Network of Child Health Advocates

From survive to thrive: A call to safeguard children's rights in times of crisis

Alternative Report

in response to South Africa's

combined third to sixth periodic report to the

United Nations Convention on the Rights of the Child

11 August 2023

About this report

This shadow report draws on the experience and expertise of academics and civil society organisations working in the fields of paediatrics, child health, poverty and nutrition in order to track recent progress towards the realisation of children's rights; reflect on current and emerging challenges; highlight gaps and inconsistencies in the most recent State Report; and make recommendations to the UN Committee on the Rights of the Child on how to strengthen systems in order to better realise children's rights in South Africa.

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Introduction

- One in every three South Africans are children under the age of 18.[1] If we, as South Africans, make the right investments to promote their optimal health and development, our young population has the potential to transform our country and drive social and economic development. Yet our youngest citizens remain disproportionately concentrated in the poorest households making them highly vulnerable to shocks such as the COVID-19 pandemic, the current economic recession and climate collapse[2].
- Even before the pandemic, many South African children were failing to thrive with more than a quarter of children under five years old stunted in their growth and development[3] and more than one in 10 children suffering from mental disorders.[4]
- The COVID-19 pandemic orphaned nearly 150,000 children in South Africa[5] while the accompanying recession pushed a further 1.5 million children into food poverty – so that by 2020, 4 in every 10 children lived in households that could not afford to meet their children's nutritional needs[6].
- Post-COVID, rising food and fuel prices have further eroded children's food security, nutritional status,[7] and access to health care services.
- The reduced utilisation of routine primary health care services seen at the start of the COVID-19 pandemic[8] has persisted[9] and is associated with low immunisation coverage as evidenced by the recent outbreaks of preventable diseases such as measles and whooping cough.[10]
- These challenges have been exacerbated by austerity measures introduced by the State's October 2022 Medium Term Budget Policy Statement. This includes cuts to health care, social services and social assistance which threaten to undermine the provision of essential child health and child protection services whilst simultaneously pushing more of South Africa's children even deeper into poverty.[11]
- We therefore urge the Committee to remind the State of its duty to uphold children's rights to social assistance, basic health care services and basic nutrition, and to remind the State that it "should not take deliberate regressive measures in relation to socio-economic rights" and that even in times of economic crisis, "regressive measures may only be considered after assessing all other options and ensuring that children are the last to be affected, especially those in vulnerable situations".[12]

Survival and development

Health data

- Monitoring the health status of children requires access to reliable data sources. Available data sources in the country are heavily biased towards mortality related data and historically health services and civil society have relied on four principal sources for data:
    - Statistics South Africa provides demographic data, including births and deaths, from the vital registration system. This is the most comprehensive dataset and includes all reported deaths from public and private sector hospitals as well as deaths outside the health sector, yet the most recent available data is for the 2018 calendar year.
    - The Medical Research Council of South Africa provides an estimate of mortality rates from vital registration data. These data include all reported deaths from public and private sector hospitals as well as deaths outside the health sector. The last report, released in 2021, provides estimates up to 2020.
- The National Department of Health District Health Information System (DHIS) national dataset includes mortality numbers and rates for select age groups and priority diseases. Data for the 2022/23 financial is available and includes in-hospital mortality rates for newborns, infants and children under-5 as well as case fatality rates for diarrhoea, pneumonia and severe acute malnutrition. But unfortunately, this database only captures public sector hospital information.
- The Child Healthcare Problem Identification Programme (Child PIP) is a hospital-based mortality audit tool for under-5 deaths in the public sector. Although data is restricted to participating hospitals it not only includes the number and causes of death, but it also identifies contributing and modifiable factors to drive quality improvement. It is therefore concerning that the number of participating hospitals has dropped from a peak of 283 hospitals in 2018 to 170 in 2022.

Recommendations

These gaps in mortality data - including the five- year delay in cause of death data - are unacceptable. We therefore call on the State to make every effort to strengthen health data systems for children:

- **Make Child PIP audits mandatory in all public sector health facilities. align DHIS and Child PIP software, and allocate resources to support this key driver of quality improvement**.

- **Make ChildPIP audits mandatory in all public sector health facilities as well as with the Perinatal Problem Identification Programme (PPIP), which captures perinatal outcomes and ensure these programmes are adequately resourced including alignment with DHIS software**.
- **Ensure that medical electronic birth registration is done at all public and private hospitals, with electronic linking of mother–infant pairs, so that cohort monitoring can be done in order to improve perinatal, neonatal and child health outcomes.**
- **Ensure Statistics South Africa addresses the inordinate delay in the analysis and release of mortality data and ensures a turnaround time of under 24 months moving forward.**

Child survival

- Mortality estimates suggest that child survival has continued to improve over the reporting period with under-five mortality decreasing from 37 deaths per 1000 live births in 2015 to 32 in 2019/20[13]. Yet mortality remains high compared to other middle-income countries such as China (14 per 1000), Brazil (14 per 1000) and Mexico (13 per 1000),[14] and efforts will need to be intensified to meet the SDG target of 25 deaths per 1000 live births by 2030.
- It is estimated that over half of all child deaths occur outside the health care system,[15] with many caregivers struggling to access facilities or seeking alternative care. There is an urgent need to improve the early identification and case management of childhood illnesses and to strengthen community-based care to reach out to children in their homes, and to that ensure caregivers recognise the danger signs and know when to seek care.
- Hospital-based DHIS data indicates that almost 90% of under-five deaths occur in the first year of life, and two-thirds in the neonatal period.
- Child PIP data suggest that the contribution of malnutrition and HIV to child mortality is declining. The proportion of under-5 deaths associated with severe acute malnutrition decreased from 27% in 2015 to 22% in 2022, and the proportion of deaths associated with HIV decreased from 37% to 26% over the same period.
- We also welcome the decrease in child homicides from 5.5 to 5.1 deaths per 100 000 and a reduction in the rape-murder of children over the same period.[16]
- As the proportion of deaths due to communicable diseases decline, we are seeing an epidemiological shift with a corresponding increase in the proportion of deaths due to

neonatal conditions, congenital disorders and non-natural causes (primarily in the 1 – 4-year age group).

- **A high proportion of these child deaths are preventable,** yet Child PIP data show very little change in modifiable factors over the past ten years at each level of care. At home caregivers still fail to recognise the severity of their child's illness and present to the health services late and with advanced disease. In hospitals, triage and initial care remains poor, clinicians fail to detect deterioration in their patient's condition and there is limited access to high and intensive care beds for children.

Recommendations

- **As there has been no improvement in neonatal mortality in over two decades new innovations are required in neonatal care including greater emphasis on Kangaroo Mother Care, the implementation of non-invasive respiratory support in district hospitals and an increase in the number of regional and tertiary level neonatal ICU beds.**

- **Initiatives are required to promote child safe homes and community initiatives to prevent burns, falls, drowning and poisoning, and reduce non-natural deaths in preschool children.**

- **All provinces need to develop accessible and capacitated critical care services for children and neonates.**

From Survive to Thrive: The First 1 000 Days

- As mortality decreases, greater investment is needed to ensure children thrive and reach their full potential, and future reporting should document progress on both *survive and thrive* interventions. The Nurturing Care Framework[17] and National Integrated Policy for Early Childhood Development (2015) both identify the Department of Health as the primary provider of services and support during the first 1000 days of life.
- We applaud the NDoH's efforts to strengthen the thrive agenda through the development of the new Road to Health Book and the accompanying Side-by-Side Campaign which not only expand the package of services for young children, but also aim to build the capacity of families and caregivers to promote children's optimal development by providing early stimulation, responsive caregiving, and ensuring children's health, nutrition and safety. An advancement of this work would be to include a continuum of similar support materials and initiatives to strengthen maternal and perinatal health service delivery.

