years. He was raised by his older siblings from his father's first marriage. His father, being a very traditional man, was a harsh disciplinarian and Themba reported regular beatings.

When Themba started high school, his father felt he was mixing with the wrong friends, so he was sent to live with an older sibling who regularly gave him beatings. Soon after his move his father died and Themba returned to live with his mother. He continued to get involved in fights at school and started to get drawn into petty crime and gangs. At the age of 17 he was convicted for killing a peer in an argument and was sentenced to a secure care facility, where he twice attempted suicide.

i A national prevalence study on child and adolescent safety in South Africa is being conducted by the Centre for Justice and Crime Prevention and the University of Cape Town's Department of Psychology and its Gender, Health and Justice Research Unit.

of sexual violence, is a relatively rare event in other countries, but was linked to 102 child murders in South Africa in 2009, and almost exclusively affects girls.[27]

Physical abuse, corporal punishment and neglect

No national data exist for physical abuse, but high levels of physical abuse and physical punishment have been reported in a population-based study in the Eastern Cape.[28] Similarly, a community-based study in Mpumalanga and the Western Cape found that over half of children (55%) report lifetime physical abuse by caregivers, teachers or relatives with no significant difference between boys and girls.[29] These rates are similar to reported rates from regional national studies of violence against children. Zimbabwe reported rates of physical violence of 48% for women and 61% for men.[30] Higher rates of physical violence were reported in Tanzania, for both girls (72%) and boys (71%).[31]

Although corporal and humiliating punishment is prohibited in public spheres, including schools, it has yet to be banned in the home. Physical punishment in the home is widespread: 58% of parents report smacking their children at some point and 33% report using a belt or object.[32] This was confirmed in an Eastern Cape study where more than a quarter of youth reported physical punishment as children that resulted in injury, and recalled daily or weekly punishment with objects such as a belt, stick or a whip.[33] Corporal punishment, although contested, continues to be widely accepted as a form of discipline. This is confirmed by the persistence of corporal punishment in schools. Fifty percent of school children still report experiencing physical punishment at school, despite this being prohibited for nearly two decades.[34] Most of these cases go unreported and schools fail to enforce the ban on corporal punishment adequately, and to take steps against educators who violate the ban.[35] (See the essay on pp. 58 – 64 for more on corporal punishment.)

Very little is known about the impact of violence on children with disabilities in South Africa, although studies from high-income settings have identified this group of children as being at an increased risk. A small-scale study in Gauteng confirmed an increased prevalence of sexual abuse and neglect among children with disabilities, but this requires further investigation.[36]

Violence also kills and is the leading cause of mortality and injury for male teenagers.[37] In 2009, 1,018 children were murdered and 45% of these murders occurred in the context of child abuse.[38] Children under the age of five are more likely to be killed in the context of child abuse and the perpetrator is usually someone close to the child, in particular the caregiver. Conversely, most murders amongst male teenagers occur in the context of interpersonal, male-on-male violence outside the home.

Fifteen percent of children report being neglected by drunken parents, which supports the notion that children's exposure to emotional violence and neglect is commonplace in South Africa.[39] Other studies reveal that between 35 – 45% of children have witnessed violence against their mothers,[40] which is associated with negative mental health effects for children.

Very little is known about emotional abuse within the South African context. A two-province study reported 35.5% of children experience emotional abuse, most commonly by caregivers[41] – this finding was similar to a regional study[42] on violence against children. The South African study also highlights multiple forms of violence experienced by children, and their overlap. For example: an 60-year-old man incarcerated for killing an intimate partner describes a sadistic beating by his father who had caught him smoking, and the impact on his self-esteem:

> *I saw him with the strap, I realised there is major trouble. I do not remember him saying anything…. . He took me by the one arm, he beat me with his left hand, that's right, he was left handed. He beat me over my neck over my back until I was lying on the floor and his words to me was "I will beat you to death you're too bad to be alive". This had a huge impact on me, after this in a way I developed an inferiority complex.*[43]

Service organisations report seeing large numbers of cases of emotional abuse,[44] but this form of violence is rarely captured in official statistics, despite its profound long-term effects.

Cultural and traditional practices

Tradition has been defined as the customs, beliefs and values of a community which govern and influence members' behaviour.[45] While many cultural practices can be beneficial, some can undermine the dignity of mainly women and girls.[46] In South Africa these practices include virginity testing, forced marriage (*ukuthwala*) and male circumcision. No data exist on the prevalence of these practices, and the psycho-social impact on victims and those closest to them are unexplored. Although the Children's Act prohibits virginity testing and forced early marriage, these practices continue. For females, practices such as virginity testing and *ukuthwala* may further silence and subordinate girls in an attempt to control their sexuality. Male circumcision as a rite of passage for young men can lead to negative consequences due to the limited control by government over circumcision practices and with large numbers of boys dying every year.[47]

What are the patterns of violence against children across the life course?

Different forms of violence are more prevalent at different stages of a child's life, and it is important to understand how violence impacts on children's psycho-social functioning at different developmental stages and across the life course.[48] This life-course perspective also highlights how early experiences of violence may increase the risk of children becoming victims or perpetrators later in life, and how the cumulative effect of violence has negative outcomes for the child in later life (see figure 1) .

Infanticide, abandonment, neglect and physical abuse are the most common forms of violence affecting young children aged 0 – 4-years-old.[49] Much of this violence remains hidden within the home, as young children lack the capacity to report and are solely dependent on their caregivers to provide nurturing and care.[50]

As children become more independent and start venturing beyond the family home to attend school or pre-school, corporal punishment in schools, sexual violence and bullying become common experiences. It is important to note that physical, psychological and sexual violence, including sexual harassment, occur across different settings – including the home, school and in the community. School-age children (5 – 12-years-old) are therefore at greater risk of sexual violence although it is not limited to this age group (see the essay on pp. 65 – 72). Sexual violence affects both girls and boys, but it is more prevalent amongst girl children.[51]

The pattern shifts as children get older, with teenage boys (15 and older) more likely to be victims of homicide and violence in community settings, particularly due to the common use of weapons and violent masculinities.[52] Conversely, teenage girls experience early forms of intimate partner violence in dating relationships. Large numbers of South Africa's girls report that their first sexual experience was forced or coerced, yet many girls and boys do not consider this as sexual violence as they view it as a norm in intimate relationships.[53] More on adolescents in the essay on pp. 73 – 79.

Social acceptance or tolerance of various forms of violence (such as intimate partner violence and corporal punishment) is a major factor in the continued perpetuation of violence. These social norms are carried forward from one generation to the next as men are viewed to have authority over women and children in the family and the community. The patriarchal (male-centred) South African society legitimises violence against women and children as a means of maintaining men in a position of power and control. In addition, widespread violence in communities desensitises children and normalises the use of violence.[54]

What are the immediate and long-term effects of violence against children?

Violence against children has major psycho-social and health consequences. The impact of violence goes beyond the physical injuries and visible scars, and evidence has shown lasting emotional and social consequences. Abuse and neglect in early childhood affect brain development and impact on cognitive and psycho-social adjustment, resulting in an increased risk of violent and anti-social behaviour.[55]

Exposure to childhood violence, including witnessing violence in the home, is consistently found to be associated with aggressive behaviour later in life, particularly rape and intimate partner violence.[56] Attachment theory highlights how poor parenting in early childhood impacts negatively on children's ability to control their emotions and interpret the emotions of others. This has important implications for later interpersonal relationships and personality development.[57] In contrast, secure attachment and social support can enhance children's resilience and ability to cope with adverse traumatic experiences.[58]

Psychological consequences such as depression, anxiety disorders, substance abuse, suicide as well as unwanted pregnancy and HIV are more common for girls who experienced physical and sexual abuse.[59] Boys' exposure to adverse childhood experiences such as neglect, physical and sexual abuse, and harsh parenting is an important factor in shaping violent behaviour,[60] including risk-taking such as truanting, gang involvement and crime later in childhood.[61]

Violence is intergenerational, as children who were exposed to violence in their early years are at increased risk of revictimisation

Figure 1: Forms of violence through the life course of a child

Case 2: The intergenerational cycle of abuse

Candice (not her real name) is a 16-year-old who disclosed rape by a 30-year-old male friend after months of feeling it was her fault. Prior to this disclosure, she lost interest in school, started using drugs and changed her circle of friends. She also suffered from stomach and headaches, was depressed and had suicidal thoughts.

Her mother noticed changes in her behaviour but was going through a difficult divorce after a very violent marriage and thought the changes in her daughter's behaviour were due to the divorce. Candice eventually told an aunt when the burden became unbearable. After Candice started to receive counselling, her mother disclosed her own experience of rape as a teenager to her daughter's counsellor. Candice's mother started reliving her own experiences of abuse as a teenager, leading to a severe depression and an inability to respond to her daughter's emotional needs. Candice stopped counselling after a few sessions as she felt it was not helping her "forget", and dropped out of school soon thereafter.

or perpetration as they get older (see case 2). Girls in particular are at risk of sexual assault and intimate partner violence; and these forms of violence also impact on their emotional availability as parents.[62] Research has shown that boys who experience violence are at increased risk of perpetrating rape and intimate partner violence, and of engaging in risky behaviour within the community context.[63]

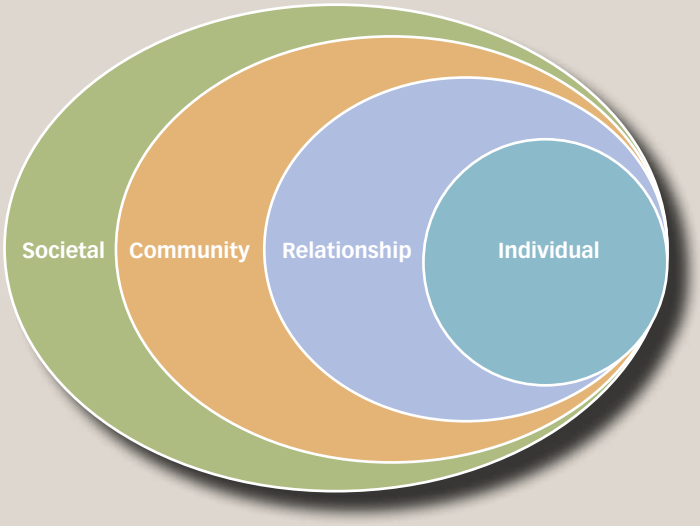
What are the risk and protective factors?

It is clear that violence is complex, and no single factor can explain why some children experience violence, but it can best be understood as the complex interaction of a number of factors. Bronfenbrenner's ecological systems theory[64] allows a better understanding of the dynamic interplay between the child and the social context such as how the family, school and community influence the child's development and long-term outcomes.

Drawing on this theory, the Centres for Disease Control in the United States of America and the World Health Organisation have proposed a social-ecological model (see figure 2) to understand violence and violence prevention.[65] It provides a useful framework for understanding how violence against children is shaped by a complex interplay of risk factors at different levels or settings of this nested and interconnected system.[66] This model identifies risk and protective factors at four levels, starting with individual characteristics and behaviours, and moving outwards to consider the impact of close relationships, the community, and wider society.

The different levels or settings in the social-ecological model highlight how the occurrence and co-occurrence of violence across different settings, from individual to societal influence children's experience of violence and long-term outcomes. The goal of this model is to stop violence before it occurs. It therefore requires an understanding of the risk and protective factors that lead to a child's vulnerability or protection from violence, and a consideration for the complex interplay between the various levels in the model. It provides an intriguing web of causes and creates a rich context for prevention strategies that should include a continuum of activities that address multiple levels of the model over time (for a more detailed discussion, see the next essay on pp. 35 – 42).

Figure 2: The social-ecological model



Individual
Identifies biological and personal history factors; such as age, education, income, substance use, or history of abuse, that increase the likelihood of becoming a victim or perpetrator of violence.

Relationship
Examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle – peers, partners and family members – influences their behaviour and contributes to their range of experience.

Community
Explores the settings, such as schools, workplaces, and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence.

Societal
Looks at the broad societal factors, such as health, economic, educational and social policies, that help create a climate in which violence is encouraged or inhibited and help to maintain economic or social inequalities between groups in society.

Source: Centres for Disease Control and Prevention (no date) *The Social-Ecological Model: A Framework for Violence Prevention.* Atlanta, GA: CDC.

Prevention efforts should therefore be developmentally appropriate, conducted across the lifespan, and multidimensional. The approach taken in this book is to use the lens of a child's life course to highlight the most common forms of violence that children experience within these different developmental phases, and how best violence can be prevented within each phase.

Table 1 provides an overview of risk and protective factors at the different levels. A risk factor is considered to be an event or situation that increases the possibility of a negative outcome for the child. A protective factor interacts with the risk and acts as a buffer to prevent an adverse outcome and increase the chance of a child's positive adjustment.

Individual

This level identifies individual characteristics and biological and behavioural factors. Age has consistently been found to be a risk factor – with younger children unable to protect themselves and at increased risk for physical violence within the home.[67] Sex is also important – girls are more likely to be victims of sexual violence and harmful traditional practices both within the home and the community.[68] Teenage boys are more likely to be victims of physical violence due to fights with peers and gang violence in the community.[69] Substance abuse increases these vulnerabilities, while alcohol and drug abuse by parents and caregivers also impacts on their ability to care adequately for their children.[70]

Table 1: Risk and protective factors for violence against children

Level	Risk factors	Protective factors
Individual	Biological and personal history factors such as: • gender, age, education level; • income; • substance abuse; • personal history of violence of parent(s); • unwanted pregnancy; etc.	• Strong attachment bonds; • available child focused support services; • increased knowledge of protection against abuse; etc.
Relationship (family)	Dynamics in close relationships including: • domestic violence; • substance abuse; • delinquency; • scarce bonding between parent(s) and child; • psychological problems of parent(s); etc.	• A cohesive and stable family unit; • adequate, accessible support for families; • healthy communication between parent and child; etc.
Community	Settings in which relationships occur (schools, work places, neighbourhoods) and characteristics of those settings including: • high level of crime in communities; • poor and/or inadequate social services; • high level of substance abuse, etc.	• Accessible health and social services to support families; • social protection programmes to mitigate impact of poverty and unemployment; • cohesive communities with accountable community leadership and structures to support responsive policing and functional criminal justice system; • adequate child care facilities as well as a supportive school environment with an inclusive teaching approach; etc.
Societal	Broader social factors including: • high unemployment rates; • high inequality and social exclusion; • availability of firearms; • weak legal, policy and regulatory framework; • gender inequality and discrimination; • social and cultural norms that justify violence; • weak law enforcement; etc.	• Legal and policy frameworks to create an enabling environment to support victims of violence; • enforced criminal justice sanctions for perpetrators of violence; • policies to regulate gun ownership and alcohol use; • gender equity promoted at highest level; • job creation programmes; • social norms challenged through media campaigns; etc.

Safe space: A mural transforms the inner courtyard of Parklands Primary where children shelter from gang violence

The family

Families have the potential to protect children from harm and take care of their physical and emotional needs.[71] The family is also the most influential socialising environment for children to learn values and norms and what is expected of them in society.[72] Warm relationships and consistent parenting practices increase the chances for a child to be well adjusted and resilient when faced with adversity.[73] However family structures have changed and fragmented due to migrant labour and the impact of HIV/AIDS in South Africa, which has resulted in large numbers of children (39%) being raised in female-headed households or with neither parent (23%).[74] The financial stress and burden of lone parenting may limit single-parents' availability to children and the consistency of their parenting practices.[75] In addition, the HIV pandemic has had a devastating impact on families with high levels of orphaning, increasing children's vulnerability to abuse and neglect.[76] Domestic violence also has a significantly negative impact on children's long-term mental health and can perpetuate the use of violence to resolve conflict.[77]

Community

Many South African townships are deprived and poverty stricken, plagued by social disorganisation caused by apartheid policies, such as forced removals, which contributed to family breakdown and the formation of street gangs.[78] High levels of violence and crime is experienced by children in the communities they live in – nearly 50% of learners report that they have witnessed violence in their community.[79]

Exposure to gang violence is particularly rife in the Western Cape, where the illegal drug and alcohol economy has flourished and systematically increased the power of gangs.[80] Dysfunctional families and limited employment opportunities for youth in many townships draw young men into crime, violence and gangs which provide them with a sense of power and respect that they are otherwise denied.[81] Children are caught up in gang violence either as perpetrators, or innocent victims.[82] Community violence, including gang fights, have been shown to result in significate psychological distress as many children report witnessing such violence.

Societal

Despite the transition to democracy, the legacy of apartheid continues to have a negative, long-lasting impact on the socio-economic status of specific population groups, and disadvantages children. The breakdown of community and family structures due to apartheid policies such as the Group Areas Act and migrant labour system; the HIV/AIDS pandemic; gender inequality; unequal access to essential services; poverty and social exclusion; high rates of unemployment and substance abuse; migratory patterns; and a high incidence of violent crime all contribute to children's experiences of violence.

Poverty affects large numbers of children. It is estimated that 60% of the R18.5 million children in South Africa are poor (see the data section on income poverty, unemployment and social grants on pp. 94 – 98). There is consensus that high levels of poverty and inequality are key drivers of violence.[83] High levels of poverty and

unemployment compromise parents' ability to fulfil children's rights and to support their optimal development. Poverty increases adolescent involvement in risk-taking behaviour, delinquency, crime, violent peer-group activities and gangs.[84] A study with men in the Eastern Cape and KwaZulu-Natal has shown that that 25% of rape could have been prevented if men were gainfully employed or not left just "hanging out" in their communities.[85]

Violence is socially constructed and a learned behaviour, and cultural and social norms are highly influential in shaping individual behaviour, including the use of violence.[86] Norms therefore influence how individuals react, for example, a culture of violence in certain settings legitimises the use of violence to resolve conflict or disputes within the home, between peers and in the community.[87] The widespread social acceptance of violence increases the child's risk to become violent or complacent.[88] This is compounded by beliefs that men have the right to exercise power and control over women and children, making women and girls particularly vulnerable to psychological, physical and sexual violence.

Similarly, social norms that consider children as the "property" of their parents and not as rights holders can place children at risk of physical violence and promote a culture of silence that hinders reporting. The low status of children, evidenced by the widespread belief that children should not question the authority of their elders, disempowers children and leaves them vulnerable to abuse and neglect.[89] This powerlessness of children, combined with the gender hierarchy, fuel the high levels of violence against children.

What are the recommendations?

Despite having ratified the UNCRC and having developed a legislative framework aimed at preventing violence, children's daily experiences of violence and the life-long social and psychological adverse effects thereof necessitate a response backed by the highest leadership. There is no easy solution to this very complex problem that has taken centuries to embed itself in the fabric of South African society. The multifaceted nature of violence requires a multipronged approach that addresses the complex interplay of underlying risk factors.

An intersectoral approach to stop the intergenerational cycle of violence by focusing on protective factors is required to shift the daily experiences of children. Changing social norms and attitudes that support the use of violence is imperative to alter current practices in order to prevent violence. This entails not only commitment from government but partnerships between the government, businesses, donors, the media, civil society organisations and citizens: preventing violence against children is everyone's business.

A key challenge facing South Africa is the need to develop a strong evidence base to inform the design of prevention programmes. This includes strengthening existing data systems, as well as qualitative research to understand the nature of the problem, and longitudinal follow-up studies to develop a better understanding of the underlying causes of violence and its outcomes within the local context. This evidence will allow for improved planning and targeting of services and help inform the design of effective prevention programmes. What is needed is investment in a strong evidence base as an essential first step in ensuring the best possible outcomes for children, and in building a society free from violence.

The essays that follow reflect on elements critical to this goal: a common understanding of a prevention model, strengthening the systems response and relevant resources, and appropriate responses across different developmental stages of the child's life cycle.

References

1 Richter LM & Dawes ARL (2008) Child abuse in South Africa: Rights and wrongs. *Child Abuse Review*, 17(2): 79-93.
2 Proudlock P, Mathews S & Jamieson L (2014) Children's rights to be protected from violence: A review of South Africa's laws and policies. In: Proudlock P (ed) *South Africa's Progress in Realising Children Rights: A Law Review*. Cape Town: Children's Institute, UCT.
3 Bruce D (2009) Dictating the local balance of power: Election-related violence in South Africa. *South Africa Crime Quarterly,* 28:3-9;
Ward C, Dawes A, Matzopoulos R (2012) Youth violence in South Africa: Setting the scene. In: Ward C, Van der Merwe & A Dawes A (eds) *Youth Violence – Sources and Solutions in South Africa.* Cape Town: UCT Press.
4 Seedat M, Van der Niekerk AV, Jewkes R, Suffla S & Ratele K (2009) Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet*, 374(9694): 1011-1022;
Centre for the Study of Violence and Reconciliation (2007) *The Violent Nature of Crime in South Africa: A Concept Paper for the Justice, Crime Prevention and Security Cluster*. Johannesburg: Project on the Violent Nature of Crime, Centre for Study of Violence and Reconciliation & Department of Safety and Security.
5 Morrell R & Richter L (2006) Introduction. In: Richter R & Morrell R (eds) *Baba: Fathers and Fatherhood in South Africa*. Cape Town: HSRC Press.
6 Morrell R, Jewkes R & Lindegger G (2012) Hegemonic masculinity/masculinities in South Africa: Culture, power, and gender politics. *Men and Masculinities*,15(1): 20.
7 See no. 5 above.
8 Mavangu M & Thomson-de Boor H (2013) "So We are ATM Fathers": A Study of Absent Fathers in Johannesburg. Centre for Social Development in Africa, University of Johannesburg & Sonke Gender Justice.
9 Van der Merwe A & Dawes A (2007) Youth violence: A review of risk factors, causal pathways and effective intervention. *Journal of Child and Adolescent Mental Health*, 19(2): 95-113.
10 Mikton C (2008) Preventing violence and reducing its impact: How development agencies can help. *Injury Prevention*, 14(4): 279.
11 Krug E, Dahlberg LL, Mercy JA, Zwi AB & Lozano R (2002) *World Report on Violence and Health*. Geneva: World Health Organisation. P. 5.
12 Office of the High Commissioner on Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly Resolution 44/25.* Geneva: United Nations. Article 19.
13 See no. 11 above. P. 29.
14 Children's Act 38 of 2005.
15 See no. 14 above. Section 1.
16 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
17 Mathews S, Jewkes R & Abrahams N (2013) Exploring mental health adjustment of children post sexual assault in South Africa. *Child Sexual Abuse*, 22(6): 639-657.
18 Gilbert R, Wodom C, Browne K, Fergusson D, Webb E & Janson S (2009) Burden and consequences of child maltreatment in high income countries. *The Lancet*, 373(9657): 68-81.
19 Runyan D, Wattam C, Ikeda R, Hassan F & Rumiro L (2002) Child abuse and neglect by parents and other caregivers. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB & Lozano R (eds) *World Report on Violence and Health*. Geneva: World Health Organisation.
20 Department of Social Development, Department of Women, Children and People with Disabilities & UNICEF (2012) *Violence Against Children in South Africa*. Pretoria: DSD, DWCPD & UNICEF.
21 Burton P (2006) Easy prey: Results of the National Youth Victimisation Study. *South African Crime Quarterly*, 16: 1-6;
Burton P (2008) *Merchants, Skollies and Stones: Experiences of School Violence in South Africa*. Cape Town: Centre for Justice and Crime Prevention;
Burton P & Leoshcut L (2013) *School Violence in South Africa: Results of the 2012 National School Violence Study*. Cape Town: Centre for Justice and Crime Prevention.
22 South African Police Services (2012) *Police Crime Statistics*. Pretoria: SAPS.
23 Jewkes R & Abrahams N (2002) The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science & Medicine*, 55(7): 1231-1244.
24 Jewkes R, Dunkle K, Nduna M, Jama N, Puren A (2010) Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth. *Child Abuse & Neglect*, 34(11): 833-841.
25 UNICEF, Centres for Disease Control and Prevention & Muhimbili University of Health and Allied Sciences (2011) *Violence Against Children in Tanzania: Findings from a National Survey 2009*. Dar es Salaam, Tanzania.
26 Zimbabwe National Statistics Agency, UNICEF & Collaborating Centre for Operational Research and Evaluation (2013) *National Baseline Survey on Life Experiences of Adolescents, 2011*. Harare, Zimbabwe.

27 Mathews S, Abrahams N, Jewkes R , Martin L & Lombard C (2013) The epidemiology of child homicides in South Africa. *Bulletin of the World Health Organization*, 91: 562-568.
28 See no. 24 above.
29 Meinck F, Cluver LD & Boyes ME (under review) Physical, emotional and sexual abuse of children in South Africa: Prevalence, incidence, perpetrators, and locations of child abuse victimization in a large community sample. [Submitted for publication in Plos One]
30 See no. 26 above.
31 See no. 25 above.
32 Dawes A, Kafaar Z, Richter L & De Sas Kropiwnicki Z (2005) Survey examines South Africa's attitude towards corporal punishment. *Article 19*, 1(2): 2-4.
33 See no. 24 above.
34 See no. 21 above (Burton & Leoshcut, 2013).
35 Veriava F (2014) *Promoting Effective Enforcement of the Prohibition Against Corporal Punishment in South African Schools*. Pretoria: Centre for Child Law, University of Pretoria.
36 Deroukakis M (2010) A Retrospective Analysis of Children With and Without Disabilities Attending The Teddy Bear Clinic, Johannesburg. Masters dissertation, University of the Witwatersrand.
37 Norman R, Matzopoulos R, Groenewald P & Bradshaw D (2007) The high burden of injuries in South Africa. *Bulletin of the World Health Organization*, 85(9): 695-702.
38 See no. 27 above.
39 See no. 4 above (Seedat et al, 2009).
40 Nagia-Luddy F & Mathews S (2011) *Service Responses to the Co-victimisation of Mother and Child: Missed Opportunities in the Prevention of Domestic Violence. Technical Report.* Cape Town: Resources Aimed at the Prevention of Child Abuse and Neglect & Medical Research Council.
41 See no. 29 above.
42 See no. 25 above.
43 Mathews S, Jewkes R & Abrahams N (2011) "I had a hard life": Exploring childhood adversity in the shaping of masculinities among men who killed an intimate partner in South Africa. *British Journal of Criminology*, 51(6): 960-977. P. 967.
44 Personal communication with Joan van Niekerk, national co-ordinator, Childline South Africa, 28 July 2014.
45 World Health Organisation (1998) *Female Genital Mutilation. An Overview*. Geneva: WHO.
46 World Health Organisation (2010) *Violence and Health in Africa*. Brazzaville, Congo: WHO Regional Office for Africa.
47 Davies R (2013) When culture and policing collide: Circumcision deaths and ukuthwala – unpunished crimes. *Daily Maverick*: www.dailymaverick.co.za.
48 Payne B & Gainey R (2009) *Family Violence and Criminal Justice: A Life-Course Approach*. 3rd Edition. New Providence: LexisNexis/Matthew Bender.
49 Pinheiro P (2006) *World Report on Violence against Children*. Geneva: United Nations;
See no. 27 above.
50 See no. 49 above
51 See no. 27 above.
52 See no. 27 above.
53 Jewkes R (2002) Intimate partner violence: Causes and prevention. *The Lancet*, 359(9315): 1423-1429.
54 See no. 3 above (Ward et al, 2012).
55 Raine A (2002) Biosocial studies of antisocial and violent behavior in children and adults: A review. *Journal of Abnormal Child Psychology*, 30(4): 311-326.
56 Abrahams N & Jewkes R (2005) Effects of South African men's having witnessed abuse of their mothers during childhood on their levels of violence in adulthood. *American Journal of Public Health*, 95(10): 1811-1816.
57 Fonargy P & Target M (2003) *Psychoanalytic Theories: Perspectives from Developmental Psychopathology*. New York: Routledge.
58 Barkai A & Rappaport N (2011) A psychiatric perspective on narratives of self-reflection in resilient adolescents. *Adolescent Psychiatry,* 1(1): 46-54.
59 Vetten L, Jewkes R, Sigsworth R, Chirstofides N, Loots L & Dunseith O (2008) *Tracking Justice: The Attrition of Rape Cases through the Criminal Justice System in Gauteng*. Johannesburg: Tswaranang Legal Advocacy Centre, Medical Research Council & the Centre for Violence and Reconciliation;
Dunkle K, Jewkes R, Brown HC, Yoshihama M, Gray GE, McIntrye JA, & Harlow SD (2004) Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology*, 160(3): 230-239.
60 See no. 43 above.
61 Bordin IA, Duarte CS, Peres CA, Nascimento R, Curto BM & Paula CS (2009) Severe physical punishment: Risk of mental health problems to poor urban children in Brazil. *Bulletin of the World Health Organization*, 87(5): 336-344.
62 See no. 59 above (Dunkle et al, 2004).
63 See no. 24 above.
64 Bronfenbrenner U (1979) T*he Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.
65 See no. 11 above.
66 See no. 11 above.
67 See no. 27 above.
68 See no. 24 above.
69 See no. 21 above (Burton, 2006).
70 See no. 4 above (Seedat et al, 2009).
71 See no. 49 above.
72 Barbarin OA & Richter LM (2001) Family influences on socio-emotional development. In: *Mandela's Children: Growing Up in Post-apartheid South Africa*. New York, NY: Routledge.
73 See no. 3 above (Ward et al, 2012).
74 K Hall and W Sambu analysis of General Household Survey 2012, Children's Institute, UCT.
75 See no. 49 above (Pinheiro, 2006).
76 Nduna M & Jewkes R (2012) Disempowerment and psychological distress in the lives of young people in Eastern Cape, South Africa. *Journal of Child and Family Studies,* 21: 1018-1027.
77 See no. 56 above.
78 Pinnock D (1984) *The Brotherhoods: Street Gangs and State Control in Cape Town*. Cape Town: David Phillip.
79 See no. 21 above (Burton & Leoshcut, 2013).
80 Standing A (2006) *Organised Crime: A Study from the Cape Flats.* Pretoria: Institute for Security Studies.
81 Luyt R & Foster D (2001) Hegemonic masculine conceptualisation of gang culture. *South African Journal of Psychology*, 31: 1-11;
Bourgois P (1996) *In Search of Respect: Selling Crack in El Barrio*. 2 Edition. Cambridge: Cambridge University Press.
82 Cooper A & Ward C (2012) Intervening with youths in gangs. In: Ward C, van der Merwe A, Dawes A. (eds): *Youth Violence – Sources and Solutions in South Africa*. Cape Town: UCT Press.
83 Gawryszewski V & Costa L (2005) Social inequality and homicide rates in Sao Paulo City, Brazil. *Rev Saude Publica*, 39(2): 191-197.
84 See no. 43 above.
85 Jewkes R (2012) *Rape Perpetration: A Review*. Pretoria: Sexual Violence Research Initiative.
86 See no. 3 above (Ward C et al, 2012).
87 Foster D (2012) Gender, class, 'race' and violence. In: Ward C, van der Merwe A, Dawes A (eds) *Youth Violence – Sources and Solutions in South Africa*. Cape Town: UCT Press.
88 See no. 3 above (Ward C et al, 2012).
89 See no. 4 above (Seedat et al, 2009).

The prevention of violence against children: Creating a common understanding

Joan van Niekerk (Childline South Africa) and Mokhantšo Makoae (Human Sciences Research Council)

The *World Study on Violence against Children* noted that violence against children is never justifiable or inevitable, and that "if its underlying causes are identified and addressed, violence against children is entirely preventable".[1] The report noted a growing evidence base to inform the design and delivery of effective prevention programmes and that these are proving to make a difference – not just in children's lives in the present – but in reducing all forms of violence in society.

This essay addresses the following questions:

- What is meant by violence prevention?
- How is South Africa doing?
- What are the recommendations?

What is meant by violence prevention?

Increasingly, countries recognise the universal value of human rights and negative public health outcomes as grounds for justifying the prevention of violence against children. Yet there are no universally accepted definitions of prevention. The World Health Organisation notes with concern that most countries follow a response-driven approach to the prevention of child maltreatment with a focus on the early identification of cases, followed by investigation and intervention.[2] Yet mitigating the consequences of violence for affected children is unlikely to decrease the incidence of violence against children in the population as a whole.

A shift to primary prevention

There is a growing recognition that interpersonal violence is preventable. This means that efforts to prevent violence should precede and prevent the occurrence of violent acts and not simply respond to violence against children once it has occurred. The Centres for Disease Control and Prevention identify three approaches to violence prevention:[3]

- primary prevention aims to prevent violence before it occurs;
- secondary prevention focuses on the immediate response to violence including emergency services and holistic care; and
- tertiary prevention involves short- and long-term approaches to reduce the impact of trauma in victims, and to rehabilitate offenders.

The Children's Act[4] uses the term "prevention" to refer to programmes that build the resilience and capacity of children and families before problems occur, and introduces the term "early intervention" for programmes that target families where children are identified as vulnerable, or at risk of harm, or where children need to be removed from the family into alternate care. Services at this level also include therapeutic programmes to reduce the need for court-ordered intervention[i] or alternative care.

Recent research[5] has contributed to a global shift from response to primary prevention services. This includes a growing understanding that:

- child maltreatment has a far-reaching impact on children's physical and mental health and ability to function;
- only a small proportion of child maltreatment cases are reported to child protection services;
- rates of violence against children in many low- and middle-income countries are higher than those in high-income countries; and
- preventing child maltreatment in the first place is cheaper and more effective than trying to remediate its effects later.

Caldwell and Noor[6] noted that the costs of prevention programming vary depending on the intensity of the services offered but are just a fraction of the child abuse treatment costs. They estimated the cost savings to range from 96% to 98% depending on the prevention model tested. This has subsequently been reinforced by further research[7] which presents a clear economic rationale for addressing early risk factors and investing in childhood. This emphasis on prevention is also in line with recommendations by the United Nations Committee on the Rights of the Child in their general comment on children's right to protection from all forms of violence.[8]

In South Africa, the child protection system has focused primarily on response services and there has been little investment in primary prevention. However, this situation is promising to change as the government is in the process of reviewing the effectiveness of current responses to violence against children. It has commissioned an analysis of the root causes of violence against children to inform its action plan to prevent violence against women and children.

A public health approach

The goal of developing a solid evidence base is aligned to a public health approach to prevention, which is multi-disciplinary and provides a systematic approach to developing and designing effective prevention programmes.

i Examples of court-ordered intervention include providing an order to remove a child from home, and placing the child in foster or institutional care, or requiring that parents or caregivers of the child undergo assessment and treatment for harmful behaviours.

This includes:[9]

- defining the problem by describing its magnitude, distribution and consequences;
- identifying risk and protective factors and underlying causes – in particular those that can be modified;
- developing and rigorously evaluating interventions that target risk factors; and
- scaling up those interventions that have been shown to work, and evaluating their cost-effectiveness.

In addition, prevention programmes need to be well targeted to minimise costs and ensure equitable access to services based on need. Gordon[10] distinguishes between universal services that target the entire population and more specialised services, and this framework has been adopted by the Department of Social Development (DSD) in its National Strategic Plan[11] for the provision of prevention and early intervention programmes which distinguishes between:

- universal prevention which includes strategies and programmes that target the general public or a whole population group;
- selective prevention which targets individuals or a sub-groups of the population whose risk is significantly higher than average; and
- indicated early interventions which focus on high-risk individuals who are identified as having minimal but detectable signs or symptoms of social problems.

Indicated early interventions are likely to be more intensive and costly than selective and universal prevention and should be carefully targeted. For example, in the Western Cape province, the BEST programme run by James House in the Western Cape uses a social-ecological approach (see pp. 30 – 33) and works with all stakeholders to ensure that teenagers with high-risk behavioural issues receive the necessary support to avert being placed in an institution or prison.[12]

The social-ecological system

The public health approach to violence prevention locates the individual child within the broader social-ecological system, and recognises that violence is not the result of a single factor, but rather the outcome of a complex interplay of individual, relationship, community, and societal factors. Prevention efforts then focus on evidence-based interventions that decrease risk factors and strengthen protective factors at each level of the system.

Intersectoral collaboration

The DSD's Draft Strategic Plan for the Comprehensive Provision of Prevention and Early Intervention Programmes[13] highlights how prevention of violence and promotion of safe childhood need to move beyond targeting individual behaviour to address broader social and environmental drivers of violence against children. Prevention strategies are therefore needed at all levels of the social-ecological model, which speaks to the need for intersectoral collaboration and the importance of community ownership and participation (illustrated in case 4 on p. 40).

The Draft Strategic Plan also highlights the need to strengthen protective factors and create supportive environments, strengthen community action and develop personal skills, including interventions that change the ways in which families and communities value and respond to children. This understanding is consistent with that of the Daphne Project's review of evidence and best practice in the European Union, which defines violence prevention as the implementation of systems, services and interventions to both reduce risk factors for child abuse and neglect, and enhance protective factors.[14] At the core of prevention are programmes with components that aim to change behaviour that contributes towards children and adults either becoming perpetrators or victims of violence.

The Children's Act obliges the DSD to collaborate with other government departments to implement prevention and early intervention programmes. While early intervention programmes traditionally rely on child protection organisations and law enforcement authorities, the shift to primary prevention (together with the emphasis on strengthening protective factors) requires collaboration with a much wider range of role-players including the Health, Basic Education, Human Settlements and Local Government departments to promote maternal and child health and well-being, early childhood development, play and schooling opportunities. This highlights the need for inter-disciplinary teams with "the diversity of expertise and breadth of intellectual focus"[15] needed to design and implement effective prevention programmes.

A life-course approach

Prevention programmes also need to be sensitive to how children's experience and exposure to violence change across the life course (as outlined in the previous essay), and design developmentally appropriate interventions. For example, information on "shaken baby syndrome" is particularly relevant during infancy and early childhood, whilst programmes that teach children to be alert and respond to high-risk situations are more appropriate in later childhood when children have the capacity to reason and anticipate potential risk and danger.

In other words, the design and implementation of prevention programmes need to take into account: the earliest possible point of intervention before risk factors become entrenched; the severity of risk factors; the appropriate level of coverage of the population; and at what stage of child development it is most appropriate to intervene.[16]

Table 2 draws on the social-ecological model to outline a range of interventions designed to prevent and respond to violence against children; which need to inform the development of a comprehensive prevention strategy in South Africa.

How is South Africa doing?

South Africa has put in place laws and policies[17] that support the prevention of violence against children, and these make clear government's intention to shift practice from tertiary to primary prevention. Globally, programmes that have been found to be

Table 2: Mapping prevention and early intervention at each level of the social-ecological model

	Individual	Relationship	Community	Society
Before violence occurs Prevention (primary prevention)	Antenatal and post-natal services that address holistic health Birth registration Enforcing payment of child maintenance orders Children's social and emotional competence are developed Programmes to build self-esteem and critical thinking Anti-bullying programmes Skills development programmes/economic empowerment Adolescent development programmes/mentorship programmes Sexual and reproductive health programmes for teenagers Confidential helplines providing information	Parenting and home-visitation programmes Support and information to families of children with disabilities Conflict resolution and communication skills Peer-support systems Recreation and sports Programmes that promote positive relationships between males and females	Changing social/gender norms Public debates on traditional practices Training teachers on positive discipline Shifting attitudes on corporal punishment Mass media and social mobilisation campaigns Edutainment (eg Soul City) Awareness of child disabilities and reducing stigma against children with disabilities Community dialogues to identify risk and protective factors and recognise signs of abuse Outreach programmes addressing community risk factors Investing in community facilities to promote safety	Legislation Policy Norms and standards for services National action plans Practice guidelines and management protocols Provincial profiles and research on need and effective programmes Job creation and economic opportunities
After violence took place Early intervention (secondary and tertiary prevention)	Confidential child helplines Targeting risk behaviour Support for alcohol and substance abuse Counselling Temporary safe care Witness preparation programmes Specialised therapeutic services for victims Offender rehabilitation and diversion programmes	Family preservation programmes Family group conferencing Court order prevention and early intervention programmes Support groups Strengthening family support structures/ social connections	Training of professionals to identify children at risk; report; refer and support victims Strengthening multi-disciplinary team work and intersectoral collaboration One-stop centres (eg Thuthuzela Care Centres; The Teddy Bear Clinic) Specialist courts and other services Disciplinary action, or prosecution of repeat offenders who use corporal punishment in schools	Legislation Policy Norms and standards National action plans Practice guidelines and management protocols Provincial profiles and research on need and effective programmes Offender registers

effective or promising are home visitation and centre-based[ii] parenting skills training for mothers and caregivers.[18]

However, implementation of these laws, especially the Children's Act, has been slow. Most child protection programmes, with the exception of social grants, are implemented by non-governmental organisations in the social welfare sector, and historically these organisations have focused on the provision of early intervention and tertiary response services. Any shift in practice will depend on the capacity and readiness of South Africa to implement prevention programmes.

The World Health Organisation recently conducted a study[19] to assess the readiness of countries to implement large-scale child maltreatment prevention programmes and highlighted a range of factors that need to be taken into consideration including:

1. legislation, mandates, policies and plans together with the political will to address the problem;
2. policy-makers' and practitioners' attitudes and knowledge about child maltreatment and its prevention;
3. the existence of large-scale prevention programmes or programmes into which child maltreatment prevention components could be integrated;

ii Group programmes delivered through community centres, schools, early childhood development centres, or clinics.

Case 3: Thula Sana – An intervention to enhance the mother–infant relationship and infant attachment

Mark Tomlinson and Sarah Skeen (Department of Psychology, Stellenbosch University), Peter Cooper abd Lynne Murray (Winnicott Research Unit, University of Reading, England) and Mireille Landman (The Parent Centre)

Sensitive maternal care and secure infant attachment are associated with a range of positive child development outcomes. Previously, researchers found high rates of insensitive parenting and insecure infant attachment in early mother–infant relationships in Khayelitsha, Cape Town.[20] In response, the research team (together with the implementing partner The Parent Centre) developed the Thula Sana intervention to promote sensitive and responsive interactions between mothers and their infants.

The intervention is designed for routine delivery within low-resource settings, and is delivered by lay community health care workers who are trained and provided with regular support and supervision. The programme is based on a manual, which is used to guide the health workers in the day-to-day delivery of the programme. During the programme, the community health worker engages in a number of activities with the mother to sensitise her to her infant's individual capacities and needs.

The intervention starts in the last trimester of pregnancy, and continues for six months after birth, with mothers receiving visits from the community worker in their homes. A total of 16 visits are made and these are particularly intensive in the first three months after the baby's birth.

An evaluation of the Thula Sana intervention found that community health workers had strong community support for their activities, and that the intervention was well received by mothers, with a low drop-out rate. Researchers found that mothers in the intervention group were significantly more sensitive in interaction with their infants, and their infants were significantly more likely to be securely attached.[21]

The research team is currently in the process of investigating the long-term impact of the programme with the participating mothers and their children, who are now 13 – 14 years old.

Through supporting the development of early child behaviour and emotional functioning, early interventions such as Thula Sana can help to promote positive, and reduce negative, patterns of parenting. Not only is this likely to reduce the use of harsh and violent discipline practices in families, but it can also reduce children's long-term risk for engaging in violent behaviour themselves.

4. material, human and technical resources; and
5. reliable data to inform the design, targeting and monitoring of services.

The study found that South Africa showed a low level of readiness based on the lack of large-scale child maltreatment prevention programmes to address the magnitude of the problem. Given the scale of the problem, it may therefore help to integrate prevention interventions into existing programmes such as maternal and child health care, early childhood development and care services and home-based care visits in order to take these to scale.[22]

Such interventions include parenting programmes to prevent physical abuse, emotional abuse and neglect. For example, the Thula Sana project (case 3 above) has demonstrated improvements in the quality of mother–infant relationship and security of infant attachment. Another promising programme to improve the well-being of children is the Isibindi[iii] model which provides psycho-social support to reduce emotional problems for vulnerable and orphaned children in the context of HIV and AIDS.[23]

A review[24] of parenting programmes in low- and middle-income countries indicates the importance of developing interventions that take account of the challenges facing children who grow up in low-income settings, including widespread violence and the impact of HIV/AIDS on families. Additional risk factors are teenage parenting, substance abuse and high levels of unemployment and poverty. Interventions that aim to improve the capacity of primary caregivers to provide nurturing care should therefore at the same time increase their knowledge and ability to respond to other risk factors in their communities.

The prevention strategies that are most consistently used in South Africa are public awareness campaigns – in particular Child Protection Week, and the 16 Days of Activism for No Violence Against Women and Children. In addition, pre-school and primary school children are being taught about unsafe situations and inappropriate behaviour. However, there is no clear evidence that these campaigns and education programmes are effective, and statistics on reported violence against children have not reduced substantially in the past two decades.

Some projects and programmes[iv] initiated by civil society organisations and research institutions show considerable promise in modifying values, norms and behaviours to promote the care, nurturing and protection of children. Most have developed (or are in the process of developing) an evidence base, yet comprehensive roll-out is limited by the lack of available resources and a comprehensive national implementation plan that co-ordinates activities at every level of prevention.

The current funding climate for such interventions, including

iii 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 nine provinces.

iv For example, Childline South Africa, Child Welfare, Sonke Gender Justice (MenCare and One Man Can programmes), the National Association of Child and Youth Care Workers (Isibindi programme), the Parent Centre (Home visiting and Teen Parenting programmes), Resources Aimed at the Prevention of Child Abuse and Neglect - RAPCAN (positive discipline advocacy), the Sexual Violence Research Initiative and the Medical Research Council (Skhokho and Stepping Stones).

increased global and national interest in addressing violence against children through prevention measures, is likely to improve the situation. The trend to focus greater attention on prevention is reflected in the meeting minutes and publications of international bodies.[25] Furthermore, both local and international donors appear to have shifted from funding responses to violence against children to supporting pilot prevention programmes and evaluating their impact in order to strengthen the evidence base.[26]

Local researchers are striving to improve the evidence base for possible scaling up by developing randomised controlled trials. Emerging evidence has primarily focused on young children, as an early start is essential to address risk factors that produce emotional and behavioural difficulties in children. The Department of Health has the potential to play a key role in prevention by helping to identify children at risk and refer them to social services.[v] While the Children's Act makes it mandatory for health care professionals to report child abuse,[27] there is a need to expand these professionals' role to include primary prevention as an integral part of maternal and child health services.

Interventions that promote respectful and equitable relationship-building, communication, and conflict resolution skills in adolescence are also showing promise in shifting violent practices in interpersonal relationships. There are a few school- and community-based prevention programmes with adolescents and young men that are showing some success, such as Stepping Stones, One Man Can, and PREPARE (see the essay on pp. 73 – 79).

Some literature[28] creates a distinction between practice and evidence-based knowledge when discussing prevention and responses to violence against children. However the value of practice analysis should not be neglected, both as a source of developing new ideas to be tested and as providing a context in which evidence is gathered. It is one of the challenges in the field of research – to bring academics and practitioners together to share research opportunities, develop strategic and programmatic ideas, and enable the development of an evidence base that can be used at the coal face of practice.

Much of the evidence-based research in the field of prevention of child violence has been done by academic and research institutions in South Africa, and tends to be published in scientific journals, which are unaffordable and inaccessible to practitioners. Co-ordination and a closer interface between research and practice will do much to strengthen prevention efforts and will encourage practitioners to develop and implement strategies and programmes that have an evidence base, and research institutions to ensure that the body of evidence-based practice continues to grow and develop.

In summary, sustained programmes and responses directed at the prevention of violence against children in South Africa, based on research, practice, evidence and careful planning, have been – and remain – lacking. Responses to violence against children have tended to be "knee-jerk" and without careful thought about the implementation consequences in the short and long term, without an evidence base, and tending to address the response to violence once it has occurred, rather than primary prevention.

Isibindi safe parks: Provide a safe environment for children after school

v For example, on 24 May 2014, the 67th World Health Assembly adopted a historic resolution entitled "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children".

Case 4: Children are precious – A comprehensive approach to child protection at community level

Christina Nomdo (Resources Aimed at the Prevention of Child Abuse and Neglect – RAPCAN)

Children Are Precious (CAP) is a comprehensive and community-based model for child protection in Lavender Hill, Cape Town, which was initiated in 2009 by RAPCAN. CAP aims to:

- identify and reduce risk factors in the family, school and community;
- enable more efficient and effective responses to child maltreatment; and
- establish and strengthen community-based primary prevention, secondary prevention and tertiary prevention strategies.[29]

At community level, a series of dialogues were held with key target audiences including mothers, young people participating in a health club, and children in aftercare. These dialogues formed part of a communication-for-social-change process that aimed to strengthen primary prevention by posing questions, providing information and eliciting rights messaging. The children and youth produced an album of songs and child rights messages which were used with the community, government officials and politicians to advocate for primary prevention.[30]

At schools, training programmes focused on creating a safe haven for children at school. RAPCAN facilitated workshops on child abuse prevention and management, positive discipline, safety, and conflict resolution, as well as the development of school safety plans. However, educators were reluctant to change behaviour when the school system did not change.[31]

Lay-support workers engaged with individual children from four schools who were experiencing barriers to learning. These sessions aimed to build children's resilience by drawing on the Heroes and Healers workbooks,[vi] and by using community mapping to identify community resources and areas of danger and safety. They also worked at community level by mentoring after-school care and strengthening referral systems. However, their efforts were undermined by the slow response of service providers in the referral system.[32]

In some ways CAP was too ambitious, working at many levels with a range of innovative intervention strategies and with constrained resources; so a collaborative venture may have been more advisable.[33] Despite these challenges, RAPCAN remains committed to a comprehensive community-based approach to preventing violence against children and, in 2014, RAPCAN's advocacy for primary and secondary prevention interventions has attracted commitment from government to support these CAP interventions.

Table 3: Intervention strategies used by CAP

Focus area	Primary prevention	Secondary prevention	Tertiary prevention
Community	Communication for social change	After-school care mentoring	Referral systems strengthening
School	Positive discipline training with educators	School safety plans	Child abuse prevention and management systems
Family and individual	Parenting support	Community mapping and Heroes workbook	Healers workbooks

These responses tend to be child welfare-oriented and include some medical interventions in the case of physical and sexual abuse. However, the role of the health sector in strengthening violence prevention interventions is neglected both in policy and practice. The use of para-professionals in the Thula Sana project is a promising model for delivery as it reduces the costs associated with parenting interventions in high-income settings.[34]

The development of a comprehensive prevention plan requires good data collection to enable an appropriate strategic and programmatic focus and evidence of efficacy.[35] Reliable and comprehensive data on violence against children in South Africa are lacking (see the previous essay). Although there are figures on broad categories of violence against children, it is widely acknowledged that there is underreporting and there is little specific data on contextual and other drivers of violence.

The family is broadly recognised in policy, law and practice as the first protection system for children, yet it is also a context in which significant acts of violence against children occur. Therefore, engagement with parents needs to be stressed in both policy and practice guidelines. Consultation with parents and caregivers is an opportunity for providing information to parents about a child's right to be safe from all forms of violence, as well as helping them develop coping mechanisms and non-violent ways of disciplining their children.

vi The Heroes workbook produced by the Regional Psycho-Social Support Initiative (REPSSI) uses storytelling to help children address and overcome psycho-social challenges, while the Healers books produced by RAPCAN are designed to support therapeutic work with children who were abused sexually.

What are the recommendations?

Preventing violence against children in South Africa is a public good. That means it not only promotes the well-being of children, it is also essential to a peaceful democracy, a healthy nation, enhanced productivity and reducing the high levels of violence in South African society. The approach to prevention must be intersectoral and inclusive of government, professionals working with children, civil society organisations, business, parents, caregivers and children, emphasising that the protection of children is "everyone's business" and a collective responsibility.

Preventing violence against children requires collaborative action on the development of strategies and programmes, testing their effectiveness and scaling up those for which there is a clear evidence base, and ensuring that the different strategies and programmes addressing other types of violence, such as gender-based violence, are integrated into an overall national plan. The following recommendations are put forward to realise this goal:

1. The Department of Social Development, as the lead department for the protection of children, together with its provincial counterparts, other relevant government departments such as Health, civil society organisations, professionals, and research institutions must combine their knowledge and practice skills to implement the National Strategic Plan. This includes the development of a carefully constructed, coherent evidence-based master plan, using an approach similar to that outlined in table 2 on p. 37, and which addresses all levels of prevention across a range of contexts. This includes preventing the use of corporal punishment and the exposure of children to domestic violence in the home.
2. Strong surveillance systems are essential for the effective targeting of services. The DSD and civil society organisations must therefore ensure the optimal functioning of the National Child Protection Register[vii] to inform the development of a prevention plan that is adequately resourced and responsive to needs on the ground. Similarly, the departments of Health and Social Development should prioritise the development and use of screening tools to identify families and children at high risk, and referrals for assistance should be monitored.
3. Effective prevention needs to be broad based, covering both universal and targeted groups, and should prioritise primary prevention interventions that clearly show how they intend to change behaviours that are associated with risk factors of violence against children in families, schools and communities. Given the historical use of the response approach to child

© Resources Aimed at the Prevention of Abuse and Neglect – RAPCAN

Children Are Precious: Communication for social change in Lavender Hill

vii The National Child Protection Register, provided for in the Children's Act, has two sections. Part A captures details of children whose abuse and/or neglect has been reported to the child protection system. Part B captures details of persons unfit to work with children. All who work with children, in either a paid or voluntary capacity, have to be screened against the register. If a person's name appears on the register, they may not be employed in any capacity to work with children. The purpose of the register is therefore two-fold – to enable knowledge of the extent of required child protection services and to protect children from abuse.

protection, South Africa needs to prioritise the reorientation of policy managers and practitioners in various sectors. This could also include the development of a framework that guides policy managers and planners to ensure effective allocation of funds and monitoring of services.