- We note with concern that there is little to no additional (dedicated) budget allocated to support the implementation of this expanded package of services, and these funding constraints will continue to hamper expansion and progress of these initiatives through the Department of Health.
- We are also concerned that current strategic efforts to revise the NIECD Policy and facilitate the function shift from Department of Social Development to the Department of Basic Education are primarily focused on early learning and centre-based provision of early care and education for older children, raising concerns that health and nutrition interventions in the first 1000 days of life may be further sidelined and underfunded. Yet it is these earliest investments that lay the foundation and are most critical for brain development.

Recommendations

Early investments to support children's optimal development during the first 1000 days of life provide a critical foundation for brain development and should be adequately resourced. We therefore call on the state to:

- **Allocate dedicated funding to support the delivery of an expanded package of services**
- **Ensure that the thrive agenda is used to strengthen care and support for women during the antenatal and perinatal period including mental health screening, social protection and respectful maternal care.**
- **Ensure that these key interventions in the first 1000 days of life are prioritised in the review and ongoing implementation of the ECD Policy.**

Children with disabilities and long term health conditions

There remain systemic gaps and deficiencies in the care of children with disabilities and long term health conditions (LTHCs), especially those with complex needs and impairments.[18] Many rehabilitation services were suspended during the COVID-19 pandemic, leaving children and families without access to services and increasing the risk of secondary disabilities. Poor management decisions, a lack of leadership and strategic direction, and the continued under-prioritisation of services and support for children with disabilities and their families, undermine children's life expectancy and quality of life.

Education

- Despite the right to equality and the right to basic education being enshrined in the Constitution and policies such as the 2001 White Paper on Inclusive Education, the State

Report indicates that 11% of children with disabilities – or 114 000 children - were not attending school. A recent report by the Equal Education Law Centre suggests that the levels of exclusion are potentially even higher ranging from 40 000 to 600 000 children – with long waiting lists for special school and discriminatory fees and expenses contributing to high levels of exclusion.[19] These failings to translate policy into the infrastructure and resources needed to realise children's right to basic education in a safe environment need to be urgently addressed.

Screening and support

- Early identification of long term and disabling conditions is vital as this allows early intervention that can mitigate disease progression, complications and secondary disability. Yet systematic early identification programmes are largely lacking in South Africa. The primary areas of responsibility for this are in health services and early childhood development (ECD) centres. It is therefore vital to strengthen protocols and training to strengthen screening systems and build the confidence and capacity of health and ECD practitioners.

- The 2014 Policy on Screening, Identification, Assessment and Support (SIAS) of school children represents a step forward in policy. It provides a framework for the education and health sectors to collaborate in identifying and meeting the needs of these children in school and potentially early childhood development centres now that these fall under the Department of Basic Education (DBE). However, implementation is partial and patchy with the bulk of practitioners in the health sector being unaware of the SIAS policy and few examples of collaboration in developing education and care plans.

- The Integrated School Health Policy (ISHP) represents another opportunity to increase the identification and support for children with long term and disabling conditions. Despite this coverage remains suboptimal (see section on school health) and support of children with long term and disabling conditions by school health teams is almost completely unrealised.

Invisible children, disability and mental health

- Children and adolescents with disabilities are also at increased risk of developing mental health problems owing to stigma and social isolation, while children struggling with mental health problems may go on to develop a psychosocial disability that impairs their ability to function and participate in society.
- Early identification and early intervention for children with intellectual and psychosocial disabilities can be difficult as current measures do not easily detect the more subtle

neurological or psychosocial disabilities. This leads to the exclusion of these 'invisible' children from early intervention strategies, which are essential for improving outcomes and preventing secondary disabilities.

Inadequate social assistance

- While most children (78%) with disabilities are accessing some form of social assistance, the majority (92%) receive the Child Support Grant (CSG) of R500, with only 5.5% of children with disabilities receiving the Care Dependency Grant (CDG) valued at R2080 (in April 2023). The CSG does not even cover the food required to satisfy a child's daily nutritional requirements, let alone the complex needs or additional expenses associated with caring for a child with a disability.

Medical assessment criteria for the CDG

- It is therefore important to expand the medical assessment criteria for the CDG to enhance the identification of children with intellectual and psychosocial disabilities – and those with LTHCs, to ensure that these 'invisible' children and their caregivers can access a basket of support services including the CDG. This reflects the general need for policies to cover both children with 'traditional' disabilities (largely neuromuscular and sensory) and those with complex medical conditions for whom costs of care are equally burdensome.

Adolescents

- Specifically, the needs of adolescents with long term and disabling conditions are poorly met, though impressive efforts have been made in certain areas such as HIV. Policies such as those that insist that children leave paediatric hospital services at the age of 13 are inimical to realising the rights and meeting the needs of young people with complex conditions. There are continued concerns about the transition of care for children with LTHCs from paediatric to adult services, poor linkages between health and education services for these children and continued underfunding of assistive devices and aids.

Piecemeal policies

- In South Africa there is no single piece of legislation governing disability. Instead, the *Integrated National Disability Strategy* is used to guide all sector-specific legislation, [20] As a result there is a piecemeal approach to policies and management systems for children with long term and disabling conditions, who are often added into policies on disability 'non-communicable disease' policies targeted at adults without due consideration for their specific needs. There is also a tendency to verticalize policies for long term conditions such as HIV

without considering the overall approach to long term care in childhood and adolescence. The deficit is also seen in the lack of indicators for this group, aggravating their invisibility.

Leadership and governance

- Leadership and strategic direction should be strengthened at all levels to enhance policy, standards, and the delivery of services to children with LTHC and disabilities. Managers at all levels of the health system need to be orientated to the detrimental consequences for children and families if services – and budgets – are not strengthened and expanded. Further, policy and programmatic guidance on how to promote inclusion of children with disabilities and LTHC in early childhood development programmes is currently unavailable.
- Leadership, coordination and service delivery could also be strengthened through monitoring from the Office for Disabilities in the Presidency and the South African Human Rights Commission, with intersectoral and policy coordination led by the Department of Health. The advent of National Health Insurance with its 'baskets of care' and emphasis on primary health care re-engineering represents an opportunity to strengthen screening and rehabilitation services to ensure that children with long term and disabling conditions are able to access quality care close to home – with an emphasis on strengthening systems and resourcing in rural districts.

Recommendations:

After many years of the state and society concentrating on unacceptable child survival statistics and systems, the time has come for children with long term and disabling conditions to receive more focus from the state and society on their health and wellbeing.

- **Develop an overarching policy to guide the delivery of services to children and adolescents with disabilities and LTHCs.**
- **Address data gaps in order to improve the identification and management of children with LTHCs and disabilities**
- **Develop an essential package of care tailored to meet the specific needs of this large and diverse group of children.**
- **Strengthen early identification and intervention services for preschool children**
- **Deliver on the commitments to inclusive education as outlined in White Paper 6**
- **Review the CDG assessment criteria to enable earlier and equitable access to social assistance for children with 'invisible disabilities' and LTHCs**
- **Rewrite the rules for admission to hospital to better support adolescents with LTHCs and disabilities' transition to adult services**

Health care services

Access, equity and non-discrimination

- Poverty, inequality and poor access to services are compounded by poor access to health care services – with children in the poorest household least able to access care – in what is frequently described as the inverse care law[21].
- Marked **inequalities** persist between public and private sectors and rural and urban areas. Quality healthcare requires access to multidisciplinary teams of skilled healthcare workers. The aspiration of the National Health Insurance (NHI) Bill is to make the best and most equitable use of the health resources we already have. But one of NHI's biggest challenges is the inequitable distribution of healthcare workers. About 70% of SA doctors work in the private sector, which is largely based in urban areas, whereas only 12 percent of doctors and less than 20 percent of nurses in the public sector work in rural areas, despite the fact that people living in these areas make up almost half of the country's population.