4. Researchers and practitioners in child protection, child health and development and civil society organisations must work more closely to strengthen prevention of violence against children. Through this co-operative approach South Africa has the potential to develop indigenous knowledge and practice on effective prevention of violence against children. Evidence-based strategies and programmes from other countries and regions that appear to hold promise should be explored but must be adapted to the culture and context of South Africa's children and families. Similarly, indigenous traditions and practices that support non-violent child-rearing and caring practices should be identified and strengthened. The National and Provincial Child Care and Protection Forums provide opportunities for closer collaboration between government, professionals, civil society and researchers to develop, test and implement effective strategies and programmes.

References

1 Pinheiro PS (2006) *World Report on Violence Against Children*. Geneva. United Nations.
2 World Health Organisation (2006) *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence*. Geneva: WHO.
3 Centres for Disease Control and Prevention (2012) T*he Public Health Approach to Violence Prevention.* Accessed on 18 July 2014: www.cdc.gov/violenceprevention/overview/publichealthapproach.html.
4 Children's Act 38 of 2005. Section 144.
5 Mikton C, Power M, Raleva M, Makoae M, Al Eissa M, Cheah I, Cardia N, Choo C & Almuneef M (2013) The assessment of the readiness of five countries to implement child maltreatment prevention programs on a large scale. *Child Abuse & Neglect*, 37(12): 1237-1251.
6 Noor I & Caldwell R (2005) *The Costs of Child Abuse vs. Child Abuse Prevention: A Multi-year Follow-up in Michigan*. Accessed on 18 September 2014: https://www.msu.edu/~bob/cost2005.pdf
7 Doyle O, Harmon CP, Heckman JJ & Tremblay RE (2009) Investing in early human development: Timing and economic efficiency. *Economics and Human Biology*, 7: 1-6.
8 Svevo-Cianci KA, Herczog M, Krappman L & Cook P (2011) The new UNCRC General Comment 13: 'The right of the child to freedom from all forms of violence' – Changing how the world conceptualizes child protection. *Child Abuse & Neglect*, 35: 979-989.
9 See no. 3 above.
10 Gordon RS (1983) An operational classification of disease prevention. *Public Health Reports*, 93(2): 107-109;
Zollner H, Fuchs KA & Fegert JM (2014) Prevention of sexual abuse: Improved information is crucial. *Child and Adolescent Psychiatry and Mental Health*, 8: 5.
11 Department of Social Development (2013) *Comprehensive National Strategy Aimed at Securing the Provision of Prevention and Early Intervention Programmes to Families, Parents, Caregivers and Children Across the Republic of South Africa: National Strategic Plan (Draft) 2013/14 – 2018/19*. July 2013. Pretoria: DSD.
12 James House (2014) *Home*. Accessed on 26 September 2014: www.jameshouse.org.za.
13 Department of Social Development (2012) *Comprehensive National Strategy Aimed at Securing the Provision of Prevention and Early Intervention Programmes to Families, Parents, Caregivers and Children Across the Republic of South Africa: National Strategic Plan (Final Draft) 2013 – 2017. November 2012*. Pretoria: DSD.
14 Netherlands Youth Institute (2012) *What Works in Tackling Child Abuse and Neglect: A Manual for Policy Makers, Managers & Professionals*. Utrecht, Netherlands: NYI.
15 Coie JD, Watt NF, West SG, Hawkins JD, Asarnow JR, Markman HJ et al (1993) The science of prevention: A conceptual framework and some directions for a national research programme. *The American Psychologist*, 48(10): 1013-1022.
16 See no. 15 above.
17 Department of Welfare (1997) *White Paper for Social Development. Principles, Guidelines, Recommendations, Proposed Policies and Programmes for Developmental Social Welfare in South Africa*. Pretoria: DoW;
Domestic Violence Act 116 of 1998;
Maintenance Act 99 of 1998;
Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007;
See no. 13 above.
18 Knerr W, Gardner F & Cluver L (2011) *Parenting and the Prevention of Child Maltreatment in Low- and Middle-Income Countries: A Systematic Review of Interventions and a Discussion of Prevention of the Risks of Future Violent Behaviour among Boys*. Pretoria: Sexual Violence Research Initiative, Medical Research Council.
19 See no. 5 above.
20 Cooper PJ, Tomlinson M, Swartz L, Woolgar M, Murray L & Molteno C (1999) Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry*, 175: 554-558;
Tomlinson M, Cooper P & Murray L (2005) The mother-infant relationship and infant attachment in a South African peri-urban settlement. *Child Development, 76(5)*: 1044-1054.
21 Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, McPherson K, Murray L (2009) Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: Randomised controlled trial. *British Medical Journal*, 338: b974.
22 See no. 5 above.
23 National Association of Child Care Workers (2010) *Annual Report 2009/2010*. Cape Town: NACCW.
24 See no. 18 above.
25 Van Niekerk J, Gray J & Hendry E (2014) *Working with Men and Boys: Preventing Child Sexual Abuse*. 20th International Society for the Prevention of Child Abuse and Neglect International Congress. 14 – 17 September 2014;
UNICEF (2014) *Ending Violence Against Children: Six Strategies for Action*. New York: UNICEF.
26 Department of Social Development (2008) *Policy on Financial Awards to Service Providers*. Pretoria: DSD;
Oak Foundation (2014) *What We Fund*. Accessed on 13 September: http://www.oakfnd.org/node/1296;
Mikton C, as quoted in: Violence Prevention Alliance & Optimus Study (2012) *Promoting Research to Prevention Child Maltreatment. Summary Report: Workshop on International Epidemiological Studies*. XIX ISPCAN International Congress on the Prevention of Child Abuse and Neglect, Turkey, September, 2012.
27 See no. 4 above. Section 110.
28 See no. 14 above.
29 RAPCAN (2008) CAP Concept Note. [Unpublished]
30 Southern Hemisphere (in press). Practitioners' formative evaluation and intervention manuals. Cape Town.
31 Centre for Justice and Crime Prevention (2013) Outcomes Evaluation of the "Children are Precious Model": An Ecological Approach to Developing a Community-based Response to Child maltreatment in the Greater Lavender Hill Area. Report on the Assessment of the Individual and School-level Services. [Unpublished]
32 De Villiers JC (2012) Evaluation of the "Children are Precious Model" Community-based Therapeutic Model and Interventions in Lavender Hill, South Africa. [Unpublished]
33 Centre for Justice and Crime Prevention (2010) Process Evaluation: The Development of the "Children are Precious Model": An Ecological approach to Develop a Community-based Response to Child Maltreatment in the Greater Lavender Hill. [Unpublished]
34 See no. 26 above (Mikton).
35 See no. 26 above (Mikton).

Towards effective child protection: Adopting a systems approach

Cathy Chames and Dena Lomofsky (Southern Hemisphere)

Whilst no violence against children is justifiable, and all violence against children is preventable,[1] South Africa's children continue to experience violence in a range of settings, including the home, school, community, alternative care and the justice system. This has serious implications for children's development and well-being.[2] This is despite the strong suite of legislation and policies put in place by the government to protect all children from violence, abuse, exploitation and neglect. The essential question thus remains: why is there a significant gap between the state's legislative and policy commitments and the real life experiences of children?

This essay argues that the gap is due to systemic challenges that need to be addressed for the implementation of effective and well co-ordinated child protection programmes and services.[i] It explores the following questions:

- What is South Africa's legal obligation to protect children from violence?
- What are the key elements of the child protection system?
- What are the systemic or design challenges?
- What are the recommendations for strengthening the system?

The main focus of the essay is on the system requirements for the Department of Social Development (DSD) as this department is tasked with leading the implementation of the Children's Act. However, effective child protection requires intersectoral collaboration, and the DSD needs to co-operate with other departments, as outlined in figure 5 on p.46. Thus, we highlight what the DSD needs, from a systems perspective, to fulfil its leadership role. Ultimately, a protective environment for children can only be achieved if all role-players, including state and non-state actors, work together in the interests of children.[3]

What is South Africa's legal obligation to protect children from violence?

Children's rights are defined internationally and regionally by the United Nations Convention on the Rights of the Child[4] and the African Charter on the Rights and Welfare of the Child,[5] while the Constitution and the Children's Act[6] protect rights at a national level (see figure 3 on the next page).

The state bears three levels of obligations to children, where the emphasis is on preventing violence in the first instance. These include the obligations to:

1. *prevent* violence against children;
2. *protect* children *from further harm* if they have already fallen victim to violence; and
3. *support and treat* children who have experienced violence so as to restore them to physical and psychological health – and prevent them from becoming either more susceptible to violence, or abusive themselves.[7]

Since all rights are related, the state must balance the right to protection with the right to family care and respect the right of both the child and family to participate in decisions affecting the child. That includes decisions at the personal and the policy level.

The rights apply to all children without discrimination. However, some children, due to their circumstances, need extra support to ensure that their rights are respected, such as children who are foreign nationals[8] and children with disabilities[9]. The Children's Act gives effect to these rights by establishing a framework for a holistic range of interventions for children and their families, including:

- prevention programmes;
- early intervention;
- statutory services; and
- reconstruction and aftercare services.

These are referred to as the "continuum of care" and the Act emphasises the importance of strengthening programmes and services at the front end of this continuum – namely prevention and early intervention, including efforts to support caregivers, families and communities to care for and protect their children.[10]

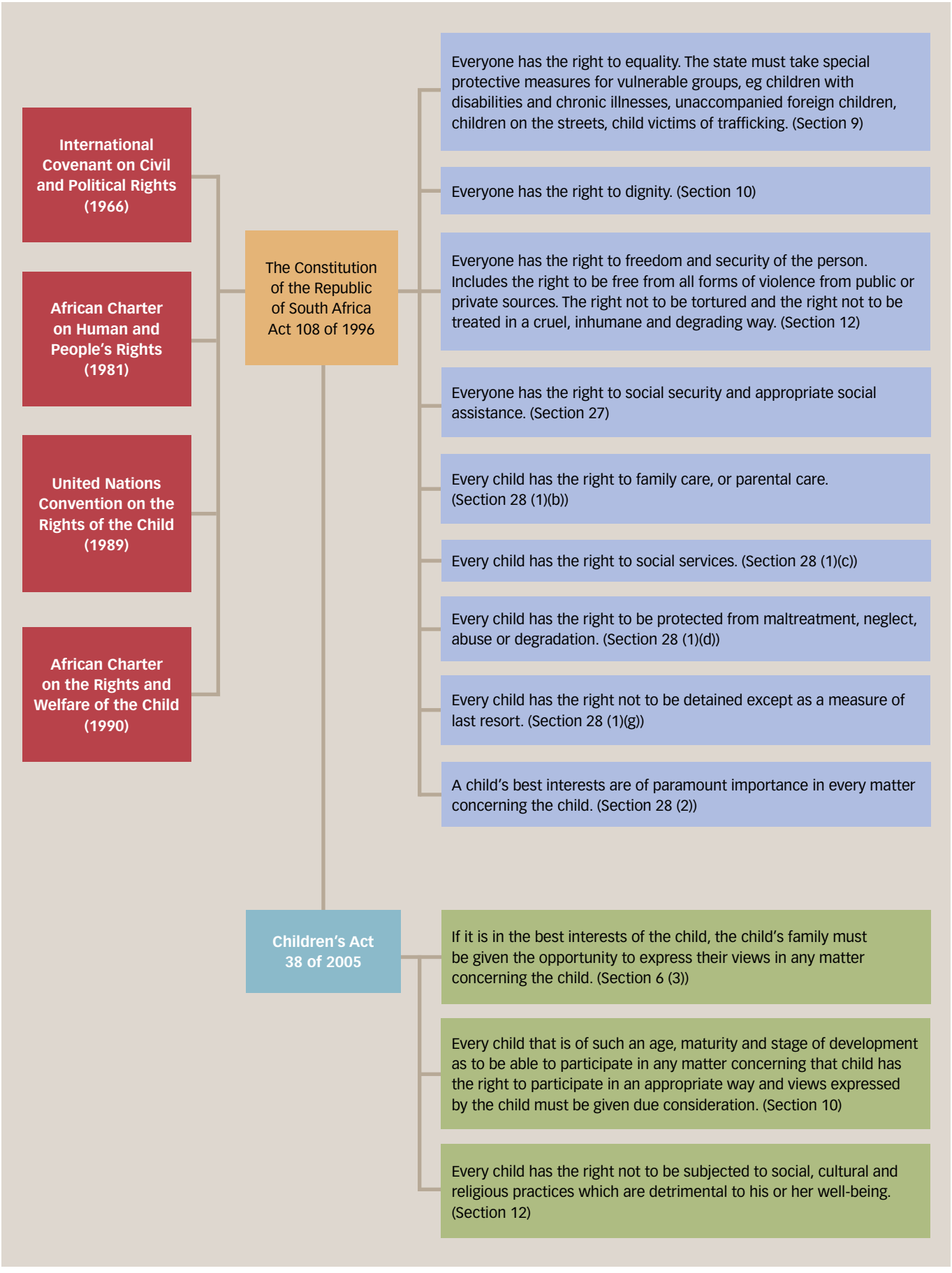
Child protection and the social development agenda

As envisioned in the White Paper for Social Welfare,[11] the Children's Act takes a developmental approach to social welfare, where human and financial resources are focused mainly on the prevention of social problems.[ii] When prevention has not been successful, the aim is to intervene through early intervention services and programmes when the first signs of social problems appear. This approach is developmental firstly because it encourages the optimum social development of the child and, secondly, because it avoids costly intervention once the problems have occurred.[12]

i It is also important to note that while many of the challenges are systemic, they appear within a very violent context which is not for the child protection system alone to address.

ii The White Paper not only shifted the approach from residual to developmental, but it brought multiple departments (each with their own sets of policies, norms and standards) into one system. This entailed a lot of change, which in itself has resulted in an ongoing complex situation that affects the effectiveness of the DSD.

Figure 3: How South African law gives effect to international rights



Current emphasis of the child protection system

Although the Children's Act requires a greater focus on prevention services, the current emphasis is on crisis intervention and statutory services. It has been suggested that within the context of limited resources, prevention and early intervention services are viewed as "less critical" than statutory protection services and alternative care. The result is a vicious cycle where social workers have to spend more time on protection and alternative care and therefore have less time to deliver prevention and early intervention services such as parenting skills development, therapeutic programmes and managing family disputes.[13] The same is true for actors in related sectors such as education, health and the police. Furthermore, intersectoral child protection protocols that were established a decade ago to guide co-ordination at provincial level are often not being used.[14] In order to address this vicious cycle, it is proposed that every element of the child protection system focuses on gradually shifting the balance from statutory services towards prevention and early intervention.[iii]

What are the key elements of the child protection system?

Providing programmes and services is only one part of the broader child protection system. The Children's Act legislates for the establishment of a properly resourced, co-ordinated and well-managed child protection system. Although not specified in the Act, the core elements which make up this system should include:[15]

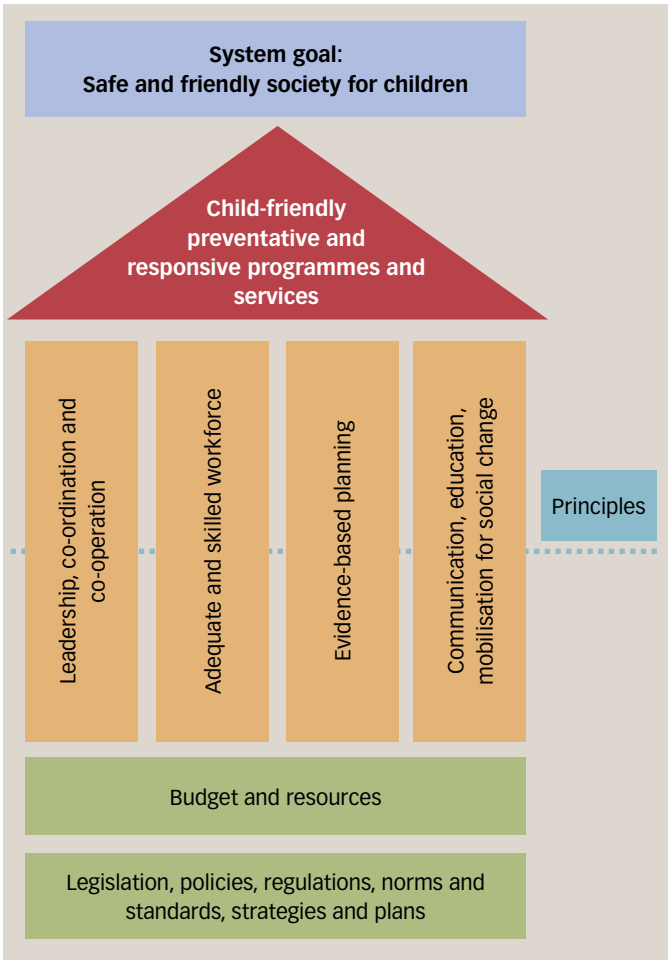
1. comprehensive child protection laws and policies aligned with international legislation; regulations, norms and standards; and up-to-date strategies and plans;
2. evidence-based planning;
3. leadership and meaningful co-ordination and co-operation across sectors;
4. communication, education and mobilisation for social change;
5. child-friendly preventative and responsive programmes and services;
6. adequate budget and resources; and
7. an adequate and skilled workforce.

These core components, which have been accepted by the DSD in their Draft Prevention and Early Intervention Strategy,[16] can be considered to be the infrastructure of the child protection system. Figure 4 illustrates how the system elements work together towards supporting a common goal.

What are the system design challenges?

This section discusses challenges with four of the child protection system elements (laws, policies, regulations, norms and standards, strategies and plans; leadership, co-ordination and co-operation; evidence-based planning; and communication, education and mobilisation for social change). Examples of child protection programmes and services are outlined in the essay on pp. 65 – 72 and financial and human resources are addressed in the next essay.

Figure 4: Key elements of the child protection system



Source: Save the Children UK (2009) A *'Rough Guide' to Child Protection Systems*. London: Save the Children UK;
Compiled from: Wulczym R, Daro D, Fluke J, Feldman S, GLodek C & Lifanda K (2010) A*dapting a Systems Approach to Child Protection: Key Concepts and Considerations:* New York; UNICEF.

Laws, policies, regulations, norms and standards, strategies and plans

The Children's Act lays a strong legislative foundation for the prevention and protection of children from violence. In addition to the Children's Act, three other pieces of legislation provide prevention and early intervention services:

- the Domestic Violence Act,[18] which aims to protect children in the cases of domestic violence;
- the Sexual Offences Act,[19] which defines and categorises sexual offences, sets out ages of consent to sexual activity and details procedures around prosecution of offenders; and
- the Child Justice Act,[20] which regulates a criminal justice system for children who are in conflict with the law and who are accused of committing offences, with the intention of (where possible) diverting children's matters away from the criminal justice system.[21]

A key design problem is that these laws were developed separately and therefore do not speak to one other, and sometimes contradict

iii This should not place children at greater risk by prematurely diverting resources away from statutory services and alternative care but ultimately there could be less demand for these response services as the emphasis shifts towards prevention and early intervention.

the other. Some examples include the variation in reporting requirements for each Act; and the lack of standardised definitions of child abuse. Furthermore, there is little clarity about how the numerous child protection-related policies, strategies and programmes which are spread across government departments articulate with one another.

The DSD has begun a comprehensive review of the Children's Act and its regulations in response to design and implementation challenges and will table amendments in Parliament based on this review. Some issues up for review include corporal punishment in the home, definitions of designated child protection organisations, definitions of terms, programmes and so on.

There is no guideline on how frequently these reviews should take place, or what principles should guide the reviews. Ideally reviews should occur on a regular basis (every five years) to ensure that lessons learnt from implementing the Act are used to improve the legal framework. A legislative review provides an opportunity for practitioners to work through co-operative forums to improve the legal framework.

Critically, the Policy on Financial Awards, which regulates the way in which non-profit organisations (NPOs) can qualify for government funding, has not yet been adjusted to take into account the requirements for implementing the Children's Act. This is despite the fact that NPOs provide the bulk of services and programmes. This issue is discussed further in the next essay.

Leadership, co-ordination and co-operation

While the DSD is the lead department for the child protection system, others – such as the departments of Health, Basic Education, and Justice and Correctional Services – also provide services to children and families which directly influence their protection.[22] The quality of co-ordination and co-operation between the child protection and other systems is therefore central for effectiveness. Figure 5 depicts the required links with other systems that need to be developed and maintained by a child protection system.

The Children's Act legislates for all spheres of government and non-governmental service providers to work together and to implement the Act in a uniform and integrated manner.[23] The Act specifically mentions the DSD as the lead department which must co-operate intersectorally and with the different spheres of government. The Inter-Ministerial Committee on Violence against Women and Children, which was established in May 2012, provides the DSD with a good mechanism to do so.

Co-operation between government and civil society is crucial since most of the services are being delivered by the non-governmental organisations (NGO) sector. The national, provincial

Figure 5: The child protection and allied systems

and local child care and protection forums provide a good platform for such collaboration, where they function well. Some challenges with their functioning include an over-representation of NGOs from Gauteng and the North West provinces on the national forum due to the costs of participation; and a high turnover of departmental representatives on provincial and district level forums.

The Child Justice Act creates the same obligation on the Department of Justice and Correctional Services and hence the establishment of the Intersectoral Committee on Child Justice, and the justice forums.

Multiple intersectoral committees – at least one for each system in figure 5 – have been established to strengthen collaboration between government departments and between the state and civil society. However, detailed research into these structures has identified several weaknesses.[24] Each structure has tended to focus on a specific issue and there is little collaboration with other structures to consider the holistic needs of children.[25] Instead each sector tends to work in isolation, leading to the duplication and fragmentation of services; a lack of and/or reluctance to commit resources; differing perspectives; and a lack of understanding of their respective roles and responsibilities.[26]

Cases 5 and 6 highlight the need to establish multi-disciplinary mechanisms to ensure a joint response and effective follow up of individual cases. Case 5 highlights how poor collaboration and communication between service providers can compromise children's safety and rights to care and protection. The three structures responsible for placing the children with the foster mother did not work in collaboration, and so did not pick up that the foster mother was caring for 12 children despite the legal limitation of six children per foster mother. Although the social worker did refer Tina's case to the police and clinic, there was no follow-up or communication to establish whether the child had received any services. Ultimately, the failure to intervene early in Tina's situation resulted in an escalation in the violation of her rights.

Case 6 on the next page describes the government's efforts to strengthen integration and the co-ordination of services at a local level through the Thuthuzela Care Centres.

Evidence-based planning

Evidence-based planning is an essential component of the child protection system. A solid evidence base is needed to inform the provision of appropriate, accessible and adequate services, and to monitor and evaluate the implementation of the Children's Act.

Child protection policies, strategies and programmes should be informed by sound empirical evidence and draw on two main types of data or evidence: These are surveillance data that measure the incidence and prevalence of violence (discussed in the essay on pp. 26 – 34), and outcome evaluations that measure what can be regarded as effective in prevention and treatment[27] (see the essay on pp. 35 – 42).

It is currently unclear how the monitoring and evaluation framework for the Children's Act is being used strategically to inform planning. The lack of reliable data limits the ability of the child protection sector to plan and design appropriate services and programmes. While the DSD reports on financial and non-financial data to National Treasury under the Public Finance Management Act, these reports do not provide a sense of the quality or reach of services. There is also lack of good quality evaluation studies, which are needed to take promising programmes to scale.[28]

Evidence gathering should be based on a strong conceptual framework that addresses the following four categories: child outcomes; social determinants for risk and protective factors based on the social-ecological systems approach (see pp. 30 – 31); and access to, and quality of, programmes and services.[29]

For strategic purposes, data must answer key questions to improve the design of holistic and integrated services. For example, where are the highest incidences of child abuse, neglect and exploitation; where are there too few child protection services; and are child protection programmes and services achieving their objectives? Answers to these questions should help ensure that prevention programmes and resources are targeted to children most in need, and quality is strengthened.

A key principle of the Children's Act, and of the Guidelines[iv] on the Principles and Core Elements for the Design and Development of Prevention and Early Intervention Programmes,[30]

Case study 5: Poor collaboration between service providers
Joan van Niekerk, Childline South Africa

Tina (not her real name), a child with special needs and from a severely disadvantaged background, was placed in foster care, along with 12 other children. Social workers did not visit regularly and the foster mother was being managed by three different organisations that were not aware of the others' involvement (the Department of Social Development and two NGOs).

Tina was abused by the foster mother's eldest son, resulting in pregnancy. Upon noticing the pregnancy, the foster mother referred the child to her social worker, to whom she disclosed the abuse. The social worker reported the case to the police and referred the child to the clinic for termination of pregnancy.

The child was sent home to the foster mother, where she was beaten for disclosing the abuse. The foster mother did not keep the appointments with the police or the clinic and continued to abuse the child physically. The other children in the foster placement continuously phoned the Childline service to report the case. Childline several times referred the case back to the social worker and her supervisor. However, before action was taken, Tina ran away from the foster home. She has not yet been traced.

iv These are guidelines for government and civil society service providers to meet the requirements of the Children's Act, the norms and standards, and the regulations pertaining to prevention and early intervention services for children and families in South Africa.

Case 6: Thuthuzela Care Centres

Pumeza Mafani, National Co-ordinator, Thuthuzela Care Centres

Thuthuzela Care Centres (TCCs) aim to provide a one-stop service for women and children who are victims of sexual violence. The centres aim to reduce secondary trauma, improve conviction rates for sexual offences, and strengthen co-ordination between different service providers. Other objectives include decreasing the turnaround time in finalising cases and increasing the number of cases that are finalised.

Thuthuzela comes from the isiXhosa word "to comfort" and the centres aim to provide a sensitive and integrated service drawing on specially trained medical personnel, police investigators, prosecutors, social workers and community volunteers. They are located in public hospitals and provide counselling and medical care, conduct medical examinations, secure forensic evidence, take statements from children and caregivers, and investigate the abuse under the guidance of a prosecutor. This centralised approach aims to enhance communication between the family and different service providers, enable more efficient and sensitive investigations, and improve data collection and prosecution rates.

In 2013, there were 51 Thuthuzela Care Centres in South Africa, of which 35 were fully operational. Over 33,000 matters were reported in 2012/2013. Of these, 49% were referred to court for prosecution, and 2,248 cases were finalised, with an average conviction rate of 61%.[31]

Key challenges include high case loads, a shortage of specialised staff (in particular police and prosecutors with the expertise to investigate and prosecute family violence, child abuse and sexual offences), and the closure of the dedicated sexual offence courts. However, the National Prosecuting Authority (NPA) continues to train prosecutors as required by the new sexual offences legislation and has trained over 1,000 prosecutors since 2007.[32] In 2013, the then Minister of Justice and Constitutional Development announced the re-establishment of sexual offences courts. These are currently being rolled out, with pending legislation for the formal establishment of these courts. All TCCs are connected to a regional criminal court, where the cases are court directed by an NPA case manager.

Cases involve children from as young as three-months-old. Staff require additional training in order to provide age-appropriate care and support for children and their caregivers. This includes working with drawings and anatomically correct dolls to help prepare children to testify in court.

The Thuthuzela project is led by the NPA's Sexual Offences and Community Affairs Unit, in partnership with various donors as a response to the urgent need for an integrated strategy for prevention, response and support for rape victims.

is that programmes and services should be planned and targeted according to local needs. So the more local level the data, the better. The international trend in child protection surveillance is to use data to understand child maltreatment at a neighbourhood level.[33] The Children's Act[34] requires all provincial departments of Social Development to compile provincial profiles that assess the need and availability of services and programmes in their province; and to develop strategies to ensure that all services are accessible to all children who need them. However, only one completed provincial profile has ever been submitted to the national DSD.[35] Therefore it can be assumed that there is a weak evidence base underpinning the annual performance plans of the provincial departments of Social Development, which are used to approve their budgets.

Case 7 on the opposite page describes how administrative data and census data can be used at a local level to identify areas where children are particularly at risk.

Communication, education, mobilisation for social change

Children often grow up exposed to high levels of violence in their homes, schools and neighbourhoods (as illustrated in the essay on pp. 26 – 34).[36] The protection of children is therefore not the sole responsibility of child protection workers, but requires the involvement and support of the wider public, who can play an active part in preventing child protection problems, identifying "at-risk" children[37] and creating safer environments for families and children[38]. Everyone has to be a child protection actor. It is not enough to have laws and systems in place if the people who children rely on for protection, do not do so.

Effective communication for social change requires a more sustained and co-ordinated communication and education effort beyond the traditional universal campaigns such as the 16 Days of Activism for No Violence Against Women and Children, and Child Protection Week.[39] Communication, education and awareness should take place at three main levels of intervention, allowing for more sustained programmes that encourage deeper engagement, dialogue and behaviour change, namely:

- the general public targeted through universal campaigns;
- high-risk communities targeted through communication and education programmes; and
- children through focused interventions.

The DSD's Strategic Plan for Prevention and Early Intervention (2014 – 2018)[40] includes public media strategies; co-ordinated community-based dialogues in high-risk communities; raising awareness through existing services for parents and children; and a methodology for child-to-child communication. The Children's Act requires government to conduct education campaigns on

Case 7: Mapping child maltreatment at local level

A study[41] conducted in Suburban County, Maryland, USA, can be considered a best practice example of the use of surveillance data to inform service provision. It examined the distribution, rates, and socio-economic predictors of physical abuse, neglect and sexual abuse. Examples include economic stress, residential mobility, and stress on families in the neighbourhoods.

The study linked administrative and census data which allowed child maltreatment to be viewed as a neighbourhood phenomenon as opposed to an individual one. It used geographic information system software to link the two data sources to geographical areas and to produce maps that show the distribution of variables. The administrative data provided the addresses of families investigated for abuse, neglect and sexual exploitation, which was then overlaid with the socio-economic variables.

In this way, the study was able to identify specific locations, such as a particular strip of housing or apartment block, which represented a high incidence area, and identify indicators for increased risk for violence. This is very powerful information to inform local area plans.

good parenting and positive discipline, and the DSD has reportedly prioritised this (see the essay on p. 58 – 64). This lends itself very well to local level community dialogues and household level prevention messages; yet parenting programmes are thinly and unevenly spread.[42]

The media, schools, religious and traditional leaders need to be brought into the on-going dialogue on child protection. Religious and traditional leaders have no formal linkages to the child protection system but have the potential to play a pivotal role in raising the awareness and support of the public, particularly in rural areas.[43] They could also play a much stronger role in challenging deeply patriarchal and rigid constructions of masculinity which make children more vulnerable (see the essay on pp. 73 – 79).

Schools are obvious sites for child protection, yet children report high degrees of violence and insecurity at schools. In 2012, the *National School Violence Study* found that one in five high school learners reported experiencing violence at school.[44] The Department of Basic Education has indicated that it has released examples of codes of conduct to schools and guidance on appropriate forms of discipline to address this problem.[45]

Child abuse and neglect is underreported in South Africa and the true scale of the problem is unknown (as discussed in the essay on pp. 26 – 34). Raising public awareness on what constitutes abuse, and how and where to report incidents are important aspects of the communication system to increase reporting. Awareness must be raised about the mandatory nature of reporting, the channels for reporting child abuse and deliberate neglect, and the support programmes and services that are available.[46]

What are the recommendations for strengthening the system?

Quality and reach of child protection programmes and services will remain a problem unless the elements of the child protection system are strengthened.

Adopting a systems approach to analyse, plan and monitor the implementation of prevention, early intervention and protection programmes and services will help to build the infrastructure of child protection.[v] The use of a systems approach by all child protection actors will provide the means by which to compel the use of resources towards achieving the common goal of the child protection system – a safe and friendly society for children.[47]

Each element of the child protection system is strengthened by the implementation of the others: leadership is strengthened by and validated by clear data and motivations built on evidence; evidence informs communication, education and mobilisation messages and strategies, and so on.

Key strategic recommendations for strengthening each of the system elements are:

Laws, policies, regulations, norms and standards

- The use of a systemic approach to address flaws in the design of child protection-related legislation focuses on tightening the processes for legislative review and improvement. This involves specifying a framework and timeframes for reviewing the Children's Act to address problematic legislation timeously.
- A review of all child protection-related legislation and policies should be undertaken across government departments with the purpose of harmonising legislation.

Leadership, co-ordination and co-operation

- To improve integration of preventative and responsive programmes and services, relevant government departments need to maintain a focus on the system goal, which in this case is "a safe and friendly society for children".[48]
- It is the DSD's responsibility to lead this and the Inter-Ministerial Committee on Violence against Women and Children provides a good platform to do so.
- The national, provincial and local child care and protection forums are good platforms to encourage co-operation between government and civil society and should be adequately resourced and attended.

Evidence-based planning

- Evidence should inform planning at all levels of government. The use of local level data to inform planning at a district level must be encouraged to enhance access and quality of programmes and services.

v This was the basis for the design of the DSD's Strategic Plan for Prevention and Early Intervention (2014 – 2018), and should be continued alongside other strategies.

- The provincial departments of Social Development must focus on completing their provincial profiles as a first step to improved implementation.

Communication, education, mobilisation for social change

- Education efforts need to extend beyond building capacity within the child protection system, and raise awareness and mobilise people for social change so that everyone becomes a child protection actor. Innovation is key to move beyond the traditional approaches to awareness campaigns. A sustained effort to engage the general public, high-risk communities and children is required, including:
  1. national communication efforts that target the general public with a strong message that encourages everyone to be a child protection actor;
  2. regular dialogues in high-risk communities; and
  3. initiatives that help children to understand that they deserve to be loved and nurtured, and provide them with information on where they can go for help, and how they can protect themselves.

References

1 Pinheiro PS (2006) *World Report on Violence against Children.* Geneva: United Nations.
2 Proudlock P, Mathews S & Jamieson L (2014) Children's rights to be protected from violence: A review of South Africa's laws and policies. In: Proudlock P (ed) *South Africa's Progress in Realising Children's Rights: A Law Review*. Cape Town: Children's Institute, UCT & Save the Children South Africa.
3 Holtmann B (2011) *What it Looks Like when it's Fixed*. South Africa: Self published.
4 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child*. *UN General Assembly Resolution 44/25*. Geneva: United Nations.
5 Organisation of the African Union (1990) *African Charter on the Rights and Welfare of the Child, 11 July 1990. OAU Doc. CAB/LEG/24.9/49*. Addis Ababa: OAU.
6 Constitution of the Republic of South Africa, 1996;
Children's Act 38 of 2005.
7 See no. 2 above.
8 United Nations Committee on the Rights of the Child (2005) *General Comment No. 6, Treatment of Unaccompanied and Separated Children Outside their Country of Origin. CRC/GC/2005/6*. Geneva: UN. Paras 39 & 40.
9 See no. 6 above. Section 11 (Children's Act).
10 The Presidency & UNICEF (2009) *Situation Analysis of Children in South Africa*. Pretoria: The Presidency of the Republic of South Africa & UNICEF.
11 Department of Welfare (1997) *White Paper for Social Welfare Principles, Guidelines, Recommendations, Proposed Policies and Programmes for Developmental Social Welfare in South Africa*. Pretoria: DoW.
12 Dutschke M (2008) Developmental social welfare policies and children's right to social services. In: Proudlock P, Dutschke M, Jamieson L, Monson L & Smith C (eds) *South African Child Gauge 2007/2008*. Cape Town: Children's Institute, UCT.
13 Giese S (2008) Setting the scene for social services: The gap between service need and delivery. In: Proudlock P, Dutschke M, Jamieson L, Monson L & Smith C (eds) *South Africa Child Gauge 2007/2008*. Children's Institute, UCT.
14 Department of Social Development (2009) *National Policy Framework for the Children's Act 38 of 2005 as Amended.* Pretoria: DSD.
15 Adapted from: Wulczyn R, Daro D, Fluke J, Feldman S, Glodek C & Lifanda K (2010) *Adapting a Systems Approach to Child Protection: Key Concepts and Considerations*. New York: UNICEF;
Save the Children UK (2009) *A Rough Guide to Child Protection Systems*. London: Save the Children UK.
16 Department of Social Development (2012) *Comprehensive National Strategy Aimed at Securing the Provision of Prevention and Early Intervention Programmes to Families, Parents, Caregivers and Children Across the Republic of South Africa - S 145.(1) of the Children's Act (25 of 2008) 2014 – 2018.* Pretoria: DSD.
17 See no. 15 above.
18 Domestic Violence Act 116 of 1998.
19 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
20 Child Justice Act 75 of 2008.
21 See no. 2 above.
22 See no. 15 above (Save the Children UK).
23 See no. 9 above. Sections 4(1) and 5.
24 Giese S & Sanders B (2008) *An Overview of Co-operative Governance Structures Relevant to Children in South Africa.* Cape Town: Alliance for Children's Entitlement to Social Security.
25 See no. 24 above.
26 See no. 14 above.
27 World Health Organisation & International Society for Prevention of Child Abuse and Neglect (2006) *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence.* Geneva: WHO.
28 See no. 2 above.
29 Dawes A, Willenberg I & Long W (2006) *Indicators For Child Protection. Report for the Research Directorate, Department of Social Services and Poverty Alleviation, Provincial Government of the Western Cape*. Cape Town: Human Sciences Research Council.
30 Department of Social Development (2012) *Guidelines on the Principles and Core Elements for the Design and Development of Prevention and Early Intervention Programmes*. Pretoria: DSD.
31 National Prosecuting Authority (2013) *Annual Report of the National Prosecuting Authority 2012/13*. Pretoria: NPA.
32 National Prosecuting Authority (2008 – 2013) Annual reports of the National Prosecuting Authority 2007/2008 – 2012/13. Pretoria: NPA.
33 Interview with Prof Andy Dawes for a study for the South African Child Protection Surveillance System Project, Department of Social Development, 2011.
34 See no. 6 above. Section 145(3) (Children's Act).
35 See no. 2 above.
36 See no. 3 above.
37 See no. 15 above (Save the Children UK, 2009).
37 See no. 33 above.
39 Chames C, Lomofsky D & Mangokwana (2010) *Baseline Study on National Child Protection Systems in South Africa, Swaziland and Zambia.* Pretoria: Save the Children Sweden.
40 See no. 16 above.
41 Ernst JS (2000) Mapping child maltreatment: Looking at neighbourhoods in Suburban County. *Child Welfare*, 79(5): 555-572.
42 Ward C & Wessels I (2013) Rising to the challenge: Towards effective parenting programmes. In: Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) *South African Child Gauge 2013.* Cape Town: Children's Institute, UCT.
43 See no. 39 above.
44 Burton P & Leoschut L (2012) *School Violence in South Africa: Results of the 2012 National School Violence Study*. Cape Town: Centre for Study of Violence and Reconciliation.
45 Veriava F (2014) *Promoting effective enforcement of the prohibition against corporal punishment in South African schools*. Commissioned by the Centre for Child Law, University of Pretoria. Pretoria University Law Press.
46 See no. 29 above.
47 See no. 15 above (Wulczyn et al, 2010).
48 See no. 16 above.

Towards effective child protection: Ensuring adequate financial and human resources

Lucy Jamieson (Children's Institute, University of Cape Town), Lorenzo Wakefield (Consortium on Crime and Violence Prevention) and Megan Briedé (independent consultant)

During the apartheid era, social services targeted a small group of (mainly White) children, and the emphasis was on providing clinical social work-type interventions to individuals after abuse took place, known as the "residual model".[1] In 1997, the (then) Department of Welfare demonstrated its commitment to the goal of establishing "a society based on democratic values, social justice and fundamental human rights"[2] through the publication of the White Paper on Social Welfare (White Paper).[3]

In line with the principles of social justice and equality, the White Paper committed to scale up services to meet the needs of all children – in other words, to universalise access.[4] The White Paper also adopted a rights-based approach to give effect simultaneously to the rights to protection from violence; physical and psychological integrity; dignity and health, amongst others (see figure 3 on p. 44). This was to be achieved by switching from the existing "residual" model to a "developmental" model of social welfare.[5] The developmental model aims to prevent abuse before it occurs by focusing not just on individuals but also on their connections to family and the wider community.

The legal and policy framework has been developed to provide for a holistic child protection system that includes prevention and early intervention as part of a continuum of care (see the essay on pp. 35 – 42). However, the delivery of effective prevention and early intervention services is dependent not only on a sound legal and policy framework but also on adequate resources.

This essay presents a brief analysis of the adequacy (or otherwise) of resources dedicated to the delivery of prevention and early intervention services in terms of the Children's Act. These programmes cover preventing all forms of harm, not just violence. After discussing the current situation, we look briefly at the future plans of the Department of Social Development, and conclude with a few recommendations to strengthen the system. In relation to the implementation of prevention and early intervention services, we ask:

- Are resources shifting to realise a developmental model of social services?
- Why has the move from the residual to the developmental model not started?
- Are the financial resources adequate?
- Are the financial resources appropriately targeted?
- Are there enough social service professionals?
- Are social service professionals sufficiently trained?
- What are government's plans to strengthen the social welfare workforce?
- What are the recommendations?

Are resources shifting to realise a developmental model of social services?

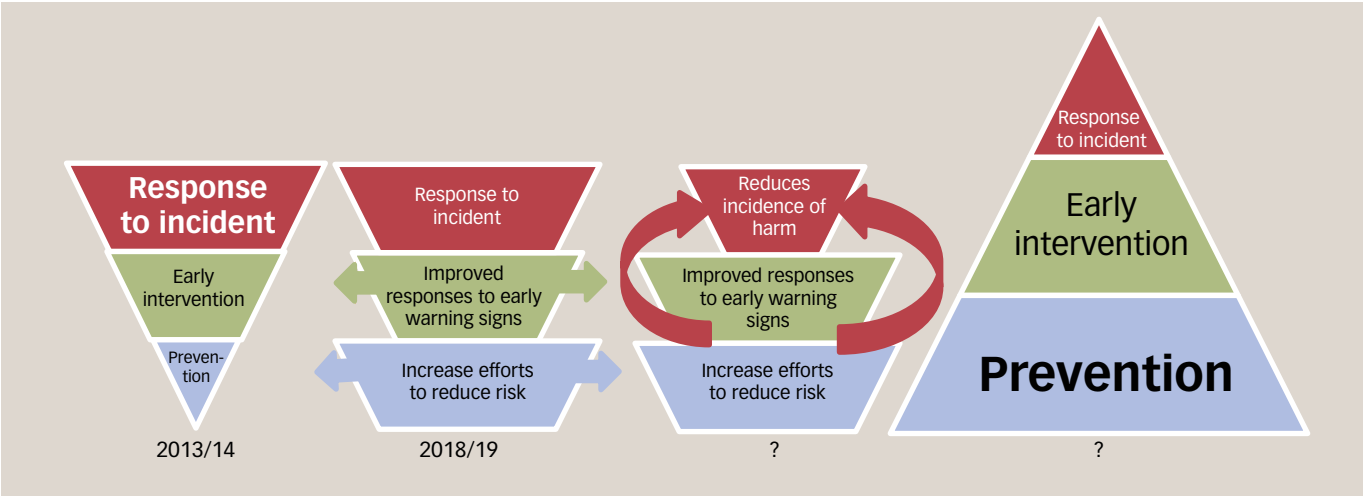
International law obliges the state to fund prevention and early intervention services, including therapeutic services, as part of a comprehensive child protection system, to the maximum extent of its available resources.[6] This legal obligation has been incorporated into the Children's Act.[7] The state must fund all these services but it must use its resources in a cost-effective manner. Not only are prevention and early intervention services less expensive than investigating abuse and removing children from their homes in the short to medium term,[8] but because child abuse has life-long adverse health, social, and economic consequences for the victims, the potential long-term economic savings to the state are substantial[9].

In the residual model of social services (on the left in figure 6 on the next page) resources are concentrated on response services (i.e. statutory on the previous page services, alternative care, etc.), whereas under the developmental model (on the right in figure 6), resources are focused on community-based prevention, and targeted early interventions. Changing the model is a process that starts with increasing efforts to reduce risk and improving responses to early warning signs. Typically, reporting of abuse increases as more resources are used for raising awareness, so in the initial stages response services cannot be reduced. However, as the prevention programmes begin to have an impact, the number of cases of abuse decline, at which point the redistribution of services can be accelerated. This needs to be done while also expanding the whole system to reach children across the country.

Why has the move from the residual to the developmental model not started?

In 2013, more than two-thirds (68%) of key prevention stakeholders, such as departmental officials, service providers and academics, considered that measures taken by South Africa to prevent child maltreatment were inadequate.[10] They cited lack of material resources as one of the biggest challenges, and less than 8% thought the number of professionals specialising in prevention was adequate for large-scale implementation of prevention programmes.

Figure 6: Gradual shift from current emphasis on crisis response to ideal future where the need for crisis intervention has been reduced



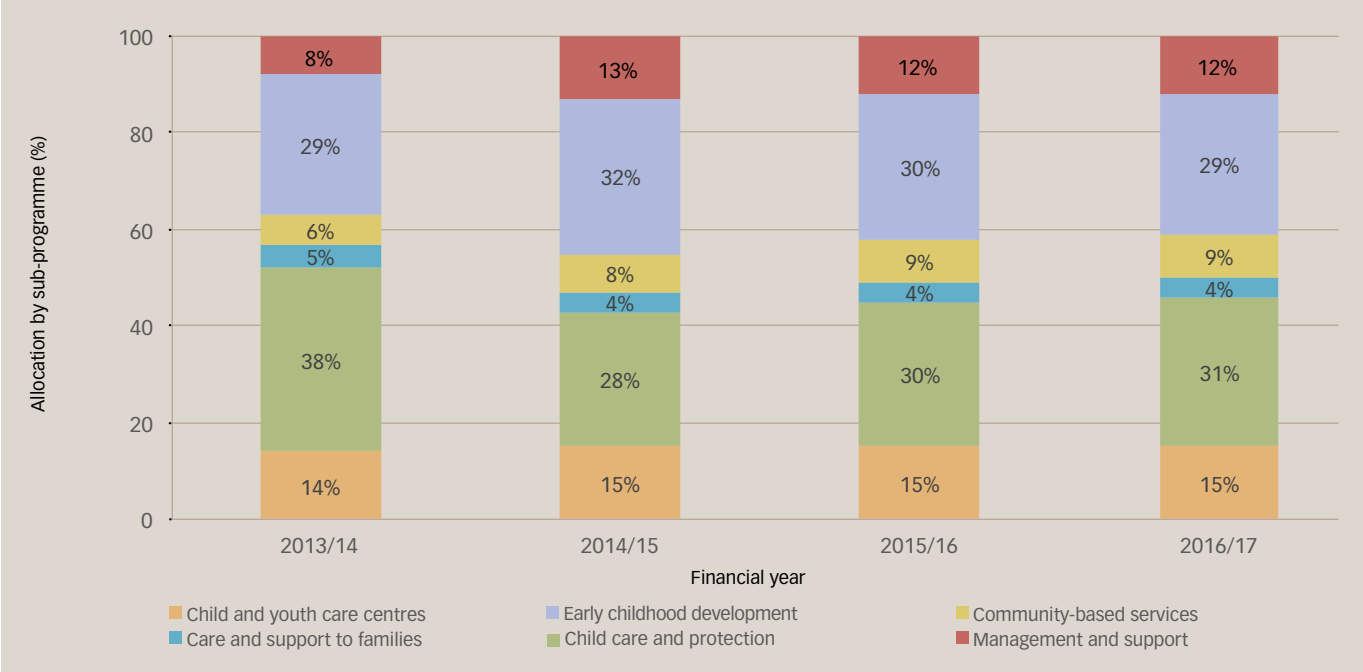
Source: Department of Social Development (2013) *Comprehensive National Strategy Aimed at Securing the Provision of Prevention and Early Intervention Programmes to Families, Parents, Caregivers and Children Across the Republic of South Africa. National Strategic Draft Plan 2013/14 – 2018/19*. Pretoria: DSD.

Are the financial resources adequate?

In 2006, Barberton and colleagues calculated the cost of implementing the Children's Act.[11] They worked on four scenarios[i]: the cheapest, called the "implementation plan low" scenario involved incrementally expanding existing services at minimum norms and standards; the most expensive scenario, called the "full cost high", was based on providing high quality services to all children who need them.[12]

The way budget allocations and expenditure are reported does not correspond neatly to the services and programmes required by the legislative framework. Most prevention and early intervention programmes are funded by the Department of Social Development (DSD). The funding however is scattered across a number of sub-programmes in the provincial budgets, making it impossible to track expenditure or even estimate how much is being spent on prevention and early intervention. Changes to the budget structure introduced for 2014/15 and the government's Medium-Term Expenditure Framework allow easier comparison with the estimated cost of implementing the Children's Act, but the budget still does not give separate figures for prevention and early intervention services. Therefore, we analyse the amounts budgeted for the children and families programme that covers all Children's Act services.

Figure 7: Distribution of the children and families budget across sub-programmes, 2013/14 – 2016/17



Source: Budlender D & Francis D (2014) *Budgeting for Social Welfare in South Africa's Nine Provinces, 2010/11 – 2016/17*. Cape Town. Chart compiled by L Jamieson, Children's Institute, UCT.

i Implementation plan low and high scenarios (based on 2005 levels of actual service delivery, scaled up in a phased manner each year), and full cost low and high scenarios (based on evidence of the numbers of children who need the services, scaled up in a phased manner each year).

The year 2014/15 corresponds to year six of the implementation of the Children's Act. According to the implementation plan low scenario, a minimum of R15,9 billion would be required for all Children's Act services, whereas the full cost high scenario estimated that in excess of R93,6 billion would be needed.[13] However, in 2014/15, allocations account for less than half (45%) of the predicted costs of the implementation plan low scenario, and only 7% of the predicted costs of the full cost high scenario.[14] Indeed, the allocations for the children and families programme have consistently been well below the estimated cost of what is needed.[15] Although, the budget is expected to grow by 6% in real terms between 2013/14 and 2016/17,[16] the allocations are expected to remain well below the estimated cost of implementation. Put simply, the budget for all Children's Act services is totally inadequate.

Recent studies of the budgets for the Sexual Offences Act[17] and Domestic Violence Act[18] also highlight under-resourcing of services for children affected by violence[19].

Figure 7 (on the opposite page) shows how the children and families budget will be divided from 2013/14 to 2016/17. In 2013/14, the largest share (38%) of the children and families budget was spent on child protection services, whereas only 5% was allocated to care and support to families that cover prevention and early intervention, and 6% to community-based services that include the Isibindi programme[ii] and drop-in centres. The apparent reduction in the share of protection services between 2013/14 is mostly due to the new budget structure rather than a reallocation of funds. From 2014/15 to 2016/17, there is no significant shift between the sub-programmes, hence it is clear that funds are not shifting towards prevention and early intervention.

Are the financial resources appropriately targeted?