Child health challenges in rural communities

- Child health is particularly compromised in rural areas where abject poverty and poor service delivery help fuel a vicious intergenerational cycle of poor health and nutrition – with four in every five children living in traditional rural areas lived below the poverty line in 2021[22].
- These high levels of deprivation lead to many young girls getting involved in relationships with older men, which end in teenage pregnancy and/or STIs and HIV. This precipitates a cascade of events within families and communities. Broken families may struggle to provide a safe, secure and nurturing care. Many children born to teenagers are raised by their grandmothers or great grandparents who often don't have information on best practices when it comes to infant feeding, the use of traditional medicines, or the danger signs when they need to seek medical care. These children may also be vulnerable to emotional abuse as they often get blamed for the actions of their parents, and they often grow up without knowing their paternal families and this causes major family disputes.
- This also places massive financial strain on caregivers who left to support such a child and depression and substance abuse is common in these communities, which may further expose children to abuse and neglect.
- We need more community health workers, social workers and child and youth care workers. We need shelters for women and children who are abandoned and the abused, and beyond

all these we need an open discussion around what it is to nurture a child so that they thrive, as this concept seems to have been lost along the way and it's disheartening to witness what is happening to children on a daily basis.

- Most parents opt out of breastfeeding, and alternative feeds are given too early with many caregivers trying to stretch the formula to cover the month leading to malnutrition. Many caregivers prefer to use traditional healers, which may further delay presentation to health care facilities and lead to adverse outcomes for children. So, we also need to address the disconnect between what is known from research and what is known and practiced by the community.

Rural health care

- At the same health resources are stretched thin: Community health workers are often unequipped and poorly supervised, leading to missed opportunities in addressing malnutrition, while a lack of public transport and limited EMS services lead to critical delays in accessing medical care by these landlocked communities. At facility level, care is often compromised by derelict infrastructure, intermittent electricity and water supply, shortages of critical equipment and supplies (such as CPAP and oxygen – which are essential for the survival of sick neonates). Long queues, staff attitudes and unavailability of medicines, doctors doctors, and poor infrastructure remain the biggest challenges. Inbuilt procurement and distribution bottlenecks, and constant stock-outs of essential medicines are a perennial problem. And at times, local political disputes spill over into the health care system, compromising care as was the case at Zithulele Hospital.[23]

- Some rural hospital and districts in various provinces are working well despite the challenges, and the continuous supply of young community service officers ensures that most junior level posts are filled. However, senior health professionals and experienced managers are hard to recruit and retain in rural areas. Good outreach from Regional and Tertiary facilities can help close the skills gap and bring expertise to the patients rather than the other way around. But there is no funding to pay for their travel or their overnight accommodation. The ratio of regional facilities to District Hospitals is very inconsistent. For example, in rural KwaZulu-Natal, one regional hospital with 7 specialists drains 3 District hospitals; all within 2 hours drive., while a second regional hospital with 9 specialists drains 16 district hospitals, with the furthest being 4,5 hours away.

- All these systemic problems have a very direct impact on maternal and neonatal deaths and morbidity, but they can be turned around by courageous leadership and committed staff who

see it as their mission to serve the poor and marginalized. For example, a number of non-governmental organizations have arisen to support health workers and district health systems in rural areas, and they are able to advocate for equity and fairness in the allocation of resources at a national level. Annually, the Rural Health Conference brings together rural doctors, nurses, rehabilitation therapists and clinical associates to share their experiences and motivation to continue working in distant and isolated parts of the country, where the greatest need is.

National access to health care remains poor

- Primary health care services are free, and pregnant women, children under five, and social grant beneficiaries are entitled to free health care, but physical and financial barriers continue to undermine access to care.
- National data suggest that children's access to health care in South Africa remains poor, with a significant drop in under-five primary health care headcounts during the COVID-19 pandemic. The **coverage of preventative programmes remains low** post-pandemic with just 85.5% of infants fully immunised at 1-year of age – way below the national target of 90%[24] - with coverage ranging from 62.8% in North West province to 94.8% in KwaZulu-Natal. These gaps in herd immunity precipitated outbreaks of vaccine-preventable diseases such as measles in 2023.
- In 2019, **1 in 5 children still travelled more than 30 minutes** to reach a health facility, and deep inequalities remain – between children who are dependent on the public health system and the minority who can afford private health care, and between those living in well-resourced urban centres and those in deep rural areas. Racial inequalities persist: while 22% of African children travel far to reach health care, this applies to only 4-9% of Indian, White and Coloured children, and while 93% of White children travel by car, 60% of African children walk to their facility.
- In addition, transport costs and safety concerns often lead to **life-threatening delays** in accessing treatment, and working mothers often struggle to get permission to take time off to seek medical care. Long distances to clinics have also been found to limit the uptake of immunisation and the use of the *Road-to-Health* booklet,[25] and Child PIP data consistently reveals delayed presentation to health services during acute illnesses as a key modifiable factor in hospital deaths.

- And in the face of recent increases in food and fuel prices families are having to make **hard choices** between feeding their children or accessing medical care, leading to anecdotal reports of a decline in compliance with medical treatment.
- Despite a range of policies promoting equality; foreign children, children with disabilities and pregnant teenagers continue to experience **discrimination** in accessing health care. For example, in December 2019, two-year-old Sibusiso Ncube died of poisoning after he was refused treatment at Charlotte Maxeke Hospital because his Zimbabwean mother could not instantly produce his birth certificate or pay R5,000.[26]
- In the face of ongoing reports of medical **xenophobia**,[27] we welcome the recent (April 2023) judgment in the Gauteng High Court which upheld the right of all pregnant and lactating women, and children under 6 to access free health services at all public health establishments, including hospitals, irrespective of their nationality and documentation status. The court also declared unlawful a policy introduced by the Gauteng Department of Health in 2020 that denied free health care services to pregnant and lactating women and young children who are asylum seekers, undocumented, or persons affected by statelessness.

Participation

- The Children's Act outlines children's rights to information about their health status, prevention and treatment, and it sets out the conditions under which children can consent to HIV testing, medical treatment, surgery operation[28] with respect for their evolving capacities and an emphasis on informed consent and ensuring that children are of 'sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment'.
- But the right to participate in the health sector goes beyond individual decision making and requires states to 'introduce measures enabling children to contribute to the planning and programming of health services'.[29] For example, young people were consulted on the *National Adolescent Sexual and Reproductive Health and Rights Framework Strategy*[30] which aims to remove barriers to access to sexual and reproductive health services and ensure these are 'friendly, non-judgemental and empathetic' to the diverse needs of adolescents irrespective of age, disability, and sexual orientation.
- While the Adolescent Youth Health Policy goes one step further and provides for adolescent and youth representation on every clinic and hospital committee and district AIDs council. Yet

it remains unclear to what extent any of these participatory measures are honoured in practice.

Recommendations

- **Respect and enable children's right to participate in health care decision-making and provide child and youth friendly materials to support informed consent.**
- **Actively include children and adolescents in the evaluation of health care services to enhance the quality of care.**

Quality of care

- Quality remains a concern and continues to be compromised by long waiting times, shortages of staff, medical supplies and equipment, and a lack of respect and confidentiality, with poor leadership, corruption and austerity cuts threatening to further erode recent gains in child health.
- Whilst the **Ideal Clinic and Ideal Hospital** programmes have set standards for health services, compliance is low and in 2022 fewer than half of all PHC clinics achieved Ideal Clinic status (1 647 out 3 475 clinics).

Stockouts

- These findings are confirmed by the most recent 2023 Ritshidze Report[31] on the quality of health care in the North West province which raises ongoing concerns about waiting times, unfriendly staff and stockouts of essential medicines such as vaccines, contraceptives, ARVs and TB medication. These **community-led surveys** play a critical role in holding the South African government accountable and improving the delivery of services with a particular focus on adult HIV and TB.
- But these problems are not confined to rural provinces or primary levels of care. Public healthcare in Gauteng province has declined to unprecedented levels where children are dying because of the terrible state of our public hospitals. One example of this is the Rahima Moosa Mother and Child Hospital in Johannesburg.

Rahima Moosa Hospital – "dirty, filthy and unsafe"

- In 2022 Rahima Moosa came into the spotlight after a video showing pregnant women sleeping on the hospital floor made news. Subsequently, a paediatrician wrote an open letter to the Daily Maverick[32] describing the harrowing conditions at the hospital. He was

subsequently suspended and then reinstated after a public outcry. There were frequent and prolonged power outages, and the generators did not function adequately, leading to newborns suffering hypothermia. There were frequent water outages, contributing to outbreaks of nosocomial sepsis in an already overcrowded neonatal ward. Critical stock items were frequently unavailable, leading to doctors driving to other hospitals to "borrow" life-saving consumables. The hospital's security is in shambles, with one junior doctor being highjacked on the premises. The hospital has not had a functioning CT scanner for most of the last two years and does not have a 24-hour laboratory or blood bank.

- The Health Ombud described the situation at Rahima Moosa Hospital as "dirty, filthy and unsafe". The CEO was found to have been absent for extended periods, and the Health Ombud identified inappropriate appointment of poorly qualified individuals to senior positions as a major factor contributing to the poor healthcare service delivery in Gauteng hospitals. Yet, despite the outcry, and recommendations and deadlines in the Ombud report, little has changed on the ground.

Recommendations:

- **Prioritise the needs of children in the strengthening of district health services including greater access to comprehensive primary health care services including oral health and rehabilitation services.**
- **Introduce innovative strategies to ensure more equitable access to specialised care across district and provincial boundaries – using outreach clinics and digital platforms to build capacity, support task shifting and mentor staff working in primary care.**
- **Strengthen local referral systems between Health, SASSA and DSD to fasttrack access to social assistance and child protection.**
- **Intensify efforts to enhance quality of care and compliance with the Ideal Hospital and Ideal Clinic Norms and Standards**
- **Build leadership for child health to drive quality improvement at district and provincial level**.

National Health Insurance and Universal Health Coverage

- We welcome the latest iteration of the National Health Insurance BIll which signals government's commitment to providing universal health care, including the emphasis on equity, social solidarity and the abolition of out-of-pocket expenses and introduction of

financial risk protection for the poor which should help level the playing fields and enable more equitable access to health care.

- In addition, we welcome the inclusion of clause 4(3) which recognises the entitled of "all children, including children of asylum seekers or illegal foreigners" to receive basic health care services.

Towards a package of basic health care services

- We also welcome the Bill's broad **definition of basic health care services** as "services provided by health care service providers which are essential for maintaining good health and preventing serious health problems including preventative services, primary health care, emergency medical services, diagnostic services, treatment services and rehabilitation services", though we note, with concern, the exclusion of palliative care which remains a critical yet seriously under-resourced element of child health.
- It is also not yet clear how children's right to basic health care services will be transformed into an essential package of services through the NHI 'baskets of care"- and to what extent these will meet the needs of children with more complex or long term health conditions. It is vital that the costing of these baskets of care extends beyond the provision of medical procedures and medicines, to ensure that sufficient time is allocated to enable effective communication, coordination and continuity of care – as these are the hallmark of quality care, and to ensure that they accommodate the needs of most vulnerable children and families who need the greatest investment in time and care.

Re-engineering primary health care

- We also welcome ongoing efforts to strengthen the district health system through the re-engineering of primary health care to ensure that children can access treatment, prevention, promotion and rehabilitation services close to home, through ward-based outreach teams of community health workers, and school health teams – but are concerned that these are under-resourced with limited reach
- We also welcome the **contracting private health providers** which may help address staff shortages in the public health system – and we hope this will include efforts to contract in nutritionists, dental therapists, audiologists, speech and hearing therapists, psychologists, optometrists and physiotherapists and occupational therapists that are currently compromising children's access to screening, treatment and rehabilitation services – especially children with disabilities and mental health problems.

- We note with concern that the **district clinical specialist teams** have not been included in final Act – so there is no longer a clear structure to provide the leadership and clinical governance needed to drive quality improvement and ensure that child health services are prioritised at district level.

Setting standards

- We welcome the certification and **accreditation of providers** against indicators of clinical care, health outcomes and clinical governance, but given the extremely low compliance with National Norms and Standards in the recent OHSC reports, we are concerned about the capacity of public clinics and hospitals to meet these quality standards; this could aggravate the already wide rural-urban public-private divide.

Recommendations

- **Ensure that the packages of care for children are defined as a matter of urgency in a way that meets the needs of all children in the country.**
- **Be transparent about progress toward PHC reengineering, including ward-based outreach teams and school health services, given the lack of clarity at present beyond the identification of facilities as being in the "ideal clinic" programme.**
- **Ensure that the transition to NHI is laid out clearly in a way that secures continuous and improved access to health care services for all children.**

Human resources and leadership for child health

- The health status and outcomes of children throughout the country are marked by inequality. Inequality between facilities in a single district, between districts in a single province and between provinces across the country. Whilst social determinants and access to health service play a role in this inequality the variable standards of health care is equally important.
- Children are not a priority in any health service and the child health workforce and resources are regularly withdrawn and redeployed to address emerging crises such as the COVID-19 pandemic or to strengthen failing programmes such as HIV/AIDS and TB.
- There is variable capacity in the child health workforce across different levels of care. Community health workers play an extremely limited role in maternal and child health services in household and communities. There is a pervasive shortage of nurses in hospitals

at all levels of care with very few paediatric nurses and virtually no qualified neonatal nurses. Whilst the medical staffing of district hospitals has improved recently the nature of the service invariably leads to a rapid turnover of doctors with more junior staff being deployed to care for children and newborns and a limited number of district hospitals have effective or experienced clinical managers for maternal and child health services. The number of specialist paediatrician and subspecialists in the public sector has improved markedly over the past decade but this has not been equitable across all provinces and access to specialist and subspecialty services is best in Gauteng, the Western Cape and KwaZulu-Natal.

- The marked inequality across the health service, the redeployment of resources for child health and the lack of effective management in health facilities reinforces the need for more effective leadership in child health. Whilst this has been recommended repeatedly in Ministerial Committee reports, implementation of these recommendations is weak: only one province currently has a provincial paediatrician and District Clinical Specialist Teams (DCSTs) remain incomplete and unable to offer the envisaged leadership in maternal and child health due to competing demands on their skills from dysfunctional district offices and other programmes.