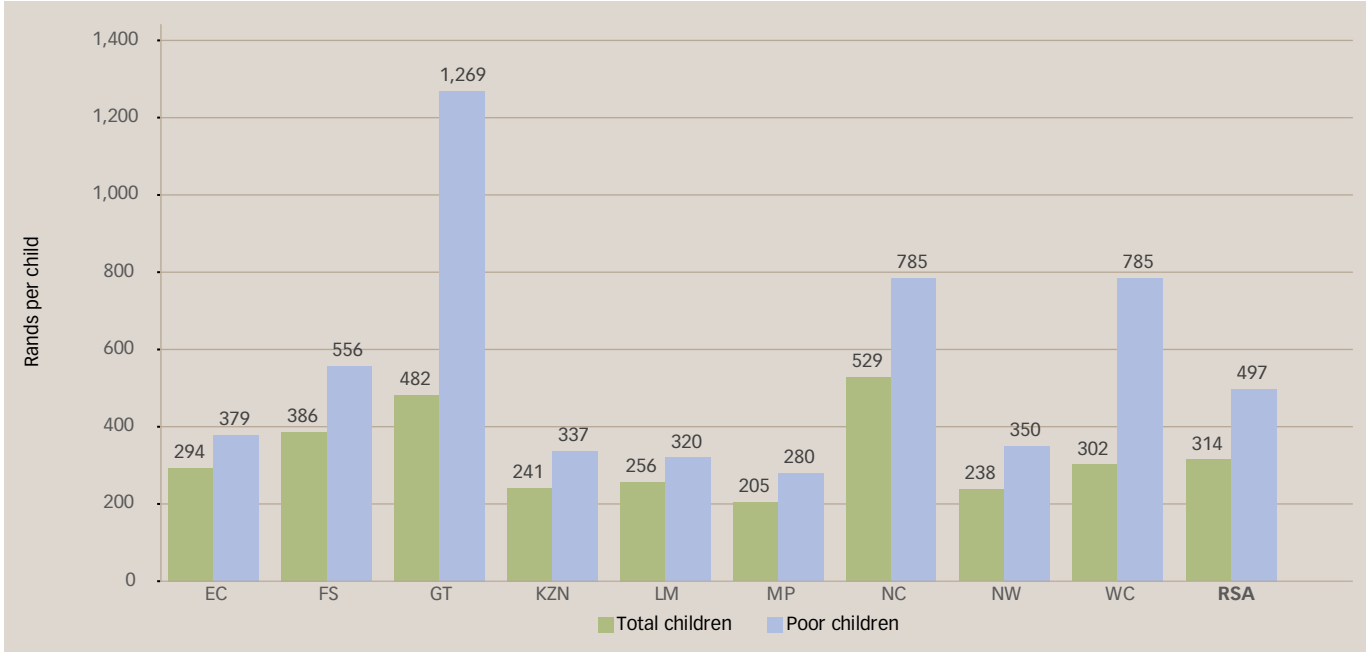
To ensure that previously marginalised groups and communities have access to services, the Children's Act requires every province to prioritise the funding of services to children with disabilities and the provision of services in under-resourced communities.[20] There is no information available to assess allocations to children with disabilities. If this information is not being collated, it is likely that funding is not being prioritised in this manner. Figure 8 below shows the per child budget allocation in the children and families programme. The allocations for poor children are significantly higher than for the total child population, suggesting that resources are being targeted at poor children within each province.

A crude comparison of the provincial share of resources with the percentage of the total child population (table 4 on the following page) reveals that resources are still unevenly distributed, suggesting the persistence of historical inequalities and calling into question universal access.

One way in which the DSD is trying to ensure that prevention and early intervention target under-resourced communities is through the Isibindi programme, which delivers services to vulnerable children in communities (mostly in remote, rural areas) with high HIV and AIDS prevalence rates, high rates of unemployment and poverty, and few existing social services.[21] The estimated total cost of rolling out the programme nationally escalates from R269 million in year 1 (2013/14), to R1,2 billion in year 5 (2017/18) and totals R3,8 billion over the five year roll-out period.[22]

The Finance Minister has allocated R650 million across the provinces in 2013/14, and R700 million in 2014/15 to cover both

Figure 8: Department of Social Development budget allocations to children and families, per child per province, 2014/15



Source: Budlender D & Francis D (2014) *Budgeting for Social Welfare in South Africa's Nine Provinces, 2010/11 – 2016/17*. Cape Town. P. 47.

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.

Isibindi and early childhood development (ECD). Experts however are warning that not all provinces are allocating the additional funds to the programmes: "In 2013/14 Limpopo planned to allocate only 12% of the additional money it would receive. Free State (54%), Eastern Cape (61%) and North West (61%) also planned to allocate much less than they would receive for Isibindi and ECD."[23]

Table 4: Comparison of the share of resources allocated for Children's Act services with the share of the child population, 2013

Province	% of national allocation for all Children's Act services*	% of child population+
Eastern Cape	10	14
Free State	8	6
Gauteng	29	18
KwaZulu-Natal	16	23
Limpopo	10	12
Mpumalanga	6	8
North West	7	7
Northern Cape	3	2
Western Cape	11	10
Total	**100**	**100**

Sources: *Budlender D & Proudlock P (2013) *Are Children's Rights Prioritised at a Time of Budget Cuts? Assessing the Adequacy of the 2013/14 Social Development Budgets for Funding of Children's Act Services.* Cape Town: Children's Institute, UCT.
+Meintjes H & Hall K (2013) Demography of South Africa's children. In: Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) (2013) *South Africa Children Gauge 2013.* Cape Town: Children's Institute, UCT.

Funding for non-profit organisations (NPOs)

The implementation of an integrated child protection system is dependent on collaboration between government and non-profit organisations (NPOs) (see the essay on pp. 43 – 50). It should be clarified that, although NPOs deliver most prevention and early intervention services,[24] the responsibility lies with government to ensure that the services are provided. As a result the government has an obligation to pay NPOs for the services they provide.

According to the Presidency, NPO funding has declined steadily since 1994, reducing the range and compromising the quality of social welfare services.[25] Since the global recession in 2008, international funding has been greatly reduced with the result that many NPOs have retrenched staff, scaled back their interventions, or closed down.[26] National government recognises that to increase the reach of social services, it will need to build better partnerships with the NPO sector.[27] Partnership could mean many things – what NPOs need is for government to pay them a fair price for the services they provide.

In 2013, the budget included an extra R600 million to support NPOs. However, several of the provinces are using some or all of this money on their internal systems for "monitoring and support" to NPOs rather than for monetary transfers to NPOs.[28] The Free State funding policy which replicates the national Policy on Financial Awards for Service Providers[29] has been successfully challenged in court.[30]

The DSD has acknowledged that it has a statutory duty to provide these services; however, it argues that its obligation is to progressively realise the right to social services. Hence, the full payment of NPOs for services is envisaged only as a future goal.[31] Although the national and Free State policy are based on the same principles, the court did not comment on the national policy. The DSD is revising the national policy but drafts published to date do not include full payment to NPOs delivering prevention and early intervention services.[32]

Are there enough social service professionals?

The Children's Act norms and standards specify that prevention and early intervention services must be based on a multi-disciplinary and intersectoral approach,[33] implying that social service practitioners are required to work with other professionals, and that they should be from more than one department. An analysis of the whole workforce is beyond the scope of this essay, which limits the analysis to the key social service professionals providing Children's Act services. The Children's Bill costing included estimates of the number of professionals required to provide children's social services and, as with the budget, four scenarios were calculated. Table 5 (on the opposite page) presents the numbers for the cheapest and the most expensive scenarios for the implementation of the Children's Act.

Over the last decade the government has introduced measures to expand the workforce, including bursaries for social work students, recognising social work as a scare skill and improved pay and compensation packages set nationally through occupation specific dispensations.

Consequently, between 2000 and 2014 the number of social workers grew from 9,072 to 18,213.[34] The DSD estimated that 1,487 social work graduates will enter the labour market in 2014/15 and a further 2,130 in 2015/16,[35] and National Treasury has allocated R938 million[iii] to the provinces to employ these graduates between 2014 and 2016[36]. Many of the provinces claim that the additional funds are inadequate to absorb the new graduates, for example in the Eastern Cape, "the R65,3 million available for 2014/15 is reported to be sufficient only for the carry through of the costs of social workers already employed."[37] Consequently, that province will not reach the national norm of one social worker per 3,000 "clients".

The DSD has also committed funding to the Isibindi programme to recruit and train an additional 9,000 community-based child and youth care workers (CYCWs) before the end of 2018.[38] By December 2013, training of child and youth care workers had commenced in all provinces, with 2,776 trainees enrolled on the programme.[39] Whilst this progress must be applauded, the DSD has described the social service workforce available to implement the Children's Act "as incomplete, underdeveloped and ill-funded", and

iii R120 million in 2013/14, R305 million in 2014/15 and R513 million in 2015/16.

Table 5: Key personnel required for Children's Act in year six of implementation

Category	Number of practitioners required	
	Implementation plan low scenario	Full cost high scenario
Social workers	16,504	66,329
Social auxiliary workers	14,648	48,660
Child and youth care workers	12,955	216,813

Source: Barberton C (2006) *The Cost of the Children's Bill – Estimates of the Cost to Government of the Services Envisaged by the Comprehensive Children's Bill for the Period 2005 to 2010*. Report for the national Department of Social Development. Johannesburg: Cornerstone Economic Research.

has acknowledged that there are shortages of all the professionals needed to implement the Children's Act.[40]

Importantly, some of these practitioners also work with other vulnerable groups, not just children, and provide services in addition to prevention and early intervention. Listed below are the total number of each type of practitioner who (potentially) can provide all services across all groups – it shows how acute the shortages are:

- In July 2014 there were 18,213 social workers, and 5,239 social auxiliary workers, registered with the South African Council for Social Service Professions (SACSSP).[41] However, one cannot assume that all of them are working, as data from previous years show. In March 2012 the total number of registered social workers was 16,740. Of these only 6,655 (40%) were employed by the government and 2,634 (16%) by NPOs – the rest (54%) were in private practice or not practicing at all.[42]
- As CYCWs are not required to register, there are no accurate figures on the total number of these practitioners. However, the SACSSP has registered 2,674 CYCWs to vote in the 2012 election of its board. In 2013, the National Association of Child Care Workers had records of 10,904 individuals who had completed one or more of the Further Education and Training Certificate (FETC) in Child and Youth Care modules. It is assumed that most of these CYCWs are employed in child and youth care centres, as in 2011 only 800 community-based CYCWs worked in the Isibindi programme.[43]

Two other categories of social service professional that provide prevention and early intervention services are ECD outreach workers and youth workers. Both groups are struggling to get professional recognition:

- Most ECD practitioners work in crèches and educare centres and there are only 1,000 ECD practitioners recorded as doing outreach work (i.e. delivering parenting programmes and support to families in the community).[44]
- Youth work[iv] has not been recognised as a professional career and consequently there are no prescribed qualifications or standard definitions of youth work. Although some provincial DSDs and NPOs employ individuals to do youth work, statistics are not collated and both the *Situational Analysis Report of the Social Service Workforce Serving Children* (Situational Analysis)[45] and the Social Service Practitioners Policy[46] are silent on the number of people performing this function.

Although the Children's Act foresees a range of social service professionals working together, it has taken years to develop a common understanding of who is a social service professional and what each profession does: "… whilst each is playing a role, there is no coherency as to who is supposed to perform which function, with the result that some functions are duplicated whilst others are not being performed at all".[47] Another problem is the over-reliance on social workers,[48] as some of the tasks that could be performed by other professions or para-professionals (who are less expensive) are reserved for social workers.

This is exacerbated by confusion around who can render prevention and early intervention services. The Children's Act chapter on prevention and early intervention specifies that services should be based on a multi-disciplinary and intersectoral approach and that service providers must have appropriate training, support and supervision. However, the definition of child protection services also includes prevention and early intervention services,[49] leading some government officials to interpret this as meaning prevention and early intervention can only be performed by designated social workers[50].

The human resources strategies need to clearly define what social work tasks can be performed by which cadres, and how the workforce should share the workload appropriately.

Are social service professionals sufficiently trained?

Large numbers of ECD outreach workers have no formal training as there is currently no publicly-funded training for ECD outreach workers.[51] Current training supply and funding is inadequate for a scaled-up ECD system. Furthermore, it is unevenly spread with an urban predominance and in terms of availability of higher level qualifications. In 2012, only six providers were accredited to offer the FETC Community Development: ECD, which caters for practitioners working with families and in the community.[52] Concerns about the lack of training opportunities are shared by other sectors.

In 2013, only 2,341 out of an estimated 10,904 CYCWs had completed the FETC in Child and Youth Care (i.e. the auxiliary level qualification).[53] At present, CYCWs do not have to register with the SACSSP and do not have to be qualified to practise only. However, draft regulations specify that, before anyone can practise, he or she must meet the minimum qualifications for child and youth care practitioners to register at each level (i.e. learner, auxiliary and professional).[54] The final regulations were due to be gazetted in 2014.[55] From the date of implementation, CYCWs will have three

iv Youth workers respond to the needs and interests of youth, who are defined as persons aged between 15 – 35. They provide services to promote the holistic development (spiritual, emotional, social, and political) and empowerment of young people, including prevention and early intervention to help young men avoid violent behaviour, and both sexes to build healthy intimate relationships.

Case 8: Community-based training of child and youth care workers
Lucy Jamieson, Children's Institute, University of Cape Town

Many students in rural communities cannot afford to travel to study or to leave their homes for extended periods of time and, even if internet access were reliable for distance learning, much of child and youth care practice is based on relational work, so many of the techniques are modelled in the classroom requiring a physical presence. The National Association of Child Care Workers (NACCW) teaches the Further Education and Training Certificate (FETC) in Child and Youth Care in the communities where skills are needed. Trainers turn churches, community halls, schools, places of traditional authority, or other suitable locations into temporary classrooms. To ensure that all the venues meet the stringent health and safety requirements set by the Health and Welfare Sector Educational Training Authority, NACCW has developed a standard kit for trainers that includes a first aid kit and laminated signs to mark exits.

The FETC is 30% classroom based and 70% practice based. The learners are supervised in the workplace by a senior CYCW, and by a mentor in the Isibindi programme. The supervisor signs a page in the logbook to testify that the student completed their practical assignments, and the trainer moderates the assignments.

The CYCWs are taught from day one to integrate the theory into daily practice and adapt it to the needs of the children they are working with. Key to their success is that these professionals blend the best global approaches with their own local knowledge. Thus CYCWs are able to provide high-quality low-cost interventions that are uniquely adapted to the context they are working in. And because CYCWs train on the job in their local communities, most of them stay in the area once they qualify.

years to comply with the qualification requirements; thus there is an incentive for them to train and – thanks to the scale-up of the Isibindi programme – there are increasing opportunities for training in the communities where services are most needed (see case 8 above).

What are government's plans to strengthen the social welfare workforce?

The Medium-Term Strategic Framework (MTSF) 2014 – 2019[56] is the first five-year building block of the National Development Plan (NDP), and includes activities to increase the supply of social service professionals. According to the MTSF, the DSD is responsible for putting in place a revised recruitment and retention strategy for social workers and social auxiliary workers as well as improved training, mentoring and supervision services. By addressing shortfalls within the workforce, the quality of interventions provided across the continuum of care will be improved.

The DSD is considering the recommendations of the Situational Analysis and the Policy for Social Service Practitioners[57] in order to strengthen the workforce. These include the need to recognise and professionalise a more extensive range of social service professions such as child and youth care work, youth development work, etc, and to develop a task-shifting document to clarify roles and responsibilities across all professions in the sector. In addition, the current policy will be aligned towards an effective regulatory framework for social service professions. The DSD needs to ensure that resources are allocated to meet these commitments.

In the MTSF, the DSD further identifies the need to strengthen the present workforce to improve the quality of services provided. Under the auspices of the Khusela Project, the DSD has put plans in place to develop additional qualifications and partial-qualifications in child protection; a formalised in-service training programme; a supervision, mentoring and coaching model as well as activities aimed at improving management, leadership, monitoring and quality assurance.[58] By introducing a more standardised approach towards building the capacity of social service workforce, it is envisaged that children across South Africa will have access to quality services.

To ensure that these plans happen from a developmental perspective by moving away from traditional child protection services towards an increased focus on prevention and early intervention, the DSD intends to develop a transformation plan that consciously ensures this shift in focus. This plan feeds into the commitments made by the DSD in relation to the NDP.

What are the recommendations?

South Africa has been very effective in reshaping the laws and policies that outline welfare services, but progress towards the transformation of social services in line with the White Paper has been very slow. Services are predominantly responsive rather than preventative and, despite measures to target poor children, inequalities between provinces remain deeply entrenched. While investment in human resources and increases in budget allocations were made, the resources to implement the services envisaged by the new laws are insufficient to meet the demand for services.

Overall the budgets for the implementation of social services for children are too low and most of the budget is allocated to protection rather than prevention services. South Africa needs to invest more resources in prevention and early intervention services, and budgets should be based on accurate costing and estimates of need – this in turn necessitates the development of effective monitoring and information management systems.

NPOs are not fairly compensated for the services they deliver. The state should purchase prevention and early intervention services from NPOs at full cost. The funding crisis is urgent and greater allocation of resources should be a priority. The publication of a revised National Financial Award to Service Providers policy is advised.

The norms and standards of the Children's Act call for the delivery of prevention and early intervention programmes by multi-disciplinary teams, yet the statutory framework regulating the sector only recognises social work professionals and para-professionals. Consequently, "the vision in the [White Paper] for a strong, united group of social service professionals has not been realised".[59] Until such time as all professions are treated fairly, the lack of co-operation between professionals will continue to hamper progress.

The state has made substantial investment to increase the number of social service professionals and the workforce is expanding; however, there is still an acute shortage of higher education opportunities for CYCWs, youth workers, and ECD practitioners. All categories of social service professional should have clear career paths and opportunities for quality training, higher education and continuous professional development. This requires mechanisms for effective workforce, rather than occupation or profession specific planning and development, including an integrated human resources strategy that covers all the practitioners in the workforce. The strategy must recognise the capacity of all practitioners to deliver prevention and early intervention services and include a task-shifting/sharing matrix to allow a redistribution of the work.

The Department of Social Development has put plans in place to capacitate social service professionals to deliver child protection services. The capacity-building interventions must focus on increasing skills and understanding of prevention and early intervention services to help shift traditional thinking in the sector towards the developmental model. This training should be incorporated into the undergraduate curriculum. Without this approach, South Africa will continue to be stuck with a reactive system and children will continue to experience violence when it could be avoided.

References

1 Titmuss R (1974) What is social policy? In: Leibfried S & Mau S (eds) (2008) *Welfare States: Construction, Deconstruction, Reconstruction Volume I, Analytical Approaches*. Cheltenham: Elgar.
2 Constitution of the Republic of South Africa, 1996. Preamble.
3 Department of Welfare (1997) *White Paper for Social Welfare*. Pretoria: DoW.
4 Lombard A (2008) The implementation of the white paper for social welfare: A ten-year review. *The Social Practitioner-Researcher*, 20(2): 1-20.
5 See no. 3 above.
6 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Geneva: United Nations. Article 4.
7 Children's Act 35 of 2005. Section 4(2) read in conjunction with section 146(1).
8 Barberton C (2006) *The Cost of the Children's Bill – Estimates of the Cost to Government of the Services Envisaged by the Comprehensive Children's Bill for the Period 2005 to 2010.* Report for the national Department of Social Development. Johannesburg: Cornerstone Economic Research.
9 Fang X, Brown DS, Florence CS & Mercy JA (2012) The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, 36(2), February 2012: 156-165.
10 Mikton C, Power M, Raleva M, Makoae M, Al EissaM, Cheah I, Cardia N, Choo C & Almuneef M (2013) The assessment of the readiness of five countries to implement child maltreatment prevention programs on a large scale. *Child Abuse & Neglect*, 37(12), December 2013: 1237-1251.
11 See no. 8 above.
12 Budlender B, Proudlock P & Giese S (2011) *Funding Services Required by the Children's Act*. Community for Social Enquiry & Children's Institute, UCT. [research summary]
13 See no. 8 above.
14 Budlender D & Francis D (2014) *Budgeting for Social Welfare in South Africa's Nine Provinces*, 2010/11 – 2016/17. Cape Town.
15 Budlender D & Proudlock P (2010) *The Children's Act has Commenced: Are the 2010/11 Budgets of the Provincial Departments of Social Development Adequate to Implement it?* Cape Town: Children's Institute, UCT;
Budlender D & Proudlock P (2011) *Funding the Children's Act: Assessing the Adequacy of the 2011/12 Budgets of the Provincial Departments of Social Development*. Cape Town: Children's Institute, UCT;
Budlender D & Proudlock P (2012) *Funding the Children's Act: Assessing the Adequacy of the 2012/13 Budgets of the Provincial Departments of Social Development*. Cape Town: Children's Institute, UCT;
Budlender D & Proudlock P (2013) *Are Children's Rights Prioritised at a Time of Budget Cuts? Assessing the Adequacy of the 2013/14 Social Development Budgets for Funding of Children's Act Services*. Cape Town: Children's Institute, UCT.
16 See no. 14 above. P.18.
17 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
18 Domestic Violence Act 116 of 1998.
19 Thorpe J (2014) *Financial Year Estimates for Spending on Gender-Based Violence by the South African Government*. Cape Town: Parliament of the Republic of South Africa;
Vetten L, Le T, Leisegang A & Haken S (2012) *The Right & the Real: A Shadow Report Analysing Selected Government Departments' Implementation of the 1998 Domestic Violence Act and 2007 Sexual Offences Act*. Johannesburg: Tshwaranang Legal Advocacy Centre.
20 See no. 7 above. Section 146(4).
21 National Association of Child Care Workers (2010) *Annual Report 2009/2010*. Cape Town: NACCW.
22 Department of Social Development (2011) Proposal for the National Roll-Out of Community Child and Youth Care Services through the Isibindi Model. [Unpublished report]
23 See no. 15 above. P. 54 (Budlender & Proudlock, 2013).
24 Martin P (2010) *Government-funded Programmes and Services for Vulnerable Children in South Africa*. Cape Town: HSRC Press.
25 The Presidency (2012) *National Development Plan 2030. Our Future Make It work*. Pretoria: National Planning Commission.
26 Financial and Fiscal Commission (2013) *The Provision and Funding of Child Welfare Services in South Africa*. Midrand: FFC;
See no. 15 above (Budlender & Proudlock, 2013).
27 The Presidency (2014) *Twenty Year Review South Africa 1994 – 2014*. Pretoria: The Presidency of the Republic of South Africa.
28 See no. 15 above (Budlender & Proudlock, 2013).
29 Department of Social Development (2005) *Policy on Financial Awards to Service Providers*. Pretoria: DSD.
30 *National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC of Social Development, Free State and Others* (1719/2010) [2010] ZAFSHC 73 (5 August 2010) and (1719/20100 [2010] ZAFSHC 84 (09 June 2011).
31 See no. 26 above.
32 Department of Social Development (2011) *Policy on Financial Awards to Service Providers*. Pretoria: DSD.
33 Children's Act, 2005. General regulations regarding children. *Government Gazette* 33076, 1 April 2010. Part IV.
34 Email communication, G Jiyane, HOD: Registration Division, South African Council for Social Service Professions, 08 July 2014.
35 See no. 15 above (Budlender & Proudlock, 2013).
36 See no. 15 above (Budlender & Proudlock, 2013).
37 See no. 14 above. P. 33.
38 See no. 15 above (Budlender & Proudlock, 2013).
39 Department of Social Development (2014) *Isibindi Roll out – Year 1 Monitoring and Evaluation Report, April 2013 – March 2014*. Pretoria: DSD.
40 Department of Social Development (2012) *Situational Analysis Report on the Social Service Workforce Servicing Children*. Pretoria: DSD. P. 20.
41 See no. 34 above.
42 South African Institute of Race Relations (2012) Social *Worker Shortage Undermines Effectiveness of Social Welfare Legislation*. Press release, 14 August 2012. Johanesburg: SAIRR.
43 Jamieson L (2013) *Child and Youth Care Workers in South Africa. Technical Brief: No. 5 March 2013* Arlington: Aidstar-Two
44 Biersteker L & Picken P (2013) *Report on a Survey of Non-Profit Organisations Providing Training for ECD Programmes and Services (Birth to Four Years)*. Cape Town: Ilifa Labantwana.
45 See no. 40 above.
46 Department of Social Development (2014) *Policy for Social Service Practitioners*. Pretoria: DSD.
47 See no. 40 above. P. 25.
48 See no. 40 above.
49 See no. 7 above. Section 105(5)(b).
50 Department of Social Development (2013) *Concept Document on Assessment Tool for Prevention and Early Intervention Programmes*. Pretoria: DSD.
51 Biersteker L & Picken P (2013) *ETDP SETA Early Childhood Development Sector Skills Plan Update 2013/14*. Johannesburg.
52 Biersteker L (2012) Human resource development for ECD programmes and services: Background paper 8. In: Richter L, Biersteker L, Burns J, Desmond C, Feza N, Harrison D, Martin P, Saloojee H & Slemming W (2012) *Diagnostic Review of Early Childhood Development*. Pretoria: DPME.
53 See no. 43 above.
54 Call for comments on the regulations for registration of student child and youth care workers and the holding of disciplinary inquiries: Registration of child and youth care workers; fees payable by child and youth care workers, auxiliary child and youth care workers: Rules relating to acts or omissions of child and youth care work at professional or auxiliary levels and student child and youth care workers which constitute unprofessional or improper conduct, and rules relating to conduct to be followed by child and youth care workers in practising their profession (code of ethics). *Government Gazette* 37689, board notice 56, 29 May 2014.
55 The short title of the regulations is "Regulations for Student Child and Youth Care Workers 2014". See no. 54 above. Section 33.
56 Department of Social Development (2014) *Medium-Term Strategic Framework 2014 – 2019*. Pretoria: DSD.
57 See no. 46 above.
58 Department of Social Development (2012) *Conceptual Framework for Capacity Building of Social Service Professionals and Occupations in Child Protection*. Khusela Project. Pretoria: DSD.
59 See no. 4 above.

Young children: Preventing physical abuse and corporal punishment

Carol Bower (Linali Consulting) and Andrew Dawes (Department of Psychology, University of Cape Town)

This essay focuses on the physical abuse and corporal punishment of children in the first five years of life, for three reasons. First, children's right to safety and protection is violated by such practices. Second, young children are particularly vulnerable to physical abuse, and those young children who frequently receive physical punishment are at greater risk of more serious forms of physical assault. Third, physical abuse and frequent harsh punishment have a long-term impact on children's development and mental health.

The essay addresses the following questions:

- What is the prevalence of physical punishment and abuse in young children?
- What are the risk factors?
- Why is it important to intervene in the early years?
- What are effective points for intervention?
- What are the recommendations?

What is the prevalence of physical punishment and abuse in young children?

Children in the 0 – 5-year age group are particularly at risk of physical punishment and abuse in the home, and are the most vulnerable to long-term negative consequences.

Exposure to physical abuse

The prevalence and incidence of physical abuse among young children in South Africa is not known as there is virtually no reliable data. However, a South African study shows that, in 2009, 44.5% of child homicides were due to abuse and/or neglect; and children under five made up 74% of all child homicides – about half of these were as a result of abandonment within the first week of life.[1] The study does not indicate the number of fatalities that were specifically attributable to physical abuse.

Fatalities are at the extreme end of the consequences of physical abuse. Several studies, including in South Africa,[2] support the observation that infants and toddlers are particularly at risk for this form of abuse;[3] and given the extent of risk factors for maltreatment, the numbers are likely to be significant.

International studies confirm the vulnerability of young children. For example, in the United States of America, children under four years accounted for 76.6% of child abuse fatalities in 2005; of these, 42% were infants.[4] And, Canadian surveillance data indicate that physical abuse accounts for 20% of substantiated maltreatment investigations (17,212 cases).[5] Rates are also highest for infants.

Corporal punishment at home

The only South African national survey[6] on attitudes to, and use of, corporal punishment by caregivers was conducted in 2003. In that investigation, 72% of caregivers agreed with the statement: "When children do wrong, it is always better to talk to them about it than give them a smack". However, 57% reported smacking their children; and 59% of this group confirmed beating their child with a belt, stick or other object. The most common age for smacking was three years, and for beatings it was four.

Reports by caregivers are likely to underestimate the use of physical punishment. In contrast to the above findings, a rural Eastern Cape study, drawing on a large sample of men and women aged 15 – 26 years, found that 89% of the women and 94% of the men experienced corporal punishment (the majority frequently) by caregivers prior to age 18.[7]

Exposure to intimate partner violence

It is estimated that around 60,000 women and children in South Africa are victims of intimate partner violence every month.[8] Population-based studies in targeted communities have found that 43 – 56% of women report experiencing intimate partner violence,[9] and surveys indicate that 22% of adolescents report exposure to violent conflict at home[10]. Based on that finding, we estimate that at least 1.1 million young children (22% of the population) are likely to be exposed to intimate partner violence.

What are the risk factors?

Risk factors for both physical abuse and the use of corporal punishment can be described at different levels of influence that interact and are nested within each other, as illustrated in figure 9.

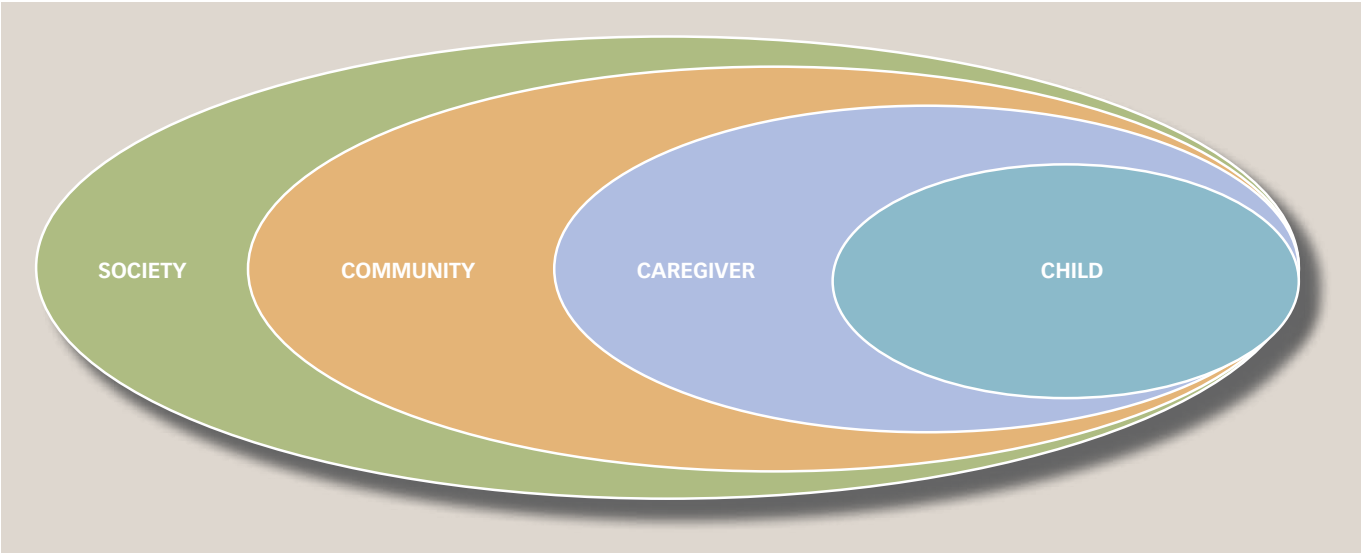
The child

Young children are made vulnerable by their age, size and developmental capacity. Their developmental status informs both their risk for victimisation and their response.

For example, crying is a normal behaviour during infancy. However, it can be a risk factor for abuse if it is excessive and the child is difficult to calm – particularly if the caregiver cannot cope with a distressed child. Studies indicate that those caregivers who feel hostile and unsympathetic to babies who cry are more likely to physically abuse their children.[11]

Finkelhor's model[12] helps explain how young children's stage of development affects the way in which they experience, understand and respond to acts of violence, and how this in turn may affect

Figure 9: Nested levels of influence



their ability to get the help they need. For example, when a four-year-old boy observes his angry father beating his mother, he may believe that it is his fault for making the father angry. This type of causal reasoning is typical of children at this age. The child copes by becoming withdrawn – to avoid causing more anger and violence; and because the child's distress is hidden, he is unlikely to be identified as a child in need of care and protection, or referred for psychological services.

As children grow older, they may present other challenges. Attention deficits, over-activity, physical and intellectual disabilities, and psychiatric conditions (such as autism and psychotic disorders) can be particularly challenging for caregivers to manage and may on occasion provoke hostility and physical punishment.

Caregivers

Most physical abuse and corporal punishment in the early years occur in the child's home.[13] Both the mother's and father's personal vulnerabilities create risk factors. These include: an authoritarian parenting style; poor bonding with the child; poor empathic capacity; inappropriate expectations; emotional immaturity; poor impulse control; low self-esteem; alcohol and drug abuse; and a personal history of violence and abuse in the caregiver's own childhood.[14] Depression and other common mental health disorders may limit a parent's capacity to provide a caring and nurturing atmosphere for young children.[15] A recent study of mothers found that those living under stressful conditions, who experienced their infants as difficult, and who supported the use of corporal punishment were significantly more likely than others to spank their infants.[16] The risks posed by these characteristics are likely to be heightened by poor social support.

Exposure to intimate partner violence is another risk factor[17] and when little children are used as shields between partners, it results in serious injury and emotional trauma.[18] Intimate partner violence also negatively affects the mother's emotional availability to the child, and increases her levels of stress – particularly when coinciding with other stresses such as poverty. A combination of poverty, young maternal age, and low maternal education are strong predictors of child maltreatment.[19]

Many young children in South Africa face these risks: 46% of 0 – 5-year-olds live with their mothers only, and most caregivers are affected by poverty and other burdens.[20]

The community

Norms that support harsh punishment, high levels of interpersonal violence and crime, high population turnover, and few support services for vulnerable families are features of neighbourhoods that place children at risk of harsh treatment.[21] These conditions are common in both urban and rural environments in South Africa.

Society

Three different components are central to children's protection. As noted above, the quality and accessibility of support services for vulnerable children and families; and cultural norms for adult relationships, parenting and child care are important for children's protection. The quality and accessibility of support services vary significantly across the country, and are especially challenging in the more rural provinces. The problem is aggravated by the fact that service providers frequently do not understand their role and legal obligations, or the laws which they are supposed to be implementing and upholding.[22] The third element is the legislative and policy environment, which while having many positive features, does not adequately protect children. This is because corporal punishment in the home has not been prohibited, and the common law defence of "reasonable chastisement" is still available to caregivers who physically assault their children.

South Africa has extraordinarily high rates of rape, intimate partner violence and intimate femicide (when a man kills his intimate partner). Social attitudes that promote male power and the subordination of women and children remain significant as underlying causes of the victimisation of both women and children.[23] Such attitudes are widely prevalent.[24]

In sum

Exposure to intimate partner violence, physical abuse and corporal punishment occurs across all socio-economic levels and family types. However, the majority of young children at risk in South Africa are likely to be living in vulnerable families. These are settings in which caregivers are placed at risk by poverty and violence by authoritarian partners, often in contexts of alcohol and drug abuse. These caregivers may not have sufficient support from family and friends, and their access to services is likely to be limited. In addition, their families and communities are likely to support the use of physical punishment when disciplining children.

Why it is important to intervene in the early years?

Early interventions are essential; firstly to prevent injury and death as consequences of abuse.[25] Secondly, they are needed to prevent the lasting neurological and psychological damage that follows exposure to violence in the early years. Recent research has increased understanding of links between early adverse experience, brain development and psychological functioning, and has demonstrated how hormonal and neurological pathways are shaped by "toxic stress" – a term that refers to exposure to ongoing stress, particularly in infancy and toddlerhood.[26] One consequence is reduced capacity for self-regulated behaviour as seen in poor attention span, poor emotional control, and aggressive conduct. In the long-term, adults who experienced maltreatment in childhood are at significantly higher risk of physical and mental health and social problems,[27] including increased substance abuse, aggression, the likelihood of acts of violence,[28] and difficulties with interpersonal relationships[29].

Given the scale of poverty and related adversities in South Africa, significant numbers of young children are at risk. Preventive interventions as early as possible are therefore essential to protect them and to reduce the long-term health, psycho-social and economic costs to the society.

What are effective points for intervention?

Given the scale of risk, vulnerable families and caregivers must be primary targets for interventions in order to make significant changes at a population level.

That said, prevention of child maltreatment is very challenging. Intervention studies show mixed findings. A full discussion of these complexities is beyond the scope of this brief contribution. The best we can do is provide some (necessarily over-simplified) pointers.

Home visiting by trained community nurses to improve early bonding and reduce the risk of inappropriate punishment and abuse during infancy has been shown in some studies to be effective.[30] Vulnerable mothers need to be identified during pregnancy, and followed after the birth.[31] An evidence-based example is the American Nurse Family Partnership (NFP) that has a long record of success in improving mother–child relationships and reducing the risk of physical abuse in vulnerable mothers.[32]

Given the scale of risk to South Africa's infants and the considerable professional and financial resources required to deliver programmes such as the NFP, less costly but nonetheless effective options need to be identified.

For home-visitation programmes to be successful, good quality resourcing, training, management, supervision and delivery are essential. Sending poorly prepared home visitors into the field to deal with very challenging situations without the necessary support is unlikely to be unsuccessful, and is a waste of resources.

The literature indicates that interventions that start during pregnancy and extend into the home after birth have the potential to help vulnerable mothers. They also have the potential to reduce the risk of harsh punishment. The significant reach required of such interventions suggests that public health facilities could be an optimal point of contact from which to deliver programmes, in partnership with community-based organisations that specialise in support to caregivers with infants and young children (where appropriate).

Maternal depression is a risk factor for neglect and harsh discipline, so mental health screening in pregnancy could enable the provision of support to women who need it, which would enhance maternal well-being and have the potential to improve mother–infant care and protect children from maltreatment. The Perinatal Mental Health Programme of the University of Cape Town is an example of such a service currently being tested.[33]

There is much focus on vulnerable women. In part this is because women carry most of child care, but it is also because research in this area has been *gendered* – it has neglected men. We do not know enough about the role of men in child care. However, we do know that men are able to either undermine or support their partners. We also know that stress factors such as poverty impact on fathers, and that the effects are amplified when they have psychological vulnerabilities. As with mothers, depression in fathers has a detrimental effect on children's behavioural and emotional development.[34] Greater attention to men is therefore appropriate.

While not necessarily focusing on corporal punishment and abuse, several South African programmes have been tested and show a range of benefits likely to reduce the risk of occurrence. This is important. A holistic preventive approach to reducing family and caregiver vulnerability is likely to promote protective factors that can reduce maltreatment risk. Multi-problem families beset by high levels of intimate partner violence, criminality and substance abuse would require more specialised interventions by professionals and are not considered here.

The Philani Plus programme has shown that an eight-session home-visiting model commencing in the final trimester of pregnancy and delivered by paraprofessionals or community members can have a range of positive effects for both mothers and children. While child maltreatment was not measured, the findings indicated greater well-being amongst mothers (including a reduction in alcohol consumption), as well as more sensitive and positive engagement with their children, which are likely to be protective to the child and reduce the risk of maltreatment.[35]

The Parent–Infant Intervention Home-Visiting Programme of the Parent Centre in Cape Town is an evidence-informed initiative

© The Parent Centre

The Parent Centre: Promotes sensitive and positive engagement with children

delivered by paraprofessionals and specifically aims to reduce the risk of neglect and maltreatment. Beneficiaries are women living in poverty who are at high risk of ante- and postnatal depression. A randomised controlled trial has demonstrated a significant positive impact on the quality of the mother–infant relationship, and on security of infant attachment; these are factors known to predict favourable child development. While maltreatment was not an outcome measured in the trial, improvement in the carer–child relationship holds the promise of reducing this risk.[36]

Parenting programmes are key to enhancing the capacity of caregivers to understand the developmental needs of young children and to be able to manage their behaviour without the need for corporal punishment. They are relevant to all parents, but particularly to those in vulnerable situations and first time young mothers. A number of programmes exist in South Africa, but there is no tested evidence-base as yet.

The elements of effective programmes for parents of young children include assisting caregivers to acquire specific parenting skills (positive discipline techniques, for example), home visits, group workshops and providing information on children's different developmental stages, and what can be expected at each stage.[37] In an ongoing randomised trial to test the effectiveness of a parenting programme designed to improve caregiver–child relationships and reduce harsh punishment, a participant reflected: "I've learned to sit down with my child, to communicate, to read stories, and maybe sometimes on the weekends, we go out. So, I spend a lot of time with my child."[38]

Interventions to strengthen parents' capacity to develop loving and non-violent relationships with their children cannot be separated from interventions to protect children from harsh discipline. However protection from corporal punishment is complicated by religious and cultural justifications. These have their roots in the deeply patriarchal and conservative attitudes held by many adults in South Africa, where women and children are regarded as inferior to men, and children are viewed as the possessions of their parents and not as rights holders in their own right.[39]

What are the recommendations?

The World Health Organisation and International Society for Prevention of Child Abuse and Neglect guidelines[40] for the prevention of child maltreatment provide some key recommendations for interventions to promote the protection of children in vulnerable families. Such interventions must be accessible and easily available to everyone, across the country, including less well-resourced rural communities.

1. Improving the protection of infants and toddlers

Provision of quality antenatal and postnatal services is key. Antenatal services must promote maternal nutrition and care to reduce the risk of low birth weight and risks for disabilities in the child. Screening for mental health problems and other vulnerabilities such as alcohol and substance abuse (in both parents where possible) is essential so that appropriate support can be provided.

Education on child development and care (and management of

Case 9: The case for the legal prohibition of corporal punishment

Carol Bower, on behalf of the Working Group on Positive Discipline and Sonke Gender Justice[i]

Corporal punishment has clear and demonstrable long-term negative effects on emotional, social and cognitive development. It has been shown to play an important role in adult aggression and violent behaviour, and is therefore of particular concern in a country where violence seems to be endemic.

The Working Group on Positive Discipline, Sonke Gender Justice and others working in the field of preventing violence against children argue that South Africa is legally bound to prohibit corporal punishment in the home by international and domestic law. South Africa's ratification of the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, as well as sections 10, 12 and 28 of the Constitution have been interpreted as placing an obligation on the state to enact the prohibition of corporal punishment. This argument is supported by the findings of the Constitutional Court regarding the unconstitutionality of corporal punishment in educational settings[50] and the juvenile justice system[51].

Motivation

Children deserve greater protection than adults because of their physical and emotional immaturity, yet they are the last to be legally protected from violence in the home. This violates children's rights to equality, human dignity, freedom and security of person,[52] protection from maltreatment, neglect, abuse or degradation,[53] and to have their best interests considered paramount[54].

An explicit legal ban of corporal punishment in the home is needed because it fulfils children's rights to protection and places an obligation on the state to support parents in using positive disciplinary strategies.

Forty-one states (including six in Africa) have prohibited corporal punishment in all settings. Research in some of these countries demonstrates that the legal prohibition has resulted in changes in child-rearing attitudes and practice in the medium to long term.[55] It is important to note that the ban in these countries was accompanied by extensive awareness-raising.

In New Zealand parents' approval of corporal punishment dropped following the introduction of the ban in 2007: In 2013, 40% of parents from a representative sample believed hitting children was acceptable, down from 58% in 2008.[56]

In Germany (where full prohibition was introduced in 2000), the rate of parental approval for corporal punishment dropped from 33% in 1996 to 26% in 2001.[57]

A Polish study conducted in 2011, involving 1,005 respondents aged 15 – 75, found decreases in the social acceptance of parents hitting children after a full prohibition in 2010.[58] In research published in 2008, 78% of respondents agreed that "there are situations when a child needs to be smacked", compared to 69% in 2011.[59] Although this represents an apparently small positive shift in attitudes, it is noteworthy that it took place in just three years, especially in light of the fact that an earlier comparison carried out in 1994 and 2008 did not reveal similar decreases in public approval of corporal punishment.[60]

Implementation

Implementation challenges are frequently cited as reasons not to prohibit corporal punishment in the home. These include myths, misinformation, and religious and cultural justifications, which are dealt with in this essay. Fears of excessive state intervention in the private sphere and fears that parents will be criminalised for every little smack are also raised, as are questions about how such a law would be implemented.

As a constitutional and secular democracy, South Africa has the legal obligation to protect all its citizens. However, the state is unlikely to prosecute parents for every little smack, given that: (a) children's best interests are seldom served by imprisoning their caregivers; (b) children rarely report even the most serious harm done to them; and (c) South African law operates on the *lex minimus* principle (the law does not concern itself with trivial matters).

Should the corporal punishment be so serious that it constitutes assault, the criminal law can and must take its course. However in most cases awareness of a family at risk provides an opportunity for early intervention. The courts would be more likely to refer the parents to a positive discipline and non-violent parenting programme. Only in the case of repeat offenders or where the child is injured or traumatised would any charges be laid.

In other countries the law against corporal punishment does not form part of the criminal code and is not intended to be punitive. A key intention of such law is to initiate a process of attitude change. A similar motivation informs the laws that regulate cigarette smoking – while no one has yet been prosecuted or imprisoned under the anti-smoking law, there has been a significant shift in the attitudes of smokers and non-smokers alike. The prevalence of cigarette smoking dropped by 20% in the first decade of anti-smoking laws.[61]

Legislation in and of itself will not necessarily stop all corporal punishment in the home – however, it will provide a starting point for raising broad public awareness and developing appropriate parenting programmes. Effective implementation will require a significant increase in the provision of evidence-based positive discipline programmes for caregivers, as provided for in the Children's Act.[62]

i The Working Group on Positive Discipline (WGPD) is a loose coalition of South African children's sector non-governmental organisations working to promote positive and non-violent parenting. The WGPD holds the view that the fourth amendment to the Children's Act should explicitly prohibit corporal punishment. See http://savethechildren.org.za/wgpd.

infant and toddler behaviour) are also vital. Clinic staff need training in the Children's Act Regulations (in particular Regulation 35), so as to improve their ability to detect maltreatment and neglect and to make the necessary reports and referrals in terms of the Act. The training of health professionals in the use of the International Statistical Classification of Diseases and Related Health Problems (ICD10) indicators for maltreatment would enhance South Africa's ability to monitor child maltreatment incidence through health system administrative data.

Home-visiting programmes with well-trained staff, which commence in pregnancy and continue into the second year of life, are recommended. This allows trained staff to provide support and guidance on a one-on-one basis, and to reach vulnerable children who might not be brought to a clinic or health facility.

Although universal access to home-visiting programmes would be the ideal, in a resource-constrained situation, programmes should target families identified as vulnerable where children are at greatest risk. These include: low-income caregivers without support from family or friends; those with a history of alcohol and substance misuse; unmarried teenage mothers; mothers with low birth weight and pre-term infants; and those with children who have chronic illness, disabilities and severe behavioural challenges.

2. Provision of non-violent parenting programmes

Programmes to promote positive parenting and discipline are relevant to all ages. Spanking (with the hand) and beatings (with objects such as belts and sticks) both cause harm.

A recent review of evidence has concluded that spanking children as a form of discipline is not effective (except in the immediate term), and is likely to *increase* incidents of aggressive behaviour in children.[41] Spanking could also lead to other negative outcomes: "Hitting, by its nature, causes physical pain, and it can be confusing and frightening for children to be hit by someone they love and respect, and on whom they are dependent. Children report fear, anger, and sadness when they are spanked; (these) feelings interfere with their ability to internalize parents' disciplinary messages".[42] Therefore, spanking is not an effective way of internalising moral ideas and practices as some might wish to claim.

Frequent and harsh corporal punishment is particularly emotionally damaging and is associated with the development of aggressive behaviour in the long term.[43] Any form of hitting teaches the wrong lessons about how to solve differences, which is not desirable in an already violent society.

Effective programmes provide practical training in positive discipline and provide parents with an opportunity to practise these skills. Such programmes work with groups at venues in the target community, and sites such as health facilities and early childhood development centres provide opportunities for delivery to groups. It is essential that participating parents and caregivers complete the full programme. Barriers to participation include caregivers' lack of familiarity with the concept of parenting programmes, distance to venues (in rural areas), travel costs, and safety concerns when programmes are delivered in evenings in communities with high rates of violence. Hence programme delivery needs to take into account the participants' circumstances and preferences.

Prevention of corporal punishment at home will require sustained and multiple strategies – from legal and policy interventions to culturally sensitive parenting programmes that assist caregivers to discipline without violence. Programmes must be evidence-based or at least informed by the best evidence available. To be effective, and to ensure that limited finances are not wasted, those on the front line must be well-trained, supervised and supported.

The United Nations Committee on the Rights of the Child (which monitors compliance with the UN Convention on the Rights of the Child – UNCRC) has called for legislative reform to ban corporal punishment in the home in its General Comment No. 8, arguing that the practice violates the child's rights to dignity, equality, physical integrity, and protection.[44] The Comment promotes positive discipline as a means of instilling respect for others, moral conduct, and compliance with rules. It also notes that the intention of a legislative ban is not punitive. Hence the Committee stresses the provision of guidance and training for parents, and recommends that only cases of significant harm should come before courts.

As South Africa has ratified the UNCRC, the state is legally bound to follow the Committee's position on the elimination of all forms of corporal punishment of children, which it has stated is an immediate and unqualified obligation. The pending revisions to the Children's Act provide an opportunity to prohibit corporal punishment in the home. Prohibition would fundamentally strengthen children's rights to protection, and send a clear signal that assault is wrong, no matter how old the victim (see case 9 on the opposite page).

The long-term goal of a kinder, less angry and punitive society begins with prohibiting all forms of violence against children. However, law reform alone will not do the job, and interventions that shift how parents and caregivers view and relate to the children in their care are essential. Sustained awareness-raising should focus on the harm done to children – physically, socially, behaviourally, cognitively and emotionally. Religious and other cultural justifications for corporal punishment must be engaged in ways that do not simply cause resistance. Faith communities should be encouraged to explore other effective ways of disciplining children, as many have already done.

In conclusion, large numbers of young children in South Africa are affected by violence and abuse. Exposure is known to impact negatively on child well-being and to have life-long detrimental consequences for the child as well as for society. Strengthening the legislative framework and providing access to quality services and support for caregivers of young children are needed to address the challenges of raising the next generation. This will not only strengthen caregivers' capacity to bring up children in loving and non-violent homes, but will support future adults to lead successful and productive lives and live peacefully and respectfully with their fellow citizens.

References

1 Mathews S, Abrahams N, Jewkes, R, Martin L & Lombard C (2013) The epidemiology of child homicides in South Africa. *Bulletin of the World Health Organization*, 91: 562-568.
2 Van As AB & Naidoo S (2008) *Paediatric Trauma and Child Abuse*. Cape Town: Oxford University Press Southern Africa.
3 Leventhal JM, Martin KD & Gaither JR (2012) Incidence of serious physical abuse in children. *Pediatrics*, 129(3): 458-464.
4 Crouch JL, Skowronski JJ, Milner, JS & Harris B (2008) Parental responses to infant crying: The influence of child physical abuse and hostile priming. *Child Abuse & Neglect*, 32: 702-710.
5 Fallon B, MacLaurin B, Daciuk J, Felstiner C, Black T, Tonmyr L & Cloutier R (2010) *Canadian Incidence Study of Reported Child Abuse and Neglect 2008. Major Findings*. Ottowa: Public Health Agency of Canada.
6 Richter LM & Dawes ARL (2003) Child abuse in South Africa: Rights and wrongs. *Child Abuse Review*,17: 79-93.
7 Jewkes RK, Dunkle K, Nduna M, Nwabisa J & Puren A (2010) Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth. *Child Abuse & Neglect*, 34: 833-841.
8 Bower C (2014) The plight of women and children: Advancing South Africa's least privileged. *The Annals of the American Academy of Political and Social Science*, 652(1): 106-126.
9 Dawes A, de Sas Kropiwnicki Z, Kafaar Z & Richter L (2006) Partner violence. In: Pillay U, Roberts B & Rule S (eds) *South African Social Attitudes: Changing Times, Diverse Voices*. Cape Town: HSRC Press.
10 Burton P & Leoschut L (2013) *School Violence in South Africa. Results of the 2012 National School Violence Survey*. Monograph Series No. 12. Cape Town: Centre for Justice and Crime Prevention.
11 See no. 4 above.
Frodi A & Lamb ME (1980) Child abusers' responses to infant smiles and cries. *Child Development*, 51: 238-241.
12 Finkelhor D (2008) *Childhood Victimisation. Violence, Crime and Abuse in the Lives of Young People*. Oxford: Oxford Univerisity Press.
13 Straus MA (2000) Corporal punishment and primary prevention of physical abuse. *Child Abuse & Neglect*, 24: 1109-1114;
See no. 12 above.
Dawes A & Ward C (2008) Levels, trends, and determinants of child maltreatment in the Western Cape Province. In: Marindo R, Groenewald C & Gaisie S (eds) *The State of Population in the Western Cape Province*. Cape Town: HSRC Press.
14 See no. 5 above.
15 Canadian Paediatric Society (2004) Maternal depression and child development. *Paediatric Child Health*, 9(8): 575-583.
16 Combs-Orme T & Cain DS (2008) Predictors of mothers' use of spanking with their infants. *Child Abuse & Neglect*, 32: 649-657.
17 See no. 5 above.
18 Van As A, Janssen TL, Van Dijk M, Malki A & van As AB (2013) Management of physical child abuse in South Africa: Literature review and children's hospital data analysis. *Paediatrics and International Child Health* 33(4): 216-227.
19 Coulton CJ, Korbin JE, Su M & Chow J (1995) Community level factors and child maltreatment. *Child Development*, 66(5): 1262-1276;
Wua RS, Maa C, Carterb RL, Arietc M, Feaverd EA, Resnicke MB & Rothe J (2004) A combination of large family size, poverty, young maternal age, and low maternal education have been cited as reliable predictors of a maltreatment report. *Child Abuse & Neglect*, 28: 1253-1264.
20 Meintjies H & Hall K (2013) Demography of South Africa's children. In: Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) *South African Child Gauge 2013*. Cape Town: Children's Institute, UCT.
21 Garbarino J & Kostelny K (1992) Child maltreatment as a community problem. *Child Abuse & Neglect*, 16: 455-464;
See no. 19 above (Coulton et al.).
22 See note 8 above.
23 Mathews S, Loots L, Sikweyiya Y & Jewkes R (2013) Sexual abuse. In: *Crime, Violence and Injury in South Africa: 21st Century Solutions for Child Safety*. Pretoria: Medical Research Council;
Jewkes R, Dunkle K, Koss M, Levin J, Nduna M, Jama N & Sikweyiya Y (2011) Gender inequitable masculinity and sexual entitlement in rape perpetration in South Africa: Findings of a cross-sectional study. *PLoS ONE*, 6(12): e29590, doi:10.1371/journal.pone.00.
24 Seedat M, Van Niekerk A, Jewkes R, Suffla S & Ratele K (2009) Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet,* 374(9694): 1011-1022;
Wood K, Lambert H & Jewkes R (2008) "Injuries are beyond love": Young South Africans' understandings of limit and legitimacy in relation to physical violence in their sexual relationships. *Medical Anthropology*, 27: 43-69;
Bower C (2013) *Prohibition of Corporal and Humiliating Punishment in the Home*. Pretoria: UNICEF.
25 Mathews S, Abrahams N, Jewkes R, Martin LJ & Lombard C (2012) *Child Homicide Patterns in South Africa: Is There a Link to Child Abuse?* South African Medical Research Council research brief. Pretoria: MRC.
26 Blair C (2010) Stress and the development of self-regulation in context. *Child Development Perspectives*, 4(3): 181-188;
Shonkoff JP (2010) Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development*, 81(1): 357-367.
27 Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP & Marks JS (1998) The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine*, 14: 245-258.
28 Gershoff E (2013) Spanking and child development: We know enough now to stop hitting our children. *Child Development Perspectives*, 7(3): 133-137.
29 Mathews S, Jewkes R & Abrahams N (2011) "I had a hard life": Exploring childhood adversity in the shaping of masculinities among men who killed an intimate partner in South Africa. *British Journal of Criminology*, 51(6): 960-977.
30 Preventing Violence Across the Lifespan Research Network (2014) *Interventions to Prevent Child Maltreatment*. PrevAiL research brief. Accessed at: http://prevail.fims.uwo.ca.
31 Tomlinson M, Dawes A & Flisher A (2012) Preventing the development of youth violence in the early years: The state of the evidence and implications for South African practice. In: Ward C, Dawes A, & van der Merwe A (eds) *Youth Violence: Sources and Solutions in South Africa.* Cape Town: UCT Press.
32 Eckenrode J, Campa M, Luckey D, Henderson CR, Cole R, Kitzman H, Anson E, Sidora Arcoleo K, Powers J & Olds D (2010) Long-term effects of prenatal and infancy nurse home visitation on the life course of youth: 19-year follow-up of a randomized trial. *Archives of Pediatrics & Adolescent Medicine*, 164(1): 9-15.
33 Honikman S, van Heyningen TS, Field S, Baron B & Tomlinson M (2012) Stepped care for maternal mental health: A case study of the perinatal mental health project in South Africa. *PLoS medicine*, 9(5): e1001222, doi:10.1371/journal.pmed.10012.
34 Ramchandani P, Stein A, Evans J & O'Connor TG (2005) Paternal depression in the postnatal period and child development: A prospective population study. *The Lancet*, 365(9478): 2201-2205.
35 Rotheram-Borus MJ, le Roux IM, Tomlinson M, Mbewu N, Comulada WS, le Roux K, Stewart J, O'Connor MJ, Hartley M, Desmond K, Greco E, Worthman CM, Idemundia F & Swendeman D (2011) Philani Plus (+): A mentor mother community health worker home visiting program to improve maternal and infants' outcomes. *PubMed*, 12(4): 372-388;
Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, McPherson K & Murray L (2009) Improving the quality of the mother-infant relationship and infant attachment in a socio-economically deprived community in a South African context: a randomised controlled trial. *British Medical Journal*, 338: b974.
36 See no. 35 above (Cooper et al 2009).
37 Ward C & Wessels I (2013) Rising to the challenge: Towards effective parenting programmes. In: Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) *South African Child Gauge 2013*. Cape Town: Children's Institute, UCT.
38 Participant in the Sinvuyo trial programme; personal communication from Cathy Ward, Department of Psycology, UCT.
39 See no. 8 above.
40 World Health Organisation & International Society for Prevention of Child Abuse and Neglect (2006) Preventing *Child Maltreatment: A Guide to Taking Action and Generating Evidence*. Geneva: World Health Organisation Press.
41 See no. 28 above.
42 See no. 28 above. P. 135.
43 Lansford JE, Wager LB, Bates JE, Pettit GS & Dodge KA (2012) Forms of spanking and children's externalizing behaviors. *Family Relations*, 61(2): 224-236.
44 United Nations Committee on the Rights of the Child (2007) *General Comment No. 8 (2006): The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment (Arts. 19; 28, Para. 2; and 37, inter alia)*, 2 March 2007, CRC/C/GC/8, Geneva: UN.

Primary school children: Widening worlds and increasing risk of sexual abuse

Lucie Cluver (Oxford University/University of Cape Town), Franziska Meinck (Oxford University) and Shaheeda Omar (The Teddy Bear Clinic for Abused Children)

Lindiwe (not her real name) has been living with her grandmother, who works as a toilet attendant in an Eastern Cape township, since her mother died of HIV in 2004. Two years ago, she was playing outside her home with her friend from church. A neighbour called her and her friend into his house, saying that he had sweets for them. He gave the friend some money and sent him to buy cool drinks. "Then", she said to me, "he locked the door and told me to lie on the bed …" After he had raped her, the man gave Lindiwe R10. She was too scared to tell her grandmother for three days. The perpetrator was arrested, but the case was dismissed in the preliminary trial; the magistrate ruled that, because the rapist had given Lindiwe money, he was "her boyfriend". The man was 63. Lindiwe was 11.

The age between early childhood and adolescence is one of rapid development and social change. Children's worlds expand, from a context of primarily home and family, to new experiences in school and the community. These changes and opportunities also bring additional risks of violence. In particular, sexual violence has long-term and intergenerational negative effects. It is essential to intervene early to prevent sexual violence and to provide treatment to mitigate the severity of its impacts.[1]

This essay will address the following questions:

- What types of violence do primary school children experience?
- What are the key risk and protective factors?
- What are effective points for intervention?
- What are the key recommendations?

What types of violence do primary school children experience?

Sexual violence against children causes multiple, severe adverse effects. At the most extreme are cases of child rape, murder, and HIV infection. For survivors of violence, there is conclusive evidence of immediate and lifetime impacts on physical and mental health, brain functioning, life expectancy, employment and sexual health.[2]

It is difficult to get accurate information about rates of sexual abuse and child rape, and especially for this age group. Children are supposed to attend primary school from the year they turn six (in grade R) until they turn 14 in grade 7. But, with around 40% of primary school children experiencing grade delay and a third repeating at least one grade,[3] many children in primary schools – particularly in low-income areas – are aged up to 16.

A national study[4] of child homicides that used mortuary data found that sexual assault was suspected in 10% of cases (102 children). For children aged 5 – 9, sexual assault was suspected only for girls, while amongst children aged 10 – 14, sexual assault was suspected mainly for girls (86%) compared to boys (14%). South African police statistics suggest 28,000 sexual offences against children under 18 in 2010/11[5] but this would be an under-estimate because the majority of rape and sexual abuse is never reported to the police. Since then, police data on sexual offences have not been disaggregated by age.

Most research studies focus on older adolescents, or ask youth or adults about sexual abuse at any time in their childhood: in a study in the Eastern Cape, 39% of women and 17% of men reported experiencing sexual abuse before the age of 18.[6] In another study, 14% of undergraduate psychology students reported sexual abuse with genital contact, and 9% reported forced sex.[7] In a nationally-representative sample of South African women, 1.6% reported forced sex before age 18.[8] In a study of 6,000 children aged 10 – 17 in Mpumalanga, KwaZulu-Natal and the Western Cape, rates of sexual abuse (genital contact or rape) were 3.6%.[9] It is important to remember that all kinds of sexual abuse are under-reported, and that adult recall of childhood abuse may not always be reliable.

Very few studies investigate who the perpetrators of sexual abuse are, but it is clear that children are most at risk from someone known to them.[10] There is a high prevalence of child-on-child sexual assault amongst primary school children, on both male and female children by both sexes.[11] In a study of 3,400 10 – 17-year-olds, most perpetrators of sexual abuse were peers (42%) or relatives (17%).[12]

In addition to sexual abuse, primary school-aged children can be exposed to other forms of violence. A new and concerning form is sexual harassment or cyberbullying via social media or cellphones. This can include children filming or "sexting"[i] abusive situations, with 33% of South African students reporting having received pornographic images on their cellphones.[13] A recent UNICEF report also noted increasing risks of children being lured or tricked into meeting strangers or being "groomed" for involvement in sexual activities.[14]

Other types of violence include physical and emotional abuse in the home, and bullying and violence in schools. Prevalence rates as high as 27% for physical abuse[15] and 35.3% for emotional abuse have been reported.[16] Children of this age need to be able to

i Sending sexually explicit text messages.

explore and play with friends, but living in dangerous communities can mean that they are at risk of community and gang violence,[17] violent service protests, taxi violence and violent crime[18].

Studies report that the attitude of the health care workers and justice and court officials are crucial to reducing secondary trauma for the child. Many report that health care providers are supportive, provide post-exposure prophylaxis to prevent HIV infection, and give informal psycho-social support,[19] and that support workers (where available) in courts are helpful. However, qualitative research has also identified risks of secondary trauma when health and justice services are unable to cope with the needs of sexually-abused children.[20] These include case reports that some court officials and health care workers had personal opinions that guided actions contrary to legal guidelines, were unaware of the need to be sensitive to child victims,[21] or lacked skills and training in communicating with children.[22] Although there has been notable improvements in the implementation of child-friendly court procedures, in many courts, close-circuit television (CCTV) systems are unavailable or do not work and intermediaries[ii] are not available, leading to postponements and in some cases further trauma if children have to testify in an open court.[23] Nationally, conviction rates of child sexual abuse that are reported to the police are estimated to be around 7%.[24] A recent Department of Justice task team has strongly advised the re-establishment of specialised sexual offences courts, based on the systemic challenges and limited capacity to provide victim-sensitive services in the existing court system.[25] It is clear that great care needs to be taken to reduce risks of secondary trauma to child victims.

What are the key risk and protective factors?

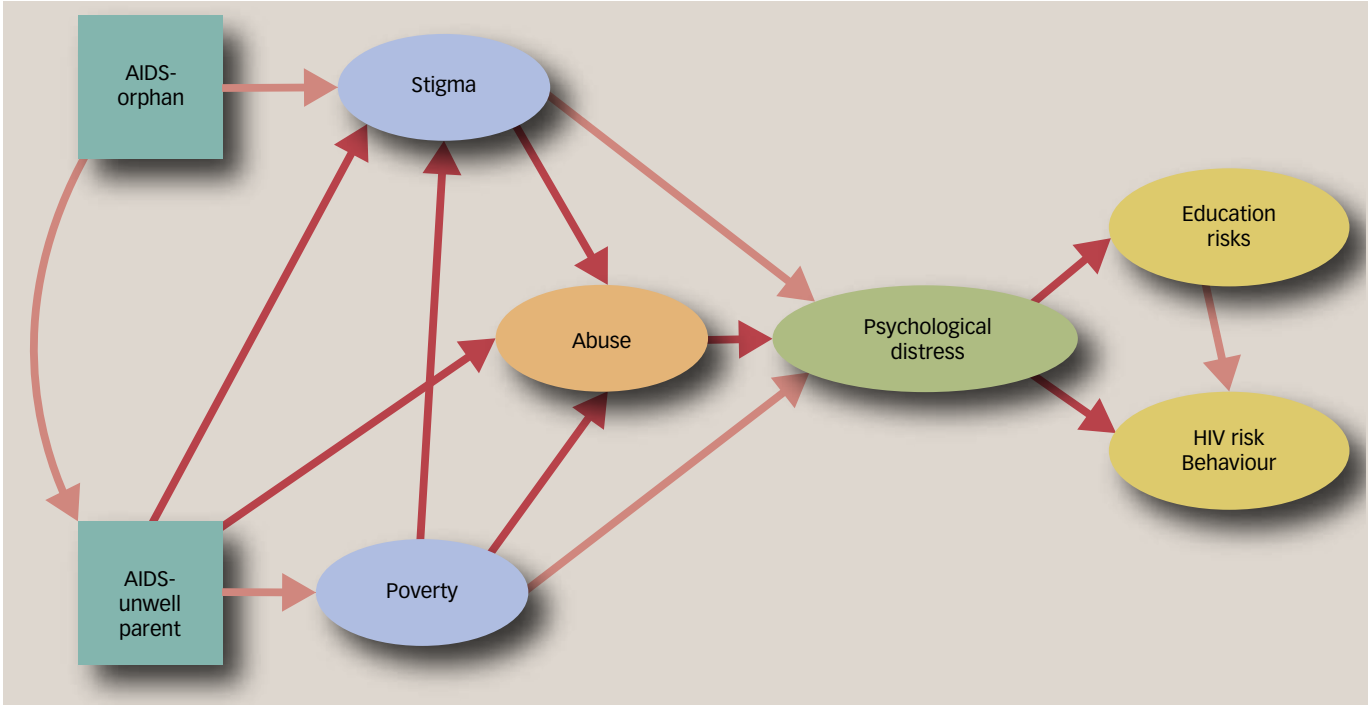
There is increasing evidence that child abuse is not caused by a single risk factor. Often, risk factors are interlinked and causally affect each other, increasing vulnerability to sexual victimisation. Studies show close associations between family AIDS, extreme poverty, stigmatisation and exposure to community violence, which combined and interacted with each other to increase the chances of a child being abused.[26]

A new review of risks for sexual abuse in Africa found a range of risks at the family level, including large families, lone parents and step-parents; exposure to domestic violence; poor parental mental health; poor parenting; and parental drug and alcohol use.[27] International research has shown that perpetrators often target those children who are least protected, for example where parents are deceased, caregivers are unavailable and families are isolated. [28]

These family-level risks can also interact with vulnerabilities at the level of the individual child. For example, children with disabilities or learning difficulties are less likely to be able to articulate or be believed when reporting abuse.[29] Reporting suggests that girls are at higher risk of sexual abuse,[30] although very little is known about rates or predictors of sexual abuse amongst boys.[31] Children who use drugs or alcohol are also at higher risk of abuse.[32]

Perpetrators of abuse may also take advantage of community-level factors such as the socialisation of children to respect and obey adults, and also conditions relating to poverty, such as overcrowding in the home.[33] Studies suggest that rapes of children

Figure 10: Social, economic and family vulnerabilities for child abuse



ii In South Africa, an intermediary system is attempting to reduce the trauma and secondary abuse often experienced by child witnesses in court cases involving sexual abuse. By separating the child from the formal courtroom and allowing an intermediary to relay questions and answers to the child via CCTV, it is hoped that the stress of the experience for these children will be reduced while retaining the rights of the accused to cross-examine witnesses, and to a fair trial. (See: Viviers A (2005) Manual on practice guidelines for intermediaries. In: *Resources Aimed at Prevention of Child Abuse and Neglect. Intermediary Training Manual, 2005*. Cape Town: RAPCAN).

are more likely in communities where the chances of prosecution are low.[34] At the broader societal level, understandings of masculinity and of hierarchy may make conditions more amenable to sexual abuse of children.[35]

A study[36] of 6,000 children in Mpumalanga, KwaZulu-Natal and the Western Cape has shown how social and economic vulnerabilities such as family AIDS, poverty and community violence can increase risks of abuse for children (see figure 10). It also showed that abuse is a key point of linkage to negative child outcomes including school drop-out, mental health distress and sexual health risks.

Research shows that it is not only the risk factors for abuse that interlink with each other, but also the different types of abuse: physical, emotional, and sexual child abuse. Children who have experienced any type of abuse, and in particular sexual victimisation,[37] are at very high risk of re-victimisation.[38]

Case 10: Building evidence for prevention – Parenting programmes

Parenting programmes are the most effective child abuse prevention approach, but too little research on these is designed for the developing world.[46] For this reason the World Health Organisation and UNICEF teamed up with the Universities of Cape Town and Oxford, and the national departments of Social Development and Basic Education with support from international research and implementation experts, the National Association of Child Care Workers and Clowns Without Borders South Africa, to develop and test parenting programmes to reduce exposure to sexual abuse in the community, and physical and emotional abuse in the home.[47]

The programmes use collaborative group problem-solving approaches that have a strong evidence-base from existing randomised trials in high-income countries. These have been adapted for South Africa and use by non-professional staff. All expertise has been donated, and the programmes are licensed under Creative Commons to ensure that they are free and non-profit.

The programmes are currently undergoing pre-post testing, adaptation and randomised controlled trials. A pilot randomised trial programme for the 2 – 9-year-olds has showed improved positive parenting and child-led play. Pre-post studies for the 10 – 17-age group show reduced child abuse, less child rule-breaking or aggression, and lower acceptance of gender violence. Tests showed improvements in involved parenting, positive parenting, supervision of children and social support. A programme for infants is also being tested. If successful, the World Health Organisation and UNICEF intend to further adapt and scale up the programmes in low- and middle-income countries.

For more information, see: http://www.who.int/violence_injury_prevention/violence/child/plh/en/

For this age group of children, risks of abuse at school are also important. Children can be more vulnerable to abuse by other children and by adults in the school environment when there is limited school management; lack of existence, implementation and enforcement of school safety policies; limited reporting mechanisms for abuse; and lack of training on or understanding amongst educators of how to identify and respond to signs of abuse.[39]

A recent report[40] also highlights key gaps in accountability systems regarding sexual violence on children in schools. These include lack of co-ordination between institutions, which means a perpetrator can go on to teach at another school. The report highlights that civil society organisations provide services for child victims, but that these are limited by lack of resources and lack of co-ordination between services. There may also be risks for children when walking or commuting to school either by taxi or other public transport.[41]

What are effective points for intervention?

The Children's Act[42] outlines four main points of intervention to address child sexual abuse: primary prevention, early intervention, protection services, and preventing perpetrators from re-offending. These are all essential components of breaking the cycle of violence against children.

Prevention and early intervention services are essential to prevent abuse before it happens. However, this is the least

Case 11: Zero tolerance in Limpopo – A multi-level community-based intervention

The Zero Tolerance Village Alliance Model was established by the Thohoyandou Victim Empowerment Programme in rural Limpopo. It uses community consultation to establish ownership of the programme and the involvement of high-ranking community officials (such as chiefs, clergy) and their constituencies. This multi-pronged intervention includes workshops on sexual rights, police training in victim empowerment, the establishment of village committees, safe houses and support groups for victims, and a "village alliance" induction ceremony.

In 2011/2012, a pre-post survey was conducted of 1,000 people in two participant villages, with a control village. Intervention villages showed an increase in knowledge of post-exposure prophylaxis, and a 5 – 6-fold increase in the reporting of sexual and gender-based violence – which is often a measure of increased awareness and success of the programme. Reporting over the subsequent 11 months demonstrated a steady decline in reports of sexual and gender-based violence in intervention villages.[48] Although the findings have not been disaggregated by age group, researchers report reductions in sexual abuse for both children and adults.

For more information, see: www.tvep.org.za.

resourced part of most child protection systems.[43] Worldwide, less than 10% of abused children access any child protection services, with even lower access to effective primary prevention programmes.[44]

There is also very little research evidence to guide effective interventions in the global South. In a recent World Health Organisation (WHO) review, 99% of rigorously-evaluated programmes were in high-income countries.[45] None were in Africa. Since then, some promising programmes have shown emerging evidence of effectiveness, but there is still not a strong evidence-base of rigorously-evaluated interventions for preventing and responding to child sexual abuse in South Africa.

This section outlines the four main types of interventions – primary prevention, early intervention, protection services, and prevention of re-offending – and discusses examples of promising programmes that operate at individual, family, school and broader community level in South Africa.

Primary prevention

Primary prevention programmes can be universal (aimed at everyone in the country), or targeted at high-risk neighbourhoods or families. They include community, school and parenting programmes (see table 6). The content of these programmes is important. A systematic review[49] found that programmes that teach children to recognise and say no to sexual abuse were effective in improving knowledge and protective behaviours, but there is no evidence that they reduce actual abuse. Evidence for media-based programmes (such as radio or other media that teach awareness of abuse) was mixed or insufficient. Parenting programmes for child abuse prevention were identified as having the best evidence in reducing child maltreatment, but these rarely measure sexual abuse as an outcome.[50]

Cases 10 and 11 (on p. 67) describe two local primary prevention programmes that aim to prevent child sexual abuse.

Table 6: Primary prevention – School- and community-based programmes

Programme	How it works	Evidence base
Teachers' Diploma in Psycho-Social Support – offered by the Regional Psycho-Social Support Initiative (REPSSI)	Trains teachers to develop a safe, protective school which seeks to realise the potential of all learners. This includes addressing barriers to learning such as abuse and being able to refer children to relevant services.	Randomised controlled trial in progress in Zambia (2013 – 2016). Qualitative evidence suggests positive results.
Parenting programmes (such as the Sinovuyo Caring Families programmes for parents, children and teenagers) – UNICEF, WHO, Oxford University and University of Cape Town	Uses collaborative, problem-solving approaches to equip guardians to reduce violent discipline and conflict with children. Works with the national departments of Social Development and Basic Education, and with NACCW and Clowns without Borders South Africa (see case 10 on p. 67).	Randomised controlled trials of programmes for 2 – 9-year-olds and 10 – 17-year-olds underway in Eastern Cape and Western Cape. Pre-post tests show reduced abuse and violence.
Isibindi Safe Parks – National Association of Child and Youth Care Workers and Department of Social Development	Provides a safe space for children after school and in the holidays, supported by home visits for vulnerable families.[51]	Qualitative evaluation reported successful provision of safe play spaces, and availability of staff to respond to reported cases of abuse.
The SAFE (Safe and Friendly Environment) programme – run by several non-governmental organisations such as Childline and The Teddy Bear Clinic	Raises children's awareness of acceptable and unacceptable behaviour, and safe and unsafe touches. School educators and supporting staff are also trained on signs and symptoms of abuse, management, legislation and referral.	No evaluation yet completed, but evaluation plans underway.
"Walking Bus" – Department of Basic Education and the International Red Cross Society	Improves safety as children walk to school in groups, led by adults.	Piloted in Western Cape, no known evaluation.
MenCare (part of the Global Fatherhood Campaign) – Sonke Gender Justice and Promundo	Aims to implement evidence-based programmes that promote men's involvement as fathers and caregivers including community-based workshops, fathers-to-fathers support groups and media advocacy.	Currently in the Western and Eastern Cape provinces. Pre-post tests suggest increases in men discussing gender-based violence and rights with family, and increases in reporting of violence.

Early intervention and protection services

Early intervention includes social work or emergency services (of assessment, removal, and placement of children into alternative care), therapeutic programmes and support to families. These are important to protect children from abusive situations, and to reduce the negative impacts of abuse on their present and future lives.

If abuse occurs, the first step is to assess the child and safety of the environment. The Children's Act, following international evidence, advises removal of children from their homes should only occur "where a serious and immediate danger to the child outweighs the trauma involved in such a removal"[52] and where prevention and early intervention services, with removal of the offender, cannot ensure the child's safety[53]. This decision is especially difficult in situations of chronic sexual abuse, where there is great tension between removing children from immediate danger, and evidence of the risks that children – especially sexually abused children – face in alternative and state care.

Very few studies worldwide examine the effectiveness of child sexual abuse response interventions. This is partly because of the major ethical issues associated with research in this area – for example it is not possible to randomise children to receive emergency abuse services or not. A recent systematic review of psychological treatments to reduce the effects of child sexual abuse found that cognitive behavioral therapy worked better than supportive, unstructured psychotherapy, but that effects were moderate.[54]

The focus of protection services is on services to support statutory intervention and prevent secondary trauma. This is particularly important in countries like South Africa, where rates of sexual abuse are high and health and justice services are often over-burdened and under-resourced. There are a number of promising programmes (see table 7), but limited evaluation of how they link to child outcomes.

Preventing perpetrators from reoffending

It is important to recognise that victims are not the only focus of intervention, and work with perpetrators is also essential in reducing risks for children. A recent systematic review of programmes to prevent re-offending by perpetrators of child sexual abuse reported that the evidence-base for effective interventions was very weak, with mixed effects of psychological and medical treatments.[57]

For young offenders, there is better evidence for multi-systemic therapy (MST).[58] This is a multi-professional intervention usually provided to the whole family. Data from Childliine South Africa indicate that around half of sexual offences against children are committed by under-18-year-olds,[59] but the evidence on MST is focused on high-income countries and requires mental health professionals for implementation. This would clearly need adaptation for a South African context, and would be extremely difficult in rural areas. Case 12 (on the next page) describes a South African programme that aims to assist children from repeating sexual abuse.

Table 7: Early intervention and protection services

Programme	How it works	Evidence base
Post-rape training for health professionals – National Department of Health	Educates health professionals about the circumstances of rape; barriers to reporting; health consequences; the social construct of gender, and sexual rights; provision of medical care including mental health care; prevention and management of pregnancies and infectious diseases; follow-up care, record-keeping and overview of the law.	In a cross-sectional study health care professionals reported increased confidence in talking with parents about supporting children who had been sexually abused.[55]
Children Are Precious Project – Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN)	Community-based approach to child protection, including community-level (communication, after-school programmes, referral systems strengthening); school level (teacher training, school safety plans) and family level (parenting support, community mapping and Heroes workbooks for children) interventions. See the case 4 on p. 40.	Pilot programme in Cape Town evaluated for process and acceptability in a high-violence Cape Town area. Many aspects of the programme worked very well, but some challenges with slow external referral processes.
Child Witness Project Model and Toolkit – Childline and RAPCAN	Sets minimum standards and provides training for court staff, including court preparation and counseling for children and families to help children become competent witnesses and prevent secondary trauma.	Qualitative evaluation reports that children and families found the service comforting and helpful.[56]
Child Protection Residential Programmes – National Association of Child Care Workers (NACCW) and Childline	Provides a residential programme for child abuse victims and their caregivers, with therapeutic lifespace work, specialised counselling and therapy. NACCW and Childline are taking this to scale, with one residential programme planned for every province in 2014.	Quasi-experimental controlled trial in progress with Children's Institute, results expected in 2016.

Case 12: Preventing perpetrators from re-offending – The Support Programme for Abuse Reactive Children

The Support Programme for Abuse Reactive Children (SPARC) is a diversion programme for young sexual offenders offered by The Teddy Bear Clinic. The sexual behaviour of children who abuse other children goes far beyond developmentally appropriate childhood exploration or sex play. Typical behaviour may include oral sex, vaginal intercourse, and forcibly penetrating the vagina or anus of another child with fingers, sticks and/or objects. These behaviours escalate over time, and the children do not and cannot stop without intensive and specialised treatment.[60]

The SPARC aims to disrupt the cycle of abuse and prevent children from turning into adult abusers. It uses creative expression and cognitive-behavioural therapy to help children (6 – 17-years-old) understand the consequences of their behaviour, and develop the skills to prevent them from re-offending. Most children in the programme have been ordered to attend by a court, and others are referred by schools, children's homes, the police or other agencies that deal with children, and occasionally voluntary clients are included.

A series of 12 group sessions take place weekly after school. This excludes the initial intake and assessment of the child, and any individual therapy that is prescribed. The group sessions are divided into two parts: Part 1 uses creative expression (dance, boxing, art or music) to enhance self-esteem and stimulate participation. Part 2 draws on cognitive-behavioural therapy to address illogical thought processes and irrational behaviours that are frequently presented by offenders. This includes anger management, problem-solving skills, developing empathy, clear boundaries and impulse control.

Parallel group sessions help parents and caregivers manage their children's behaviour appropriately and constructively. All sessions are documented and a final report is collated by the co-ordinator of the diversion programme for submission to the court for children who were ordered to attend. A series of three follow-up sessions are held every six months to check on progress and, if there is no need for further intervention, the file is closed.

Evaluation has shown that the programme is effective in disrupting the cycle of abuse and 95% of children who attended the programme from 2001 – 2012 did not reoffend.[61]

For more information, see: www. ttbc.org.za

What are the key recommendations?

There is very clear evidence that sexual abuse has severe and long-lasting negative effects on children. There is also increasing evidence that rates of child sexual abuse and rape are disproportionately high in sub-Saharan Africa. It is essential that researchers, government and non-governmental organisations (NGOs) work together to develop a rigorous evidence-base of interventions to prevent and respond to sexual violence against children.

There are some important preventative interventions that have very strong potential to reduce risks for children. These include programmes that reduce children's time spent unaccompanied in communities by providing activities in safe settings (such as after-school care and safe parks) and accompanied travel (such as walking to and from school). Other preventative interventions with potential include parenting programmes that can help families to plan how to keep children supervised and safer. Finally, community-focused programmes that raise awareness and encourage reporting of sexual violence are promising.

There are also interventions that have potential in responding to child sexual abuse. For example, programmes that train teachers and community workers to identify signs, respond to disclosure and make referrals of child sexual abuse are important in increasing the likelihood of identification and active responses. Therapeutic programmes such as The Teddy Bear Clinic, and the National Association of Child Care Workers' child protection residential programmes, are important but unavailable to the vast majority of sexually-abused children in South Africa. In addition to these, low-resource, scaleable programmes are also necessary.

Preventing secondary trauma through services is clearly also important. Improved training of health care, social and criminal justice workers could help to make the experience of reporting and testifying about sexual abuse less traumatic for children. Facilities such as child-friendly rooms, CCTV access in courts and court preparation for children and families are likely to be of great value, and the expansion of specialised courts has been recommended to the Ministry of Justice by an internal task team.

Finally, working with perpetrators to prevent re-offending is valuable. Although there is little evidence of successful interventions for adult offenders, there is evidence suggesting value in intensive therapies for juvenile offenders.

Child sexual abuse remains a major problem in South Africa, and internationally. The challenges should not be underestimated: it is a multifaceted and often unpredictable problem that is difficult to identify, to address and to prevent. It is clear that a single approach – prevention, response or work with offenders – will never be sufficient, and that a comprehensive package of evidence-based approaches is needed. Rigorous research is needed to test these and other potential interventions,[62] and the combinations of interventions that will be most effective.

There remain challenges for responding to child sexual abuse that need to be addressed at the implementation level. It is a complex issue that requires integrated programming across departments such as Health, Justice, Basic Education and Social Development: this presents challenges in any national system and requires innovative approaches, capacity-building and strong leadership. There are also significant challenges at the service level, including insufficient numbers of social workers, lack of transport,

RAPCAN social change initiatives: Include children as agents of change

excessive caseloads and burnout, affecting the implementation of services to children and families. As with many services, children in rural areas often have the least access to services, and most NGOs focusing on child sexual abuse are located in major cities.

But South Africa also has notable strengths and potential to respond to child sexual abuse. It has one of the strongest legislative frameworks in Africa, with clear commitments at government level to prioritise violence against children. It has international NGOs such as UNICEF, Save the Children, World Vision and others, with departments dedicated to child protection. It has many examples of determined local NGOs, and social workers – both qualified and lay staff – who work with traditional and elected leaders to address abuse. And it has strong public and media support for a co-ordinated response.

Children who have been exposed to sexual abuse are already amongst the most vulnerable in the country. Those who are at risk of sexual abuse still have the opportunity to be protected from the long-term, severe impact thereof. Sexual abuse is not limited by racial group, social or economic status, and it is not restricted to cities where services are most available. The very least that these children deserve is rigorously-evaluated, effective programmes. And it is a legal, moral and public health imperative that these are scaled and maintained throughout South Africa.

References

1 Dawes A (2002) *Sexual Offences against Children in South Africa*. Cape Town: Children's Institute, UCT.
2 Anda R, Felitti V, Bremner J, Walker J, Whitfield C, Perry B, Dube S & Giles W (2006) The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience,* 256: 174-186;
Shonkoff JP, Garner AS, Siegel BS, Dobbins MI, Earls MF, McGuinn L, Pascoe J &. Wood DL (2012) The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129: e232-46.
3 Meny-Gilbert S & Russell B (2010) Treading Water: Enrolment, delays, and completion in South African schools. *Findings from the Access to Education Study*. Gauteng: Social Surveys Africa & Centre for Applied Legal Studies, University of the Witwatersrand.
4 Mathews S, Abrahams N, Jewkes R, Martin LJ & Lombard C (2013) The epidemiology of child homicides in South Africa. *Bulletin of the World Health Organization*, 91: 562-568.
5 South African Police Service (2011) *Annual Report 2010/11*. Pretoria: SAPS.
6 Jewkes R, Dunkle K, Nduna M, Jama P & Puren A (2010) Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth. *Child Abuse & Neglect*, 34: 833-841.
7 Madu SN, Idemunda S & Jegede A (2003) Some perceived parental undesirable behaviours predicting child abuse: A study among a sample of university students in South Africa. *Journal of Social Science*, 7: 111-119.
8 Jewkes R, Levin J, Mbananga N & Bradshaw D (2002) Rape of girls in South Africa. *The Lancet*, 359(9303): 319-320.
9 Cluver L, Orkin M, Boyes ME, Sherr L, Makasi D & Nikelo J (2013) Pathways from parental AIDS to child psychological, educational and sexual risk: Developing an empirically-based interactive theoretical model. *Social Science and Medicine*, 87: 185-193.
10 Richter L, Dawes A & Higson-Smith C (2004) The *Sexual Abuse of Young Children in Southern Africa*. Cape Town: HSRC Press.
11 Omar S (2011) A Study of Child-on-Child Sexual Abuse of Children Under 12 Years. Doctoral dissertation, University of Johannesburg.
12 Meinck F, Cluver L & Boyes M (under review) Physical, emotional and sexual abuse of children in South Africa: Prevalence, incidence, perpetrators, and locations of child abuse victimization in a large community sample. [Submitted for publication in *Plos ONE*]
13 Chetty I & Basson A (2006) *Report on Internet Usage and the Exposure of Pornography to Learners in South African Schools*. Johannesburg: Film and Publications Board.
14 Beger G, Sinha A & Pawelczyk K (2012) *South African Mobile Generation: Study on South African Young People on Mobiles*. New York: UNICEF Digital Citizenship Safety.
15 Meinck F, Cluver LD, Boyes ME & Mhlongo EL (2014) Risk and protective factors for physical and sexual abuse of children and adolescents in Africa: A review and implications for practice. *Trauma, Violence, & Abuse*, 18 March 2014, doi: 10.1177/1524838014523336.

16 Madu S, Idemudia S & Jegede A (2002) Perceived parental disorders as risk factors for child sexual, physical and emotional abuse among high school students in the Mpumalanga province, South Africa. *Journal of Social Science*, 6: 103-112.
17 Shields N, Nadasen K & Pierce L (2009) A comparison of the effects of witnessing community violence and direct victimization among children in Cape Town, South Africa. *Journal of Interpersonal Violence*, 24: 1192-1208.
18 Ward CL, Flisher AJ, Zissis C, Muller M & Lombard C (2001) Exposure to violence and its relationship to psychopathology in adolescents. *Injury Prevention*, 7: 297-301.
19 Arend E, Maw A, De Swardt C, Denny LA & Roland M (2013) South African sexual assault survivors' experiences of post-exposure prophylaxis and individualized nursing care: A qualitative study. *Journal of the Association of Nurses in AIDS Care*, 24: 154-165.
20 Jewkes R, Penn-Kekanab L & Rose-Juniusc H (2005) "If they rape me, I can't blame them": Reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science & Medicine*, 61: 1809-1820.
21 Waterhouse S, Rezan B, Townsend L & Nomdo C (2014) *Implementation Brief on the Management of Child Sexual Offences in Courts: Failing Systems, Broken Promises*. Cape Town: Resources Aimed at the Prevention of Child Abuse and Neglect.
22 Centre for Applied Legal Studies (2014) Sexual *Violence by Educators in South African Schools: Gaps in Accountability Gauteng*. Johannesburg: School of Law, University of the Witwatersrand; Cornell Law School's Avon Global Centre for Women & the Justice and International Human Rights Clinic.
23 See no. 21 above.
24 See no. 21 above.
25 Ministerial Advisory Task Team on the Adjudication of Sexual Offence Matters (2013) *Report on the Re-establishment of Sexual Offences Courts*. Gauteng: Department of Justice and Constitutional Development.
26 See no. 9 above.
27 See no. 15 above.
28 Finkelhor D & Baron L (1986) Risk factors for child sexual abuse. *Journal of Interpersonal Violence*, 1: 43-71.
29 Davies EA & Jones AC (2013) Risk factors in child sexual abuse. *Journal of Forensic and Legal Medicine*, 20: 146-150.
30 See no. 15 above.
31 Mathews S, Loots L, Sikweyiya Y & Jewkes R (2013) Sexual abuse. In: Van Niekerk A, Suffla S & Seedat M (eds) *Crime, Violence and Injury Prevention in South Africa: Developments and Challenges*. Pretoria: Medical Research Council & University of South Africa.
32 Pluddemann A, Flisher AJ, Mathews C, Carney T & Lombard C (2008) Adolescent methamphetamine use and sexual risk behaviour in secondary school students in Cape Town, South Africa. *Drug and Alcohol Review*, *27: 687-692*;
Palen L, Smith E, Flisher A, Caldwell L & Mpofu E (2006) Substance use and sexual risk behaviour among South African eighth grade students. *Journal of Adolescent Health*, 39: 761-763.
33 Richter L & Dawes A (2008) Child abuse in South Africa: Rights and wrongs. *Child Abuse Review*, 17: 79-93.
34 See no. 20 above.
35 See no. 31 above.
36 Cluver L, Orkin M, Boyes M E, Sherr L, Makasi D & Nikelo J (2013) Pathways from parental AIDS to child psychological, educational and sexual risk: Developing an empirically-based interactive theoretical model. *Social Science and Medicine*, 87: 185-193.
37 Finkelhor D, Ormrod R & Turner H (2007) Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect*, 31: 7-26.
38 Classen CC, Palesh OG & Aggarwal R (2005) Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse*, *6*: 103-129.
39 Burton P & Leoscut L (2013) *School Violence in South Africa: Results of the 2012 National School Violence Study.* Monograph Series, No 12. Cape Town: Centre for Justice and Crime Prevention;
See no. 8 above.
40 See no. 22 above.
41 Hampshire K, Porter G, Mashiri M, Maponya G & Dube S (2011) Proposing love on the way to school: Mobility, sexuality and youth transitions in South Africa. *Culture, Health & Sexuality*, 13: 217-231.
42 Children's Act 38 of 2005.
43 Dawes A & Ward CL (2011) Violence and violence prevention: New roles for child and adolescent mental health practitioners. *Journal of Child and Adolescent Mental Health*, 23(1): 1-4.
44 Finkelhor D, Ormrod R, Turner H & Hamby S (2011) School, police, and medical authority involvement with children who have experienced victimization. *Archives of Pediatrics and Adolescent Medicine*, 165: 9-15.
45 Mikton C & Butchart A (2009) Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization*, 87: 353-361.
46 See no. 45 above;
Richter LM & Naiker S (2013) *A Review of Published Literature on Supporting and Strengthening Child-Caregiver Relationships (Parenting)*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.
47 Ward CL, Mikton C, Cluver L, Cooper P, Gardner F, Hutchings J, Lachman JM, Murray L, Tomlinson M & Wessels I (2014) Reducing violence against children through parenting programmes: From South Africa to other low- and middle-income countries. *Early Childhood Matters*, June 2014, 122: 49-53.
48 Carty C (2012) *Zero Tolerance Village Alliance Intervention Model: Evaluation and Report 2010 – 2012.* The Thohoyandou Victim Empowerment Programme.
49 See no. 45 above.
50 See no. 46 above (Richter & Naiker, 2013).
51 Wilson T & Annandale J (2009) *Safe Parks Research Report*. National Association of Child Care Workers.
52 See no. 52 above. Regulation 35(5)(d).
53 Children's Act 38 of 2005. General regulations regarding children. *Government Gazette* 33076, 1 April 2010. Regulation 35(5)(b).
54 Macdonald J, Higgins J, Ramchandani P, Valentine JC, Bronger L, Klein P, O'Daniel R, Pickering M, Rademaker B, Richardson G & Taylor M (2012) Cognitive-behavioural interventions for children who have been sexually abused. *Campbell Systematic Reviews*, 14, doi: 10.4073/csr.2012.14.
55 Jina R, Jewkes R, Christofides N & Loots L (2014) A cross-sectional study on the effect of post-rape training on knowledge and confidence of health professionals in South Africa. *International Journal of Gynecology Obstetrics*, 126(2):187-192.
56 Palm S (2014) *Process Evaluation of the Child Witness Programme Handover. December 2013 – March 2014.* Cape Town: RAPCAN.
57 Långström N, Enebrink P, Laurent E-M, Lindblom J, Werkö S & Hanson RK (2013) Preventing sexual abusers of children from reoffending: Systematic review of medical and psychological interventions. *British Medical Journal*, 347: f4630.
58 Vizard E (2007) Adolescent sexual offenders. *Psychiatry*, 6: 433-437.
59 Van Niekerk J (2004) At the coalface: The Childline experience. In: Richter L, Dawes A & Higson-Smith C (eds) *Sexual Abuse of Young Children in Southern Africa*. Cape Town: HSRC Press.
60 Gil E & Johnson TC (1993) *Sexualized Children: Assessment and Treatment of Sexualized Children and Children who Molest*. Rockville, Maryland: Launch Press; Lyme Regis, Dorset: Russell House.
61 Angasami J, Stewart M & Maharaj S (2012) *Impact Evaluation of The Teddy Bear Clinic's Support Programme for Abuse Reactive Children (SPARC)*. Impact Consulting: Cape Town.
62 Ward CL, Artz L, Berg, J, Boonzaier F, Crawford-Browne S, Dawes A, Foster D, Matzopoulos R, Nicol A, Seekings J, Van As AB & Van der Spuy E (2012) Violence, violence prevention, and safety: A research agenda for South Africa. *South African Medical Journal*, 102: 215-218.

Adolescents: Preventing interpersonal and gender-based violence

Pinky Mahlangu and Anik Gevers (Gender and Health Research Unit, Medical Research Council)
and Ariane De Lannoy (Children's Institute, University of Cape Town*)

Adolescence is generally perceived as starting with puberty and ending when young people begin to transition into adulthood by taking up "adult roles" such as employment, parenting and marriage.[1] This includes young people between the ages of 12 and 24.[2] For many young people these transitions into adulthood may happen at an earlier age or may be postponed in a context of rising youth unemployment and job insecurity.

Nevertheless, adolescents are generally considered as entering a stage with a higher level of risk.[3] As young adults move further away from home and family in search of connections with peers, risk-taking behaviour and their exposure to and engagement with different forms of violence may increase. In addition, structural factors such as poor quality education, economic hardship, unemployment, and family and community vulnerability may lead young people to be attracted to crime and gang membership.[4]

Adolescence sets a tone and influences future progression into adulthood. It is therefore important that the nature of violence in adolescence and the contexts in which it occurs are understood to enable the development of effective primary prevention interventions. This essay therefore aims to address the following questions:

- What types of violence do adolescents experience?
- What is the impact of violence in adolescence?
- What are the key risk and protective factors?
- What are promising interventions to address violence in adolescence?
- What are the recommendations?

What types of violence do adolescents experience?

Young people are most likely to be both the victims and perpetrators of violence.[5] Adolescents are exposed to different types of violence in their relationships, in their homes, at school and in the community.[6] This includes homicides and other crimes, intimate partner violence, and rape.[7] While there are many other forms of violence involving adolescents in South Africa, this essay will focus on interpersonal violence between young men, and gender-based violence.

A 2008 study[8] indicated that 14% of youth aged 12 – 22 had been assaulted, about a tenth had been robbed, and close to 4% reported having been sexually assaulted or raped. Slightly older youth, aged 18 – 22, were more likely than younger ones to experience violent crimes such as assault, robbery and sexual assault.[9]

Violence in adolescence takes a gendered form: Young men are more likely to be victims and perpetrators of male-on-male interpersonal violence that leads to death and injury, while young women are more likely to be victims of dating and sexual violence perpetrated by men. Victims of violence are likely to experience a long-term negative impact on their health and well-being.

Violence and unintentional injuries are the second leading cause of death and disability in South Africa, and men are predominantly affected.[10] Interpersonal violence accounts for nearly half of these deaths, with homicide rates (59.2 per 100,000) six times the global average and the highest reported rate (149.3 per 100,000) for men aged 25 – 29 years.[11] There is a steady increase in homicide rates from age 10 – 14 (2.46 per 100,000); age 15 – 19 (48.1 per 100,000) to age 20 – 24 (115.6 per 100,000).[12] A distinct feature of violence in South Africa is the disproportionate position of young men both as victims and as perpetrators.[13] This was confirmed by a child homicide study that found the highest rate of childhood male homicide (28 per 100,000) for young men aged 15 – 17 years.[14] Most of them were killed with sharp objects (stabbed) or by blunt force (beaten) in the context of interpersonal violence with someone they knew.[15] The same study found that homicide was lower amongst adolescent women. The rate among girls (15 – 17 years) was 4.6 per 100,000.

Intimate partner violence includes three types of acts:

- physical violence which includes slapping, hitting, kicking and beating;
- sexual violence including forced intercourse and other forms of coerced sex; and
- emotional or psychological violence which involves intimidation and humiliation.[16]

A study among school-going adolescents in Cape Town found that half of surveyed males (49.8%) and over half of surveyed females (52.4%) reported involvement in a physically violent dating relationship either as a perpetrator and/or victim. More women (41.7%) reported being victims of a violent dating relationship than men (37.8%).[17] A school-based survey on intimate partner violence among Cape Town adolescents found that 12% of grade 8 girls reported experiencing physical violence at the hand of their boyfriends, and 16% of boys reported using physical violence towards their girlfriends.[18]

Surveys of adolescent sexuality conducted in South Africa have consistently found more than one third of adolescent girls reporting forced sexual initiation. In community surveys, about 40%

* Ariane De Lannoy joined UCT's Southern Africa Labour and Development Research Unit in July 2014.

AMANDLA EduFootball: Provides a safe space for youth, promotes fair play, build resilience and develops young leaders

of all women who reported rape to the police in 1999 were under the age of 18.[19] Findings of these studies suggest that teenagers are at much higher risk of rape than the population as a whole.[20] Another study conducted with a sample of over 1,000 men between 18 – 49 years in the Eastern Cape and KwaZulu-Natal found that rape was highly prevalent, with 27.6% (466 of 1,689) male participants stating they had raped a woman or girl. Most of the men in this study who raped started as adolescents.[21] Of the 27.6% of men in this study who reported having committed rape, 75% had done so before age 20.[22] Similar findings were documented in a study amongst adolescents in Soweto, where 5% of those who disclosed having committed rape had done so before age 15.[23] The data on both interpersonal and intimate partner violence indicate an urgent need to develop both primary and secondary prevention and response interventions that engage young people.

What is the impact of violence in adolescence?

The literature distinguishes between the short-term and long-term impact of violence.[24] Homicide is the most severe consequence of violence and has a huge cost to families, friends and society. Violence has an impact not only on physical well-being (such as illness and disability, which require medical and social services) but also has consequences for the immediate and long-term quality of life.[25] In the short term, physical violence may result in injuries and risky behaviour that compromise individual health such as unsafe sex, substance abuse, and suicide attempts, but long-term effects can vary by gender.[26] Males have been found to show externalising, risk-taking behaviour such as truanting, involvement in crime and substance abuse, while girls are more likely to display internalising behaviours such as depression, anxiety, and suicidal thoughts.[27]

Violence has a long-term impact on young people's physical and psychological health and may threaten progress into healthy adulthood.[28] Severe intimate partner violence is associated with physical injuries and trauma, sexually-transmitted infections and HIV/AIDS, unwanted pregnancy, low birth weight, prematurity, depression, anxiety, substance abuse and post-traumatic stress disorder. Childhood trauma (such as sexual abuse or witnessing intimate partner violence) may lead to mood disturbances, poor self-image and difficulties in forming stable adult relationships, and is associated with borderline personalities and committing rape.[29]

The impact of violence in adolescence extends beyond the individual and also affects the manner in which both victims and perpetrators relate to others. Girls who were sexually abused in childhood have been found to have an increased risk of experiencing intimate partner violence in later relationships. Boys who were sexually abused are at risk of perpetrating such abuse in adulthood.[30]

What are the key risk and protective factors?

Violence in adolescence is driven by a complex interplay of risk factors at different levels of the social-ecological system (discussed in more detail on pp 30 – 31). This includes both the broader structural drivers of violence such as poverty and inequality as well as the influence of peers, friends, siblings, parents and others in the home, school, street and wider community.

Individual risk and protective factors

Individual risk factors include witnessing violence in the home, which is associated with young men becoming perpetrators of violence and young girls being victims in their own relationships. Exposure

to high levels of violence in the home and child maltreatment in childhood may lead to increased levels of aggression and other psychological problems in adolescence. It may also cause these children to disconnect from school and become increasingly more engaged with delinquent behaviour. Young girls may also be at risk of becoming victims in their own relationships.[31]

Substance (alcohol and drugs) misuse is a major contributing factor in becoming either a victim or perpetrator of violence. Nearly two-thirds of patients who arrived with injuries at trauma units in three major cities in South Africa registered blood alcohol levels above the legal limit.[32] Similarly, a study with young men in the Eastern Cape and KwaZulu-Natal found an association between substance use and rape.[33] In addition, the use of methamphetamine (known as "crystal meth", or "tik") was found to be associated with an increased risk for aggression, sexual-risk behaviour, mental health problems and school drop-out among high-school students in Cape Town.[34]

Relationship risk and protective factors

Violence occurs in the context of shared lives and ongoing relationships[35] with peers, friends, siblings, parents and others in the home, school and wider community. Peer approval and acceptance become critical during adolescence, and peers influence most aspects of intimate relationships.[36] Intimate relationships are highly gendered.[37] Boys seem to have more power and take more initiative than girls, who play more passive roles in relationships. A survey on dating violence found that a significant proportion of secondary school learners considered violence to be a normal part of a romantic relationship, and some regarded violence as a way of "expressing love" or claiming "respect".[38]

Peer pressure to use alcohol and drugs, or participate in unsafe sex and gang-related activities, increases the risk of victimisation and perpetration in adolescence.[39] Simple disagreements between young men often lead to violence which in many instances may be fuelled by informal peer groups or more formalised structures such as gangs.[40] Peers, however, can also play a positive role in adolescence in offering advice when a friend is in an abusive relationship,[41] and affiliation with peers who disapprove of delinquency lowers its likelihood.[42]

Family remains an important influence. As noted earlier, continued exposure to violence and victimisation during childhood increase the chances that young people will have difficulty forming healthy relations and increase the risk of anti-social, violent or delinquent behaviour (including rape and assault or homicide), all of which may start to manifest during adolescence.[43] Exposure to violence in the family has been linked to physical and psychological abuse of intimate partners and children later in life.[44] At the same time, family support can potentially function as a buffer or "safe haven" for adolescents who are exposed to violence at school or in the community. Young people are also less likely to become aggressive when raised in families where parents have a warm relationship with their children, supervise adequately, consistently, and in a non-harsh way.[45]

Structural risk and protective factors

Violence in adolescence needs to be understood within the broader context of inequality, discrimination and exclusion in post-apartheid South Africa. The majority of young people continue to live in poverty-stricken environments, unable to protect or enact their social, political and economic rights. Their aspirations for a better life are high,[46] but are continuously violated as they are confronted with an education system that remains largely dysfunctional, leading many to drop out before completing grade 12. Approximately 50% of 18 – 25-year-olds are unemployed.[47] In addition, HIV and AIDS have a significant impact and many experience illness and death in their close environments, or become infected.