Recommendations

- **Build leadership within each cadre of staff (nursing, medical and allied professions) and at provincial, district and facility levels. This includes the urgent appointment of provincial and district specialists who are responsible for the quality of services and driving intersectoral collaboration to enhance the health of all children in their catchment area.**
- **Adopt staffing norms for all cadres of health staff so that we know if sufficient human resources are in place to provide quality care.**
- **In the context of current fiscal constraints, ensure staff shortages are distributed equitably across services & programmes.**
- **Avoid rotation of staff to ensure continuity of care and the development of institutional memory in paediatric and neonatal wards.**

Core health services

Community based care

- Community health workers providing home- and community-based services have the potential to improve the reach of PHC, enable early identification of sick and vulnerable children and encourage health promoting family behaviours. Whilst the state report outlines six activities at community level to address root causes of high rates of infant and child mortality there is no data provided to indicate to what extent these activities have been implemented.

- On the contrary available data suggests that these activities are not being implemented on a wide scale. Immunisation coverage for children under 1 year for 2022 was reported to be 85.5% and the severe acute malnutrition case fatality rate at 7.9% for Apr 2021 to Mar 2022[33]. If activities such as ''improved caregiver's use and understanding of the Road to Health Booklet (RTHB)'' and ''trained caregivers and families on the use of child health tools, mid-upper arm circumference (MUAC) measurement and the RTHB for Prevention, early recognition and referral for severe acute malnutrition (SAM) and danger signs'' were being implemented as stated this should be reflected in higher immunisation coverage and lower SAM case fatality. Research has shown that very little time of CHWs is spent on visiting families with pregnant women and children under five because of competing priorities of ensuring medication adherence for communicable and non-communicable diseases.[34]]

Recommendations:

- **Increase investment in the numbers, training and supervision of community health workers**
- **Ensure maternal and child health is given greater priority in the package of community based services, and**
- **Strengthen data systems to monitor implementation.**

School health services

- School health initiatives play a critical role in promoting and establishing healthy behaviours in the lives of school-going children at an early stage. These initiatives provide an opportunity for health education and interventions to address the various health and socioeconomic factors that affect children.[35]
- An effective school health initiative can be one of the most cost-effective investments that a country can make to improve education and health simultaneously.[36] School health is an

important component of the overall health care delivery system of any country, and it is an essential point of regular contact between children and the broader health systems.

- The Primary Health Care Reengineering Draft policy (2010) and the Integrated School Health Programme (ISHP) initiated in 2012 by the South African government aim to provide a comprehensive package of services to school-going children.

Gaps and challenges

- The ISHP promises to offer a comprehensive and integrated package of services, including screening for barriers to learning and common health problems in grades 1 4, 8 and 10, coupled with a range of other services such as deworming, immunisation and sexual reproductive health services. While we welcome some signs of improvement over the reporting period, coverage of even the most basic screening of grade 1 and grade 8 learners remains suboptimal- reaching learners in only 1 in 3 junior schools, and 1 in 4 high schools.

School health screening coverage, 2015 – 2019

Year	Grade 1	Grade 8
2015/16	29.1	12.8
2016/17	33	19.8
2017/18	33.2	21.8
2018/19	32.7	22.1
2019/20	34.2	26.4

District Health Information Systems data, District Health Barometer

- Thirteen years on, the rollout of the school health services has been plagued with a host of problems. Some schools are excluded, and the full package of services is not provided to all learners in those schools that are covered. Screening services are not offered in many schools due to a shortage of nurses, mobile clinics (equipped vehicles), medical equipment and supplies.[37,38] In addition, school health professionals are not able to visit all participating schools twice a year as mandated in the school health policy.
- Follow-up services after screening are almost non-existent. Once children are screened in schools and referred to primary health care clinics and hospitals, but there is no mechanism to follow-up to ensure they access services at the public health facilities. Indeed, recent studies show that many are not able to access follow-up services due to financial constraints, transport problems and other issues.[39,40,41]

- Key stakeholders in the initiative often have limited knowledge about the programme as well as limited understanding of their respective roles in the initiative.[42] And these problems are compounded by a lack of adequate policy guidelines to guide the implementation process, and this has resulted in poor coordination and a lack of synergy between the departments of Education, Health and Social Development.[43,44]

Recommendations

- **Clarify roles and responsibilities to improve delivery and coordination between the departments Health, Education and Social Development.**
- **Put in place the necessary human and financial resources to expand the programme to all schools**
- **Develop mechanisms for following up on referrals to ensure that children access treatment and support[45].**

Neonatal care

- While under-five mortality rates are on the decline, **neonatal mortality rates** (NMR) have remained static at 12 deaths per 1000 live births.[46] Key causes of neonatal mortality in SA are prematurity and hypoxia.
- The quality of neonatal care needs to improve as a matter of urgency in order to enable better neonatal outcomes. This is achievable if every mother-infant dyad is able to access early and comprehensive care within their community. The health care system must therefore be supported, dedicated and appropriately trained at the community level to allow early detection and referral to higher levels of care. Pathways to care should be clearly established and efficient to allow a smooth transition especially for small (preterms) and sick neonates.
- Once admitted to the neonatal wards and NICU these require dedicated trained staff, with functional equipment and proper infrastructure to provide neonatal care.

Recommendations

- **Strengthen leadership and accountability by establishing clinical governance structures and hosting regular mortality and morbidity meetings to improve quality of care – especially in provinces and districts where NMR is below the national average.**
- **Ensure compliance with the norms and standards outlined in the Neonatal Essential Package Toolkit for staff, infrastructure, equipment and patient care**

- **Ensure all decisions are data-based and evidence-driven: "Evidence based obstetric interventions must be implemented to reduce the incidence of small and vulnerable infants and their associated poor outcomes" as outlined in the Lancet Series on Small and Vulnerable Newborns.[47]**

Emergency and intensive care

- Efforts to strengthen the district health system and primary health are essential for the prevention and treatment of common illness, but it is equally important to ensure that children's needs are met at secondary and tertiary level and that children can access emergency and intensive care.
- Paediatric **emergency medical services** (EMS) are thinly and unevenly stretched: Ambulance crews have extremely limited training in the management of sick or injured children, paediatric emergencies or life support; and most EMS services do not carry the necessary equipment to manage the resuscitation and safe transport of children.
- Only 4% of intensive care beds in South Africa were specifically allocated for children in 2007,[48] and there continue to be major shortages in the number of PICU beds available for **acute care**.[49] Nearly 25% of children requiring mechanical ventilation received this outside of an ICU[50] and in at least one province >30% of children referred to a quaternary PICU were refused admission,[51] with these gaps in care contributing to higher mortality.
- A recent study on the impact of COVID-19 on elective cardiac surgery in Cape Town[52] illustrates how a lack of PICU beds also restricts children's access to important and urgent **elective major surgery** - resulting in poorer outcomes and increased costs.
- These problems are likely to intensify due to inadequate recruitment, burnout and projected shortages of paediatric intensive care nurses.