Within this context, gender relationships remain imbalanced. Especially in their private lives, women and children remain especially vulnerable to abuse and violence. Much of the literature refers to masculine identities to explain the high levels of interpersonal and intimate partner violence, but gender equality can only truly be achieved when the norms, values and identities (both masculine and feminine) that place women and children in more vulnerable positions are altered.[48]

Research has repeatedly pointed out that a life in deprivation may lead to the development of anti-social and violent forms of masculinity.[49] As young men strive to reach the hegemonic ideal of being a "real man", they may turn to violence in an attempt to at least gain some form of respect.[50] Hegemonic masculinities are dominant cultural views of what it means to be "a real man"[51] – successful, respected, in control, tough, and a provider for their family. In a context of severe inequality and poverty, this position of "a real man" and the respect that comes with it are not easily gained through traditional pathways such as education, employment or a middle-class lifestyle. Success and respect may instead be earned and defended through violent behaviour, acted out towards the more vulnerable in society: children, women, or less powerful men. Gang life offers another opportunity for young men to achieve status and respect.[52]

When young men move into adolescence, they need to negotiate their position in relation to the hegemonic male ideal. They may encounter violent behaviour from other men and need to decide what kind of man they wish to be in relationships with women. Similarly, young women will need to negotiate relationships in a context where female submission is often regarded as "right" and "respectful" by men, and where peer pressure and economic necessity may influence their engagement in, for example, unprotected sex.[53]

All will encounter, in their homes, schools and wider environments, dominant beliefs and social norms that allow for the use of violence in interpersonal and romantic relationships.[54] The "normalisation" of violence is then further compounded by the failure in the criminal justice system to convict offenders: For example, in a study on men who rape, only 21.2% of perpetrators were arrested, and of those only half were jailed.[55]

Case 13: Stepping Stones – An intervention for addressing violence

Mzikazi Nduna (Department of Psychology, University of Witwatersrand and previously a member of the Gender and Health Research Unit, Medical Research Council)

Stepping Stones[56] consists of a series of 13 peer-facilitated workshops to address various topics relating to relationships and sexual and reproductive health. The workshop topics include discussions of pregnancy, sexually-transmitted diseases, relationship-building, communication, intimate partner violence, HIV/AIDS and talking about death and dying. The workshops are suitable for both old and young people, men and women. All workshops are facilitated in peer groups of the same age and gender with opportunities created for dialogues between women and men during sessions that bring the smaller peer groups together.

Stepping Stones particularly helps young people to address the challenges of peer pressure, substance abuse and social norms that promote violence between young men and their intimate partners. Through participatory sessions that emphasise open communication in relationships, participants learn non-violent ways of communicating, listening, reflection and empathy.

The programme recognises that participants have valuable life experiences that they share in the workshops; in the process there is peer-group sharing and affirmation of positive behaviour. The facilitator, through exercises, acknowledges existing knowledge, beliefs and attitudes and creates opportunities for new learning through group dialogue, critical reflection, games, and role playing. Participants explore, reflect and assume new behaviours and attitudes. The method uses participatory exercises so participants do not need high levels of literacy to engage with the programme.

A South African randomised-controlled trial was conducted in the Eastern Cape with young people aged 15 – 26. Most of them were in-school youth, and some were out of school. They were recruited from villages and townships. Results demonstrated a positive impact as a lower proportion of young men reported committing intimate partner violence during the two years of follow-up in the study.[57] Young men also reported a desire to be "better" men, less violent and not anti-social.[58] Stepping Stones continues to be a highly recommended intervention for promoting gender equity.

See www.mrc.ac.za/gender/stepping.htm for more information.

Despite this context, young people continuously express a wish to lower the levels of violence in their environments,[59] and acknowledge that the use of violence is "wrong"[60]. It is therefore important to remember that masculine and feminine identities are in flux. Even in a context of extreme adversity, many young men actively seek supportive relationships which enable them to define their masculinity based on caring and providing for others, and embrace gender equity and non-violence towards women.[61]

What are promising interventions to prevent violence in adolescence?

The World Health Organisation has adopted a public health approach to violence prevention and seeks to improve the health and safety of all individuals by addressing underlying risk factors that increase the likelihood that an individual will become a victim or perpetrator of violence.[62] There is a shift from viewing violence as an individual problem to acknowledging the complex social context in which it occurs. Therefore the key to effective and lasting violence prevention and health promotion lies in understanding and responding to risk and protective factors at multiple levels of the social-ecological model.

Existing programmes and services that prevent and respond to violence are primarily designed for adults, not adolescents. However, primary prevention of intimate partner violence requires early intervention, in adolescence, to address core risk and protective factors during this critical stage when individuals start getting involved in intimate relationships.[63] Strengthening adolescents' communication and conflict resolution skills helps promote more respectful and equitable relationships across a range of settings. In addition, challenging dominant constructions of gender addresses a core risk factor for both intimate partner and interpersonal violence. Therefore, interventions can target multiple forms of violence by addressing the core underlying risk factors and building common protective factors.

Programmes that aim to improve social skills (such as communication, problem-solving and conflict resolution) have proved effective in preventing violence and aggressive behaviour amongst adolescents.[64] Ideally these programmes involve both young men and women and actively build connections between various stakeholders in the wider community. There are a number of promising school- and community-based violence prevention programmes for adolescents in South Africa.[65] One example is the Stepping Stones programme (see case 13), which helps young people address the challenges of peer pressure and violence in intimate relationships.

Schools offer a particularly effective strategy for reaching large numbers of young people, most of whom attend school at least until grade 9.[66] School-based interventions are also helpful because they extend beyond individuals and can address interpersonal violence involving peers, parents and teachers.[67] The school context allows for a multi-faceted approach that has the potential to influence both the school culture and home environment by engaging with teens (including their peers and potential partners), educators and school management, and potentially parents. For example, the PREPARE programme (see case 14 on the opposite page) combines life-skills education with a school safety audit and the development

of a school safety plan that strengthens links between the school and local support services.

The Skhokho Supporting Success intervention led by the Medical Research Council is another good example of a multi-faceted school-based intervention that engages teenagers, parents and the teachers, with promising results.[68] This intervention includes:

1. *Supporting Success for Teens:* A set of workbooks for grade 8 learners which aims to build learners' capacity to address challenges such as gender inequality, poor communication skills, substance use and violence, and which are aligned with the life-orientation curriculum.
2. *Supporting Success for Schools*: Incorporating (a) capacity-building for life-orientation teachers; (b) workshops for educators and school leadership (including school governing board members) on adolescent development, positive discipline, and creating healthy, vibrant learning communities; and (c) learner clubs that encourage volunteers from the school to contribute to a safe and vibrant school community.
3. *Supporting Success for Families*: Strengthening relationships between caregivers and young teenagers with a focus on emotional support, positive discipline, open communication, negotiation, conflict resolution, and the use of adaptive coping skills in response to stress.

Community-based interventions such as AMANDLA EduFootball (case 15 on p. 78) can engage with both in-school and out-of-school youth, community leaders and organisations, and potentially involve families and formal and informal institutions or sectors such as health services, social development, and faith-based organisations. Such interventions may have additional benefits of curbing leisure boredom and multiple types of risk behaviour such as substance use, criminal activity, and risky sexual behaviour.[69]

It is also essential to complement local interventions with work at the macro level[70] to address poverty, inequality and improve young people's access to quality education and employment opportunities. Education offers alternative pathways to respect, and can help "young men experience mastery without resorting to domination".[71] Career guidance, second-chance education and technical colleges are also needed to help young adults access the world of work and entrepreneurship.

What are the recommendations?

Interpersonal and intimate partner violence among adolescents can have multiple, serious and long-lasting negative effects on individuals, families, and communities. While it is important to provide evidence-based support services for survivors and perpetrators of such violence, it is critical to address the underlying, "up-stream" risk and protective factors that drive (or divert from) such violence. Addressing these factors among young people provides an opportunity to prevent violence before it ever occurs. Such programmes should be multi-faceted and engage multiple stakeholder groups to address the drivers of violence at all levels of the social-ecological model.

It is essential that policy-makers and implementing organisations rely on evidence-based programmes and retain loyalty to these models to ensure continued effectiveness and the associated benefits of these interventions.

Case 14: The PREPARE programme – Promoting sexual and reproductive health and reducing intimate partner violence and sexual violence among adolescents in the Western Cape

Cathy Mathews (Health Systems Research Unit, Medical Research Council)

PREPARE is an adolescent HIV-prevention programme that aims to reduce sexual risk behaviour and intimate partner violence which contribute to the spread of sexually-transmitted diseases (STIs). Forty percent of young adolescents in intimate relationships in the Western Cape have experienced intimate partner violence.[72] Schools are a common site for sexual assault. So the PREPARE programme has developed a school-based intervention for young adolescents (12 – 14 years) before they have established sexual behaviour patterns and before they have been exposed to the risk of STIs.

The programme draws explicitly on psychological and behaviour change theory to identify the individual and social determinants that underpin sexuality, intimate partner violence and sexual violence. This includes understanding how social norms and individual attitudes, intentions, self-confidence and perceptions about the perceived pros and cons of the desired behaviour may either enable or inhibit behaviour change.

The curriculum is delivered during grade 8 life-skills classes and aims to "change the norms that legitimate male dominance, increase young women's agency, improve communication in order to reduce violence in relationships and increase the ability of young people to negotiate safer sex".[73] A series of 21 lessons focus on developing individuals' motivation and skills – with a focus on gender and power, relationships, assertiveness and communication, decision-making, risk-taking, violence, self-protection and support. In addition, the programme aims to create a supportive school environment by working with students, teachers, parents and the police to conduct a participatory school safety audit, develop a safety plan, create a climate of zero tolerance towards violence and strengthen links with local support services.

A randomised control trial is currently underway to evaluate the effects of the intervention on sexual risk behaviour and intimate partner violence, and to assess the extent to which norms, attitudes and experiences of intimate partner violence influence sexual risk behaviour.

See http://prepare.b.uib.no/ for more information.

Researchers need to translate research findings into practical recommendations and include programmatic or process learning that will aid implementation and the scaling up of effective or promising interventions. Furthermore, researchers should partner with implementing organisations to plan scale up of interventions. This includes integrating monitoring, evaluation and learning systems to ensure that programmes are working and to improve them as needed, based on this evidence. Many of these programmes could be integrated into existing services and systems such as schools, community organisations and health services. However, it is essential that adequate budgets and resources are allocated for the successful and sustained implementation of these interventions.

Finally, violence intervention and prevention programmes should respond to young people's needs across a range of contexts – not only in schools, but also in homes, neighbourhoods and the larger South African context – to enable young people to build on their own sense of agency and to transition into meaningful adulthood.

Case 15: AMANDLA EduFootball – Creating a safe hub and promoting fair-play

Guy Lamb (Safety and Violence Initiative, University of Cape Town)

AMANDLA EduFootall was established in 2007 as a non-profit organisation with head offices in Cape Town and Munich (Germany). It has sought to create "safe spaces that bring together the power of football and learning to empower youth and change lives".[74] Its flagship project, which has been in operation since 2008, is the Khayelitsha Safe-Hub, which is located in Site B, U-Section next to Ikhusi Primary School. It comprises a secure artificial football pitch with multi-use clubhouse facilities.

A weekly football league for both girls and boys is held at the Khayelitsha Safe-Hub, which draws in more than 2,000 young people from surrounding, violence-affected, neighbourhoods. The league combines conventional football with a "Fair Play" life-skills system where teams gain additional points for good sportsmanship, teamwork and legitimate community work. Points are deducted for unruly behaviour on the pitch. There are however prerequisites to participating in the league, which include regular school attendance and refraining from taking drugs.

Preliminary findings of the Khayelitsha Youth Violence Panel Study, an independent research project overseen by a researcher from the International Committee of the Red Cross, has shown that the Khayelitsha Safe-Hub may have contributed to the prevention of youth violence at the community level through fostering positive school attachment, along with other resilience factors to violence. This study followed 300 subjects over a period of three years.[75]

In mid-2014 AMANDLA, in partnership with the Western Cape provincial government, opened a new Safe-Hub facility opposite Nyanga Junction train station in the vicinity of Gugulethu and Manenberg.

See http://www.edufootball.org/ for more information.

References

1 Flisher AJ & Gevers A (2010) Adolescence. In: Petersen I, Bhana A, Flisher AJ, Swartz L & Richter L (eds) *Promoting Mental Health in Scarce-Resource Contexts: Emerging Evidence and Practice*. Cape Town: HSRC Press.
2 Ward CL, Dawes A & Matzopoulos R (2012) Youth violence in South Africa: Setting the scene. In: Ward CL, Van der Merwe A & Dawes A (eds) *Youth Violence: Sources and Solutions in South Africa.* UCT Press.
3 Steinberg L (2004) Risk taking in adolescence: What changes and why? *Annals of the New York Academy of Sciences*, 1021: 51-58, June 2004.
4 See no. 2 above.
5 See no. 2 above.
6 Flisher AJ, Myer L, Mèrais A, Lombard C & Reddy P (2007) Prevalence and correlates of partner violence among South African adolescents. *Journal of Child Psychology and Psychiatry,* 48(6): 619-627.
7 Dunkle KL, Jewkes RK, Brown HC, Yoshihama M, Gray GE, McIntyre JA & Harlow SD (2004) Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology*, 160(3): 230-239;
Jewkes R, Sikweyiya Y, Morrell R & Dunkle K (2014) Why, when and how men rape: Understanding rape perpetration in South Africa. *South African Crime Quarterly*, 34: 23-31;
Jewkes RK, Levin JB, & Penn-Kekana LA (2003) Gender inequalities, intimate partner violence and HIV preventive practices: Findings of a South African cross-sectional study. *Social Science & Medicine,* 56(1), 125-134;
Russell M, Cupp PK, Jewkes RK, Gevers A, Mathews C, LeFleur-Bellerose C & Small J (2014) Intimate partner violence among adolescents in Cape Town, South Africa. *Prevention Science*, 15(3): 283-295;
Seedat M, Van Niekerk A, Jewkes R, Suffla S & Ratele K (2009) Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet*, 374(9694): 1011-1022;
Wood K & Jewkes R (2005) "Dangerous" love: Reflections on violence among Xhosa township youth. In: Morrell R (ed) *Changing Men in Southern Africa.* Pietermaritzburg/ London: University of Natal Press/Zed Books.
8 Leoschut L (2009) *Running Nowhere Fast: Results of the 2008 National Youth Lifestyle Study.* Cape Town: Centre for Justice and Crime Prevention.
9 See no. 8 above.
10 Norman R, Matzopoulos R, Groenewald P & Bradshaw D (2007) The high burden of injuries in South Africa. *Bulletin of the World Health Organization,* 85(9): 695-702.
11 Institute of Health Metrics and Evaluation (2012) *Global Burden of Disease Study 2010. Southern Sub-Saharan Africa Results by Risk Factor 1990* – 2010. Accessed 1 August 2014: http://viz.healthmetricsandevaluation.org/gbd-compare/.
12 See no. 11 above.
13 See no. 7 above (Seedat et al, 2009).
14 Mathews S, Abrahams N, Jewkes R, Martin L & Lombard C (2013) The epidemiology of child homicides in South Africa. *Bulletin of the World Health Organization*, 91: 562-568.
15 See no. 14 above.
16 World Health Organisation (2005) *Summary Report. WHO Multi-Country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses*. Geneva: WHO.
17 Swart LA, Seedat M, Stevens G & Ricardo I (2002) Violence in adolescents' romantic relationships: Findings from a survey amongst school-going youth in a South African community. *Journal of Adolescence*, 25(4): 385-395.
18 See no. 7 above (Russell et al, 2014).
19 Jewkes R & Abrahams N (2002) The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science & Medicine*, 55(7): 1231-1244.
20 See no. 19 above.
21 Jewkes R, Sikweyiya Y, Morrell R & Dunkle K (2011) The relationship between intimate partner violence, rape and HIV amongst South African men: A cross-sectional study. *PLOS One*, 6(9): e24256.
22 See no. 21 above.
23 Dunkle KL, Jewkes RK, Nduna M, Levin J, Jama N, Khuzwayo N, Koss M & Duvvury N (2006) Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa. *Aids*, 20(16): 2107-2114.
24 See no. 2 above.
25 Krug EG, Dahlberg LL, Mercy JA, Zwi AB & Lozano R (2002) *World Report on Violence and Health*. Geneva: World Health Organisation.
26 Dunkle KL, Jewkes RK, Brown HC, Yoshihama M, Gray GE, McIntyre JA & Harlow SD (2004) Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology*, 160(3): 230-239;
Jewkes R (2000) Violence against women: An emerging health problem. *International Clinical Psychopharmacology*, 15: S37-45.

Jewkes R, Dunkle K, Nduna M, Levin J, Jama N, Khuzwayo N, Koss M, Puren A & Duvvury N (2006) Factors associated with HIV sero-positivity in young, rural South African men. *International journal of epidemiology, 35*(6): 1455-1460;
Wolfe DA, Crooks C, Jaffe P, Chiodo D, Hughes R, Ellis W, Stitt L & Donner A (2009) A school-based program to prevent adolescent dating violence: A cluster randomized trial. *Archives of Pediatrics & Adolescent Medicine, 163*(8): 692-699.
27 Bordin IA, Duarte CS, Peres CA, Nascimento R, Curto BM & Paula CS (2009) Severe physical punishment: Risk of mental health problems to poor urban children in Brazil. *Bulletin of the World Health Organisation*, 87: 336-344.
28 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(1): 31;
See nos. 28 and 7 above (Russell et al, 2014);
Williams LM (2003) Understanding child abuse and violence against women: A life course perspective. *Journal of Interpersonal Violence*, 18(4): 441-451.
29 Jewkes R, Sikweyiya Y, Morrell R & Dunkle K (2011) Gender inequitable masculinity and sexual entitlement in rape perpetration South Africa: Findings of a cross-sectional study. *PLoS ONE*, 6(12), e29590.
30 See no. 29 above;
Watkins B & Bentovim A (1992) The sexual abuse of male children and adolescents: A review of current research. *Journal of Child Psychology and Psychiatry, 33*(1): 197-248.
31 See no. 2 above.
32 Plüddemann A, Parry C, Donson H & Sukhai A (2004) Alcohol use and trauma in Cape Town, Durban and Port Elizabeth, South Africa: 1999 – 2001. *Injury Control and Safety Promotion*,11: 265-267.
33 See no. 29 above.
34 Plüddemann A & Parry C (2012) *Methamphetamine Use and Associated Problems Among Adolescents in the Western Cape Province of South Africa. Policy Brief*. Cape Town: Alcohol and Drug Research Unit, Medical Research Council.
35 See no. 28 above (Williams, 2003).
36 Gevers A, Jewkes R, Mathews C & Flisher A (2012) "I think it's about experiencing, like, life": A qualitative exploration of contemporary adolescent intimate relationships in South Africa. *Culture, Health & Sexuality,* 14(10): 1125-1137.
37 See no. 36 above.
38 See no. 17 above.
For a study on the "rules of violence" as applied by young people themselves, see: Swartz S & Scott D (2013) The rules of violence: A perspective from youth living in South African townships. *Journal of Youth Studies*, 17:3, 324-342.
Also corroborated in: UN-HABITAT (2007) *Strategy Paper on Urban Youth in Africa.* Nairobi, Kenya: UN-HABITAT.
39 See no. 19 above;
Gevers A & Flisher AJ (2012) School-based youth violence prevention Interventions. In: Ward CL, Van der Merwe A & Dawes A (eds) *Youth Violence: Sources and Solutions in South Africa*. Cape Town: UCT Press;
Liang H, Flisher AJ & Lombard CJ (2007) Bullying, violence, and risk behaviour in South African school students. *Child Abuse & Neglect,* 31(2007): 161-171.
40 Cooper A & Ward C (2012) Intervening with youths in gangs. In: Ward C, van der Merwe A & Dawes A (eds) *Youth Violence: Sources and Solutions in South Africa.* Cape Town: UCT Press.
41 Gevers A (2013) An Exploration of the Nature of Contemporary Adolescents' Intimate Relationships. Doctoral thesis of philosophy, University of Cape Town.
42 See no. 2 above.
43 See nos. 2 and 19 above.
44 Cast AD, Schweingruber D & Berns N (2006) Childhood physical punishment and problem solving in marriage. *Journal of Interpersonal Violence,* 21(2): 244-261;
Skuja K & Halford WK (2004) Repeating the errors of our parents? Parental violence in men's family of origin and conflict management in dating couples. *Journal of Interpersonal Violence*, 19(6): 623-638.
45 Ward C, Artz L, Berg J, Boonzaaier F, Crawford-Browne S, Dawes A, Foster D, Matzopoulos R, Nicol A, Seekings J, Van As A & Van der Spuy E (2012) Violence, violence prevention and safety: A research agenda for South Africa. *South African Medical Journal*, 102(4): 215-218.
46 Swartz S (2009) *Ikasi: The Moral Ecology of South Africa's Township Youth*. Johannesburg: Wits University Press;
Swartz S, Hamilton Harding J & De Lannoy A (2012) Ikasi style and the quiet violence of dreams: A critique of youth belonging in post-apartheid South Africa. *Comparative Education*, 48(1): 27-40.
47 Statistics South Africa (2012) *Census 2011. Statistical Release (Revised) P0301.4*. Pretoria: Stats SA.
48 Gevers A, Shai N & Sikweyiya Y (2013) Gender-based violence and the need for evidence-based primary prevention in South Africa. *African Safety Promotion Journal,* 11(2): 14-20.
49 Morrell R (1998) Of boys and men: Masculinity and gender in southern African studies. *Journal of Southern African Studies*, 24(4): 605-630.
50 See no. 48 above.
51 Morrell R (2000) (ed) *Changing Men in Southern Africa*. Pietermaritzburg, South Africa/ London: University of Natal Press/Zed Books. P. 7;
See no. 48 above.
52 Bility KM (1999) School violence and adolescent mental health in South Africa: Implications for school health programs. *Sociological Practice: A Journal of Clinical and Applied Research*, 1(4): 285-303.
53 Gevers A & Flisher AJ (2012) School based youth violence prevention interventions. In: Ward CL, Van der Merwe A & Dawes A (eds) *Youth Violence: Sources and solutions in South Africa*. Cape Town: UCT Press.
54 Swartz & Scott d (2014) The rules of violence: A persepctive from youth living in South African townships. J*ournal of Youth Studies,* 17(3): 324-342.
55 See no. 29 above.
56 Jewkes R & Cornwall A (1998) *Stepping Stones, South African Adaptation* (*adapted from the origin Stepping Stones package by Alice Welbourn*). 1st Edition. Pretoria: Medical Research Council;
Jewkes R, Nduna M & Jama PN (2002) *Stepping Stones, South African Adaptation.* 2nd Edition. Pretoria: Medical Research Council.
Jewkes R, Nduna M & Shai Jama PN (2010) *Stepping Stones, South African Adaptation.* 3rd Edition. Pretoria: Gender and Health Research Group; Medical Research Council.
57 Jewkes R, Nduna M, Levin J, Jama N, Dunkle K, Puren A & Duvvury N (2008) Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: Cluster randomised controlled trial. *British Medical Journal*, 337(7666). doi: a506 10.1136/ bmj.a506.
58 Jewkes R, Wood K & Duvvury N (2010) "I woke up after I joined Stepping Stones": Meanings of an HIV behavioural intervention in rural South African young people's lives. *Health Education Research*, 25(6), 1074-1084.
59 De Lannoy A & Swartz S (forthcoming) *You don't want to die. You want to reach your goals. Alternative voices among young black men in urban South Africa.* In: Parkes J (ed) *Gender Violence in Poverty Contexts. The Educational Challenge.* London: Routledge.
60 See no. 54 above.
61 Morrell R & Jewkes R (2011) Carework and caring: A path to gender equitable practices among men in South Africa? *International Journal for Equity in Health*. 10: 17.
62 World Health Organisation & London School of Hygiene and Tropical Medicine (2010) *Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence*. Geneva: WHO.
63 See no. 48 above;
Van den Berg W, Hendricks L, Hatcher A, Peacock D, Godana P & Dworkin S (2013) "One man can": Shifts in fatherhood beliefs and parenting practices following a gender-transformative programme in Eastern Cape, South Africa. *Gender & Development*, 21(1): 111-125.
64 See no. 7 above (Russell et al, 2014);
Jewkes R, Nduna M, Levin J, Jama N, Dunkle K, Puren A & Duvvury N (2008) Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: Cluster randomised controlled trial. *British Medical Journal,* 337: a506.
65 See no. 53 above.
66 See no. 53 above.
67 See no. 53 above.
68 Gevers A (2014) Skhokho Supporting Success project: Interview with study PI. Medical Research Council. [Unpublished]
69 Smith EA, Palen LA, Caldwell LL, Flisher AJ, Graham JW, Mathews C, Wegner L & Vergnani T (2008) Substance use and sexual risk prevention in Cape Town, South Africa: An evaluation of the HealthWise program. *Prevention Science*, 9(4): 311-321.
70 World Health Organisation (2010) *Violence Prevention, the Evidence. A Series of Briefings on Violence Prevention.* Geneva: WHO Press.
71 Oduro G, Swartz S & Arnot M (2012) Gender-based violence: Young women's experiences in the slums and streets of three sub-Saharan African cities. *Theory and Research in Education*, 10(3): 275-294. P. 290.
72 Mathews C, Aarø LE, Flisher AJ, Mukoma W, Wubs A, Schaalma H (2009) Predictors of early first sexual intercourse among adolescents in Cape Town, South Africa. *Health Education Research*, 24(1):1-10.
73 Aarø LE, Mathews C, Kaaya S, Katho AR, Onya H, Abrahm C, Klepp K, Wubs A, Eggers SM & de Vries H (2014) *BMC Public Health*, 14(54): 2.
74 AMANDLA EduFootball (2012) *Mission Statement*. Accessed at: http://www.edufootball.org/about-us/mission/.
75 Edelstein I (2013) *Analysis of the Second Wave of Panel Data in the Khayelitsha Youth Violence Reduction Study: Understanding Youth Violence and Assessing Intervention*. Cape Town: International Committee of the Red Cross & University of Cape Town.

Adopting a violence prevention approach: Shifting from policies and plans to implementation

Mastoera Sadan (Programme to Support Pro-poor Policy Development, National Planning Commission, The Presidency)
and Shanaaz Mathews (Children's Institute, University of Cape Town)

The 20 years of democracy celebrations provide an opportunity to reflect on the founding principles of South Africa's Constitution, which gives every child the right to be protected from maltreatment, neglect, abuse or degradation.[1] Yet, children's daily experiences clearly indicate that violence has been normalised and that we have a long way to go before realising their fundamental right to be protected from violence.

This essay draws together some of the key arguments raised in the preceding essays and reflects on what is needed to translate policy into practice for a sustained violence prevention approach. It aims to answer the following questions:

- What are the current dimensions of violence against children?
- What are the opportunities and challenges to prevent violence?
- What is needed to translate policy into a sustained approach to prevention?

What are the current dimensions of violence against children?

There is a lack of data on the exact number of abused and neglected children in South Africa due to an inefficient surveillance system, and a lack of nationally representative research that systematically explores children's experiences of violence. Nevertheless, existing evidence suggests that large numbers of children are affected (see the essay by Mathews and Benvenuti on pp. 26 – 34). Limited evidence on some forms of violence such as emotional abuse, humiliating punishment and children with disabilities has meant that these issues are not discussed in this publication, but these areas will need to be addressed as a part of a comprehensive response to violence against children.

The normalisation of violence in South Africa's past has resulted in a widespread tolerance of violence which enables perpetrators to act with impunity.[2] This is compounded by high levels of poverty, unemployment and income inequality, and patriarchal notions of masculinity that support the use of violence and risk-taking – all which contribute to the extraordinary high levels of violence in South Africa.[3]

Mathews and Benvenuti describe how a complex web of interrelated risk factors contributes to the vulnerability of children. Poverty and inequality shape children's life experiences and outcomes, and increase their risk of experiencing violence.[4] Patterns of violence change across the life-course: Young children are most vulnerable in the home and, as they get older, a distinct gendered pattern emerges, with girls at increased risk of sexual assault and boys more likely to become perpetrators or victims of physical abuse or assault (see the essay by Mahlangu, Gevers and De Lannoy, pp. 73 – 79). Gender inequality and patriarchy contribute to the subordinate position of children, and increase their vulnerability to violence in the home, community and school (see Dawes and Bower's essay on pp. 58 – 64, and Mahlangu et al, on pp. 73 – 79).

The widespread acceptance of violence against children permits harsh parenting practices, and contributes to a culture of silence which allows violence to occur without consequences. Violence has a long-term adverse impact on multiple generations, as evidenced by boys' increased risk of becoming perpetrators of violence if they have witnessed violence in the community or at home. It is therefore critical to address social norms in order to break this cycle and protect children from violence. The "One Man Can" community mobilisation intervention (see case 16 on the opposite page) is an example of good practice that draws on a range of strategies to challenge social norms and cultural practices and to end violence through a shift in men's and boys' behaviour and attitudes to gender equality.

The impact of violence occurs at multiple levels with subtle, life-long intergenerational consequences, hampering a child's development, learning ability, self-esteem and emotional security, and can lead to risk-taking and violent outcomes. The impact of violence goes beyond the physical scars to have a lasting impact on the child's self-esteem, psychological development, learning ability, employment prospects and life expectancy, and can lead to risk-taking and violent outcomes, which in turn compromise the well-being and life chances of future generations (outlined in Dawes and Bower's essay on pp. 58 – 64). This requires an urgent response and greater investment in violence prevention, as the benefits to child well-being and human and social development outweigh the adverse long-term impact of violence. In addition, evidence shows that treating the effects of violence after it has happened is more costly and less effective than primary prevention.[5]

What are the opportunities and challenges to prevent violence?

South Africa has made significant strides over the past two decades in developing policies to ensure that children are given the protection from abuse and neglect promised by the Bill of Rights. In 1997, the White Paper for Social Welfare introduced an approach to transform the welfare system by laying the conceptual foundation for a shift from a response-driven approach to prevention and early

intervention (see the essay by Jamieson, Wakefield and Briede on pp. 51 - 57). Yet, as outlined in this essay, most government funds continue to be channelled into response services.

The slow shift in translating policy into practice is arguably due in part to the lack of policy coherence across departments responsible for addressing children's issues. While the Children's Act[6] outlines a range of social services to ensure the care and protection of children, a wide range of government departments such as Health, Social Development, Basic Education, Justice and Correctional Services, Public Works and Police Services are responsible for the delivery of services to children and families. However, government programmes tend to operate in isolation as if they are not aimed at the same child population. Synergies across programmes and interventions are not explored enough to maximise impact, resulting in fragmented service provision.

The Department of Social Development's Draft National Strategic Plan (NSP)[7] is a welcome development as the strategy acknowledges that prevention and early intervention programmes have not been given the necessary attention although the Children's Act provides for these. The slow shift in practice is arguably due to a number of factors such as a limited conceptual understanding of prevention and early intervention, limited budgets for prevention programmes, and a limited workforce to deliver prevention and early intervention services.[8] In addition, the Children's Act does not articulate smoothly with the public health model and has implications for planning and resourcing. Evidenced-based planning is at the centre of the public health model to inform the design and targeting of prevention programmes. The Children's Act requires provincial Social Development departments to compile profiles of existing prevention and protection services in relation to the need for these to inform both national and provincial strategies. To date, only one province has completed their provincial profile.[9]

The challenges are to respond to the levels of violence against children and to shift to a prevention approach over time; yet there is limited empirical evidence of what works. The NSP outlines a five-year strategy that aims to strengthen prevention efforts. It is envisaged that this intervention will decrease the demand for child protection services. However, five years is too short a period to achieve significant impact, and the NSP is pragmatic in this regard as it asserts that the shift to prevention would be gradual. The NSP notes that if prevention interventions are well designed and effectively implemented, they may, over the short to medium term, increase awareness of violence against children and lead to an increase in reporting and demand for statutory interventions.

Case 16: One Man Can – Mobilising men to end violence

Wessel van den Berg (Sonke Gender Justice)

The One Man Can (OMC) campaign is a multi-level community mobilisation intervention of Sonke Gender Justice that uses innovative education and advocacy processes to encourage community members to take action to end violence, improve gender equality and promote human rights. The programme actively engages with community members, especially men and boys, in the process of understanding, reflecting on, and reconfiguring masculinities and gender inequalities in their families and communities.

Several evaluations have been conducted on the impact of OMC. An impact evaluation[10] found that more than half of the 265 randomly selected participants in OMC activities responded better to incidents of gender-based violence than prior to their involvement in OMC by reporting these to the police. A qualitative study[11] completed with 78 men in nine focus groups across six provinces in South Africa found that men reported less HIV-risk-taking behaviour like using alcohol, and an increased likelihood to share parenting tasks:

> *OMC helped me in that regard because I was a person that used to like fun and drinking alcohol. I was always out there with the boys drinking. I didn't have time for my girlfriend and my daughter… OMC changed the way I live my life and the decisions that I make as a man. I have done away with some things that I used to do because they were not helping me. Being a better man is good because it means I can give my daughter all the attention she needs.*[12]

In a qualitative impact evaluation[13] in 2010, 60 in-depth interviews were carried out with men who had completed OMC workshops. Men described reductions in the use of violence against women by learning, for example, how to control their anger:

> *Attending the OMC workshops, I got to understand the wrongs of my past behaviour and I started understanding that men should also listen to the women's inputs. During the workshops I would feel as if the facilitators were talking directly to me or that maybe one of them knew about my life.*[14]

> *OMC changed me in a way because it changed my own relationship. If my girlfriend is angry with me and even if she is the one that is wrong, I calm down and talk to her without fighting. I respect her and I know that I should not beat her up. She even told me that things have changed in the way I act in our relationship and she is happy about it*.[15]

Men also spoke about how they shifted towards becoming more caring towards children:

> *OMC changed a lot of things in me. I used to be the kind of person who was feared in the village by young people because of my tough reputation. I was the kind of man whom, when a child cries would be told "I will call him," and the child would go quiet. The training I got from OMC changed me in a way that I was taught not to intimidate children but be more caring to them.*[16]

Sonke Gender Justice: Challenges gender inequality and promotes men's involvement as fathers

Despite these challenges, the NSP is a step in the right direction and the first five years should be seen as the first phase of a longer-term strategy of investments towards more enduring change. It may take decades to change the situation due to the large numbers of children affected and because of the associated normalisation of violence in South African society. Despite these challenges, the prevention interventions featured in this issue of the *South African Child Gauge* illustrate that change is possible. At the same time, it is critical that increased government investment in prevention programmes should not come at the expense of response services as both are necessary to break the intergenerational cycle of violence.

The NSP proposes more research but it very narrowly focuses this recommendation on studies on the effectiveness of interventions. Ideally, the research agenda needs to be much wider and should address the key gaps in the knowledge base. Data on violence against children in South Africa come predominantly from cross-sectional studies that provide limited evidence on risk and protective factors, which is essential for the design of effective prevention programmes.

In addition, broader societal factors such as the role of patriarchy and changing masculinities (including how men perceive their role in society in relation to other men, women and children and, importantly, the role men play as fathers) all require in-depth understanding. In addition, qualitative research should be undertaken on perceptions of children and their place within the social hierarchy of the family and society more broadly.

The NSP acknowledges the multi-sectoral nature of prevention and early intervention and proposes that an internal task team of key role-players should be set up to build an integrated prevention and early intervention system and drive the implementation of the NSP. A key function of this task team will be co-ordination at national, provincial and local level, with the national Department of Social Development driving this process. This interdepartmental functioning is fundamental to its success, but it is precisely institutional issues and co-ordination that have bedevilled implementation in the past. It will require political will and leadership from the department, through the Deputy Director-General responsible for violence prevention, who should lead the task team and who should make the human and financial resources available for the successful planning and implementation of the strategy (as outlined in the Jamieson, Briede and Wakefield essay on pp. 51 – 57).

Given that violence prevention is a societal issue, the task team should also include key role-players outside government. An important question is how the task team will do things differently as there are currently a myriad of task teams and interdepartmental committees across government that have proved ineffective. The task team should also take into account existing structures. For instance, the Inter-Ministerial Committee (IMC) on Root Causes of Violence Against Women and Children, formed in 2012, was tasked to develop a five-year action plan led by the Deputy Director-General responsible for social services in the Department of Social Development. A Programme of Action for 2013 – 2017 has since been developed and approved by Cabinet, but has not yet been made public. This raises concerns about government's delay in consulting civil society partners, who will be partly responsible for its implementation.

Case 17: Isibindi safe parks – Creating safe spaces for children to play

Moefeeda Salie-Kagee (National Association of Child Care Workers)

Isibindi Safe Parks were designed and conceptualised by the National Association of Child Care Workers (NACCW) in 2002. The parks provide safe, supervised, exciting and happy places for children affected by poverty and HIV/AIDS to play, access developmental opportunities and be with caring adults. Currently 187 Isibindi Safe Parks operate throughout South Africa with a focus on rural and underserviced areas.

Isibindi Safe Parks hosted play and recreational activities for over 35,325 children between April 2013 and March 2014.[17] Children visited safe parks an average of 33 times each year across 1,847 formal projects and 143 informal projects, amounting to over one million visits during this period. While the parks provide a safe, supervised place for children to play, they also provide a space in which adults are able to teach children about their rights, address issues of child abuse and help children access other resources.

Child and youth care workers who work directly with children in the parks come from the communities they serve and provide an authentic voice to debunk myths that place children at risk. In addition, the Isibindi Safe Parks offer adolescent development programmes that address issues such as HIV, gender, abuse and domestic violence.

The Isibindi Safe Parks are implemented in partnership with civil society organisations, communities and provincial departments of Social Development. The parks open during "children's hours" – after school and during weekends, public holidays and school holidays. Child participation is encouraged and formalised through structured programmes (including a local version of the Hyde Park "soap box" concept), and children with disabilities are included.

The programme is grounded in child and youth care theory and practice, and minimum standards[18] guide every aspect of service delivery in line with international criteria for successful play services.[19]

Currently being successfully replicated in Zambia by the Zambian Association of Child Care Workers, the model is also informing an international response to refugee children being mounted by the Swiss Foundation of the International Social Services and the International Ferderation of Educative Communitites (FICE International).

Similarly, the Council on Gender-Based Violence was formed in 2012 to co-ordinate a multi-sectoral response to gender violence, led by the Department of Women, Children and People with Disabilities. Following the 2014 national elections, this department no longer exists and the Minister in The Presidency is now responsible for women's affairs, but the fate of the council is yet to be determined. Unless the co-ordination of these committees is streamlined, we will continue to have a fragmented response to a complex problem that requires co-ordinated efforts and strong leadership from within government.

What is needed to translate policy into a sustained approach to prevention?

The public health approach to violence prevention[20] has been widely promoted and is the approach adopted in this book (as outlined in Van Niekerk and Makaoe's essay on pp. 35 – 42). The aim is to stop violence through a systematic, multi-sectoral approach by preventing the problem from occurring (primary prevention), detecting it early when it has occurred (secondary prevention) and responding to reduce the long-term impact (tertiary prevention).[21] This approach aims to address risk and protective factors across multiple levels of the social-ecological model (see pp. 30 – 31): from the individual, through to relationship, community and societal factors. The following shifts from policy to practice are essential for a prevention agenda:

1. Build a common understanding of prevention

It is important to build a common understanding of what constitutes prevention. In particular, this understanding of prevention needs to inform the design and delivery of effective primary prevention programmes and be incorporated into the education and training of social service professionals. Services have focused on responding to violence rather than targeting families and communities to prevent violence before it occurs. Planning of services needs to take into account community profiles so that programmes can target the identified risk factors in each community.

Traditional approaches to violence prevention have addressed mainly risk factors, but more recently emphasis has been placed on boosting protective factors.[22] Here the focus is on identifying existing strengths and building the resilience of children and their families through collaboration with other service providers. This resonates with the NSP, as it highlights the importance of intersectoral collaboration between government departments and non-profit organisation service providers as well strengthening families to protect children and prevent statutory intervention.

2. Develop a coherent policy framework

The current conceptualisation of prevention and early intervention in the Children's Act does not neatly map onto the public health approach to violence prevention, which is promoted globally. The current scope of early intervention services outlined in the Children's Act encompasses an array of violence prevention interventions that include both secondary and tertiary prevention that can lead to confusion and inaction. The pending Children's Act amendment process provides an opportunity to align the South African prevention framework with international thinking.

3. Promote an evidence-based approach to planning

The NSP highlights evidence-based planning as one of its strategic objectives and emphasises the need for a functional surveillance system across departments. The National Child Protection Register[i] (NCPR) is a potential source of data but it is currently not functioning as an effective tool to monitor the incidence of children in need of care and protection. It is critical that administrative data sources, such as the NCPR and the National Register for Sex Offenders[ii] be streamlined and managed effectively. Surveillance is the cornerstone of understanding the pattern of violence against children, and where and how services should best be targeted. There is an urgent need for national prevalence and incidence data to enable effective planning. In addition, the provincial profiles[iii] stipulated in the Children's Act should urgently be completed to document the current extent of protection and prevention progammes in relation to provincial needs.

4. Develop an evidence base to demonstrate what works

Very little is known about what kinds of prevention programmes work in low- and middle-income settings.[23] The evidence base for South Africa is limited to a few programmes that have been evaluated.[24] Most interventions are currently modelled on what has been shown to be effective in high-income settings, such as the promotion of parenting programmes, but simply importing "effective" programmes might not mean they are effective in our local setting. It is also important to draw on home-grown solutions. For example, the Isibindi Safe Parks (case 17 on p. 83) is a promising model of primary prevention that has now been adopted in other countries. It is therefore important to invest in developing an evidence-base of what works in the South African context. This will require government, civil society and research institutes to work in partnership to generate a knowledge base that will inform the design and development of effective programmes.

5. Invest in prevention programmes

Investing in primary prevention is clearly in the best interests of the child and will reduce the long-term costs to individuals and society. Primary prevention of violence should however not be at the cost of response services and both are needed to shift social norms in the long term. Prevention efforts, to be most successful, should start early with both the caregiver and child to reduce the risks and enhance protective factors (see Dawes and Bower's essay on pp. 58 – 64). In addition, programmes should be costed and adequately budgeted for. Currently, primary prevention programmes are mainly delivered by non-profit organisation services with limited funding from government. Multi-dimensional programmes and sustained budgets are required to tackle violence effectively and ensure long-term results.

6. Adopt a multi-sectoral response

Preventing violence against children is multi-dimensional and cuts across government departments. Although the Children's Act outlines a framework for prevention and early intervention services, it requires departments to work collaboratively and with defined roles and responsibilities. Prevention of violence is not just a responsibility of the Department of Social Development and should be integrated into performance areas across numerous departments, including Health, Basic Education, Justice and Correctional Services, and the Police Services.

Strong leadership from within the Department of Social Development is needed to build consensus and develop a common strategy for preventing violence that is incorporated across government departments and civil society. For example, parenting programmes have been prioritised by the Department of Social Development as part of their early childhood and development strategy. This dovetails with violence prevention initiatives and for this reason synergies with existing programmes should be sought for maximum impact.

Conclusion

Violence affects large numbers of children daily and South Africa has a legal obligation to address this problem and ensure that children are protected. The Children's Act provides a framework for prevention and early intervention programmes, but this policy has not yet been implemented at scale. Preventing violence against children is not a "luxury". It is a necessity in order to stem the tide of violence in society as a whole. Investing in violence prevention is therefore a priority – but should not be at the cost of response services. Both approaches are critical to shifting children's experiences and to ensure that they become productive and well-integrated members of society.

Prevention programmes should not be viewed in isolation, but should be seen as central to contributing to the well-being of children and their families. Programmes should target children throughout the life-course, starting in the early years to prevent violence before it occurs. This means the focus is not just on social services. Prevention interventions also need to be integrated into primary health care and early childhood development services and schools to make optimum use of these key points of contact with children and families. Finally, violence prevention requires stewardship at the highest level to drive a national strategy, forge intersectoral partnerships and unlock the resources that are needed to make a difference in the lives of children.

> *We owe our children – the most vulnerable citizens in society – a life free from violence and fear.*[25] Nelson Mandela

i The National Child Protection Register is provided for by the Children's Act and should serve as a register of all children who have been abused or deliberately neglected in order to protect abused children from further harm, monitor progress of cases and plan services for prevention.
ii The National Register for Sex Offenders provides a record of perpetrators convicted of committing sexual offences against children and is designed to prevent them from working with children.
iii The Act says that the Member of the Executive Council for Social Development in each province is responsible for the compilation of provincial profiles a year after the Act came into effect, and that these should be updated on an annual basis.

References

1 Constitution of the Republic of South Africa, 1996. Section 28(1)(d).
2 Centre for the Study of Violence and Reconciliation (2007) *The Violent Nature of Crime in South Africa: A Concept Paper for the Justice, Crime Prevention and Security Cluster.* Johannesburg, Pretoria: CSVR & Department of Safety and Security;
Ward C, Artz L, Berg J, Boonzaier F, Crawford-Brown S, Dawes A, Foster D, Matzopoulos R, Nicol A, Seekings J, Van As AB & Van der Spuy A (2012) Violence, violence prevention: A research agenda for South Africa. *South African Medical Journal*, 12(4): 215-218.
3 Seedat M, Van der Niekerk AV, Jewkes R, Suffla S & Ratele K (2009) Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet*, 374(9694): 1011-1022.
4 South African Human Rights Commission & UNICEF (2014) *Poverty Traps and Social Exclusion Among Children in South Africa.* Pretoria: SAHRC.
5 Mikton C & Butchart A (2009) Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization*, 87(9): 353-361.
6 Children's Act 38 of 2005.
7 Department of Social Development (2013) *Comprehensive National Strategy Aimed at Securing the Provision of Prevention and Early Intervention Programmes to Families, Parents, Caregivers and Children Across the Republic of South AfricaNational Strategic Plan (Draft) 2013/14 – 2018/19.* July 2013. Pretoria: DSD.
8 Resources Against Child Abuse and Neglect (in press) Prevention and early intervention programming in provincial social development budgets: A first look. Cape Town: RAPCAN.
9 Personal communication, Agnes Muller, national Department of Social Development, 7 October 2014.
10 Sonke Gender Justice (2009) *Summary of Research Findings on Sonke Gender Justice Network's "One Man Can" Campaign.* Press release, 5 October 2009.
11 Van den Berg W, Hendricks L, Hatcher A, Peacock D, Godana P & Dworkin S (2013) "One Man Can": Shifts in fatherhood beliefs and parenting practices following a gender-transformative programme in Eastern Cape, South Africa. *Gender & Development*, 21(1): 111-125.
12 See no. 11 above. P. 120.
13 Dworkin SL, Hatcher AM, Colvin C & Peacock D (2013) Impact of a gender-transformative HIV and antiviolence program on gender ideologies and masculinities in two rural, South African communities. *Men and Masculinities*,16(2): 181-202.
14 See no. 13 above. P. 192.
15 See no. 13 above. P. 194.
16 See no. 13 above. P. 194.
17 Department of Social Development (2014) *Isibindi Rollout Report – Year 1 Monitoring and Evaluation Report. April 2013 – March 2014.* Pretoria: DSD.
18 Department of Social Development (2013) *Isibindi Safe Parks: Service Standards and Practice Guidelines.* Version 1. Pretoria: DSD.
19 Hughes B (1996) Criteria for an enriched play environment. In: *Play Environments: A Question of Quality*. London: PLAYLINK;
Play England (2009) *Playable Space Quality Assessment Tool*. Developed by INSPIRE Consultancy;
Shackell A, Butler B, Doyle P & Ball D (2008) *Design for Play: A Guide to Creating Successful Play Spaces.* London: Department for Children, Schools and Families; Department for Culture, Media and Sport & Play England.
20 Butchart A & Phinney-Harvey A (2006) *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence*. Geneva: World Health Organisation & International Society for Prevention of Child Abuse and Neglect;
Also see no. 6 above.
21 See no. 20 above (Butchart A & Phinney-Harvey, 2006).
22 Child Welfare Information Gateway (2014) *Protective Factors Approaches in Child Welfare.* Washington, DC: U.S. Department of Health and Human Services.
23 See no. 5 above.
24 Skeen S & Tomlinson M (2013) A public health approach to preventing child abuse in low- and middle-income countries: A call for action. *International Journal of Psychology*, 48: 108-116.
25 Mandela N (2002) Foreword. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB & Lozano R (eds) *World Report on Violence and Health.* Geneva: World Health Organisation.


Road
HOPE

PART THREE:

Children Count – The Numbers

Part three presents child-centred data to monitor progress and track the realisation of children's socio-economic rights in South Africa. This year it presents data from 2002 – 2012 and identifies main trends over this 11-year period. A set of key indicators track progress in the following domains:

- Demography of South Africa's children;
- Income poverty, unemployment and social grants;
- Child health;
- Children's access to education;
- Children's access to housing; and
- Children's access to basic services

A full set of indicators and detailed commentary are available on www.childrencount.ci.org.za

Introducing Children Count – *Abantwana Babalulekile*

South Africa's commitment to the realisation of socio-economic rights is contained in the Constitution, the highest law of the land, which includes provisions to ensure that no person should be without the basic necessities of life. These are specified in the Bill of Rights, particularly section 26 (access to adequate housing); section 27 (health care, sufficient food, water and social security); section 28 (the special rights of children) and section 29 (education).

Children are specifically mentioned, and are also included under the general rights: every child has the right to basic nutrition, shelter, basic health care services and social services. These form part of what are collectively known as socio-economic rights. While these rights are guaranteed by the Constitution, the question is: how well is South Africa doing in realising these rights for all children? In order to answer this question, it is necessary to monitor the situation of children, which means there is a need for regular information that is specifically about them.

A rights-based approach

Children Count – Abantwana Babalulekile, an ongoing data and advocacy project of the Children's Institute, was established in 2005 to monitor progress for children. It provides reliable and accessible child-centred information which can be used to inform the design and targeting of policies, programmes and interventions, and as a tool for tracking progress in the realisation of children's rights.

Child-centred data

Any monitoring project needs regular and reliable data, and South Africa is fortunate to be a fairly data-rich country. There is an array of administrative data sets, and the national statistics body, Statistics South Africa, undertakes regular national population surveys which provide useful information on a range of issues. However, most information about the social and economic situation of people living in South Africa does not focus on children, but rather counts all individuals or households. This is the standard way for central statistics organs to present national data, but it is of limited use for those interested in understanding the situation of children.

"Child-centred" data does not only mean the use of data about children specifically. It also means using national population or household data, but analysing it at the level of the child. This is important, because the numbers can differ enormously depending on the unit of analysis. For example, national statistics describe the unemployment rate, but only a child-centred analysis can tell how many children live in households where no adult is employed. National statistics show what proportion of households is without adequate sanitation, but when a child-centred analysis is used, the proportion is significantly higher.

Counting South Africa's children

Children Count – Abantwana Babalulekile presents child-centred data on many of the areas covered under socio-economic rights. As new data become available with the release of national surveys and other data sources, it is possible to track changes in the conditions of children and their access to services over time. This year, national survey data are presented for each year from 2002 to 2013, and many of the indicators in this issue compare the situation of children over this 11-year period.

The tables on the following pages give basic information about children's demographics, care arrangements, income poverty and social security, education, health and nutritional status, housing and basic services. Each table is accompanied by commentary that provides context and gives a brief interpretation of the data. The data are presented for all children in South Africa and, where possible, by province.

The indicators in this *South African Child Gauge* are a sub-set of the *Children Count – Abantwana Babalulekile* indicators on demographics and socio-economic rights. The project's website contains the full range of indicators and more detailed data, as well as links to websites and useful documents. It can be accessed at **www.childrencount.ci.org.za.**

Confidence intervals

Sample surveys are subject to error. The proportions or percentages simply reflect the mid-point of a possible range, but the true values could fall anywhere between the upper and lower bounds. The confidence intervals indicate the reliability of the estimate at the 95% level. This means that, if independent samples were repeatedly taken from the same population, we would expect the proportion to lie between upper and lower bounds of the confidence interval 95% of the time.

It is important to look at the confidence intervals when assessing whether apparent differences between provinces or sub-groups are real: the wider the confidence interval, the more uncertain the proportion. Where confidence intervals overlap for different sub-populations or time periods, it is not possible to claim that there is a real difference in the proportion, even if the mid-point proportions differ. In some of the accompanying bar graphs, the confidence intervals are represented by vertical lines at the top of each bar (I).

Data sources and citations

Children Count – Abantwana Babalulekile uses a number of data sources. Most of the indicators draw on the General Household Survey conducted by Statistics South Africa, while some draw on administrative databases used by government departments (Health, Education, and Social Development) to record and monitor the services they deliver.

Most of the indicators presented were developed specifically for this project. Data sources are carefully considered before inclusion, and the strengths and limitations of each are outlined on pp. 115 – 116, and on the project website. Definitions and technical notes for the indicators are included in the accompanying commentary, and can also be found on the website.

Here are a couple of examples of how to reference Children Count data correctly:

When referencing from the Demography section in this publication, for example:

> Hall K, Meintjes H & Sambu W (2014) Demography of South Africa's children. In: Mathews S, Jamieson L, Lake L & Smith C (eds) *South African Child Gauge 2014*. Cape Town: Children's Institute, University of Cape Town.

When referencing from the Housing and Services online section, for example:

> Hall K (2014) Housing and Services – Access to adequate water. *Children Count – Abantwana Babalulekile* website, Children's Institute, University of Cape Town. Accessed on 20 August 2014: www.childrencount.ci.org.za

Each domain is introduced below and key findings are highlighted.

Demography of South Africa's children

(pages 90 – 93)

This section provides child population figures and gives a profile of South Africa's children and their care arrangements, including children's co-residence with biological parents, the number and proportion of orphans and children living in child-only households. There were 18.6 million children in South Africa in 2012. Nineteen percent of children are orphans who have lost a mother, father or both parents; 23% of children do not live with either of their biological parents; and 0.5% of children live in child-only households.

Income poverty, unemployment and social grants

(pages 94 – 98)

In 2012, over half of children (56%) lived below the poverty line (with a per capita income below R635 per month), and 32% lived in households where no adults were employed. Social assistance grants are therefore an important source of income for caregivers to meet children's basic needs. In March 2013, over 11.1 million children received the Child Support Grant; 512,000 children received the Foster Child Grant; and a further 121,000 children received the Care Dependency Grant.

Child health

(pages 99 – 103)

This section monitors child health through a range of indicators. The most recent and reliable estimates suggest that under-five mortality is decreasing and stood at 41 deaths per 1,000 live births in 2012. The infant mortality rate has followed a similar trend and is estimated at 27 deaths per 1,000 live births for 2012. In the same year, 29.5% of pregnant women were estimated to be HIV positive. Nearly 25% of children travel far to reach their health care facility and 14% of children live in households that reported child hunger.

Children's access to education

(pages 104 – 109)

Many children in South Africa have to travel long distances to school. One in seven children (14%) live far from their primary school and this increases to one in five children (20%) in high school. Despite these barriers, South Africa has made significant strides in improving access to education with a gross attendance rate of 97% in 2012. Access is also increasing in the preschool years, with 90% of 5 – 6-year-olds attending some kind of educational institution or care facility. However, this does not necessarily translate into improved educational outcomes or progress through school. In 2012, 85% of 10 – 11-year-olds had completed grade 3, and only 61% of 16 – 17-year-olds had completed grade 9.

Children's access to housing

(pages 110 – 112)

This section presents data on children living in rural or urban areas, and in adequate housing. The latest available data show that, in 2012, 55% of children were living in urban areas, and 74% of children lived in formal housing. Just over two million children lived in backyard dwellings and shacks in informal settlements, and one in five children (19%) lived in overcrowded households.

Children's access to basic services

(pages 113 – 114)

Without water and sanitation, children face substantial health risks. In 2012, two-thirds of children (66%) had access to drinking water on site, while children's access to adequate toilet facilities rose to 69%.

Demography of South Africa's children

Katharine Hall, Helen Meintjes and Winnie Sambu (Children's Institute, University of Cape Town)

The UN General Guidelines for Periodic Reports on the Convention on the Rights of the Child, paragraph 7, says that reports made by states should be accompanied by "detailed statistical information … Quantitative information should indicate variations between various areas of the country … and between groups of children …".[1]

The number and proportion of children living in South Africa

In mid-2012, South Africa's total population was estimated at 52 million people, of whom 18.6 million were children (under 18 years). Children therefore constitute 36% of the total population.

It is not uncommon in South Africa for children to live separately from their biological parents, in the care of other relatives. The distribution of children across provinces is slightly different to that of adults, with a greater proportion of children living in provinces with large rural populations and with greater proportions of adults in the largely metropolitan provinces. Together, KwaZulu-Natal, the Eastern Cape and Limpopo accommodate half of all children in South Africa. A further 19% of children live in Gauteng, a mainly metropolitan province, and 10% of children in the Western Cape. Despite being the smallest province in the country, Gauteng accommodates more than a quarter of all households and adults, but less than a fifth of children. This is because of the relatively large number of adult-only households in that province.

There have been striking changes in the provincial child populations over time. While there has been a decrease in the number of children living in the Free State, Eastern Cape, Limpopo, KwaZulu-Natal, and the Northern Cape provinces from 2002 to 2012, the number of children living in Gauteng and Western Cape has risen by 23% and 15% respectively. This is caused partly by population movement (for example, when children are part of migrant households or move to join existing urban households), and partly by natural population growth (new births within the province).

We can look at inequality by dividing all households into five equal groups or quintiles, based on total income to the household (including earnings and social grants): with quintile 1 being the poorest 20% of households, quintile 2 being the next poorest and so on. Quintile 5 consists of the least-poor 20%. Nearly two-thirds of children live in the poorest 40% of households.

Children are fairly equally distributed across the age groups, with on average just over one million children in each year under 18. The gender split is equal for children, while it is slightly skewed towards females (52%) in the adult population.

These population estimates are based on analyses of the General Household Survey (GHS), which is conducted annually by Statistics South Africa. The population numbers derived from the survey are weighted to the general population using weights provided by Statistics South Africa. The weights are revised from time to time, and the estimated child population size changes as a result. Using previously weighted data, it appeared that the child population had grown by about 6% (a million children) between 2002 and 2012. However the most recently revised weights, applied retrospectively, produce a slight reduction (of 0.2%) in the child population over the 11-year period from 2002 to 2012. There is considerable uncertainty around the official population estimates, particularly in the younger age groups.[2]

Table 1a: Distribution of households, adults and children in South Africa, by province, 2012

PROVINCE	Households		Adults		Children	
	Number	%	Number	%	Number	%
Eastern Cape	1,655,000	12	3,890,000	12	2,696,000	15
Free State	821,000	6	1,823,000	5	925,000	5
Gauteng	3,751,000	27	8,935,000	27	3,529,000	19
KwaZulu-Natal	2,551,000	18	6,274,000	19	4,071,000	22
Limpopo	1,378,000	10	3,222,000	10	2,230,000	12
Mpumalanga	1,033,000	7	2,517,000	7	1,558,000	8
North West	999,000	7	2,274,000	7	1,273,000	7
Northern Cape	308,000	2	735,000	2	418,000	2
Western Cape	1,586,000	11	4,031,000	12	1,873,000	10
South Africa	**14,083,000**	**100**	**33,701,000**	**100**	**18,574,000**	**100**

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002*; *General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children living with their biological parent(s)

Many children in South Africa do not live consistently in the same dwelling as their biological parents. This is a long-established feature of childhoods in South Africa, and is related to many factors including historic population controls, labour migration, poverty, housing and educational opportunities, low marriage rates and cultural practice. It is common for relatives to play a substantial role in child-rearing. Many children experience a sequence of different caregivers, are raised without fathers, or live in different households to their biological siblings.

Virtually all children live with at least one adult, and the vast majority live in households where there are two or more co-resident adults. This indicator examines co-residence between children and their biological parents specifically. Although many children live with just one of their biological parents (usually the mother), this does not mean that the mother is a "single parent" as she is not necessarily the only adult caregiver in the household. In most cases, there are other adult household members such as aunts, uncles and grandparents, who may contribute to the care of children.

The proportion of children living with both parents decreased from 39% in 2002 to 35% in 2012. Thirty-nine percent of all children – more than seven million children – live with their mothers but not with their fathers. Only 3% of children live in households where their fathers are present and their mothers absent. Twenty-three percent do not have either of their biological parents living with them. This does not necessarily mean that they are orphaned: in most cases (81%), children without any co-resident parents have at least one parent who is alive but living elsewhere.

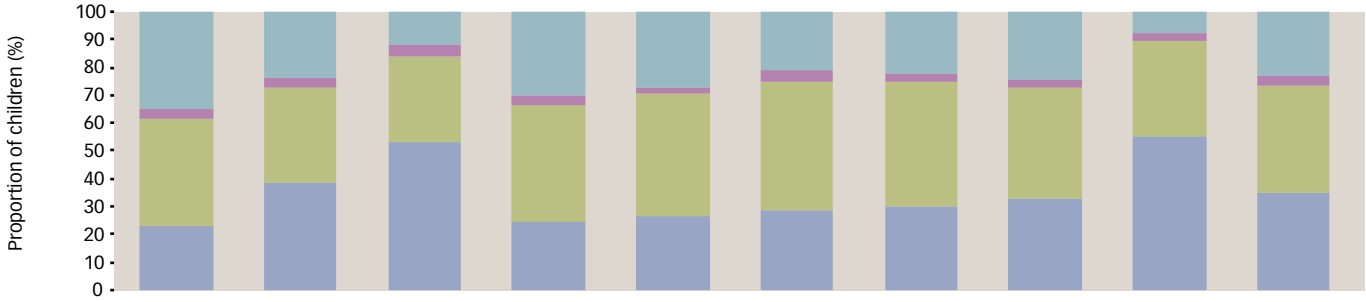
There is some provincial variation in these patterns. In the Western Cape and Gauteng, the proportion of children living with both parents is significantly higher than the national average, with around half of children resident with both parents (56% and 53% respectively). Similarly, the number of children living with neither parent is low in these two provinces (8% and 12%). In contrast, over a third of children (35%) in the Eastern Cape live with neither parent. These patterns are consistent from 2002 to 2012.

Children in the poorest 20% of households are least likely to live with both parents: only 18% have both parents living with them, compared with 78% of children in the least-poor 20% of households.

Less than one third (29%) of African children live with both their parents, while the vast majority of Indian and White children (79% and 78% respectively) are resident with both biological parents. Just over a quarter (26%) of all African children do not live with either parent and a further 42% of African children live with their mothers but without their fathers. These figures are striking for the way in which they suggest the limited presence of biological fathers in the domestic lives of large numbers of African children.

Younger children are more likely than older children to have co-resident mothers while older children are more likely to be living with neither parent. While 8% of children under two years were not resident with either parent in 2012, this situation applied to a quarter of children aged 7 – 9 years, and to 30% of children aged 12 – 17 years. Overall, 18% of children aged 0 – 9 years were not resident with their biological parents in 2012.

Figure 1a: Number and proportion of children living with their parents, by province, 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Both parents	23.4%	38.7%	53.1%	24.4%	26.7%	28.7%	30.4%	32.6%	55.5%	34.8%
	632,000	358,000	1,873,000	995,000	595,000	446,000	387,000	136,000	1,041,000	6,455,000
Mother only	37.8%	34.2%	30.7%	41.7%	44.3%	46.4%	44.6%	40.3%	34.2%	38.8%
	1,020,000	317,000	1,083,000	1,699,000	987,000	723,000	568,000	168,000	641,000	7,208,000
Father only	4.0%	3.3%	4.2%	3.9%	1.8%	3.8%	2.5%	2.6%	2.6%	3.4%
	109,000	30,000	148,000	161,000	39,000	59,000	32,000	11,000	48,000	637,000
Neither parent	34.7%	23.8%	12.1%	29.9%	27.3%	21.1%	22.5%	24.6%	7.7%	23.0%
	935,000	220,000	426,000	1,217,000	609,000	329,000	286,000	103,000	144,000	4,274,000

Source: Statistics South Africa (2003, 2013) *General Household Survey 2002*; *General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of orphans living in South Africa

An orphan is defined as a child under the age of 18 years whose mother, father or both biological parents have died (including those whose living status is reported as unknown, but excluding those whose living status is unspecified). For the purpose of this indicator, orphans are defined in three mutually exclusive categories:

- A maternal orphan is a child whose mother has died but whose father is alive.
- A paternal orphan is a child whose father has died but whose mother is alive.
- A double orphan is a child whose mother and father have both died.

The total number of orphans is the sum of maternal, paternal and double orphans. This definition differs from those commonly used by United Nations agencies and the Actuarial Society of South Africa (ASSA), where the definition of maternal and paternal orphans includes children who are double orphans. As the orphan definitions used here are mutually exclusive and additive, the figures differ from orphan estimates provided by the ASSA models.

In 2012, there were approximately 3.54 million orphans in South Africa. This includes children without a living biological mother, father or both parents, and is equivalent to 19% of all children in South Africa. The total number of orphans has increased by 19% since 2002, with 560,000 more orphaned children in 2012 than in 2002.

Orphan numbers do not indicate the nature or extent of care that children are receiving. It is important to disaggregate the total orphan figures because the death of one parent may have different implications for children than the death of both parents. In particular, it seems that children who are maternal orphans are slightly more at risk of poorer outcomes than paternal orphans – for example, in relation to education.[3]

The vast majority (around 60%) of all orphans in South Africa are paternal orphans (with living mothers). In 2012, 3% of children were maternal orphans with living fathers, 12% were paternal orphans with living mothers, and a further 4% were recorded as double orphans. This means that 16% of children in South Africa did not have a living biological father and 8% did not have a living biological mother. The numbers of paternal orphans are high because of the higher mortality rates of men in South Africa, as well as the frequent absence of fathers in their children's lives (280,000 children have fathers whose vital status is reported to be "unknown").

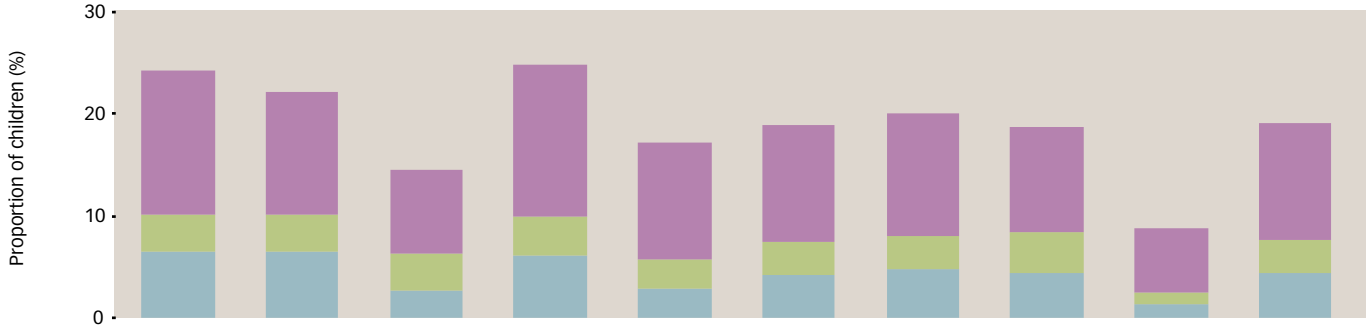
The number and proportion of double orphans has more than doubled since 2002 (from approximately 360,000 to 810,000), translating to an increase of two percentage points in double orphans in South Africa (2002: 2%; 2012: 4%). These increases are likely to be driven primarily by AIDS. Three provinces carry particularly large burdens of care for double orphans: 6% of children living in KwaZulu-Natal and the Eastern Cape have lost both parents. In the Free State, 7% of children have lost both parents.

Throughout the period 2002 – 2012, roughly half of all orphans in South Africa have been located in KwaZulu-Natal and the Eastern Cape. KwaZulu-Natal has the largest child population and the highest orphan numbers, with 25% of children in that province recorded as orphans who have lost a mother, a father or both parents. Orphaning rates in the Eastern Cape are similarly high, at 24%, followed by the Free State, at 22%. The lowest orphaning rates are in the Western Cape (9% of children have lost at least one parent) and Gauteng (15%).

The poorest households carry the greatest burden of care for orphans. Close to half (47%) of all orphans are resident in the poorest 20% of households. Around a quarter of children in the poorest 20% of households are orphans, compared with the richest 20% where total orphaning rates are around 2%.

Figure 1b: Number and proportion of orphans, by province, 2012

(Y-axis reduced to 30%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Double orphan	6.4%	6.5%	2.7%	6.2%	2.9%	4.2%	4.7%	4.4%	1.3%	4.4%
	174,000	61,000	95,000	250,000	65,000	65,000	60,000	18,000	24,000	812,000
Maternal orphan	3.7%	3.5%	3.6%	3.8%	2.8%	3.3%	3.3%	4.0%	1.3%	3.3%
	99,000	33,000	127,000	156,000	61,000	52,000	42,000	17,000	24,000	611,000
Paternal orphan	14.1%	12.0%	8.2%	14.8%	11.5%	11.3%	12.1%	10.3%	6.1%	11.5%
	381,000	111,000	289,000	604,000	257,000	176,000	154,000	43,000	115,000	2,130,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002*; *General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children living in child-only households

A child-only household is defined as a household in which all members are younger than 18 years. These households are also commonly known as "child-headed households".

There has been much concern within government and civil society that the number of children living in child-only households is escalating as the number of orphaned children increases due to AIDS-related deaths of parents. It has been argued that kinship networks are stretched to their limits and are struggling to provide support to orphaned children. While orphaning undoubtedly places a large burden on families, there is little evidence to suggest that their capacity to care for orphans has been saturated, as commentators have feared. Rather than seeing increasing numbers of orphaned children living without adults, the vast majority of orphans live with family members, and child-headed households are not primarily the result of orphaning.[4] Nevertheless it will be important to monitor the prevalence and nature of child-headed households as the HIV/AIDS pandemic continues.

There were about 87,000 children living in a total of 40,000 child-only households across South Africa in 2012. This equates to 0.5% of all children. While children living in child-only households are rare relative to those resident in other household forms, the number of children living in this extreme situation is of concern.

Importantly, however, there has been no significant change in the proportion of children living in child-only households in the period between 2002 and 2012, nor has there been any change in the proportion of child-only households over the same period. This is despite a marked increase in orphans in South Africa over the same period. Predictions of rapidly increasing numbers of child-headed households as a result of HIV are at this point unrealised. An analysis of national household surveys to examine the circumstances of children in child-headed households in South Africa reveals that most children in child-only households are not orphans.[5] These findings suggest that social phenomena other than HIV may play important roles in the formation of these households.

While it is not ideal for any child to live without an adult resident, it is positive that over half (53%) of all children living in child-only households are aged 15 years and above. Children can work legally from the age of 15, and from 16 they can obtain an identity book and receive grants on behalf of younger children. Only 7% of children in child-headed households are under six years.

Research suggests that child-only households are frequently temporary arrangements, and often exist just for a short period, for example while adult migrant workers are away, or for easy access to school during term-time, or after the death of an adult and prior to other arrangements being made to care for the children (such as other adults moving in or the children moving to live with other relatives).[6]

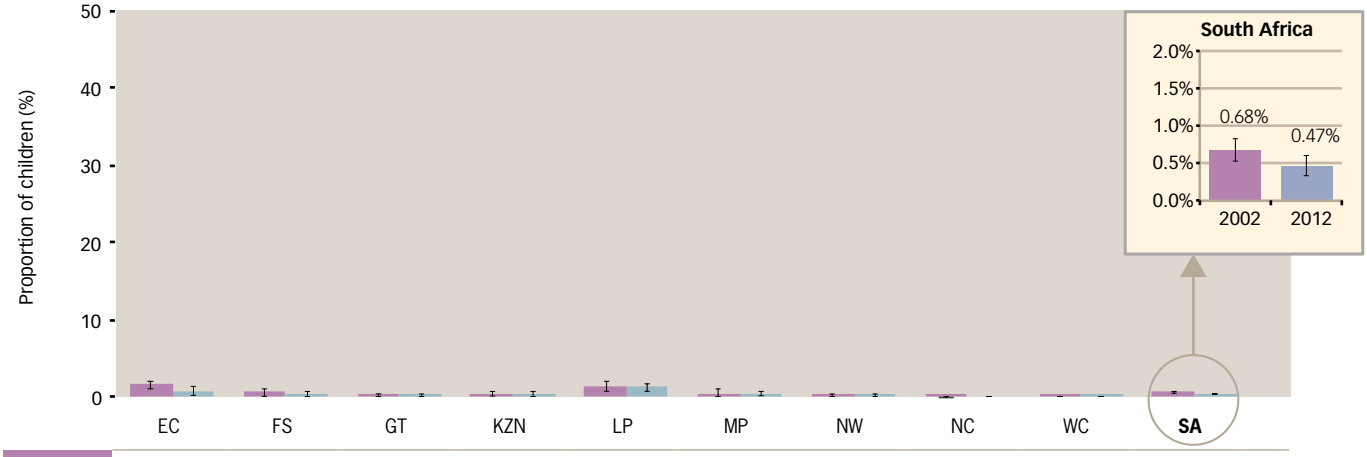
Three-quarters of all children in child-only households live in three provinces: Limpopo (which accounts for 33% of children in child-only households), Eastern Cape (26%) and KwaZulu-Natal (16%). From 2002 to 2012, these provinces have consistently been home to the majority of children living in child-only households.

Relative to children in mixed-generation households, child-only households are vulnerable in a number of ways. Child-only households are predominantly clustered in the poorest 20% of households. In addition to the absence of adult members who may provide care and security, they are at risk of living in poorer conditions, with poor access to services, less (and less reliable) income, and low levels of access to social grants.

There has been very little robust data on child-headed households in South Africa to date. The figures should be treated with caution as the number of child-only households forms just a very small sub-sample of the General Household Survey. In particular, we caution against reading too much into the provincial breakdowns, or into apparent differences between the 2002 and 2012 estimates.

Figure 1c: Number and proportion of children living in child-headed households, by province, 2002 & 2012

(Y-axis reduced to 50%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2002	1.6%	0.7%	0.1%	0.4%	1.4%	0.5%	0.2%	0.1%	0.0%	0.7%
	50,000	7,000	4,000	19,000	35,000	8,000	3,000	0	0	127,000
2012	0.8%	0.4%	0.2%	0.3%	1.3%	0.5%	0.2%	0.0%	0.0%	0.5%
	22,000	4,000	6,000	14,000	29,000	8,000	3,000	0	1,000	87,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012.* Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

References

1 United Nations Children's Fund (1990) *First Call for Children. World Declaration and Plan of Action from the World Summit for Children*. New York: UNICEF.
2 Dorrington R (2013) *Alternative South African Mid-year Estimates, 2013*. Centre for Actuarial Research Monograph 13, University of Cape Town.
3 Ardington C & Leibrandt M (2010) Orphanhood and schooling in South Africa: Trends in the vulnerability of orphans between 1993 and 2005. *Economic Development and Cultural Change*, 58(3): 507-536.
4 Meintjes H, Hall K, Marera D & Boulle A (2010) Orphans of the AIDS epidemic? The extent, nature and circumstances of child-headed households in South Africa. *AIDS Care*, 22(1): 40-49.
5 See no. 3 above (Meintjes).
6 Hill C, Hosegood V & Newell M-L (2008) Children's care and living arrangements in a high HIV prevalence area in rural South Africa. *Vulnerable Children and Youth Studies*, 3(1): 65-77.

Income poverty, unemployment and social grants

Katharine Hall and Winnie Sambu (Children's Institute, University of Cape Town)

The Constitution of South Africa, section 27(1)(c), says that "everyone has the right to have access to … social security, including, if they are unable to support themselves and their dependants, appropriate social assistance".[1]

The UN Convention on the Rights of the Child, article 27, states that every child has the right "to a standard of living adequate for his or her development" and obliges the state "in case of need" to "provide material assistance". Article 26 guarantees "every child the right to benefit from social security".[2]

The number and proportion of children living in income poverty

International law and the Constitution recognise the link between income and the realisation of basic human rights, and acknowledge that children have the right to social assistance (social grants) when families cannot meet children's basic needs. Income poverty measures are therefore important for determining how many people are in need of social assistance, and for evaluating the state's progress in realising the right to social assistance.

A lack of sufficient income can compromise children's rights to nutrition, education, adequate living environments and health care. One way of identifying how many children are living without enough resources to meet their needs is to use a poverty line and measure how many children live under it.

No poverty line is perfect. Using a single income measure tells us nothing about how resources are distributed between family members, or how money is spent. But it does give some indication of how many children are living with severely constrained resources.

This indicator shows the number and proportion of children living in households that are income-poor. The income threshold used here is a lower bound "ultra" poverty line, set at R322 per person per month in 2000 prices.[3] The poverty line increases with inflation and was equivalent to R635 in 2012. Per capita income is calculated by adding all reported income for household members older than 15 years, including social grants, and dividing the total household income by the number of household members.

South Africa has very high rates of child poverty. In 2012, 56% of children lived below the lower poverty line (R635 per month). Income poverty rates have fallen consistently since 2003. This poverty reduction is largely the result of a massive expansion in the reach of the Child Support Grant over the same period. Although there have been reductions in child poverty rates, large numbers of children still live in extreme poverty: in 2012 over 10 million children lived below the "lower bound" poverty line.

There are substantial differences in provincial poverty rates. Using the lower bound poverty line, over 70% of children in Limpopo and the Eastern Cape are poor. Gauteng and the Western Cape have the lowest child poverty rates, at 34% and 27% respectively.

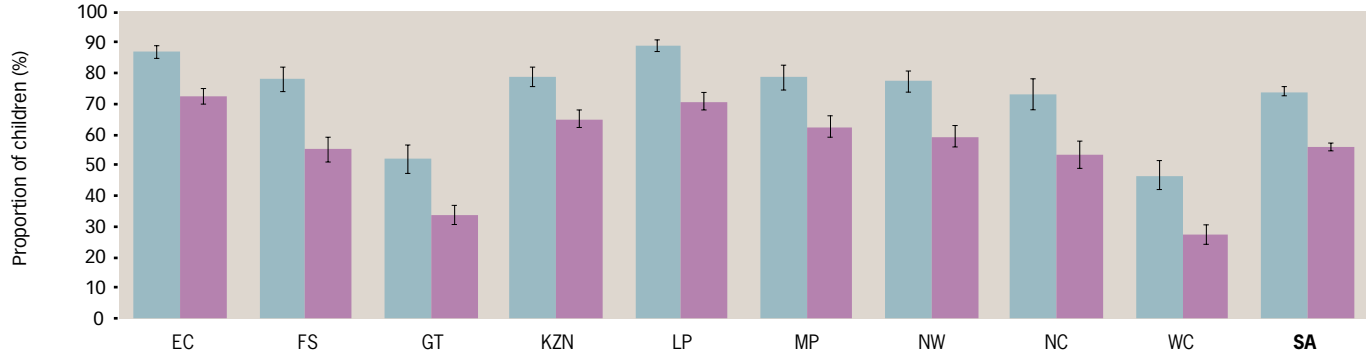
There are glaring racial disparities in income poverty: while 63% of African children lived in poor households in 2012, only 1% of White children lived below this poverty line, and poverty rates for Coloured and Indian children were 28% and 7% respectively. There were no significant differences in child poverty levels across gender or age groups.

The poverty analysis uses 2003 as its baseline because the General Household Survey did not capture information on social grants in its first year, so income from grants could not be included in household income calculations for 2002.

Other poverty lines can be used to analyse and compare different levels of income poverty. The international poverty line used to track progress towards the Millennium Development Goals (MDG) is $1.25 per person per day. This translates to R203 per person per month in 2012, using the IMF purchasing power parity conversion. The MDG goal was to reduce by half the number of people living below this poverty line. In 2002, 30% of children (5.7 million) lived below the MDG poverty line. In 2012 this had reduced to 15% (2.8 million). The MDG line is extremely low, and is probably not appropriate for South Africa. See **www.childrencount.ci.org.za** for additional poverty lines.

Figure 2a: Children living in income poverty, by province, 2003 & 2012

("Lower bound" poverty line: Households with monthly per capita income less than R635, in 2012 Rands)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2003	87.0%	77.9%	51.9%	78.8%	88.8%	78.6%	77.4%	73.0%	46.7%	74.0%
	2,581,000	857,000	1,526,000	3,344,000	2,183,000	1,202,000	977,000	316,000	776,000	13,760,000
2012	72.4%	55.2%	33.9%	65.0%	70.8%	62.4%	59.4%	53.4%	27.4%	55.7%
	1,951,000	511,000	1,196,000	2,648,000	1,578,000	972,000	756,000	223,000	512,000	10,347,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children living in households without an employed adult

This indicator measures unemployment from a children's perspective and gives the number and proportion of children who live in households where no adults are employed in either the formal or informal sector. It therefore shows the proportion of children living in "unemployed" households where it is unlikely that any household members get income from labour or income-generating activities.

Unemployment in South Africa continues to be a serious problem. The official national unemployment rate was 25.5% in the third quarter of 2012.[4] This rate is based on a narrow definition of unemployment that includes only those adults who are defined as economically active (i.e. they are not studying or retired or for some reason voluntarily at home) who actively looked but failed to find work in the four weeks preceding the survey.[5] An expanded definition of unemployment, which includes "discouraged work-seekers" who were unemployed but not actively looking for work in the month preceding the survey, would give a higher, more accurate, indication of unemployment. Gender differences in employment rates are relevant for children, who are more likely to co-reside with their mother than their father. Unemployment rates remain considerably higher for women than for men.

Apart from providing regular income, an employed adult may bring other benefits to the household, including health insurance, unemployment insurance and maternity leave that can contribute to children's health, development and education. The definition of "employment" is derived from the Quarterly Labour Force Survey and includes regular or irregular work for wages or salary, as well as various forms of self-employment, including unpaid work in a family business.

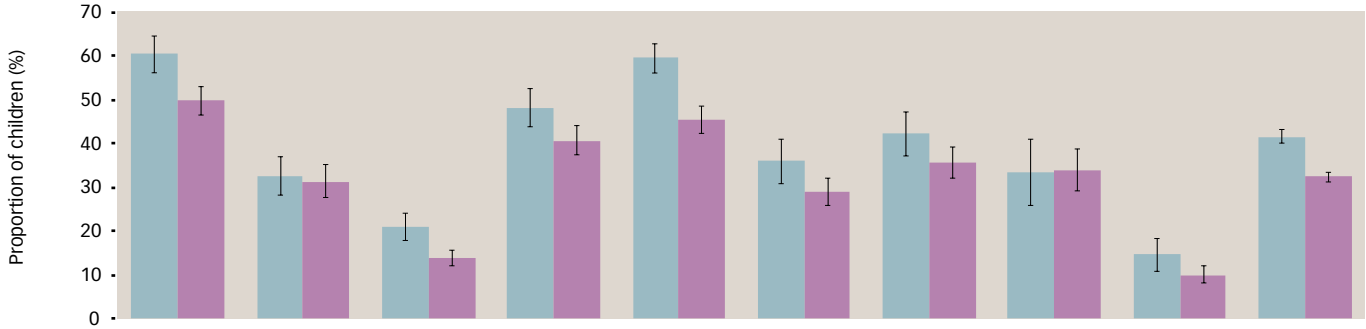
In 2012, 68% of children in South Africa lived in households with at least one working adult. The other 32% (over six million children) lived in households where no adults were working. The proportion of children living in households where there is unemployment has decreased by over 9% since 2003 when the proportion was 42%.

This indicator is very closely related to the income poverty indicator in that provinces with relatively high proportions of children living in unemployed households also have high rates of child poverty. Gauteng and the Western Cape have the lowest levels of income poverty, and less than 15% of children in these provinces live in unemployed households. In contrast, over 45% of children in the Eastern Cape and Limpopo live in households without any employed adults. These two provinces are home to large numbers of children, and have the highest rates of child poverty.

Racial inequalities are striking: 37% of African children have no working adult at home, while 12% of Coloured children, 7% of Indian children and 2% of White children live in these circumstances. There are no significant differences in child-centred unemployment measures when comparing age groups or sex. But income inequality is clearly associated with unemployment. Nearly 70% of children in the poorest income quintile (4.7 million) live in households where no adults are employed.

Figure 2b: Children living in households without an employed adult, by province, 2003 & 2012

(Y-axis reduced to 70%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2003	60.4%	32.7%	20.9%	48.1%	59.5%	35.9%	42.0%	33.2%	14.6%	41.6%
	1,790,000	359,000	614,000	2,041,000	1,462,000	548,000	531,000	144,000	243,000	7,733,000
2012	49.6%	31.4%	13.8%	40.6%	45.4%	28.8%	35.5%	33.8%	10.0%	32.4%
	1,337,000	290,000	486,000	1,654,000	1,012,000	449,000	452,000	142,000	187,000	6,009,000

Source: Statistics South Africa (2004; 2013) *General Household Survey 2003; General Household Survey 2012.* Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children receiving the Child Support Grant

This indicator shows the number of children receiving the Child Support Grant (CSG), as reported by the South African Social Security Agency (SASSA) which disburses social grants on behalf of the Department of Social Development.

The right to social assistance is designed to ensure that people living in poverty are able to meet basic subsistence needs. Government is obliged to support children directly when their parents or caregivers are too poor to do so. Income support is provided through social assistance programmes, such as the CSG, which is an unconditional cash grant paid to the caregivers of eligible children.

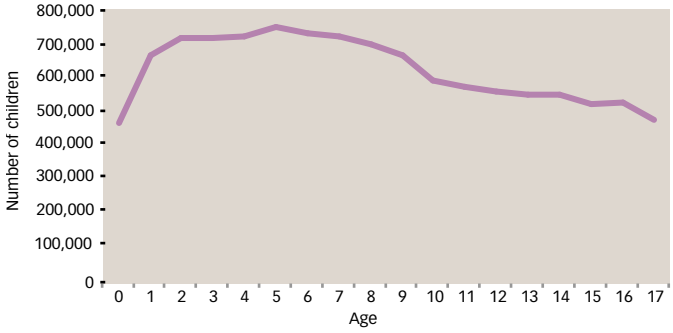
Introduced in 1998 with a value of R100, the CSG has become the single biggest programme for alleviating child poverty in South Africa. Take-up of the CSG has increased dramatically over the past decade and, at the end of March 2014, a monthly CSG of R300 was paid to over 11.1 million children aged 0 – 17 years. This is slightly down from 11.3 million in 2013. In addition to the regular termination of grants to children who reach the age threshold of 18, over a million "invalid beneficiaries", were identified during a re-registration process and removed from the system.[6] The amount of the grant increases slightly each year and was worth R320 in October 2014.

There have been two important changes in eligibility criteria related to the age and income thresholds. The first concerns age eligibility. Initially the CSG was only available for children aged 0 – 6 years. Later it was gradually extended to older children up to the age of 14. Since January 2012, following a second phased extension, children are eligible for the grant until they turn 18. The second important change concerns income eligibility. From 1998, children were eligible for the CSG if their primary caregiver and his/her spouse had a joint monthly income of R800 or less and lived in a formal house in an urban area. For those who lived in rural areas or informal housing, the income threshold was R1,100 per month. This threshold remained static for 10 years until a formula was introduced for calculating income threshold – set at 10 times the amount of the grant. In October 2014 the income threshold was R3,200 per month for a single caregiver and R6,400 per month for the joint income of the caregiver and spouse, if the caregiver is married.

There is substantial evidence that grants, including the CSG, are being spent on food, education and basic goods and services. This evidence shows that the grant not only helps to realise children's right to social assistance, but is also associated with improved nutritional, health and education outcomes.[7]

Given the positive and cumulative effects of the grant, it is important that caregivers access it for their children from as early as possible. One of the main concerns is the slow take-up for young children. An analysis of exclusions from the CSG found that take-up rates for eligible infants under a year were as low as 50% in 2011, up only three percentage points from 47% in 2008. Exclusion rates were found to be highest in the Western Cape and Gauteng.[8] Barriers to take-up include confusion about eligibility requirements and the means test in particular; lack of documentation (mainly identity books or birth certificates, and proof of school enrolment, although the latter is not an eligibility requirement) and problems of institutional access (including the time and cost of reaching SASSA offices, long queues and lack of baby-friendly facilities).

Figure 2c: Children receiving the Child Support Grant, by age, 2014



Source: South African Social Security Agency (2014) SOCPEN database – special request. Pretoria: SASSA.

Table 2a: Children receiving the Child Support Grant, by province, 2008 – 2014

PROVINCE	Number of child beneficiaries at end March						
	2008	2009	2010	2011	2012	2013	2014
Eastern Cape	1,478,176	1,564,602	1,668,408	1,769,949	1,837,801	1,843,684	1,777,042
Free State	453,730	467,743	527,077	583,524	617,311	637,075	630,717
Gauteng	954,500	1,022,984	1,153,481	1,276,109	1,387,159	1,581,756	1,548,796
KwaZulu-Natal	2,094,613	2,282,246	2,439,781	2,623,772	2,726,635	2,746,888	2,662,100
Limpopo	1,270,893	1,358,313	1,460,328	1,584,855	1,497,044	1,588,489	1,626,113
Mpumalanga	655,695	690,944	750,661	806,581	1,008,223	1,051,626	984,641
North West	629,539	661,807	715,997	752,026	793,189	751,195	754,935
Northern Cape	180,982	200,387	224,346	246,233	262,488	277,835	275,849
Western Cape	471,847	516,328	630,208	728,901	797,881	863,440	865,753
South Africa	8,189,975	8,765,354	9,570,287	10,371,950	10,927,731	11,341,988	11,125,946
CSG amount	**R 220**	**R 240**	**R 250**	**R 270**	**R 280**	**R 290**	**R 300**

Source: South African Social Security Agency (2008 – 2014) SOCPEN database – special request. Pretoria: SASSA.
Notes: SOCPEN figures are taken from the end of March each year (the financial year-end).
For the years 2005 – 2008, the CSG was only available to children aged 0 – 13 years (under-14s). In 2009, the grant was extended to include children aged 14 years (under-15s), in 2010 to children aged 15 years (under-16s), and in 2011 to children aged 16 (under-17s). From 2012 the CSG has been available to children until they turn 18 years.

The number of children receiving the Foster Child Grant

This indicator shows the number of children who are accessing the Foster Child Grant (FCG) in South Africa, as recorded in the SOCPEN administrative data system of the SASSA.

The FCG is available to foster parents who have a child placed in their care by an order of the court. It is a non-contributory cash grant valued at R830 per month from April 2014. The grant was initially intended as financial support for children removed from their families and placed in foster care for protection in situations of abuse or neglect. However, it is increasingly used to provide financial support to caregivers of children who are orphaned. The appropriateness and effectiveness of this approach have been questioned.[9]

The number of FCGs remained stable for many years while foster care was applicable only to children in the traditional child protection system. Its rapid expansion since 2003 coincides with the rise in HIV-related orphaning and an implied policy change by the Department of Social Development, which from 2003 started encouraging family members (particularly grandmothers) caring for orphaned children to apply for foster care and the associated grant. Over the following five years the number of FCGs increased by over 50,000 per year as orphans were brought into the foster care system. The increases were greatest in provinces with large numbers of orphaned children: the Eastern Cape, KwaZulu-Natal, Limpopo and Mpumalanga.

However, by 2009 the foster care system itself was struggling to keep pace with the number of FCGs due to the required initial investigations and reports by social workers, court-ordered placements through a children's court, and additional two-yearly social worker reviews and court-ordered extensions. Neither the welfare services nor the courts had the capacity to keep up with the two-yearly extensions. SASSA, which administers the grants, is not allowed to pay the FCG without a valid court order or extension order. Over 110,000 FCGs lapsed in the two years between April 2009 and March 2011 because of backlogs in the extensions of court orders.[10] This is reflected on the graph as a leveling of FCGs, as new FCGs were still being processed during this period.

In 2011 a court-ordered settlement stipulated that the foster care court orders that had expired – or that were going to expire in the following two years – must be deemed to have been extended until 8 June 2013. This effectively placed a moratorium on the lapsing of these FCGs. As a temporary solution social workers could extend orders administratively until December 2014, by which date a comprehensive legal solution must have been found to prevent qualifying families from losing their grants in future.[11]

Since 2011, the number of new FCGs appears to have declined, and there has been a substantial increase in the number of grants that terminate at the end of each year, when children turn 18. The reason for further lapsing of grants between 2013 and 2014 remains to be investigated. In March 2014, 512,000 FCGs were paid each month to caregivers of children in foster care, down from 532,000 in March 2013. Nearly half of all grants go to just two provinces: KwaZulu-Natal (126,000) and Eastern Cape (116,000). These are also provinces with large numbers of maternal and double orphans.

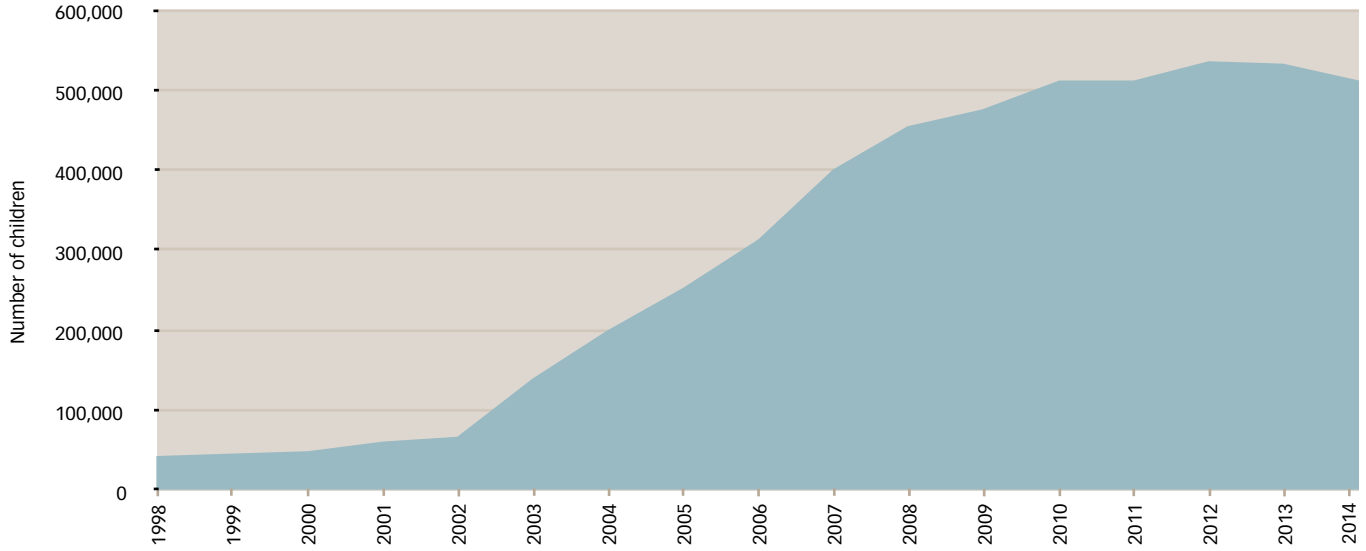
It is not possible to calculate a take-up rate for the FCG as there is no accurate record of how many children are eligible for placement in foster care – and indeed, no clear guidelines about how it should be targeted in the context of rising orphaning rates. The systemic problems which caused FCGs to lapse will be addressed through legislative amendment, which will need to clarify the eligibility criteria for foster care and the FCG.

Table 2b: Children receiving the Foster Child Grant, by province, 2014

Province	Children
Eastern Cape	116,172
Free State	39,178
Gauteng	55,027
KwaZulu-Natal	125,702
Limpopo	58,571
Mpumalanga	33,877
North West	40,726
Northern Cape	14,307
Western Cape	28,495
South Africa	**512,055**

Source: South African Social Security Agency (2014) SOCPEN database – special request. Pretoria: SASSA.

Figure 2d: Growth of the Foster Child Grant, 1998 – 2014



Sources: Department of Social Development (1998 – 2002) SOCPEN database – special request. Pretoria: DSD;
National Treasury (2005) *Provincial Budgets and Expenditure Review 2001/02 – 2007/08*. Pretoria: National Treasury;
National Treasury (2008) *Estimates of National Expenditure 2008*. Pretoria: Treasury; South African Social Security Agency (2008 – 2014) SOCPEN database – special request. Pretoria: SASSA.

The number of children receiving the Care Dependency Grant

This indicator shows the number of children who are accessing the Care Dependency Grant (CDG) in South Africa, as recorded in the SOCPEN administrative data system of the SASSA.

The CDG is a non-contributory monthly cash transfer to caregivers of children with severe disabilities who require permanent care or support services. It excludes those children who are cared for in state institutions because the purpose of the grant is to cover the additional costs (including opportunity costs) that the parent or caregiver might incur as a result of the child's disability. The child needs to undergo a medical assessment to determine eligibility and the parent must pass an income or "means" test.

Although the CDG targets children with severe disabilities, children with chronic illnesses are eligible for the grant once the illness becomes disabling, for example children who are very sick with AIDS-related illnesses. Children with severe disabilities and chronic illnesses need substantial care and attention, and parents may need to stay at home or employ a caregiver to tend to the child. Children with health conditions may need medication, equipment or to attend hospital often. These extra costs can put strain on families that are already struggling to make ends meet. Poverty and chronic health conditions are therefore strongly related.

It is not possible to calculate a take-up rate for the CDG because there is little data on the number of children living with disabilities in South Africa, or who are in need of permanent care or support services. At the end of March 2014, 121,000 children were receiving the CDG, valued at R1 270 per month.

The provincial distribution of CDGs is fairly consistent with the distribution of children. The provinces with the largest numbers of children, KwaZulu-Natal and the Eastern Cape, receive the largest share of CDGs. There has been a consistent and gradual increase in access to the CDG since 2005.

Table 2c: Children receiving the Care Dependency Grant, by province, 2008 – 2014

Province	Number of child beneficiaries at end March						
	2008	2009	2010	2011	2012	2013	2014
Eastern Cape	19,484	19,297	18,915	18,417	18,235	18,429	18,199
Free State	4,104	4,228	4,577	4,925	5,419	5,864	6,146
Gauteng	12,680	12,834	13,248	13,649	14,170	15,783	15,428
KwaZulu-Natal	29,763	32,040	33,866	34,377	34,969	36,012	35,392
Limpopo	11,812	12,353	12,844	12,650	11,318	11,913	12,559
Mpumalanga	5,306	5,617	5,877	6,050	7,950	8,652	8,807
North West	8,192	8,946	8,553	8,668	8,736	8,339	8,463
Northern Cape	3,552	3,790	3,952	4,094	4,236	4,485	4,610
Western Cape	7,399	7,960	8,899	9,355	9,960	10,791	11,028
South Africa	102,292	107,065	110,731	112,185	114,993	120,268	120,632
FCG amount	**R 940**	**R 1 010**	**R 1 080**	**R 1 140**	**R 1 200**	**R 1 260**	**R 1 270**

Source: South African Social Security Agency (2008 – 2014) SOCPEN database – special request. Pretoria: SASSA.

References

1 Constitution of the Republic of South Africa, 1996.
2 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly Resolution 44/25.* Geneva: United Nations.
3 Hoogeveen J & Özler B (2006) Poverty and inequality in post-apartheid South Africa: 1995 – 2000. In: Bhorat H & Kanbur R (eds) *Poverty and Policy in Post-Apartheid South Africa*, Cape Town: HSRC Press.
4 Statistics South Africa (2012) *Quarterly Labour Force Survey: Quarter 3, 2012. Statistical release P0211*. Pretoria: StatsSA.
5 Statistics South Africa (2012) *General Household Survey Metadata*. Pretoria: StatsSA.
6 Minister of Finance (2014) Budget Speech 2014: Check Against Delivery. Pretoria: National Treasury;
Parliamentary Monitoring Group (2014) *Social Development. Question Number: 2014/08. Written reply to parliamentary question 334/2014*. Available: www.pmg.org.za/questions-and-replies/2014/03/28/social-development.
7 Department of Social Development, South African Social Security Agency & UNICEF (2012) *The South African Child Support Grant Impact Assessment: Evidence from a Survey of Children, Adolescents and their Households*. Pretoria: UNICEF South Africa;
Budlender D & Woolard I (2006) *The Impact of the South African Child Support and Old Age Grants on Children's Schooling and Work.* Geneva: International Labour Office;
Case A, Hosegood V & Lund F (2005) The reach and impact of Child Support Grants: Evidence from KwaZulu-Natal. In: *Development Southern Africa*, 22(4), October 2005: 467-482;
Samson M, Lee U, Ndlebe A, Mac Quene K, Van Niekerk I, Ghandi V, Harigaya T & Abrahams C (2004) *The Social and Economic Impact of South Africa's Social Security System.* Commissioned by the Department of Social Development. Cape Town: Economic Policy Research Institute.
8 South African Social Security Agency & UNICEF (2013) P*reventing Exclusion from the Child Support Grant: A Study of Exclusion Errors in Accessing CSG Benefits*. Pretoria: UNICEF South Africa.
9 Meintjes H, Budlender D, Giese S & Johnson L (2003) *Children 'in Need of Care' or in Need of Cash? Questioning Social Security Provisions for Orphans in the Context of the South African AIDS Pandemic*. Joint working paper of the Children's Institute & the Centre for Actuarial Research, UCT.
10 Hall K & Proudlock P (2011) *Orphaning and the Foster Child Grant: A Return to the 'Care or Cash' Debate*. Children Count brief, July 2011. Cape Town: Children's Institute, UCT;
Proudlock P (2012) *The Case of Child SS and 1.1 Million Others like Him – Orphan Children in Need of Social Assistance.* Paper presented at "Towards Carnegie3: Strategies to Overcome Poverty & Inequality" conference, 3 – 7 September 2012, UCT.
Skelton A (2012) *The Story of 110 000 Foster Child Grants that Stopped being Paid in 2010/2011*. Paper presented at "Towards Carnegie3: Strategies to Overcome Poverty & Inequality" conference, 3 – 7 September 2012, UCT.
11 *Centre for Child Law v Minister of Social Development and Others*, North Gauteng High Court, Case no. 21726/11.

Child health

Nadine Nannan (Medical Research Council), Katharine Hall and Winnie Sambu (Children's Institute, University of Cape Town)

Section 27 of the Constitution of South Africa provides that everyone has the right to have access to health care services. In addition, section 28(1)(c) gives children "the right to basic nutrition and basic health care services".[1]

Article 14(1) of the African Charter on the Rights and Welfare of the Child states that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health".[2]

Article 24 of the UN Convention on the Rights of a Child says that state parties should recognise "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". It obliges the state to take measures "to diminish infant and child mortality" and "to combat disease and malnutrition".[3]

The infant mortality rate and under-five mortality rate

Nadine Nannan (Burden of Disease Research Unit, Medical Research Council)

The infant and under-five mortality rates are key indicators of heath and development. They are associated with a broad range of bio-demographic, health and environmental factors which are not only important determinants of child health but are also informative about the health status of the broader population.

The infant mortality rate (IMR) is defined as the probability of dying within the first year of life, and refers to the number of babies under 12 months who die in a year, per 1,000 live births during the same year. Similarly, the under-five mortality rate (U5MR) is defined as the probability of a child dying between birth and the fifth birthday. The U5MR refers to the number of children under five years old who die in a year, per 1,000 live births in the same year.

This information is ideally obtained from vital registration systems. However, under-reporting of births and deaths renders the South African system inadequate for monitoring purposes. For example, the vital registration data reported by Statistics South Africa in 2009 showed a stark increase in the number of under-five deaths, almost doubling from 32,485 in 1997 to over 61,335 in 2007.[4] However it is not possible to determine the extent to which this increase was the result of improved death registration, as opposed to a rise in the actual number of deaths. The number of reported under-five deaths declined after the mid-2000's, reaching a 10-year low of 38,000 in 2011.[5] Again, it is not clear to what extent the rate of reduction parallels the real decline in under-five mortality over the same period.

Like many middle-income countries, South Africa is reliant on alternative methods, such as survey and census data, to measure child mortality. Despite several surveys which should have provided information to monitor progress in child survival, the lack of reliable data since 2000 has led to considerable uncertainty around the level of child mortality. This lack of reliable survey data, together with incomplete vital registration, has made it very difficult to track South Africa's progress towards the Millennium Development Goal (MDG) 4, which requires a two-third reduction in the U5MR by 2015.[6]

The 2007 Community Survey included questions to women of reproductive age about the number of children they had given birth to, and the number of surviving children. Such information can be used to estimate child mortality rates using demographic models. The survey results provided information on the level of under-five mortality from which to estimate the extent of under-registration of infant and 1 – 4-year-old deaths. This showed improvement in overall registration of deaths under age five, from 50% in 1997 to about 90% in 2006.[7]

In the absence of any more recent survey data, important progress has been made in the development of a rapid mortality surveillance (RMS) system based on the deaths recorded on the population register by the Department of Home Affairs.[8]

The RMS data have been recommended by the Health Data Advisory and Co-ordinating Committee because corrections have been made for known biases. In other words, the indicators shown in table 3a are nationally representative. The RMS reports vital registration data adjusted for under-reporting and the recent RMS estimates allow evaluation of annual trends. They suggest the infant mortality rate peaked in 2003 when it was 53 per 1,000 and decreased to 28 per 1,000 in 2011. Over the same period the under-five mortality rate decreased from 81 per 1,000 to 41 per 1,000, which equates to a 10% annual rate of reduction up until 2011, with no further decline in 2012.