Recommendations

- **Increase investment in paediatric critical care services, including the number and proportion of ICU beds dedicated to children and neonates, and the number of paediatric critical care nurses.**
- **Ensure each district hospital has at least two paediatric high care beds**
- **Ensure EMS teams have the necessary equipment and training to transport sick and injured children and provide life support.**

Palliative care

- Palliative care alleviates unnecessary pain and suffering and is an essential element of the children's right to basic health care services. As such it is not subject to progressive realisation, yet the state's inadequate implementation of the National Palliative Care Policy (2017- 2022) means that over 1 million children are not able to access palliative care and pain-relieving medications.
- With no government funded post for the previously donor funded Deputy Director of Palliative Care in the National Department of Health as well as uncertainty around which directorate will take the implementation of this policy forward, there is concern that some of the gains made during this first policy period will be lost. In addition, the country is now without a current palliative care policy and urgently needs a driver in the National Department of Health to develop the next policy (2025 – 2030).
- Much of the focus in this first policy period has been on the development of adult palliative care services and palliative care for children is being left behind. Only 1 palliative care nurse and 1 x 10- hour paediatric palliative care doctor receive government funding for their posts with the bulk of specialist Paediatric Palliative Care still being provided by a stretched NGO sector.

Recommendations

- **Reinstate the National Palliative Care Coordinator post.**
- **Draft a revised policy to guide delivery over the 2025 - 2030 term.**
- **Develop a separate Palliative Care Policy for Children to ensure children's needs do not or children lags behind.**
- **Include more palliative care indicators to enable monitoring through the District Health Information System.**

Essential medicines

- A full review of the paediatric Essential Drug List (EDL) for hospital level paediatrics was released in August 2023, and the Primary Healthcare, and Tertiary and Quaternary lists were updated in 2022. While the primary healthcare EML makes frequent reference to children, the tertiary and quaternary lists (which regulate the use of specialist medication in children) only make specific mention of children in 9 out of approximately 150 medication entries. This suggests that despite consistent engagement in reviewing the essentials medicines lists, there is still not sufficient focus on children.

- Procurement of medicine nationally tends to focus on adults and often fails to consider children's specific needs —including the need for lower doses and medicines that are palatable and easy to swallow. As a result pharmacists often have to manipulate adult medicines to suit children and this unlicensed usage may put children at risk. While a panel of paediatric experts provides guidance on appropriate and affordable drugs for children, the main EDL committee is not always sensitive to children's needs. A separate paediatric committee with a separate budget allocation may prove more effective in addressing children's health care needs (as is the case in many developed countries). In addition, it would be helpful to develop a pharmacopeia for children which would provide clear guidance on how to safely adapt adult medicines for children.

Critical conditions: HIV, TB and mental health

HIV and TB have exacted a particularly heavy toll on children in South Africa, who are affected by HIV and TB either directly through infection, or indirectly through the illness or death of family members and caregivers.[53] Similarly, children may be directly or indirectly affected by poor mental health, with children of parents with mental illness at greater risk for developing mental health problems. Although various interventions have been implemented to enhance prevention and access to treatment, investments in services for children continue to lag behind and greater efforts, resources and political will is needed to improve outcomes in children.

Tuberculosis

- Tuberculosis (TB) remains a major threat to health and survival for SA children. It causes death from meningitis, malnutrition and/or pneumonia and often leads to debilitating chronic illnesses – severe brain damage, chronic respiratory disease and physical disability. The burden of tuberculosis in South African children is one of the highest in the world with local data showing up to 12% of children getting infected every year in early childhood[54]. TB also has devastating economic and social consequences for families, through increased health costs, loss of work and function, and disruption of family structure; all factors that impact children's ability to grow and thrive.
- While the State report mentions efforts to integrate TB screening and care in services; and improve access to appropriate treatments, TB is still regularly missed and diagnosed late with devastating consequence to children and families.

Recommendations:

- **Strengthen efforts to protect children from infection when family members are either short on treatments options (extreme drug resistance) or not adherent to treatment that should and could work.**
- **Include screening for TB should in the assessment of all children with acute lower respiratory tract infections.**
- **Provide point of care diagnostics to maximise diagnosis and early treatment.**
- **Ensure more equitable access to paediatric TB drug formulations for the treatment of TB in children.**
- **Follow up all children after completion of TB treatment to ensure that those with post tuberculosis lung disease (PTLD) access appropriate care.**

HIV

Prevention

- New HIV infections in children (<15 years) dropped from 62, 000 in 2008 to 10,000 in 2021, driven primarily by the rollout of PMTCT.[55] Yet 30% of pregnant women (15 – 49 years) are living with HIV,[56] and there is growing concern about the health of one in five children who are uninfected but HIV-exposed[57]
- Greater investment is therefore needed to prevent HIV as adolescents and young adults (15 – 24 years) account for over a third (32%) of all new infections, and young women and adolescent girls are almost four times more likely to become infected than young men.[58]
- HIV pre-exposure prophylaxis (PrEP) for women at high risk of infection would help prevent infant HIV infections. Although access to PrEP has rapidly increased since the approval of its implementation policy in 2016,[59] access is uneven and utilisation rates remain inadequate to reduce the national HIV incidence.[60] This is partly due to the limited availability of healthcare workers who can initiate PrEP. Task shifting PrEP initiation to non-ART trained nurses could overcome this barrier but they are not currently permitted to prescribe PrEP.[61] Monitoring the care of women at risk of HIV infection, those living with HIV and their children is also inadequate.

Recommendations:

- **Increase access and utilization of HIV prevention interventions such as PrEP, particularly amongst vulnerable groups such as young women and adolescent girls by integrating these interventions into family planning and antenatal clinics and peer support groups.**
- **Identify and close the gaps in the treatment and care of women and children living with HIV by supporting community and health facility-based peer mentor groups.**
- **integrate HIV care in all reproductive and sexual health and maternal and child health services to Improve monitoring and timely access to care for women at risk of HIV infection, those living with HIV and their children.**

Access to condoms

- A recent South African study found that increasing the distribution of condoms that are specifically branded and targeted at young people could lead to a 12% to 31% reduction in new HIV infections over five years[62]. This is potentially more cost effective than increasing the uptake of pre-exposure prophylaxis (PrEP).

- Schools are a place where condoms could be effectively promoted and accessibly distributed. There are policies in place to enable the promotion of condoms at schools, and the curriculum includes lesson plans for condom promotion and comprehensive sexuality education[63], but many schools are refusing to implement these aspects of the curriculum.

Recommendations:

- **Produce and distribute one hundred million "youth" condoms each year that are especially designed to appeal to young people.**
- **Introduce measures to ensure that schools implement the structured lesson plans for comprehensive sexuality education including the condom education.**
- **Put in place accessible, confidential condom distribution systems for young people, including at schools and other places where young people routinely congregate.**

Testing, treatment and adherence

- In November 2022 a Children's Summit was hosted by the Children's Sector, Civil Society Forum, South African AIDS Council (SANAC) in preparation for the finalisation of the *National Strategic Plan on HIV/AIDS, TB and Sexually Transmitted Infections* (NSP). While the rollout of the Prevention of Mother to Child Transmission Programme has led to a significant decline of children contracting HIV through vertical transmission, Dr Xulu,[64]CEO of SANAC, noted that the coverage of children's programmes was "shocking": Only 80% of children with HIV know their HIV status, 55% of these are on treatment, and 56% of these are virally supressed – falling way below the Global AIDS 90/90/90 targets, and South Africa's national coverage of 93/78/90.[65]
- Children's vulnerability to infection and progression to AIDS illness is exacerbated by several factors:
  - The COVID-19 epidemic heightened poverty and the vulnerability of children to sexual exploitation and violence
  - High levels of child and adolescent pregnancy
  - The difficulty parents/caregivers have in discussing HIV with their children, leaving many children unaware of their status
- Participants in the Summit therefore resolved to motivate for greater focus on children in the National Strategic Plan (NSP) 2023 - 2028. Yet, despite active lobbying, children were not granted more focussed attention in the 2023 - 2028 NSP.