The neonatal mortality rate (NMR) is the probability of dying within the first 28 days of life per 1,000 live births. The NMR was 12 per 1,000 live births in 2012. Estimates on the NMR are based on registered deaths for the period 2006 – 2010 and the District Health Information System for 2010 – 2012.

The decline in infant- and under-five mortality has occurred mostly in HIV-related deaths and is consistent with the findings of a 2011 evaluation of the prevention of mother-to-child transmission (PMTCT) programme, where observed national transmission rates for 4 – 8 week-old infants had dropped to below 2.7%.[9] While dependent on inter-related factors, it is generally assumed that, in the absence of any intervention, vertical transmission ranges between 25% and 30%. The South African Every Death Counts Working Group has identified five categories of death requiring action to achieve the health-related MDGs: non-HIV deaths due to pregnancy, childbirth complications, newborn illness, childhood infections and malnutrition.[10]

The successes in the PMTCT programme and the improvement in completeness of registration over the past decade are commendable. However, if South Africa is committed to the health targets enshrined in the MDGs, it should prioritise the collection of detailed pregnancy histories through a national survey. This information is necessary in order to understand the changes in the relative contribution of the neonatal, post-neonatal and child age groups.

In the spirit of South Africa's progress towards improving child survival, it is essential to build equitable and sustainable administrative systems across the provinces, which will lay the basis for improved delivery in all public sector initiatives that affect the survival and development of children.

Table 3a: Child mortality indicators, 2009 – 2012

INDICATOR	2009	2010	2011	2012
Under-five mortality rate per 1,000 live births	56	52	40	41
Infant mortality rate per 1,000 live births	39	35	28	27
Neonatal mortality	14	14	13	12

Source: Bradshaw D, Dorrington RE & Laubscher R (2014) *Rapid Mortality Surveillance Report 2012*. Cape Town: Medical Research Council.

HIV prevalence in pregnant women

The HIV status of pregnant women is vitally important for children. Around 70% of maternal deaths in South Africa are due to HIV,[11] and HIV continues to be a major contributor to child mortality. Of all children who died in hospital in 2011, only 31% were known to be HIV negative. Twenty-two percent were HIV exposed, and a further 21% were definitely HIV infected. The HIV status of the remaining 15% of children was not known.[12]

The HIV prevalence amongst pregnant women is the proportion of pregnant women (aged 15 – 49 years) who are HIV positive. The majority of children who are HIV positive have been infected through mother-to-child transmission. Therefore the prevalence of HIV amongst infants and young children is largely influenced by the HIV prevalence of pregnant women and interventions to prevent mother-to-child transmission (PMTCT).

The PMTCT programme had a notoriously slow start in South Africa, with only an estimated 7% of pregnant women receiving HIV counselling and testing in 2001/02. Following legal action by the Treatment Action Campaign, the Department of Health was ordered to make PMTCT services available to all pregnant women, and testing rates increased rapidly in subsequent years. Since 2009 HIV testing has been almost universal.[13] The most recent evaluation of the PMTCT programme shows that transmission rates have declined to as low as 2.7%.[14]

HIV prevalence is measured in the National HIV and Syphilis Prevalence Survey which targets pregnant women aged 15 – 49 years who attend a public health facility. The most recent publicly available estimate, for 2012, is 29.5%. Prevalence rates increased steadily from 1% in 1990 when the first antenatal prevalence survey was conducted, to 25% in 2000 and 30% in 2005, and have remained at around this level since. Results are reported in five-year age bands, and show that HIV-prevalence rates are consistently high amongst women in their early 30s (a prevalence rate of 43% in 2012) followed by those in their late 30s (40%).

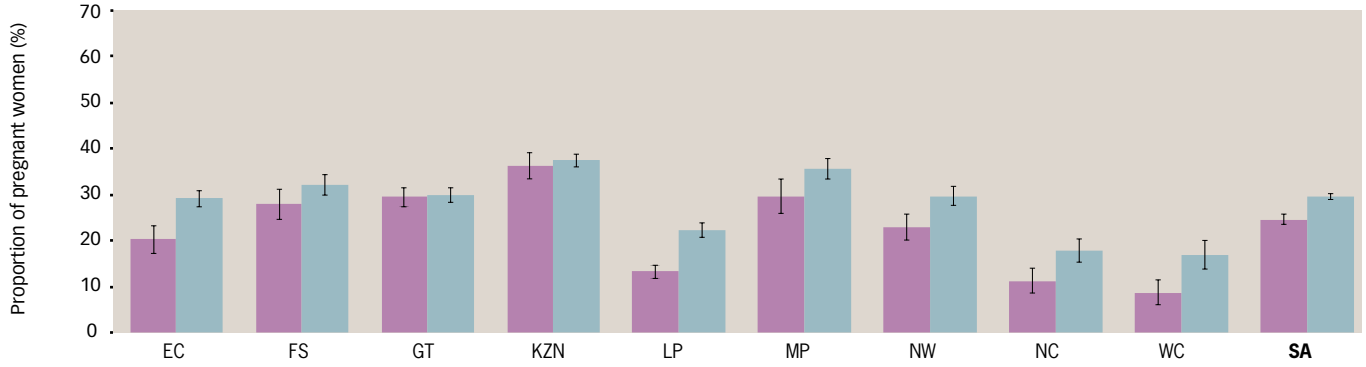
There are substantial differences in HIV prevalence between South Africa's provinces. KwaZulu-Natal has consistently had the highest HIV rates, with prevalence in excess of 36% since 2000. In contrast, the Western Cape has had relatively low prevalence, although the rate has increased by eight percentage points to 17% over the 13-year period since 2000. Other provinces with relatively low HIV prevalence are the Northern Cape and Limpopo, with HIV-prevalence levels at 18% and 22% respectively in 2012.

These inter-provincial differences are partly a reflection of differences in HIV prevalence between different racial and cultural groups. For example, male circumcision is believed to be a major factor explaining inter-regional differences in HIV prevalence within Africa,[15] and its prevalence differs substantially between South Africa's provinces[16]. Other factors such as differences in urbanisation, migration, socio-economic status and access to HIV-prevention and treatment services could also explain some of the differences in HIV prevalence between provinces.

Although HIV testing is almost universal in public health facilities, the antenatal prevalence survey does not include pregnant women who attend private health facilities, or women who deliver at public health facilities without having made a booking visit. Women with higher socio-economic status (proxied by post-secondary levels of education) and those seeking antenatal care in the private health sector have a relatively low prevalence of HIV.[17] Thus the surveys, which are conducted only in public health facilities, are likely to over-estimate HIV prevalence in pregnant women generally.

Figure 3a: HIV prevalence in pregnant women attending public antenatal clinics, by province, 2000 & 2012

(Y-axis reduced to 70%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2000	20.2%	27.9%	29.4%	36.2%	13.2%	29.7%	22.9%	11.2%	8.7%	24.5%
2012	29.1%	32.0%	29.9%	37.4%	22.3%	35.6%	29.7%	17.8%	16.9%	29.5%

Source: Department of Health (2001; 2013) *National HIV and Syphilis Prevalence Survey 2000; National Antenatal Sentinel HIV and Herpes Simplex Type-2 Prevalence Survey 2012*. Pretoria: DoH.

The number and proportion of children living far from their health facility

This indicator reflects the distance from a child's household to the health facility they normally attend. Distance is measured through a proxy indicator: length of time travelled to reach the health facility, by whatever form of transport is usually used. The health facility is regarded as "far" if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport.

A review of international evidence suggests that universal access to key preventive and treatment interventions could avert up to two-thirds of under-five deaths in developing countries.[18] Preventative measures include promotion of breast- and complementary feeding, micronutrient supplements (vitamin A and zinc), immunisation, and the prevention of mother-to-child transmission of HIV, amongst others. Curative interventions provided through the government's Integrated Management of Childhood Illness strategy include oral rehydration, infant resuscitation and the dispensing of medication.

According to the UN Committee on Economic, Social and Cultural Rights, primary health care should be available (in sufficient supply), accessible (easily reached), affordable and of good quality.[19] In 1996, primary level care was made free to everyone in South Africa, but the availability and physical accessibility of health care services remain a problem, particularly for people living in remote areas.

Physical inaccessibility poses particular challenges when it comes to health services because the people who need these services are often unwell or injured, or need to be carried because they are too young, too old or too weak to walk. Physical inaccessibility can be related to distance, transport options and costs, or road infrastructure. Physical distance and poor roads also make it difficult for mobile clinics and emergency services to reach outlying areas. Within South Africa, patterns of health care utilisation are influenced by the distance to the health service provider: those who live further from their nearest health facility are less likely to use the facility. This "distance decay" is found even in the uptake of services that are required for all children, including immunisation and maintaining the clinic card (Road-to-Health booklet).[20]

A quarter (25%) of South Africa's children live far from the primary health care facility they normally use, and over 90% attend the facility closest to their home. Amongst households with children, only 8% do not usually attend their nearest health facility, and within the poorest 40% of households, only 5% do not use their nearest facility, while 16% of children in upper quintile households (the richest 20%) travel beyond their nearest health facility to seek care. The main reasons for attending a more distant health service relate to choices based on perceptions of quality: preference for a private doctor, long waiting times at clinics, non-availability of medicines.[21]

In total, 4.7 million children travel more than 30 minutes to reach their usual health care service provider. This is a significant improvement since 2002, when 37% (or 6.9 million children) lived far from their nearest clinic.

It is encouraging that the greatest improvements in access have been made in provinces which performed worst in 2002: the Eastern Cape (where the proportion of children with poor access to health facilities dropped from 55% in 2002 to 37% in 2012), KwaZulu-Natal (down from 49% to 33%), Limpopo (from 43% to 27%) and North West (from 39% to 29%) over the 11-year period. Provinces with the highest rates of access are the largely metropolitan provinces of Gauteng and the Western Cape, both at 11%.

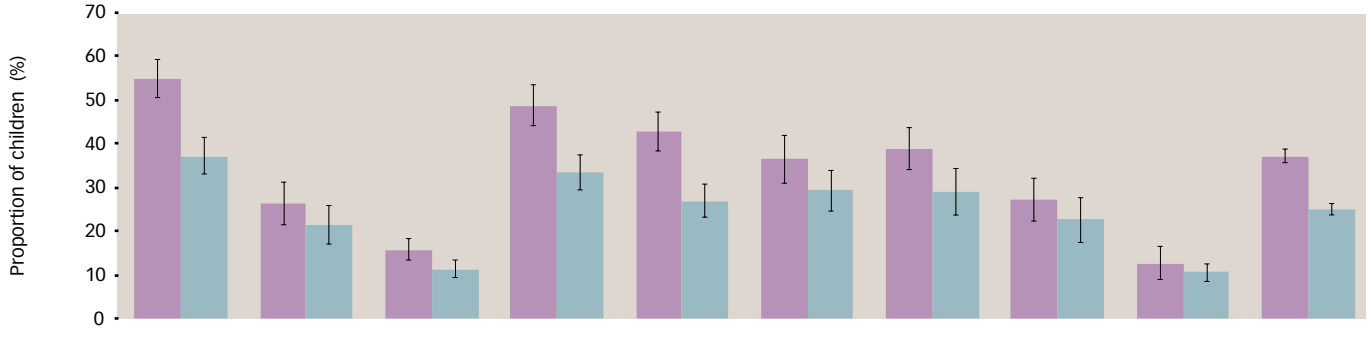
There are also significant differences between population groups. Over a quarter (28%) of African children travel far to reach a health care facility, compared with only 6 – 10% of Coloured, Indian and White children. Racial inequalities are amplified by access to transport: if in need of medical attention, 96% of White children would be transported to their health facility in a private car, compared with only 9% of African children and 30% of Coloured children.

Poor children bear the greatest burden of disease, partly due to poorer living conditions and levels of services (water and sanitation). Yet health facilities are least accessible to the poor. Over a third of children (36%) in the poorest 20% of households have to travel far to access health care, compared with 6% of children in the richest 20% of households.

There are no significant differences in patterns of access to health facilities when comparing children of different sex or age groups.

Figure 3b: Children living far from their health facility, by province, 2002 & 2012

(Y-axis reduced to 70%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	54.8%	26.3%	15.8%	48.7%	42.7%	36.4%	38.9%	27.0%	12.6%	37.1%
	1,653,000	285,000	454,000	2,089,000	1,061,000	559,000	490,000	118,000	205,000	6,914,000
2012	37.1%	21.4%	11.3%	33.2%	26.8%	29.2%	28.9%	22.5%	10.5%	25.1%
	1,002,000	198,000	399,000	1,350,000	598,000	455,000	367,000	94,000	197,000	4,656,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012.* Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children living in households where there is reported child hunger

Section 28(1)(c) of the Bill of Rights in the Constitution gives every child the right to basic nutrition. The fulfilment of this right depends on children's access to sufficient food. This indicator shows the number and proportion of children living in households where children are reported to go hungry "sometimes", "often" or "always" because there isn't enough food. Child hunger is emotive and subjective, and this is likely to undermine the reliability of estimates on the extent and frequency of reported hunger, but it is assumed that variation and reporting error will be reasonably consistent so that it is possible to monitor trends from year to year.

The government has introduced a number of programmes to alleviate income poverty and to reduce hunger, malnutrition and food insecurity, yet 2.5 million children (14%) lived in households where child hunger was reported in 2012. There was a significant drop in reported child hunger, from 31% of children in 2002 to 16% in 2006. Since then the rate has remained fairly consistent, suggesting that despite expansion of social grants, school feeding schemes and other efforts to combat hunger amongst children, there may be targeting issues which continue to leave households vulnerable to food insecurity.

There are large disparities between provinces and population groups. Provinces with relatively large numbers of children and high rates of child hunger are the Eastern Cape (20%) and KwaZulu-Natal (16%), which together have over a million children living in households that report having insufficient food for children. These provinces consistently reported high rates of child hunger throughout the past decade, although the proportion of children experiencing hunger has declined substantially in all provinces over the period. Limpopo has a large rural child population with high rates of unemployment and income poverty, yet child hunger has remained well below the national average, reported at 4% in 2012.

Hunger, like income poverty and household unemployment, is most likely to be found among African children. In 2012, some 2.4 million African children lived in households that reported child hunger. This equates to 15% of the total African child population, while relatively few Coloured (10%) children lived in households where child hunger was reported, and the proportions for Indian and White children were below 1%.

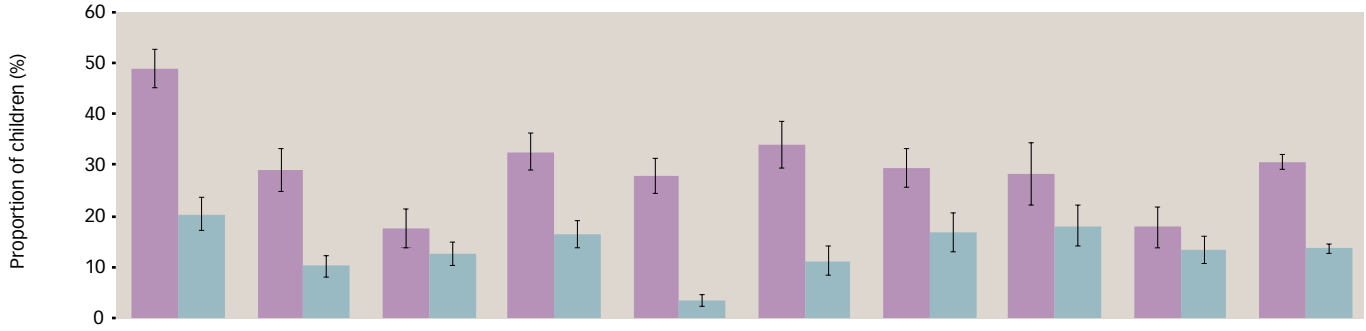
Although social grants are targeted to the poorest households and are associated with improved nutritional outcomes, child hunger is still most prevalent in the poorest households: 23% of children in the poorest quintile go hungry sometimes, compared with 1% in the wealthiest quintile of households.

There are no significant differences in reported child hunger across age groups. However, over 800,000 children aged less than five years are reported to have experienced child hunger. Young children are particularly vulnerable to prolonged lack of food, which increases their risk of nutritional deficiencies which may result in stunting. Inadequate food intake compromises children's growth, health and development, increases their risk of infection, and contributes to malnutrition. Stunting (or low height-for-age) indicates an ongoing failure to thrive. It is the most common form of malnutrition in South Africa and affects 25% of children under five.[22]

It should be remembered that this is a household-level variable, and so reflects children living in households where children are reported to go hungry often or sometimes; it does not reflect the allocation of food within households.

Figure 3c: Children living in households where there is reported child hunger, by province, 2002 & 2012

(Y-axis reduced to 60%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	48.8%	29.0%	17.5%	32.6%	27.8%	34.0%	29.3%	28.3%	17.8%	30.6%
	1,474,000	314,000	503,000	1,397,000	690,000	521,000	370,000	124,000	292,000	5,696,000
2012	20.4%	10.1%	12.4%	16.4%	3.5%	11.2%	16.7%	18.1%	13.3%	13.7%
	550,000	94,000	439,000	668,000	78,000	174,000	213,000	76,000	250,000	2,540,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002*; *General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

References

1 Constitution of the Republic of South Africa, 1996.
2 Organisation of the African Union (1990) *African Charter on the Rights and Welfare of the Child, 11 July 1990. OAU Doc. CAB/LEG/24.9/49.* Addis Ababa: OAU.
3 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child. UN General Assembly Resolution 44/25*. Geneva: United Nations.
4 Statistics South Africa (2009) *Mortality and Causes of Death in South Africa, 2007. Findings from Death Notification. Statistical Release P0309.3.* Pretoria: StatsSA.
5 Statistics South Africa (2014) *Mortality and Causes of Death in South Africa, 2011. Findings from Death Notification. Statistical release P0309.3.* Pretoria: StatsSA.
6 United Nations (2000) *United Nations Millennium Declaration. Resolution Adopted by the General Assembly. A/RES/55/2, 18 September 2000.* UN: New York.
7 Nannan N, Dorrington RE, Laubscher R, Zinyakatira N, Prinsloo M, Darikwa TB, Matzopoulos R & Bradshaw D (2012) *Under-5 Mortality Statistics in South Africa: Shedding Some Light on the Trends and Causes 1997 – 2007.* Cape Town: Medical Research Council.
8 Bradshaw D, Dorrington RE & Laubscher R (2014) *Rapid Mortality Surveillance Report 2012.* Cape Town: Medical Research Council.
9 Goga AE, Dinh TH & Jackson DJ for the SAPMTCTE study group (2013) *Early (4 – 8 weeks post-delivery) Population-level Effectiveness of WHO PMTCT Option A, South Africa, 2011.* Medical Research Council, Department of Health & PEPFAR/US Centers for Disease Control and Prevention.
10 South Africa Every Death Counts Writing Group (2008) Every death counts: Use of mortality audit data for decision making to save the lives of mothers, babies and children in South Africa. *The Lancet,* 371(6920): 1294-1304.
11 Department of Health (2012) *Saving Mothers 2008 – 2010: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa.* Pretoria: DoH.
12 Stephen CR & Bamford LJ (eds) (2013) *Saving Children 2010 – 2011. A Seventh Survey of Child Healthcare in South Africa.* Pretoria: Tshepesa Press, Medical Research Council & Centers for Disease Control and Prevention.
13 Barron P, Pillay Y, Doherty T, Sherman G, Jackson D, Bhardwaj S, Robinson P & Goga A (2013) Eliminating mother-to-child HIV transmission in South Africa. *Bulletin of the World Health Organization*, 91: 70-74.
14 See no. 9 above.
15 Auvert B, Buvé A, Ferry B, Caraël M, Morison L, Lagarde E, Robinson NJ, Kahindo M, Chege J, Rutenberg N, Musonda R, Laourou M & Akam E (2001) Ecological and individual level analysis of risk factors for HIV infection in four urban populations in sub-Saharan Africa with different levels of HIV infection. *AIDS*, 15(Suppl 4): S15-30;
Williams BG, Lloyd-Smith JO, Gouws E, Hankins C, Getz WM, Hargrove J, de Zoysa I, Dye C & Auvert B (2006) The potential impact of male circumcision on HIV in Sub-Saharan Africa. *PLoS Medicine*, 3(7): e262.
Maughan-Brown B, Venkataramani A, Nattrass N, Seekings J & Whiteside A (2011) A cut above the rest: Traditional male circumcision and HIV risk among Xhosa men in Cape Town, South Africa. *Journal of Acquired Immune Deficiency Syndrome*, 58(5): 499-505.
16 Connolly C, Simbayi LC, Shanmugam R & Nqeketo A (2008) Male circumcision and its relationship to HIV infection. *South African Medical Journal,* 98(10): 789-794.
17 Johnson L, Dorrington R, Bradshaw D, du Plessis H & Makubalo L (2009) The effect of educational attainment and other factors on HIV risk in South African women: Results from antenatal surveillance, 2000 – 2005. *AIDS*, 23(12): 1583-1588;
Bärnighausen T, Hosegood V, Timaeus I & Newell M (2007) The socioeconomic determinants of HIV incidence: Evidence from a longitudinal, population-based study in rural South Africa. *AIDS,* 21(Suppl 7): S29-S38;
Wilkinson D (1999) HIV infection among pregnant women in the South African private medical sector. *AIDS*, 13(13): 1783.
18 Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS & Bellagio Child Survival Study Group (2003) How many deaths can we prevent this year? *The Lancet,* 362(9977): 65-71.
19 United Nations Economic and Social Council (2000) I*nternational Covenant on Economic, Social and Cultural Rights, Article 12: The Right to the Highest Attainable Standard of Health: General Comment No. 14.* Geneva: Committee on Economic, Social and Cultural Rights.
20 McLaren Z, Ardington C & Leibbrandt M (2013) *Distance as a Barrier to Health Care Access in South Africa*. A Southern Africa Labour and Development Research Unit Working Paper no. 97. Cape Town: SALDRU, UCT.
21 K Hall analysis of *General Household Survey 2012*, Children's Institute, UCT.
22 Hall K, Nannan N & Sambu W (2013) Child Health and Nutrition. In: Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) *South African Child Gauge 2013*. Cape Town: Children's Institute, UCT.

Children's access to education

Katharine Hall (Children's Institute, University of Cape Town)

Section 29(1)(a) of the South African Constitution states that "everyone has the right to a basic education", and section 29(1)(b) says that "everyone has the right to further education", and that the state must make such education "progressively available and accessible".[1]

Article 11(3)(a) of the African Charter on the Rights and Welfare of the Child says "States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realisation of this right and shall in particular … provide free and compulsory basic education".[2]

Article 28 of the UN Convention on the Rights of the Child recognises "the right of the child to education" and also obliges the state to "make primary education compulsory and available free to all".[3]

Number and proportion of children attending an educational institution

This indicator reflects the number and proportion of children aged 7 – 17 years who are reported to be attending a school or educational facility. This is different from "enrolment rate", which reflects the number of children enrolled in educational institutions, as reported by schools to the national Department of Basic Education early in the school year.

Education is a central socio-economic right that provides the foundation for life-long learning and economic opportunities. Children have a right to basic education and are admitted into grade 1 in the year they turn seven. Basic education is compulsory in grades 1 – 9, or for children aged 7 – 15. Children who have completed basic education also have a right to further education (grades 10 – 12), which the government must take reasonable measures to make available.

South Africa has high levels of school enrolment and attendance. Amongst children of school-going age (7 – 17 years) the vast majority (97%) attended some form of educational facility in 2012. Since 2002, the national attendance rate has seen a 2.5 percentage point increase. Of a total of 11.2 million children aged 7 – 17 years, 290,000 are reported as not attending school in 2012.

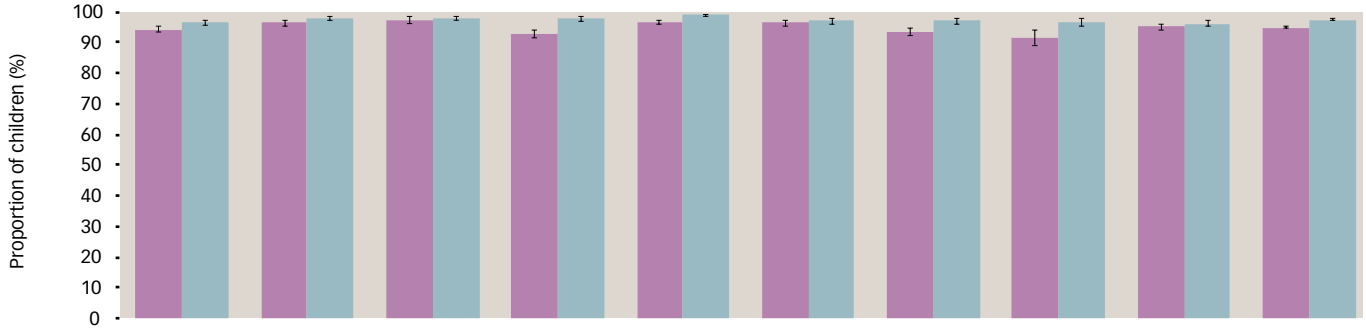
At a provincial level, the Northern Cape, North West and KwaZulu-Natal have all seen significant increases in attendance rates. In the Northern Cape, attendance increased by five percentage points from 91% in 2002 to 96% in 2012. In KwaZulu-Natal, the attendance increased from 93% in 2002 to 98% in 2012, while in the North West, it increased by three percentage points in the same period. There has been a small but real increase in reported attendance rates for African and Coloured children over the 11-year period since 2002. Attendance rates for Coloured children remained slightly below the national average in 2012, at 95%.

Overall attendance rates tend to mask the problem of drop-out among older children. Analysis of attendance among discrete age groups shows a significant drop in attendance amongst children older than 14. Whereas 99% of children in each age year from seven to 13 are reported to be attending an educational institution, the attendance rate drops to 98% and 97% for 14- and 15-year-olds respectively. Schooling is compulsory only until the age of 15 or the end of grade 9, and the attendance rate decreases more steeply from age 16 onwards, with 94% of 16-year-olds, 89% of 17-year-olds, and 81% of 18-year-olds reported to be attending school (based on those who have not successfully completed grade 12).[4]

Although there are differences in school attendance rates between boys and girls in the upper teens, with boys more likely to be attending school, the difference is not significant if one excludes those who have successfully completed grade 12.

Amongst children of school-going age who are not attending school the main set of reasons for non-attendance relate to financial constraints. These include the cost of schooling (18%), or

Figure 4a: School-age children attending an educational institution, by province, 2002 & 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	94.1%	96.3%	97.2%	92.6%	96.6%	96.3%	93.6%	91.4%	95.1%	94.8%
	1,793,000	621,000	1,616,000	2,444,000	1,495,000	889,000	692,000	239,000	927,000	10,715,000
2012	96.5%	97.9%	97.9%	97.5%	98.9%	96.9%	97.0%	96.4%	96.2%	97.4%
	1,589,000	530,000	2,044,000	2,442,000	1,336,000	906,000	714,000	242,000	1,080,000	10,884,000

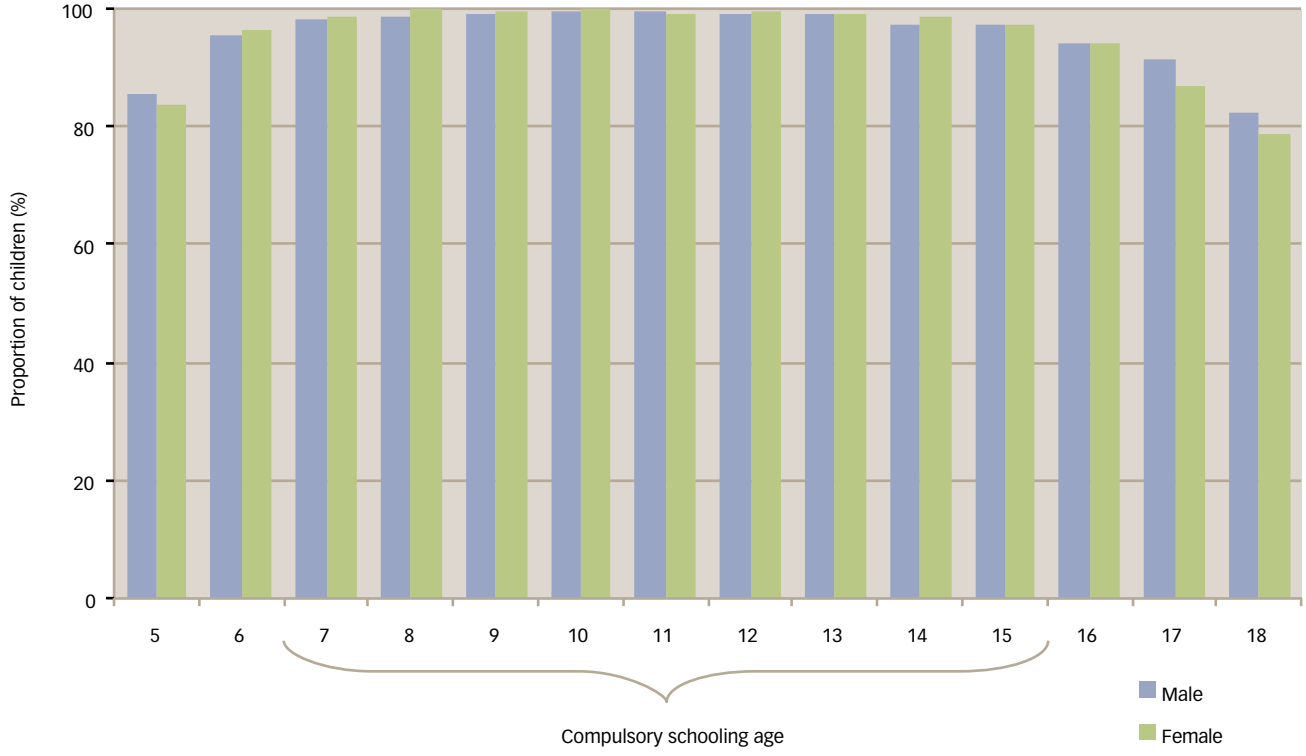
Source: Statistics South Africa (2003, 2013) *General Household Survey 2002; General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

the opportunity costs of education, where children have family commitments such as child minding (9%) or are needed to work in a family business or elsewhere to support household income (3%). The second most common set of reasons is related to perceived learner or education system failures, such as a perception that "education is useless" (12%), feeling unable to perform at school (8%), or exam failure (4%). Other reasons for drop-out are illness (8%) and disability (9%). Pregnancy accounts for around 10% of drop-out amongst teenage girls not attending school (or 5% of all non-attendance).[5]

Attendance rates alone do not capture the regularity of children's school attendance, or their progress through school. Research has shown that children from more "disadvantaged" backgrounds – with limited economic resources, lower levels of parental education, or who have lost one or both parents – are indeed less likely to enrol in school and are more prone to dropping out or progressing more slowly than their more advantaged peers.[6] Racial inequalities in school advancement remain strong. Similarly, school attendance rates tell us nothing about the quality of teaching and learning.

There is little variation in school attendance rates across the income quintiles. Irrespective of whether children live in the poorest or wealthiest 20% of households, school attendance rates remain high – between 96% and 99%.

Figure 4b: Reported attendance at an educational institution, by age and sex, 2012



Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Access to early childhood learning programmes

This indicator reflects the number and proportion of children aged 5 – 6 years who are reported to be attending an early childhood development (ECD) centre or educational institution – in other words, those attending out-of-home care and learning centres. It includes those who attend ECD centres as well as those attending pre-grade R, grade R or grade 1 in ordinary schools. While all these facilities provide care and stimulation for young children, the emphasis on providing learning opportunities through structured learning programmes differs by facility type.

Educational inequalities are strongly associated with structural socio-economic (and therefore also racial) inequalities in South Africa.[7] These inequalities are evident from the early years, even before entry into primary school. They are exacerbated by a very unequal schooling system,[8] and are difficult to reverse. But early inequalities can be reduced through pre-school exposure to developmentally appropriate activities and programmes that stimulate cognitive development.[9] Provided that they are of good quality, early learning programmes are an important mechanism to interrupt the cycle of inequality by reducing socio-economic differences in learning potential between children before they enter the foundation phase of schooling.

The Action Plan[10] of the Department of Basic Education (DBE) includes a broad goal to "improve the access of children to quality early childhood development below Grade 1", and specifically to improve the quality and achieve universal access to grade R by 2014 (thus extending the original deadline of 2010). The plan does not mention pre-grade R learning programmes, but current evidence suggests that quality group learning programmes are beneficial for cognitive development from about three years of age.[11] The DBE funds and monitors thousands of community-based grade R centres in addition to the school-based grade R classes. The National Planning Commission has proposed the introduction of a second year of pre-school education, and that both years be made universally accessible to children.[12] It therefore makes sense to monitor enrolment in early learning programmes of children in the 5 – 6-year pre-school age group.

In 2012, there were 265,105 "learners" attending 3,961 ECD centres in South Africa, according to the DBE's administrative data. The number of learners in ECD centres dropped by 7% between 2011 and 2012. The DBE snap survey counts another 815, 935 learners attending grade R or pre-grade R at primary schools, of whom 94% were at public (government schools) while 6%, or 49,000, were at independent schools.[13]

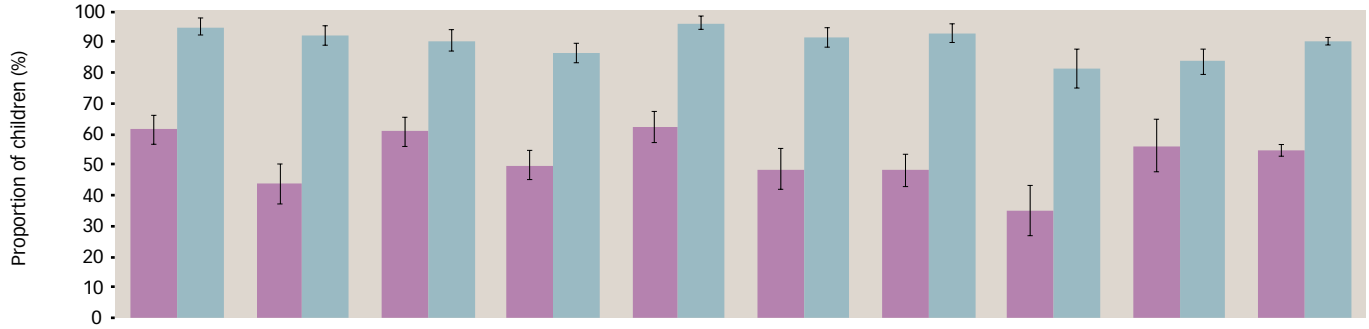
In 2012, 90% of children (1.9 million) in the pre-school age group (5 – 6-year-olds) were reported to be attending some kind of educational institution. This was an increase of 36 percentage points since 2002, when 1.1 million were reported to be attending an educational institution. Of the 1.9 million 5 – 6-year-olds attending an educational institution in 2012, 40% (or 740,000 children) were already in grade 1.

Attendance rates are high across all provinces. The highest attendance rates in 2012 were in Limpopo (96%), the Eastern Cape (95%) and North West (93%), and the lowest in the Western Cape (84%). This pattern differs from many other indicators, where the Western Cape usually out-performs the poorer and more rural provinces like the Eastern Cape and Limpopo. Similar patterns were found in analyses of the 2007 Community Survey and the 2008 National Income Dynamics Survey.[14]

Given the inequities in South Africa, it is pleasing to see that there are no substantial racial differences in access to educational institutions by African and White children of pre-school age, although levels of enrolment among Coloured and Indian children remain below the national average, at 83% and 84% respectively. It is also encouraging that, as with formal school attendance, there are no strong differences in pre-school enrolment across the income quintiles. As would be expected in the South African context, no gender differences in access to early learning are observed.

As with the indicator that monitors school attendance, it should be remembered that this indicator tells us nothing about the quality of care and education that young children receive. High rates of attendance provide a unique opportunity because almost all children in an age cohort can be reached at a particularly important developmental stage; but this is a lost opportunity if the service is of poor quality.

Figure 4c: School or ECD facility attendance among children aged 5 – 6 years only, by province, 2002 & 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	61.4%	43.7%	60.7%	49.7%	62.2%	48.4%	48.2%	35.0%	56.1%	54.6%
	208,000	53,000	189,000	231,000	168,000	83,000	69,000	18,000	102,000	1,120,000
2012	94.9%	92.0%	90.5%	86.4%	96.2%	91.5%	93.0%	81.2%	83.6%	90.3%
	296,000	95,000	362,000	411,000	226,000	162,000	128,000	36,000	181,000	1,898,000

Source: Statistics South Africa (2002; 2013) *General Household Survey 2002; General Household Survey 2012*. Pretoria: StatsSA.
Analysis by Katharine Hall and Winnie Sambu, Children's Institute, UCT.
Note: Prior to 2009, enrolment in crèches, playgroups and ECD centres would have been under-reported as the survey only asked about attendance at "educational institutions". More specific questions about ECD facilities were introduced in the 2009 survey, and are likely to have resulted in higher response rates.
(For a more detailed technical explanation, see www.childrencount.ci.org.za.)

Number and proportion of children living far from school

This indicator reflects the distance from a child's household to the school s/he attends. Distance is measured through a proxy indicator: length of time travelled to reach the school attended, which is not necessarily the school nearest to the child's household. The school the child attends is defined as "far" if a child has to travel more than 30 minutes to reach it, irrespective of mode of transport. Children aged 7 – 13 are defined as primary school age, and children aged 14 – 17 are defined as secondary school age.

Access to schools and other educational facilities is a necessary condition for achieving the right to education. A school's location and distance from home can pose a barrier to education. Access to schools is also hampered by poor roads, transport that is unavailable or unaffordable, and danger along the way. Risks may be different for young children, for girls and boys, and are likely to be greater when children travel alone.

For children who do not have schools near to their homes, the cost, risk and effort of getting to school can influence decisions about regular attendance, as well as participation in extramural activities and after-school events. Those who travel long distances to reach school may wake very early and risk arriving late or physically exhausted, which may affect their ability to learn. Walking long distances to school may also lead to learners being excluded from class or make it difficult to attend school regularly.

Close to three-quarters (72%) of South Africa's learners walk to school, while 8% use public transport. Only 1% report using school buses or transport provided by the government. The vast majority (84%) of White children are driven to school in private cars, compared with only 11% of African children.[15] These figures illustrate pronounced disparity in child mobility and means of access to school.

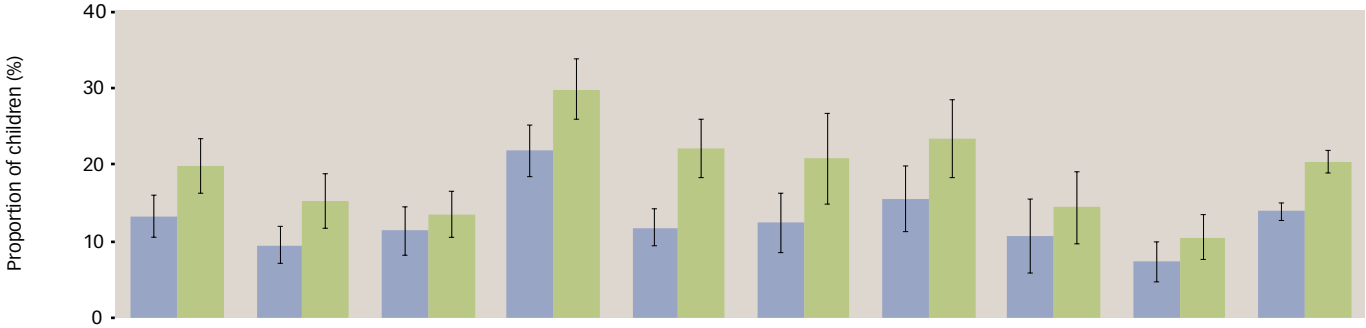
Assuming that schools primarily serve the children living in communities around them, the ideal indicator to measure physical access to school would be the distance from the child's household to the nearest school. This analysis is no longer possible due to question changes in the General Household Survey. Instead, the indicator shows the number and proportion of children who travel far (more than 30 minutes) to reach the actual school that they attend, even if it is not the closest school. School-age children not attending school are therefore excluded from the analysis.

Overall, the vast majority (84%) of the 10.9 million children who attend school travel less than 30 minutes to reach school and most learners (83%) attend their nearest school. Children of secondary age are more likely than primary school learners to travel far to reach school. In mid-2012 there were over seven million children of primary school age (7 – 13 years) in South Africa. Close to one million of these children (14%) travel more than 30 minutes to and from school every day. In KwaZulu-Natal this proportion is significantly higher than the national average, at 22%. Of the four million children of secondary school age (14 – 17 years), 20% travel more than 30 minutes to reach school.

Physical access to school remains a problem for many children in South Africa, particularly those living in more remote areas where public transport to schools is lacking or inadequate and where households are unable to afford private transport for children to get to school.[16] A number of rural schools have closed since 2002, making the situation more difficult for children in these areas. Nationally, the number of public schools has dropped by 8% (over 2,000 schools) between 2002 and 2012, with the largest decreases in the Free State, North West and Limpopo. Over the same period, the number of independent schools has risen by 386 (33%).[17]

Figure 4d: School-aged children living far from school, by province, 2012

(Y-axis reduced to 40%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Primary	13.2%	9.5%	11.4%	21.8%	11.8%	12.3%	15.6%	10.6%	7.3%	13.9%
	131,000	32,000	157,000	347,000	93,000	74,000	73,000	17,000	52,000	976,000
Secondary	19.8%	15.3%	13.6%	29.8%	22.0%	20.8%	23.3%	14.4%	10.5%	20.4%
	130,000	31,000	96,000	272,000	124,000	69,000	63,000	13,000	43,000	845,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012.* Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Children's progress through school

Systemic evaluations by the Department of Education have recorded very low pass rates in numeracy and literacy amongst both grade 3 and grade 6 learners.[18] Despite measures to address the inherited inequities in the education system through revisions to the legislative and policy framework and to the school funding norms, continued disparities in the quality of education offered by schools reinforce existing socio-economic inequalities, limiting the future work opportunities and life chances of children who are born into poor households.[19]

Children are required to attend school from the year they turn seven, and to stay in school until they have completed grade 9 or reached the age of 15. School attendance rates are very high during this compulsory schooling phase. However, attendance tells us little about the quality of education that children receive, or how well they are progressing through the education system.

South Africa has poor educational outcomes by international standards and even within Africa[20] and high rates of grade repetition have been recorded in numerous studies. For example, a study of children's progress at school found that only about 44% of young adults (aged 21 – 29) had matriculated, and of these less than half had matriculated "on time".[21] In South Africa, the labour market returns to education only start kicking in on successful completion of matric, not before. However it is important to monitor progress and grade repetition in the earlier grades, as slow progress at school is a strong determinant of school drop-out.[22]

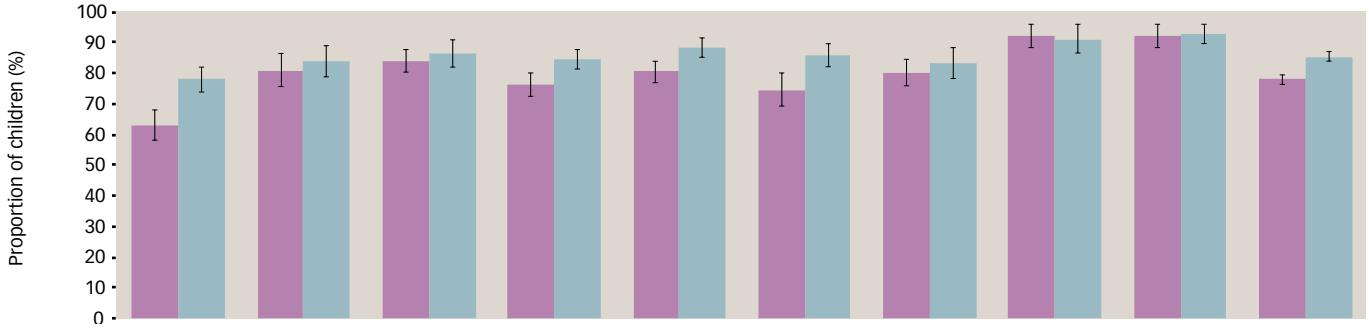
Assuming that children are enrolled in primary school at the prescribed age (by the year in which they turn seven) and assuming that they do not repeat a grade or drop out of school, they would be expected to have completed the foundation phase (grade 3) by the year that they turn nine, and the general education phase (grade 9) by the year they turn 15.

This indicator allows a little more leeway: it measures the number and proportion of children aged 10 and 11 years who have completed a minimum of grade 3, and the proportion of those aged 16 and 17 years who have completed a minimum of grade 9. In other words, it allows for the older cohort in each group to have repeated one grade, or more if they started school in the year before they turned seven.

In 2012, 85% of all children aged 10 and 11 were reported to have completed grade 3. This was up from 78% in 2002. This improvement in progress through the foundation phase was evident across most of the provinces, with significant improvements in KwaZulu-Natal (from 76% to 84%) and Mpumalanga (from 75% to 86%). The best performing provinces in 2012 were Limpopo, Northern Cape and the Western Cape – although by 2012 provincial variation was not very pronounced. Only the Eastern Cape lagged behind, with 78% of its 270,000 children in this age group having completed the foundation phase.

As would be expected, the rate of progression through the entire general education and training band (grades 1 – 9) is lower, as there is more time for children to have repeated or dropped out by grade 9. Sixty-one percent of children aged 16 – 17 years had completed grade 9 in 2012. This represents an overall improvement of nearly 12 percentage points over the 10-year period, from 48% in 2002. Provincial variation is slightly more pronounced than for progress through the foundation phase: Gauteng had the highest rate of grade 9 progression (75%), followed by the Western Cape (70%). Progress was poorest in the Eastern Cape, where less than half (48%) of children had completed grade 9 by the expected age.

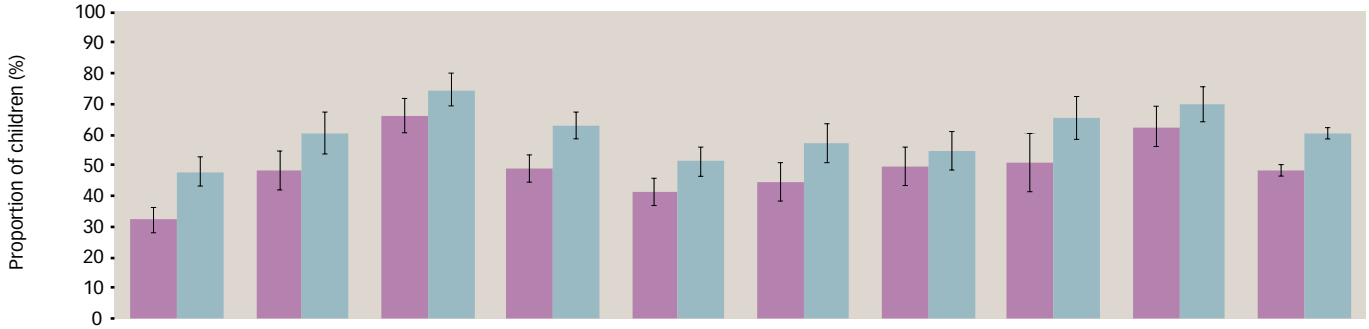
Figure 4e: Children aged 10 – 11 years who have passed grade 3, by province, 2002 & 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2002	63.1%	80.8%	84.1%	76.1%	80.5%	74.6%	80.3%	92.0%	92.0%	78.0%
	210,000	95,000	248,000	370,000	216,000	131,000	111,000	52,000	167,000	1,599,000
2012	77.9%	83.8%	86.4%	84.4%	88.4%	85.7%	83.3%	91.2%	92.8%	85.4%
	211,000	88,000	332,000	343,000	212,000	151,000	110,000	41,000	181,000	1,669,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Figure 4f: Children aged 16 – 17 who have passed grade 9, by province, 2002 & 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	32.1%	48.3%	66.1%	48.8%	41.3%	44.6%	49.6%	50.8%	62.6%	48.4%
	107,000	54,000	191,000	227,000	113,000	71,000	63,000	21,000	107,000	953,000
2012	48.0%	60.5%	74.6%	62.9%	51.2%	57.2%	54.8%	65.4%	69.9%	60.5%
	162,000	63,000	276,000	272,000	150,000	97,000	75,000	31,000	138,000	1,263,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

As found in other analyses of transitions through school,[23] educational attainment (measured by progress through school) varies along economic and racial lines. These differences become more pronounced as children advance through the grades. Gender differences in school progression, on the other hand, have remained consistent and even widened over the years: girls are more likely than boys to progress through school at the expected rate, and the difference becomes more pronounced in the higher grades. In 2012, 88% of girls aged 10 – 11 had completed grade 3, compared with 82% of boys; in the same year, 67% of 16 – 17-year-old girls had completed grade 9, compared with only 54% of boys in the same age cohort. This finding is consistent with analyses elsewhere.[24]

Of course, grade progression and grade repetition are not easy to interpret. Prior to grade 12, the promotion of a child to the next grade is based mainly on the assessment of teachers, so the measure may be confounded by the extent of the teacher's competence to assess the performance of the child. Analyses of the determinants of school progress and drop out point to a range of factors, many of which are interrelated: there is huge variation in the quality of education offered by schools. These differences largely reflect the historic organisation of schools into racially defined and inequitably resourced education departments. Household-level characteristics and family background also account for some of the variation in grade progression. For example, the level of education achieved by a child's mother explains some of the difference in whether children are enrolled at an appropriate age and whether they go on to complete matric successfully.[25] This in turn suggests that improved educational outcomes for children will have a cumulative positive effect for each subsequent generation.

References

1 Constitution of the Republic of South Africa, 1996.
2 Organisation of the African Union (1990) *African Charter on the Rights and Welfare of the Child, 11 July 1990. OAU Doc. CAB/LEG/ 21.8/49.* Addis Ababa: OAU.
3 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly resolution 44/25*. Geneva: United Nations.
4 A similar trend of lower numbers among higher grades is found in the enrolment data presented by the Department of Education over the years. See for example: Department of Basic Education (2011) *Macro Indicator Trends in Schooling: Summary Report 2011*. Pretoria: DBE.
5 K Hall analysis of General Household Survey 2011, Children's Institute, UCT.
For more information on school drop-out, see also:
Branson N, Hofmeyer C & Lam D (2014) Progress through school and the determinants of school dropout in South Africa. *Development Southern Africa*, 31(1): 106-126;
Gustafsson M (2011) *The When and How of Leaving School: The Policy Implications of New Evidence on Secondary School in South Africa*. Stellenbosch Economic Working Papers 09/11. Stellenbosch: Stellenbosch University.
6 Crouch L (2005) *Disappearing Schoolchildren or Data Misunderstanding? Dropout Phenomena in South Africa.* North Carolina, USA: RTI International;
Lam D & Seekings J (2005) T*ransitions to Adulthood in Urban South Africa: Evidence from a Panel Survey.* Prepared for the International Union for the Scientific Study of Population (IUSSP) general conference, 18 – 23 July 2005, Tours, France;
Lam D, Ardington A & Leibbrandt M (2011) Schooling as a lottery: Racial differences in school advancement in urban South Africa. *Journal of Development Economics*, 95: 121-136.
7 See for example: Van der Berg S, Burger C, Burger R, de Vos M, Gustafsson M, Moses E, Shepherd D, Spaull N, Taylor S, van Broekhuizen H & von Fintel D (2011) *Low Quality Education as a Poverty Trap.* Stellenbosch: Stellenbosch University;
Also see no. 6 above (Lam et al, 2011).
8 Spaull N (2012) *Poverty & Privilege: Primary School Inequality in South Africa.* Paper presented at the "Towards Carnegie3: Strategies to Overcome Poverty & Inequality" conference, 3 – 7 September 2013, UCT.
9 Heckman J (2006) Skill formation and the economics of investing in disadvantaged children. *Science*, 312: 1900-1902;
Southern and Eastern Africa Consortium for Monitoring Education Quality (2011) *Learner Preschool Exposure and Achievement in South Africa.* SACMEQ Policy Brief No. 4, April 2011. Pretoria: Ministry of Education.
10 Department of Basic Education (2011) *Action Plan to 2014: Towards the Realisation of Schooling 2025.* Pretoria: DBE.
11 Engel P, Black M, Behrman JR, de Mello MC, Gertler PJ, Kapiriri L, Martorell R, Young ME & International Child Development Steering Group I (2007) Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world. *The Lancet*, 369(9557): 229-242.
12 National Planning Commission (2012) *National Development Plan – Vision for 2030*. Pretoria: The Presidency.
13 Department of Basic Education (2014) *Education Statistics in South Africa 2012*. Pretoria: DBE.
14 Gustafsson M (2010) *Policy Note on Pre-primary Schooling: An Empirical Contribution to the 2009 Medium Term Strategic Framework.* Stellenbosch Economic Working Papers 05/10. Stellenbosch: Stellenbosch University.
15 See no. 5 (Hall K) above.
16 See no. 5 (Hall K) above.
17 Department of Education (2004) *Education Statistics in South Africa at a Glance in 2002*. Pretoria: DOE;
Department of Basic Education (2014) *Education Statistics in South Africa 2012.* Pretoria: DBE. [Calculations by K Hall, Children's Institute, UCT]
18 Department of Basic Education (2013) *Report on the Annual National Assessments 2013*. Pretoria: DBE.
19 Zoch A (2013) *Life Chances and Class: Estimating Inequality of Opportunity in South Africa for Various Life Stages.* Stellenbosch Economic Working papers 08/13. Stellenbosch University.
20 See no. 7 above (Van der Berg S et al, 2011).
21 Timæus I, Simelane S & Letsoalo T (2013) Poverty, race and children's progress at school in South Africa. *The Journal of Development Studies*, 49(2): 270-284.
22 See no. 5 above (Branson et al, 2013).
23 Branson N & Lam D (2010) Educational inequality in South Africa: Evidence from the National Income Dynamics Study. *Studies in Economics and Econometrics,* 34(3): 85-105.
See no 6 (Lam et al, 2008) and no. 7 (Van der Berg et al, 2011) above.
24 See, for example: Fleisch B & Shindler J (2009) Gender repetition: School access, transitions and equity in the 'Birth-to-Twenty' cohort panel study in urban South Africa. *Comparative Education,* 45(2): 265-279;
See no. 5 above (Branson et al, 2013).
25 See no. 21 above.