- In 2022 South Africa was invited to join the African chapter of the *Global Alliance to Eliminate HIV in Children by 2030* and a national implementation plan was developed outlining a series of specific interventions to address key challenges including:
    - Optimising testing, treatment and comprehensive care for infants, children and adolescents living with and exposed to HIV
    - Closing the treatment gap for pregnant and breastfeeding adolescent girls and women living with HIV and optimizing continuity of treatment
    - Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women
    - Addressing rights, gender equality and the social and structural barriers that hinder access to services.
- While we welcome this ambitious plan, we note that no new resources have been allocated to support its implementation.

Recommendations

- **Educate and support health workers, parents and caregivers so that they better equipped to talk to children about their HIV status and the need to take their medication.**
- **Intensify efforts to provide child/adolescent friendly clinics that treat young people with care and respect their confidentiality.**
- **Greater focus on life skills education in the curriculum, taught by competent and knowledgeable educators.**
- **Establish more support groups to encourage adherence and support.**
- **Work with boys and men to prevent violence against women and girls**

Integrated support for adolescents living with HIV

- 20% of all adolescents and youth living with HIV globally live in South Africa, the highest number of HIV infections worldwide.[66] As of 2021, over 421 100 adolescents were estimated to be living with HIV in South Africa [67] and this group account for the largest share of new HIV cases. Adolescents living with HIV (ALHIV) continue to experience life-threatening challenges including poor adherence to antiretroviral therapy (ART),[68] exposure to violence,[69] unintended pregnancies, limited access to family planning and safe contraception[70] and poor mental health [71].
- ALHIV face various challenges that significantly impact their capacity to adhere to ART medication leading to poor health outcomes. These include limited access to comprehensive care, inadequate healthcare infrastructure, long clinic travel times, and a lack of specialized

clinics[72]. Furthermore, there is limited access to timely viral load testing for ALHIV[73], especially those in resource-poor settings[74] which makes U=U difficult to realize in South Africa, despite a strong data warehouse and monitoring system.

Recommendations:

- **Strengthen collaboration between stakeholders both within and beyond the health care system to provide healthcare services are tailored to the needs of a growing cohort of adolescents living with HIV, including young parents living with HIV.**
- **Integrate HIV, mental health support services[75] and violence prevention services including parental monitoring[76] to support prevention and early diagnosis and adherence to treatment.**
- **Provide accessible[77] and youth-friendly healthcare services[78] offering confidential HIV testing, counselling, treatment, and support.[79]**
- **Continue advocacy against HIV-related stigma[80], and provide comprehensive sexual and reproductive health education,**
- **Support access to existing poverty reduction programs such as HIV-sensitive social protection[81] to enhance ART adherence.[82]**

Sexual and reproductive health services

- Adolescent girls in South Africa continue to have high rates of unintended pregnancies (more than half are <17 years old) and limited access to contraception and HIV prevention. Since 2020, there has been an unprecedented increase of pregnancies, including a 49% increase in live births among 10 – 14-year-old girls.[83]
- Rates of contraception use among young women who have already had a first child remain unacceptably low, with over 99% postpartum contraception, but around two-thirds current use. This situation calls for a need to review and revamp the implementation of the Integrated School Health Policy by several national departments.
- Key barriers to accessing SRH services among adolescents and young people include a lack of support from parents, sexual partners' and health workers compounded by stock-outs of contraceptives at public clinics – with a severe disruption of services during lockdown.
- Gender-based violence is endemic and 1 in 3 children have experienced sexual violence, yet the focus is often on criminal justice rather than providing therapeutic services to help children and their caregivers cope with trauma.

Recommendations:

We therefore call on the state to:

- **Report transparently on progress on the school- and community-based provision of sexual and reproductive health services (SRHS)**
- **Monitor, adjust and improve the provision of adolescent and youth friendly health services which are at their core respectful and confidential in an age and life-stage appropriate way.**
- **Put in place measures to prevent stockouts and ensure accessible, confidential, high quality contraceptive services for adolescent girls, including during humanitarian/ pandemics/ climate/ or conflict crises**
- **Support highly vulnerable groups of adolescents and young people to access sexual health services, for example by integrating HIV prevention into existing SRHS and antenatal and postnatal care**
- **Establish, refine and monitor the linkages between schools and social protection programmes to SRH services and products/technologies**
- **Assess children's access to Thuthuzela Centres and the quality of medical treatment and mental health care for child survivors of sexual and physical abuse.**

Mental health

- Children in South Africa are exposed to high levels of adversity, and it is therefore not surprising that an estimated 17% of children in South Africa have a diagnosable and treatable mental disorder.[84] And the COVID-19 pandemic and climate change are further increasing pressure on young people's mental health.
- Mental disorders interfere with children's ability to function in everyday life. Without adequate support, children may struggle at school with higher rates of absenteeism, grade repetition and dropout, undermining their education and economic prospects. Others may start to self-medicate with substances or resort to self-harm to cope with their symptoms, or they may channel their anger and distress outwards through disruptive, harmful, and, some instances, criminal behaviour. In this way, our failure to support children's mental health ripples out across their lives - and across generations. A staggering 50% of all mental disorders begin before the age of 14 years, so we need to intervene early in childhood and adolescence to break the cycle of violence, poverty and poor mental health.

- Similarly, mental health stressors combined with a lack of social support for adolescent girls and young women increase risk-taking behaviour and the risk of early pregnancy, HIV infection and poor mental health, while high levels of perinatal depression undermine mothers' capacity to care for young children.
- It is therefore critical to integrate mental health services into primary health care, school health and SRH services. Yet there are only 15 child and adolescent psychiatrists working in the public health system in South Africa. In most communities, mental health services for young people are simply unavailable - leaving 9 in every 10 children with a diagnosable mental disorder unable to access treatment.
- Table 32 in Annex A of the State report creates an impression that there are significant human resources dedicated to child and adolescent mental health services (CAMHS) but this simply not the case. Already the table highlights huge disparities in distribution of CAMHS between rural and urban provinces and districts – with CAMH professionals concentrated in the urban centres of GT, WC, EC and KZN – and many districts relying on a handful of social workers who are not equipped to diagnose or treat children with mental disorders We also wish to question the extent to which these health professionals are actually providing services to children and adolescents. For example, the State report claims that there are 58 clinical psychologists providing services to children and adolescents in the City of Cape Town, yet those working in field indicate that there are less than 10 dedicated child and adolescent psychologists working in the public health system in Cape Town.
- Few health facilities have dedicated facilities for children and adolescents with acute mental illness. As a result, adolescents are often kept in adult wards where they may be exposed to adult psychiatric patients and assessed by staff who lack the appropriate skills and expertise.
- These problems are rooted in government's failure to allocate adequate resources to mental health services and violate children's rights to mental health care.
- In addition, parental mental illness is an important risk factor, and therefore adult mental health services also need to adopt a family-centred approach by helping parents with mental illness to cope the challenges of parenting, and by reaching out to support their children who may be struggling with feelings of shame, isolation and self-blame.