Children's access to housing

Katharine Hall (Children's Institute, University of Cape Town)

Section 26 of the Constitution of South Africa provides that "everyone has the right to have access to adequate housing", and section 28(1)(c) gives children "the right to … shelter".[1]

Article 27 of the UN Convention on the Rights of the Child states that "every child has the right to a standard of living adequate for his/her development" and obliges the state "in cases of need" to "provide material assistance and support programmes, particularly with regard to … housing".[2]

Distribution of children living in urban and rural areas

This indicator describes the number and proportion of children living in urban or rural areas in South Africa.

Location is one of the seven elements of adequate housing identified by the United Nations Committee on Economic, Social and Cultural Rights.[3] Residential areas should ideally be situated close to work opportunities, clinics, police stations, schools and child-care facilities. In a country with a large rural population, this means that services and facilities need to be well distributed, even in areas which are not densely populated. In South Africa, service provision and resources in rural areas lag far behind urban areas.

The General Household Survey captures information on all household members, making it possible to look at the distribution of children in urban and non-urban households and compare this to the adult distribution. Nearly half of South Africa's children (45%) lived in rural households in 2012 – equivalent to 8.4 million children. Looking back over a decade, there seems to be a slight shift in the distribution of children towards urban areas: in 2002, 47% of children were found in urban households, and this increased to 55% by 2012.

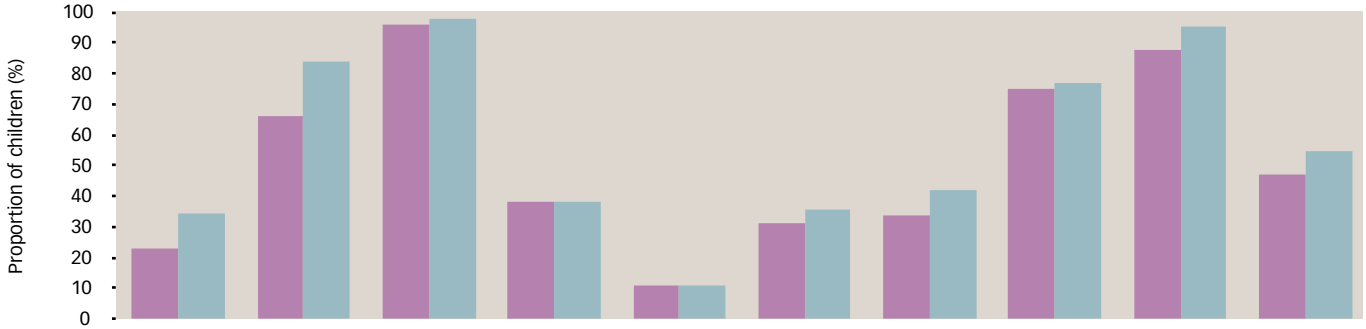
A consistent pattern over the years is that children are more likely than adults to live in rural areas: In 2012, 67% of the adult population were urban, compared with only 55% of children.

There are marked provincial differences in the rural and urban distribution of the child population. This is related to the distribution of cities in South Africa, and the legacy of apartheid spatial arrangements, where women, children and older people in particular were relegated to the former homelands. The Eastern Cape, KwaZulu-Natal and Limpopo provinces alone are home to about three-quarters (74%) of all rural children in South Africa. KwaZulu-Natal has the largest child population in numeric terms, with 2.5 million (62%) of its child population being classified as rural. The province with the highest proportion of rural children is Limpopo, where only 11% of children live in urban areas. Proportionately more children (42%) live in the former homelands, compared with adults (29%), while 58% of adults live in urban formal areas, compared with 47% of children. Eight percent of children live in urban informal areas, and the remaining 3% live in "formal rural" areas – these being mainly commercial farming areas. Over 99% of children living in the former homeland areas are African.

Children living in Gauteng and the Western Cape are almost entirely urban-based (98% and 95% respectively). These provinces have historically large urban populations. The greatest provincial increase in the urban child population has been in the Free State, where the proportion of children living in urban areas increased from 66% of the child population in 2002 to 84% in 2012. In the Eastern Cape, the urban child population has increased by over 11 percentage points, signifying a possible urban trend.

Rural areas, and particularly the former homelands, are known to have much poorer populations. Children in the poorest income quintile are more likely to be living in rural areas (67%) than those in the richest quintile (8%). These inequalities also remain strongly racialised. Over 90% of White, Coloured and Indian children are urban, compared with 47% of African children.

Figure 5a: Children living in urban areas, by province, 2002 & 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2002	23.0%	65.8%	95.7%	38.4%	11.0%	31.4%	33.5%	75.1%	87.8%	47.0%
	693,000	714,000	2,752,000	1,647,000	273,000	482,000	423,000	329,000	1,436,000	8,749,000
2012	34.3%	84.0%	97.7%	38.2%	10.6%	35.8%	42.1%	76.7%	95.2%	54.6%
	924,000	777,000	3,448,000	1,554,000	236,000	558,000	535,000	321,000	1,784,000	10,138,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012.* Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children living in adequate housing

This indicator shows the number and proportion of children living in formal, informal and traditional housing. For the purposes of the indicator, "formal" housing is considered a proxy for adequate housing and consists of: dwellings or brick structures on separate stands; flats or apartments; town/cluster/semi-detached houses; units in retirement villages; rooms or flatlets on larger properties. "Informal" housing consists of: informal dwellings or shacks in backyards or informal settlements; dwellings or houses/flats/rooms in backyards; caravans or tents. "Traditional dwelling" is defined as a "traditional dwelling/hut/structure made of traditional materials". These dwelling types are listed in the General Household Survey, which is the data source.

Children's right to adequate housing means that they should not have to live in informal dwellings. One of the seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights is that it must be "habitable".[4] To be habitable, houses should have enough space to prevent overcrowding, and should be built in a way that ensures physical safety and protection from the weather.

Formal brick houses that meet the state's standards for quality housing could be considered "habitable housing", whereas informal dwellings such as shacks in informal settlements and backyards would not be considered habitable or adequate. Informal housing in backyards and informal settlements makes up the bulk of the housing backlog in South Africa. "Traditional" housing in rural areas is a third category, which is not necessarily adequate or inadequate. Some traditional dwellings are more habitable than new subsidy houses – they can be more spacious and better insulated, for example.

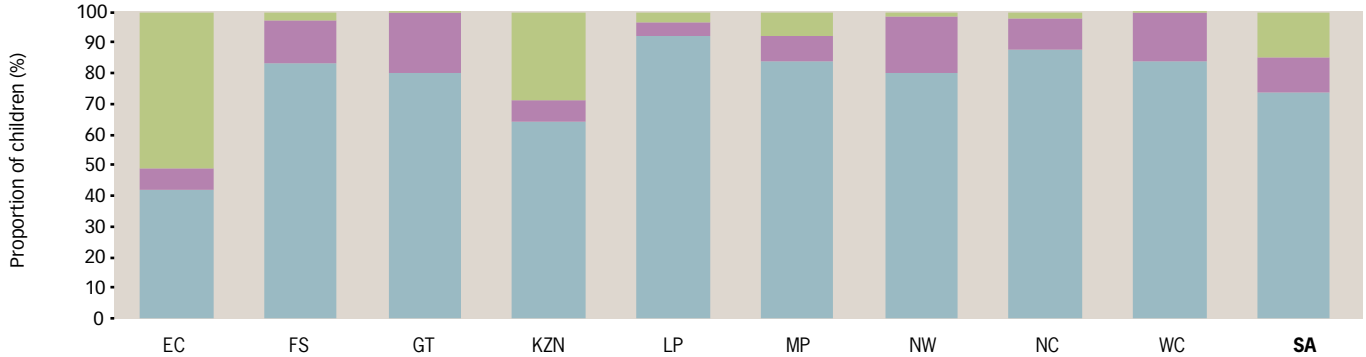
Access to services is another element of "adequate housing". Children living in formal areas are more likely to have services on site than those living in informal or traditional dwellings. They are also more likely to live closer to facilities like schools, libraries, clinics and hospitals than those living in informal settlements or rural areas. Children living in informal settlements are more exposed to hazards such as shack fires and paraffin poisoning.

The environmental hazards associated with informal housing are exacerbated for very young children. The distribution of children in informal dwellings is slightly skewed towards younger children and babies: 42% of children in informal housing are in the 0 – 5-year age group. Of children under two years, 16% live in informal dwellings, after which the rate declines slightly with age. Nine percent of children over 10 years are informally housed. Given that this trend has remained consistent over a number of years, it seems likely that it is the result of child mobility or changing housing arrangements for children as they get older, rather than indicating an increase in informality over time.

In 2012, over 1.6 million children (9%) in South Africa lived in backyard dwellings or shacks in informal settlements. The number of children in informal housing has declined slightly from 2.3 million (12%) in 2002. The main provinces with informally-housed child populations are Gauteng (20% of children), North West (18%), and the Western Cape (16%). Limpopo has the lowest proportion (5%) of children in informal housing and the highest proportion (92%) in formal dwellings. The Eastern Cape and KwaZulu-Natal have by far the largest proportions of children living in traditional dwellings (51% and 29% respectively).

The distribution of children in formal, informal and traditional dwellings has remained fairly constant since 2002. But racial inequalities persist. Almost all White children live in formal housing, compared with only 70% of African children. Access to formal housing increases with income. Virtually all children in the wealthiest 20% of households live in formal dwellings, compared with only 63% of children in the poorest quintile.

Figure 5b: Children living in formal, informal and traditional housing, by province, 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
Formal	42.1%	83.4%	80.0%	64.3%	92.1%	84.0%	80.2%	87.6%	83.8%	73.6%
	1,136,000	771,000	2,823,000	2,619,000	2,053,000	1,308,000	1,021,000	366,000	1,569,000	13,676,000
Informal	6.8%	13.9%	20.0%	6.7%	4.6%	7.9%	18.0%	10.0%	16.1%	11.3%
	183,000	129,000	705,000	275,000	103,000	123,000	229,000	42,000	302,000	2,096,000
Traditional	51.1%	2.7%	0.0%	28.9%	3.3%	8.1%	1.8%	2.4%	0.1%	15.1%
	1,377,000	25,000	1,000	1,178,000	74,000	127,000	23,000	10,000	2,000	2,802,000

Source: Statistics South Africa (2013) *General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children living in overcrowded households

Children are defined as living in overcrowded dwellings when there is a ratio of more than two people per room (excluding bathrooms but including kitchen and living room). Thus, a dwelling with two bedrooms, a kitchen and sitting-room would be counted as overcrowded if there were more than eight household members.

The UN Committee on Economic, Social and Cultural Rights defines "habitability" as one of the criteria for adequate housing.[5] Overcrowding is a problem because it can undermine children's needs and rights. For instance, it is difficult for school children to do homework if other household members want to sleep or watch television. Children's right to privacy can be infringed if they do not have space to wash or change in private. The right to health can be infringed as communicable diseases spread more easily in overcrowded conditions, and young children are particularly susceptible to the spread of disease. Overcrowding also places children at greater risk of sexual abuse, especially where boys and girls have to share beds, or children have to share with adults.

Overcrowding makes it difficult to target services and programmes to households effectively – for instance, urban households are entitled to six kilolitres of free water, but this household-level allocation discriminates against overcrowded households because it does not take account of household size.

In 2012, 3.6 million children lived in overcrowded households. This represents 19% of the child population – much higher than the proportion of adults living in crowded conditions (11%).

Overcrowding is associated with housing type: 54% of children who stay in informal dwellings also live in overcrowded conditions, compared with 28% of children in traditional dwellings and 12% of children in formal housing.

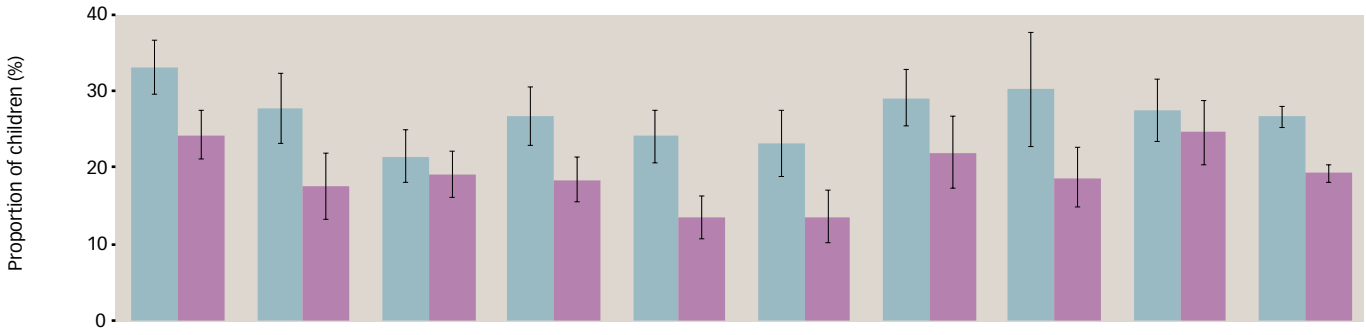
Young children are significantly more likely than older children to live in overcrowded conditions. Twenty-five percent of children below two years live in crowded households, compared to 16% of children over 10 years.

There is a strong racial bias in children's housing conditions. While 21% of African and Coloured children live in crowded conditions, very few White and Indian children live in overcrowded households. Children in the poorest 20% of households are more likely to be living in overcrowded conditions (26%) than children in the richest 20% of households (1%).

The average household size has gradually decreased from 4.5 at the time of the 1996 population census, to around 3.6 in 2012, indicating a trend towards smaller households, which may in turn be linked to the provision of small subsidy houses. Households in which children live are larger than the national average. The mean household size for adult-only households is 1.8 (median: two people), while the mean household size for households with children is 4.9 (median: four members).[6]

Figure 5c: Children living in crowded households, 2002 & 2012

(Y-axis reduced to 40%)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	33.1%	27.7%	21.5%	26.7%	24.1%	23.1%	29.0%	30.1%	27.4%	26.6%
	997,000	301,000	618,000	1,144,000	598,000	354,000	366,000	132,000	448,000	4,959,000
2012	24.3%	17.6%	19.1%	18.4%	13.4%	13.6%	22.0%	18.7%	24.5%	19.2%
	654,000	163,000	675,000	748,000	299,000	212,000	280,000	78,000	460,000	3,569,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012*. Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

References

1 Constitution of the Republic of South Africa, 1996.
2 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Geneva: United Nations.
3 Office of the United Nations High Commissioner for Human Rights (1991) *The Right to Adequate Housing (art.11 (1)): 13/12/91. CESCR General Comment 4*. Geneva: United Nations.
4 See no. 3 above.
5 See no. 3 above.
6 Statistics South Africa (2013) *General Household Survey 2012*. Pretoria: Stats SA. [Analysis by K Hall & W Sambu, Children's Institute, UCT]

Children's access to services

Katharine Hall and Winnie Sambu (Children's Institute, University of Cape Town)

Section 27(1)(b) of the Constitution provides that "everyone has the right to have access to … sufficient … water" Section 24(a) states that "everyone has the right to an environment that is not harmful to their health or well-being".[1]

Article 14(2)(c) of the African Charter on the Rights and Welfare of the Child obliges the state to "ensure the provision of … safe drinking water".[2]

Article 24(1)(c) of the UN Convention on the Rights of the Child says that states parties should "recognise the right of the child to the enjoyment of the highest attainable standard of health" and to this end should "take appropriate measures to combat disease and malnutrition …, including the provision of clean drinking-water".[3]

The number and proportion of children living in households with adquate water

This indicator shows the number and proportion of children who have access to a safe and reliable supply of drinking water at home – either inside the dwelling or on site. All other water sources, including public taps, water tankers, dams and rivers, are considered inadequate because of their distance from the dwelling or the possibility that water is of poor quality. The indicator does not show whether the water supply is reliable or if households have broken facilities.

Clean water is essential for human survival. The World Health Organisation has defined "reasonable access" to water as being a minimum of 20 litres per person per day.[4] This minimum is linked to the estimated average consumption when people rely on communal facilities and need to carry their own water for drinking, cooking and the most basic personal hygiene. It does not allow for bathing, showering, washing clothes or any domestic cleaning.[5] The water needs to be supplied close to the home, as households that travel long distances to collect water often struggle to collect enough.

Young children are particularly vulnerable to diseases associated with poor water quality. Gastro-intestinal infections with associated diarrhoea and dehydration contribute to high child mortality rates.[6] Lack of access to adequate water is closely related to poor sanitation and hygiene. In addition, children may be responsible for fetching and carrying water to their homes from communal taps, or rivers and streams. Carrying water is a physical burden which can lead to back problems or injury from falls. It can also reduce time spent on education and other activities, and can place children at personal risk.[7] For purposes of the child-centred indicator, therefore, adequacy is limited to a safe water source on site.

Over six million children live in households that do not have access to water on site. In 2012, 75% of adults lived in households with drinking water on site – a significantly higher proportion than children (66%). There has been little improvement in children's access to water over the last decade.

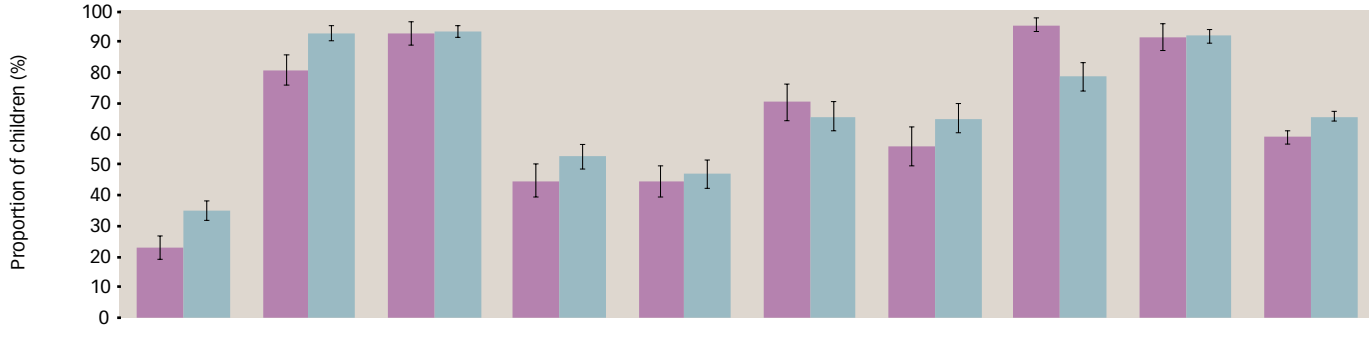
Over 90% of children in the Free State, Gauteng and the Western Cape have an adequate supply of water. However, access to water remains poor in KwaZulu-Natal (53%), Limpopo (47%) and the Eastern Cape (35%). The Eastern Cape appears to have experienced the greatest improvement in water provisioning since 2002 (when only 23% of children had water on site). The apparent decline in access to water in the Northern Cape may reflect a deterioration in water access, or may be the result of weighting a very small child population.

Children living in formal areas are more likely to have water services on site than those living in informal settlements or in the rural former homelands. While 78% of children in formal dwellings have water, it decreases to 64% for children in informal dwellings. Only 15% of children living in traditional housing have clean water available on site.

The vast majority of children living in traditional dwellings are African, so there is a pronounced racial inequality in access to water. Just 60% of African children have water on site, while over 95% of all other population groups have clean drinking water at home.

Inequality in access to safe water is also pronounced when the data are disaggregated by income category. Amongst children in the poorest 20% of households, only 47% have access to water on site, while over 96% of those in the richest 20% of households have this level of service. In this way, inequalities are reinforced: the poorest children are most at risk of diseases associated with poor water quality, and the associated setbacks in their development.

Figure 6a: Children living in households with water on site, by province, 2002 & 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2002	22.7%	80.8%	92.8%	44.6%	44.3%	70.3%	56.0%	95.6%	91.5%	58.8%
	685,000	876,000	2,670,000	1,914,000	1,101,000	1,079,000	707,000	418,000	1,497,000	10,948,000
2012	34.7%	92.7%	93.2%	52.7%	46.9%	65.8%	64.9%	78.5%	91.8%	65.6%
	935,000	858,000	3,287,000	2,145,000	1,045,000	1,025,000	826,000	328,000	1,720,000	12,180,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012.* Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of children living with basic sanitation

This indicator shows the number and proportion of children living in households with basic sanitation. Adequate toilet facilities are used as proxy for basic sanitation. This includes flush toilets and ventilated pit latrines that dispose of waste safely and that are within or near a house. Inadequate toilet facilities include pit latrines that are not ventilated, chemical toilets, bucket toilets, or no toilet facility at all.

A basic sanitation facility is defined in the government's Strategic Framework for Water Services as the infrastructure necessary to provide a sanitation facility which is "safe, reliable, private, protected from the weather and ventilated, keeps smells to a minimum, is easy to keep clean, minimises the risk of the spread of sanitation-related diseases by facilitating the appropriate control of disease carrying flies and pests, and enables safe and appropriate treatment and/or removal of human waste and wastewater in an environmentally sound manner".[8] Adequate sanitation prevents the spread of disease and promotes health through safe and hygienic waste disposal. To do this, sanitation systems must break the cycle of disease. For example the toilet lid and fly screen in a ventilated pit latrine stop flies reaching human faeces and spreading disease. Good sanitation is not simply about access to a particular type of toilet. It is equally dependent on the safe use and maintenance of that technology; otherwise toilets break down, smell bad, attract insects and spread germs.

Good sanitation is essential for safe and healthy childhoods. It is very difficult to maintain good hygiene without water and toilets. Poor sanitation is associated with diarrhoea, cholera, malaria, bilharzia, worm infestations, eye infections and skin disease. These illnesses compromise children's health and nutritional status. Using public toilets and the open *veld* (fields) can also put children in physical danger. The use of the open *veld* and bucket toilets is also likely to compromise water quality in the area and to contribute to the spread of disease. Poor sanitation undermines children's health, safety and dignity.

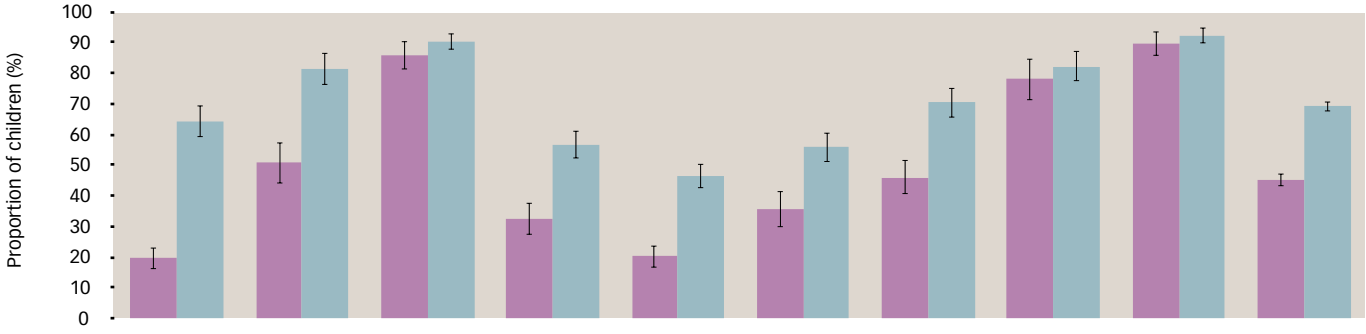
The data show a gradual and significant improvement in children's access to sanitation over the 11-year period 2002 – 2012, although the proportion of children without adequate toilet facilities remains worryingly high. In 2002 less than half of all children (45%) had access to adequate sanitation. By 2012 the proportion of children with adequate toilets had risen by over 20 percentage points to 69%. But five million children still use unventilated pit latrines, buckets or open land, despite the state's reiterated goals to provide adequate sanitation to all, and to eradicate the bucket system. Children (31%) are more likely than adults (24%) to live in households without adequate sanitation facilities.

As with other indicators of living environments, there are great provincial disparities. In provinces with large metropolitan populations, like Gauteng and the Western Cape, over 90% of children have access to adequate sanitation, while provinces with large rural populations have the poorest sanitation. The provinces with the greatest improvements in sanitation services are the Eastern Cape (where the number of children with access to adequate sanitation nearly tripled from 0.6 million to 1.7 million over 11 years), KwaZulu-Natal (an increase of over 900,000 children with adequate sanitation) and the Free State (where the proportion of children with sanitation improved from 51% in 2002 to 81% in 2012). Although there have also been significant improvements in sanitation provision in Limpopo, this province still lags behind, with only 46% of children living in households with adequate sanitation in 2012. It is unclear why the vast majority of children in Limpopo are reported to live in formal houses, yet access to basic sanitation is the poorest of all the provinces. Definitions of adequate housing such as those in the UN-HABITAT and South Africa's National Housing Code include a minimum quality for basic services, including sanitation.

The statistics on basic sanitation provide yet another example of persistent racial inequality: Over 95% of Indian, White and Coloured children had access to adequate toilets in 2012, while only 64% of African children had access to basic sanitation. This is a marked improvement from 36% of African children in 2002. Children in relatively well-off households have better levels of access to sanitation than poorer children. Amongst the richest 20% of households, 97% of children have adequate sanitation, while only 56% of children in the poorest 20% of households have this level of service.

Due to the different distributions of children and adults across the country, adults are more likely than children to have access to sanitation. However, there are no significant age differences in levels of access to adequate sanitation within the child population.

Figure 6b: Children living in households with basic sanitation, by province, 2002 & 2012



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	19.7%	50.8%	85.6%	32.3%	20.1%	35.6%	46.0%	77.9%	89.6%	45.2%
	594,000	551,000	2,462,000	1,387,000	499,000	547,000	580,000	341,000	1,467,000	8,425,000
2012	64.2%	81.4%	90.4%	56.7%	46.4%	55.9%	70.4%	82.1%	92.2%	69.2%
	1,730,000	753,000	3,191,000	2,308,000	1,036,000	871,000	896,000	344,000	1,727,000	12,857,000

Source: Statistics South Africa (2003; 2013) *General Household Survey 2002; General Household Survey 2012.* Pretoria: Stats SA.
Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

References

1 Constitution of the Republic of South Africa, 1996.
2 Organisation of the African Union (1990) *African Charter on the Rights and Welfare of the Child, 11 July 1990. OAU Doc. CAB/LEG/21.8/49*. Addis Ababa: OAU.
3 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly resolution 44/25.* Geneva: United Nations.
4 Ki-moon B (2007) *Children and the Millennium Development Goals: Progress towards a World Fit for Children.* UNICEF: New York.
5 Howard G & Bartram J (2003) *Domestic Water Quantity, Service Level and Health*. Geneva: World Health Organisation.
6 Westwood A (2011) Diarrhoeal disease. In: Stephen C, Bamford L, Patrick W & the MRC Unit for Maternal and Infant Health Care Strategies (eds) *Saving Children 2009: Five Years of Data. A Sixth Survey of Child Healthcare in South Africa.* Pretoria: Tshepesa Press, Medical Research Council & Centre for Disease Control and Prevention.
7 COHRE, AAAS, SDC & UN-Habitat (2007) *Manual on the Right to Water and Sanitation*. Geneva: Centre on Housing Rights and Evictions.
8 Department of Water Affairs and Forestry (2003) *Strategic Framework for Water Services*. Pretoria: DWAF.

Technical notes on the data sources

General Household Survey:[1]

The GHS is a multi-purpose annual survey conducted by the national statistical agency, Statistics South Africa (Stats SA), to collect information on a range of topics from households in the country's nine provinces. The survey uses a sample of approximately 30,000 households. These are drawn from census enumeration areas using a two-stage stratified design with probability proportional to size sampling of primary sampling units (PSUs) and systematic sampling of dwelling units from the sampled PSUs. The resulting weighted estimates are representative of all households in South Africa.

The GHS sample consists of households and does not cover other collective institutionalised living-quarters such as boarding schools, orphanages, students' hostels, old-age homes, hospitals, prisons, military barracks and workers' hostels. These exclusions should not have a noticeable impact on the findings in respect of children.

Changes in sample frame and stratification

The sample design for the 2012 GHS was based on a master sample that was originally designed for the Quarterly Labour Force Survey (QLFS) and was used for the GHS for the first time in 2008. The same master sample is shared by the GHS, the QLFS, the Living Conditions Survey and the Income and Expenditure Survey. The previous master sample for the GHS was used for the first time in 2004. This again differed from the master sample used in the first two years of the GHS: 2002 and 2003. Thus there have been three different sampling frames during the 11-year history of the annual GHS, with the changes occurring in 2004 and 2008. In addition, there have been changes in the method of stratification over the years. These changes could compromise comparability across iterations of the survey to some extent, although it is common practice to use the GHS for longitudinal monitoring and many of the official trend analyses are drawn from this survey.

Weights

Person and household weights are provided by Stats SA and are applied in Children Count analyses to give estimates at the provincial and national levels.

The GHS weights are derived from Stats SA's mid-year population estimates. The population estimates are revised retrospectively from time to time when it is possible to calibrate the population model to larger population surveys (such as the Community Survey) or to census data. In 2013, Stats SA revised the population model to produce mid-year population estimates in light of the census 2011 results. The new data were used to adjust the benchmarking for all previous GHS data sets, which were re-released with the revised population weights by Stats SA.[2] All the Children Count indicators have been re-analysed retrospectively, using the revised weights provided by Stats SA. The estimates are therefore comparable over the period 2002 to 2012. The revised weights particularly affected estimates for the years 2002 – 2007. Users may find that the baseline estimates reported here are different from those reported in previous editions of the *South African Child Gauge*. The revised indicators for all the intervening years are available on the website: www.childrencount.ci.org.za.

Survey data are prone to sampling and reporting error. Some of the errors are difficult to estimate, while others can be identified. One way of checking for errors is by comparing the survey results with trusted estimates from elsewhere. Such a comparison can give an estimate of the robustness of the survey estimates. For this project, weighted GHS population numbers were compared with population projections from the Actuarial Society of South Africa's ASSA2008 AIDS and Demographic model (full version).

Analyses of the 11 surveys from 2002 to 2012 suggest that some over- and under-estimation may have occurred in the weighting process, but that much of this has been resolved by the adjusted weights produced by Stats SA:

- When comparing the previously weighted 2002 data with the ASSA2008 AIDS and Demographic model estimates, the number of children appeared to have been under-estimated by 5% overall, with the most severe under-estimation in the youngest age group (0 – 4 years) where the weighted numbers of boys and girls yield under-estimations of 15% and 16% respectively. Running the same comparison against the GHS2002 but applying the revised weights, the difference is substantially reduced. Assuming that ASSA2008 provides the best population estimates, the newly-weighted GHS2002 is much more closely aligned in all age groups, with the 0 – 4-year group slightly under-estimated by 2%. The next age group (5 – 9 years) was previously under-estimated for both boys and girls, at around 7% each. The revised weights produce a slight over-estimate in the region of 4% of boys and 3% for girls in this age group. The 10 – 14-year age group also appears to have been slightly over-estimated when using revised weights (around 3% for both boys and girls), whereas the previous weights had produced a slight under-estimate for this age group. In contrast, the previously weighted data yielded over-estimates of boys and girls in the upper age group (15 – 19 years), with the GHS over-counting these children by about 5%. After re-weighting, the GHS appears to slightly under-count this age group by nearly 6% for boys, and a lower 2.5% for girls. Over the entire 0 – 19-years age group, the population numbers yielded by the revised GHS weights deviate by less than 1% from the ASSA2008 projections. Overall, then, it appears that the re-weighting of the GHS has produced more plausible estimates for 2002, which is the baseline year for most Children Count analyses.
- Population weights derived from the GHS 2012 data are similarly close to the ASSA2008 projects for the 0 – 19-year age group overall, with a difference of less than 1% between the two estimates for both boys and girls. A detailed comparison of individual age groups has not been undertaken as it is acknowledged that the ASSA2008 model was likely to have over-estimated the extent of AIDS mortality and mother-to-child transmission of HIV in South Africa.[3] This in turn is likely to affect the child population projections in more recent years. A new model is under development and will address these problems, but was not available at the time of publication.

Apparent discrepancies in male-to-female ratios over the 11 years of data may slightly affect the accuracy of the Children Count estimates. From 2005 to 2008, consistently distorted male-to-female ratios mean that the total estimates for certain characteristics would be somewhat slanted toward the male pattern. This effect is reduced from 2009, where more even ratios are produced, in line with the modelled estimates.

Reporting error

Error may be present due to the methodology used, i.e. the questionnaire is administered to only one respondent in the household who is expected to provide information about all other members of the household. Not all respondents will have accurate information about all children in the household. In instances where the respondent did not or could not provide an answer, this was recorded as "unspecified" (no response) or "don't know" (the respondent stated that they didn't know the answer).

SOCPEN database:[4]

Information on social grants is derived from the Social Pensions (SOCPEN) national database maintained by the South African Social Security Agency (SASSA), which was established in 2004 to disburse social grants for the Department of Social Development. Prior to this, the administration of social grants and maintenance of the SOCPEN database was managed directly by the department and its provincial counterparts.

There has never been a published, systematic review of the social grants database, and the limitations in terms of validity or reliability of the data have not been quantified. However, this database is regularly used by the department and other government bodies to monitor grant take-up, and the computerised system, which records every application and grant payment, minimises the possibility of human error. Take-up data and selected reports are available from the department on request throughout the year. Children Count provides grant take-up figures as at the end of March.

References

1 Statistics South Africa (2003 – 2013) *General Household Survey Metadata 2002 – 2012*. Pretoria: Stats SA. Available: http://interactive.statssa.gov.za:8282/webview/.
2 Statistics South Africa (2013) *General Household Survey 2012. Statistical Release P0318*. Pretoria: Stats SA.
3 Actuarial Society of South Africa (2012) *Note to users of the ASSA2008 AIDS and Demographic model, 27 August 2012. http://aids.actuarialsociety.org.za/*
4 South African Social Security Agency (2004 – 2013) SOCPEN social grants data. Pretoria: SASSA.

About the contributors

Patrizia Benvenuti holds a BA degree in Political Science from the Ca' Foscari University of Venice, Italy; and an MSc in Social Policy and Planning from the London School of Economics, United Kingdom. She started her development career with the Italian Embassy in the People's Republic of China in 1998. In 2004 she joined the United Nations Emergency Children's Fund (UNICEF) and worked in the area of child protection in Somalia, Bolivia, Dominican Republic, Haiti and Nepal. She is currently based in Pretoria and heads the Child Protection Programme of UNICEF South Africa.

Carol Bower is an independent consultant in the child rights field, with nearly 40 years' experience in women's and child rights civil society organisations. She holds an Honours degree in Psychology. Currently her main focus is the prohibition of corporal punishment in the home and advocacy for children's rights to protection from abuse and violence. She has been an active member of the Working Group on Positive Discipline since its inception and has produced a number of papers and presentations on the prohibition of corporal punishment and the promotion of non-violent, nurturing parenting and positive discipline on behalf of the Working Group.

Megan Briedé has an Honours degree in Social Work and Psychology and has worked extensively within the child protection sector for over 20 years. Whilst an independent consultant, she is presently technical director for the Government Capacity Building and Support Programme at Pact South Africa, which focuses on strengthening social systems for the improvement of services to vulnerable children.

Cathy Chames is a senior consultant at Southern Hemisphere, a social development consultancy based in Cape Town. She has a Masters in Social Development (University of Cape Town) and has experience in the fields of applied research, planning, monitoring and evaluation, and training. She has a particular interest and experience in applying a systems approach as a conceptual framework for the design of research, programme evaluations and policy in the children's sector.

Lucie Cluver is an associate professor at the Department of Social Policy and Intervention, Oxford University and the Department of Psychiatry and Mental Health, University of Cape Town. She works closely with South African government departments, UNICEF, USAID-PEPFAR and Save the Children to develop evidence-based programming for vulnerable children in Southern Africa. She has an exceptional team of collaborators, PhD students and postdoctoral colleagues.

Peter Cooper is research professor of Psychopathology at the University of Reading in the United Kingdom, and professor extraordinaire at Stellenbosch University. His principal area of current research interest is the development and evaluation of interventions to prevent the adverse impact of early adversity on child socio-emotional and cognitive development, especially in low- and middle-income country contexts.

Andy Dawes is an associate professor emeritus in the Department of Psychology at the University of Cape Town. His primary endeavour over the past 10 years has been to encourage evidence-based approaches to South African policy-making and interventions for child protection and the promotion of early childhood development. He has recently led the development of a national rights-based approach to child well-being indicators for South Africa. His primary interest is in population-level interventions that enhance the rights, well-being and development of children living in disadvantaged circumstances.

Ariane De Lannoy is a senior researcher at the Poverty and Inequality Initiative at the University of Cape Town. She holds a PhD in Sociology. Her research work focuses particularly on youth growing up in the rapidly urbanising environments of post-apartheid South Africa. Within the Poverty and Inequality Initiative, she facilitates knowledge exchange between researchers, policy-makers and practitioners interested in bringing about change in the lives of young people in South Africa.

Bathabile Dlamini was appointed Minister of Social Development in October 2010, and she was reappointed to the portfolio after the 2014 general elections. She studied for a BA degree in Social Work at the University of Zululand in 1989, and worked as a social worker with the physically disabled in Pietermartizburg. Bathabile became a Member of Parliament following the first democratic elections in 1994, and from 1998 – 2008 she served as secretary-general of the ANC Women's League. She is currently a member of both the African National Congress's National Executive Committee, and National Working Committee.

Aník Gevers is a specialist scientist at the Gender and Health Research Unit, Medical Research Council. She holds an honorary faculty position at the Department of Psychiatry and Mental Health, University of Cape Town. She specialises in intervention development, primary prevention of gender-based violence, child and adolescent mental health and well-being, and trauma-related mental health issues.

Katharine Hall is a senior researcher at the Children's Institute, University of Cape Town. Her work focuses on child poverty and inequality. Her specific interests relate to social protection, and to the dynamics of household form, mobility and care arrangements for children. Her Masters thesis examined the targeting of the Housing Subsidy Scheme from a child rights perspective; her PhD investigates patterns of child mobility in the context of female migration, and decision-making about care arrangements. Katharine leads "Children Count", a continuous indicator project which analyses national survey data to monitor trends in a range of child-focused indicators.

Lucy Jamieson is a senior researcher at the Children's Institute, University of Cape Town. She has a BA (Hons) in Politics and an MSocSci in Democratic Governance. She has 18 years of experience in political campaign management, communications co-ordination and public consultation.

Lori Lake is commissioning editor at the Children's Institute, University of Cape Town. She has specialised in the development of educational support materials in the fields of health, child protection and early childhood development, and currently co-convenes the Children's Institute short course in child rights and child law for health and allied professionals.

Guy Lamb is the director of the Safety and Violence Initiative at the University of Cape Town. Prior to this he was a senior research fellow and programme head of the Arms Management Programme at the Institute for Security Studies. He has undertaken research and published on arms control, violence reduction, conflict management and peace building issues in Africa for more than 15 years. He has served on the United Nations Security Council Panel of Experts on Liberia and was a member of the UN's Small Arms Control Standards Expert Reference Group. He has worked extensively with a number of African governments to strengthen firearms control processes in Southern Africa.

Mireille Landman is a clinical psychologist in private practice and a consultant, supervisor and trainer for parent–infant services at the Parent Centre, a not-for-profit organisation offering a broad spectrum of services to carers of children in the Western Cape and beyond. She has a doctorate in Clinical Psychology and an area of special interest to her is the promotion of parent–infant mental health in poorly resourced communities.

Dena Lomofsky is a managing member of Southern Hemisphere, a social development consultancy based in Cape Town. She is a development sociologist with an MA in Development Studies. She practises as a consultant in programme design and planning, monitoring and evaluation, applied research, training and facilitation. Her special interest areas are participatory processes, children's programmes, policy influence and community development.

Pumeza Mafani is the national co-ordinator of the Thuthuzela Care Centres (TCCS) of the National Prosecuting Authority. She has a BA Honours in Political Studies, and is busy completing an LLB degree. Her responsibilities include, amongst others, reviewing and evaluating the technical, institutional and financial feasibility and constraints of the TCCs for effectiveness and sustainability.

Mokhantšo Makoae is a senior research specialist at the Human Sciences Research Council. She has a PhD in Sociology and specialises in research on the ethic of care and child well-being with a focus on the primary prevention of child maltreatment and child–family services for secondary and tertiary prevention.

Pinky Mahlangu is a senior scientist working on the Skhokho Supporting Success project, a school-based, gender-based violence intervention of the Gender and Health Research Unit at the Medical Research Council. She has a Masters in Development Planning and specialises in research on gender-based violence, policy analysis and governance issues.

Catherine Mathews is the director of the Health Systems Research Unit, South African Medical Research Council. She is also an honorary Associate Professor at the University of Cape Town, in the School of Public Health and Family Medicine and in the Department of Psychiatry and Mental Health. She has a PhD in Public Health, and her research is in the field of HIV prevention and adolescent sexual and reproductive health.

Mike Masutha was appointed the Minister of Justice and Correctional Services in May 2014. He studied for a BJuris degree at the University of Limpopo in 1988 and was admitted to practice as an Advocate of the High Court of South Africa in 1995. Minister Masutha has been a member of Parliament from 1999 to date. He served as the Deputy Minister of Science and Technology from 2013 to 2014.

Shanaaz Mathews is the director of the Children's Institute, University of Cape Town, and has a PhD in Public Health. Prior to this appointment she was a specialist scientist for the Gender and Health Research Unit of the Medical Research Council for 11 years. Her research interests include violence against women and children, as well as pathways to violent masculinities using both qualitative and quantitative approaches. Her current research projects have a focus on programme evaluation and strengthening child protection systems.

Franziska Meinck is a post-doctoral research fellow at the Centre for Evidence-Based Interventions at the University of Oxford. She has a BA in Social Work and an MSc and a PhD in Evidence-Based Social Interventions. Franziska's research focuses on child abuse victimisation.

Helen Meintjes is currently the programmes manager at the Children's Hospital Trust. A social anthropologist by training, her research has focused primarily on the nature of formal and informal care for children in the context of the AIDS pandemic in South Africa.

Lynne Murray is professor of Developmental Psychopathology at the University of Reading, United Kingdom, and extraordinary professor at Stellenbosch University. Her scholarly work concerns the effects of adversity (eg parental psychiatric disorder, poverty, child congenital disorder) on parenting and child development; and the development of interventions to support parenting and prevent adverse child outcomes.

Nadine Nannan is a senior researcher with the Burden of Disease Research Unit, at the Medical Research Council. She holds Masters degrees in Molecular Biology and Medical Demography. Her interests are in child mortality, inequalities in child health and burden of disease.

Mzikazi Nduna holds a PhD degree and is a National Research Foundation Y-rated scientist and an associate professor in the Department of Psychology, University of the Witwatersrand. She has research interests in HIV/AIDS, father connections, sexual and reproductive health and rights, gender and gender-based violence.

Christina Nomdo is the executive director of Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN). She has a Masters in Gender Studies and specialises in institution building, advocacy, research and training. Her special interests are children's autonomy rights, child rights budgeting and youth development

Shaheda Omar is the clinical director of The Teddy Bear Clinic for Abused Children, and has been involved in the child protection field for over 20 years. She completed her doctorate in Social Work at the University of Johannesburg in 2011, contributing a risk assessment tool for child sexual offenders. Her areas of expertise are: child-on-child sexual abuse, the development and implementation of diversion programmes for young sex offenders, forensic assessments, advocacy, and training in the field of child abuse. Shaheda sits on various local and national child protection committees, contributing to legislation and policy development.

Mastoera Sadan is the programme manager of the Programme to Support Pro-poor Policy Development (PSPPD), a partnership of the Presidency, Republic of South Africa and the European Union. She also manages the National Income Dynamics Study, South Africa's national panel survey. Mastoera is a doctoral candidate at Rhodes University. She has a particular interest in state forms and social policy, and poverty and inequality. She was a visiting scholar at the University of Oxford in 2002/03. She holds an MSc from the London School of Economics.

Moefeeda Salie-Kagee is the social work consultant to the Isibindi project nationally and senior mentor for the National Association of Child Care Workers' Western Cape office. She holds a BA in Social Work with over 18 years' experience in direct work, programme development and training in the areas of children's rights and child protection.

Winnie Sambu is a researcher at the Children's Institute, University of Cape Town. She holds an MA in Development Management at Ruhr-Universität Bochum and a Masters degree in Economics (Development Studies) from the University of the Western Cape. Her focus at the Institute has been on quantitative research surrounding socio-economic issues such as poverty and inequality, food and nutrition security, and household living conditions.

Marta Santos Pais is the Special Representative of the UN Secretary-General on Violence against Children. Actively engaged in human rights for more than 30 years, she participated in the drafting of the United Nations Convention on the Rights of the Child and was the Rapporteur of the UN Committee established to monitor its implementation. In UNICEF, she was director of the Innocenti Research Centre and of Evaluation, Policy and Planning. She served as Special Advisor to the Machel Study on Children in Armed Conflict and to the UN Study on Violence against Children and has authored many studies and publications.

Sarah Skeen is the programme director of the Partnership for Alcohol and AIDS Intervention Research, Centre for Public Mental Health, Stellenbosch University. Her work focuses on evaluating interventions for child development, mental health and psycho-social well-being. Her interests include child and adolescent mental health, substance use, health policy, and research communication.

Charmaine Smith is the communication and knowledge manager of the Children's Institute, University of Cape Town. A journalist in background, she has been applying her media and communication skills in the development sector for the past 13 years. She is mainly responsible for the communication and marketing of the Institute and its work and publications, and been privileged to serve on all the editorial teams of the *South African Child Gauge* since its start-up in 2005. She is busy completing a Masters degree in Journalism.

Nikki Stein is an attorney at SECTION27, a public interest law centre based in Johannesburg. She has a Masters in Law from the University of Virginia. The focus of her work is on the right to basic education, and the obligations of state and non-state actors arising from that right. She has worked on cases around provision of textbooks,

infrastructure, furniture and school sanitation as well as specific provision for learners with special educational needs. She also works on cases involving sexual and other violence against learners in schools.

Mark Tomlinson is a professor in the Department of Psychology at Stellenbosch University. His scholarly work has involved a diverse range of topics that have in common an interest in factors that contribute to compromised maternal health, to understanding infant and child development in contexts of high adversity and how to develop community-based intervention programmes. He has a particular interest in understanding infant and child development in the context of caregiver mental illness. He has published over 100 papers in peer-reviewed journals, edited two books and published numerous chapters.

Wessel van den Berg is the Child Rights and Positive Parenting portfolio manager at Sonke Gender Justice in Cape Town. In this capacity he supports Sonke's work on children's rights in the Africa region, and globally. The portfolio includes the MenCare Fatherhood Campaign and advocacy for positive discipline towards the prohibition of physical and humiliating punishment in all settings. Wessel has worked within the social change environment on youth development, public health, gender transformation and sustainable development. He holds a Masters degree in Sustainable Development (cum laude) and is currently enrolled for a PhD research focused on the men, care and gender justice in South Africa.

Joan van Niekerk has worked in child protection for the past 25 years and has a specific interest in law and policy relating to children's rights. She served as director for Childline KwaZulu-Natal and developed many of their prevention and response programmes, and then worked as the national co-ordinator for Childline South Africa. She has provided training on child protection issues in South Africa and internationally, and is the president of the International Society for the Prevention of Child Abuse and Neglect.

Lorenzo Wakefield is the research fellow for the Consortium on Crime and Violence Prevention established by the African Policing Civilian Oversight Forum and the Centre for Justice and Crime Prevention. He holds a Masters degree in International and Human Rights Law from the University of the Western Cape. He specialises in research, advocacy, training and lecturing in children's rights (especially matters in relation to justice for children) and women's rights (especially matters in relation to gender-based violence). He is currently conducting research and advocacy on crime and violence prevention.

Samantha Waterhouse is the head of the Parliamentary Programme at the Community Law Centre, University of the Western Cape. She has focused on advocacy for law reform and implementation on children's rights and sexual offences, emphasising the importance of civil society engagement with state processes. She is currently completing an MPhil in Social Justice.

About the *South African Child Gauge*

The *South African Child Gauge* is an annual publication of the Children's Institute, University of Cape Town that monitors progress in the realisation of children's rights. Key features include a series of essays to inform national dialogue on a particular area which impacts on South Africa's children; a summary of new legislative and policy developments affecting children; and quantitative data which track demographic and socio-economic statistics on children.

Previous issues of the *South African Child Gauge*:

2013: Essential services for young children

2012: Children and inequality: Closing the gap

2010/2011: Children as citizens: Participating in social dialogue

2009/2010: Healthy children: from survival to optimal development

2008/2009: Meaningful access to basic education

2007/2008: Children's constitutional right to social services

2006: Children and poverty

2005: Children and HIV/AIDS

All issues of the *South African Child Gauge* are available for download at **www.ci.org.za**

The Children's Institute, University of Cape Town, has been publishing the *South African Child Gauge*® every year since 2005 to track progress towards the realisation of children's rights.

The *South African Child Gauge 2014* is the ninth issue, and focuses on the theme of preventing violence against children by breaking the intergenerational cycle of violence. This issue also discusses recent legislative developments affecting children, and provides child-centred data on children's access to social assistance, education, health care, housing and basic services.

The Children's Institute aims to contribute to policies, laws and interventions that promote equality and improve the conditions of all children in South Africa, through research, advocacy, education and technical support.

"The *Child Gauge 2014* gives us a unique opportunity to consider the breadth and depth of actions taken by the many contributors to [protect children], and also to begin to document the areas of common endeavour that will translate the promise of a better life, including child protection especially for many vulnerable children in South Africa, into a living reality."
Ms Bathabile Dlamini, MP, Minister of Social Development, 2014

"The *South African Child Gauge 2014* is particularly timely, as South Africa commemorates 20 years of the advent of democracy. This is a uniquely auspicious time to mark the start of an era where all boys and girls enjoy a childhood free from violence."
Marta Santos Pais, Special Representative of the United Nations Secretary-General on Violence against Children, 2014

"The *South African Child Gauge* can help us to advance an agenda to make citizenship and rights a reality for children, and achieve Vision 2030."
Viviene Taylor, Head of the Department of Social Development at the University of Cape Town, and Commissioner on the National Planning Commission, 2013

"The most important investment that we can make as a country is to invest in the well-being and development of our children so that they can go on to lead healthy and active lives. The *South African Child Gauge* makes an important contribution to the debate on how we can best achieve this objective."
Trevor Manuel, (former) Minister in the Presidency: National Planning Commission, 2012

46 Sawkins Road, Rondebosch
Cape Town, 7700, South Africa
Tel: +27 21 650 1473
Fax: +27 21 650 1460
E-mail: info@ci.org.za
Web: www.ci.org.za