Recommendations

- **Close the treatment gap by radically increasing the number of facilities offering child and adolescent mental health services.**
- **Ensure these services are private, confidential and open at times that work for children and adolescents.**
- **Invest in the training, supervision and support of health workers at primary levels of care so that they can screen and treat children with common mental disorders and refer those requiring more specialised care.**
- **Scale up specialized training of child psychiatrists, child psychiatric nurses and psychologists and social workers, and ringfence budgets to drive the implementation of CAMH services on the ground.**

Risk behaviour and the commercial determinants of health

All too often we focus on adolescent risk behaviour and fail to recognise and address the powerful influence of marketing practices of the alcohol and tobacco industries in shaping young people's choices. It is therefore essential to address these broader commercial determinants of health as outlined in the 2023 Lancet Series.[85]

Alcohol related harm

- Alcohol use has been identified as the leading risk factor for death and disability in sub-Saharan Africa, and globally for persons aged 15 – 19 years.[86] In South Africa, in 2017 a nationally representative household survey found that 4.4% of persons in this age group could be classified as hazardous or harmful alcohol consumers or alcohol dependent (AUDIT scores ≥5), 6.1% of males and 2.7% of females.[87] Direct and indirect consequences of drinking among children and adolescents in South Africa include rape, interpersonal violence, absenteeism, school failure, unwanted pregnancies, sexually transmitted infections, and HIV.[88] Drinking during pregnancy can damage the unborn child, and rates of FASD in South Africa have been found to be among the highest in the world, with a recent study reporting population levels of between 21% and 27% for grade 1 learners in certain mainly rural communities of the Western Cape.[89]The consequences of underage drinking were seen most strikingly in June 2022 when 21 teenagers, the youngest being 13 years of age, died at a tavern outside East London.[90]

- The government's response to the problem of underage drinking appears to reflect a continued reliance on education and awareness programmes, despite the very weak evidence base supporting such approaches.[91]

- The much-anticipated Control of Marketing of Alcoholic Beverages Bill of 2017, approved by Cabinet in September 2017, has floundered as did the 2016 Liquor Amendment Bill, which aimed to raise the drinking age, better control the sale and provision of alcohol to minors and their exposure to alcohol marketing.

- The Department of Basic Education has also introduced the Basic Education Laws Amendment Bill 2022[92] which includes an amendment to the National Schools Act that will permit the Head of Department, upon application from the governing body to to permit the possession, consumption or sale of liquor at school events for fundraising purposes.

Recommendations

- **Retract the proposed amendments to the Basic Education Law Amendment Bill that allow for the sale of alcohol to ensure that schools remain a safe alcohol-free sanctuary for children.**
- **Take decisive action and move forward with the 2016 Liquor Amendment Bill and add in measures to better control home deliveries of alcohol.**
- **Take decisive action and move forward with the Control of Marketing of Alcoholic Beverages Bill of 2013 to limit children and adolescents' exposure to alcohol marketing, including sports sponsorship, digital media and cross-border marketing as recommended in the WHO Global Alcohol Action Plan 2022- 2030.[93]**

Tobacco and electronic nicotine delivery systems

- Exposure to tobacco smoke increases children's risk of lower respiratory tract infections, ear infections and asthma, while smoking during pregnancy increases the risk of stillbirth, low birth weight, cancer and respiratory illness later in life. We therefore welcome government's earlier efforts to prohibit sales and marketing of cigarettes to children and to protect them from second hand smoke.
- In recent years, South Africa has become prey to the unregulated distribution and marketing of e-cigarettes or electronic nicotine delivery systems (ENDS). A recent survey of Western Cape high schools revealed that 1 in 4 adolescents vape.[94] Urgent action is needed to update legislation to protect children, as children of any age can access these products freely.
- Emerging data have shown that ENDS are dangerous and arguably more dangerous for children who otherwise would not have initiated smoking.[95] Long-term consequences of ENDS use are as yet unknown, but there is evidence of carcinogenic volatile compounds in the urine of adolescents who use ENDS.[96] The use of ENDS is also associated with DNA damage,[97] and significant adverse immunological and cardiorespiratory changes (including COPD and asthma[98]) and that they serve as a gateway to cigarette smoking.[99]. ENDS are high in nicotine (sometimes higher than cigarettes) and nicotine is a highly addictive drug, especially dangerous to the young brain.[100]
- Conventional cigarettes are also cheaper than ENDS in South Africa, raising the possibility that young people drawn into nicotine addiction by ENDS will switch to cheaper cigarettes to satisfy their habit.

- We therefore welcome the updated Tobacco Products and Electronic Delivery Systems Control Bill of 2022 – first introduced five years ago and its clear focus on children and youth including:
  - regulation of electronic nicotine and non-nicotine delivery systems
  - protection of children from exposure to second-hand smoke
  - restricting visibility of all products covered by the Bill,
  - plain packaging and graphic health warnings,
  - increasing the range of smoke-free spaces
  - tighter restrictions on advertising across mainstream and social

Recommendations

- **Fasttrack the passage of the Tobacco Products and Electronic Delivery Systems Bill.**
- **Ensure that ENDS and non-nicotine electronic delivery systems are licenced as smoking cessation aids by the South African Health Products Regulatory Authority and can only be prescribed by a doctor as is the case in Australia.**
- **Educate health workers, the general public and children about the risks and dangers of tobacco and ENDS.**

Cannabis

- In September 2018, the Constitutional Court found that it was unconstitutional for the state to criminalize the possession, use or cultivation of cannabis by adults for personal consumption in private,[101] and in March 2022, this judgement was extended to children.[102] So, while it remains illegal for children to use or possess cannabis for private purposes, they may not be arrested or prosecuted.
- While we support the Constitutional Courts reasoning that it is not in children's best interests to criminalise or incarcerate children or their parents for possession of cannabis, we note with concern the slow progress of passage the Department of Justice and Correctional Service's *Cannabis for Private Purposes Bill* which was first introduced in 2020. The Bill intends to introduce measures to protect children from exposure to second hand smoke and will make it an offence for guardians to permit their children to smoke, cultivate or deal in cannabis. But three years later, the Bill has yet to be enacted. Over the same period, we have witnessed the rapid expansion of the cannabis industry in South Africa and with it the marketing and promotion of its health benefits, with few adults and children aware of the risks and potential harm.

- While we recognise that cannabis has an important role in a limited number of medical treatments, it is important to recognise how cannabis use in adolescents can alter development of the cerebral cortex, the brain's centre of reasoning and executive function, at a time when the brain is undergoing rapid maturation and is uniquely sensitive to environmental exposures, leading to attentional impulsivity or an inability to concentrate or focus. In a small proportion of cases, cannabis use may also trigger a first psychotic or depressive episode., Rates of psychosis in the US have increased following a rapid increase in the recreational use and potency of cannabis.[103]
- Evidence also suggests that cannabis use during pregnancy increases the risk of adverse outcomes for women and their newborns, including an increased risk of low birth weight and childhood behavioural disturbances. and attention deficit hyperactivity disorder during childhood, which affect academic performance and social adjustment.[104]

Recommendations

We therefore call on the state to put in place measures similar to those used to protect children and adolescents from alcohol and tobacco-related harm. In addition to the measures proposed in the bill that prohibit adults from supplying children with cannabis, this should include measures to:

- **Prohibit/restrict the marketing of cannabis on radio, television, print media, billboards and social media.**
- **Educate parents, caregivers, children and adolescents about the harms associated with cannabis use, with a particular focus on child and adolescent physical and emotional development.**
- **Monitor the use of cannabis by high school students to assess changes over time as well as the potency of cannabis that is being sold and consumed (especially edibles).**
- **Provide mental health support to parents, caregivers, children and adolescents experiencing problems linked to their use of cannabis.**

Climate change and environmental health

Air Quality and Child Health

- South Africa's National Ambient Air Quality Standards[105] fall way below the initial standards set by the World Health Organisation and its more recent 2020 Air Quality Guidelines.[106] Children are particularly at risk and have been found to experience adverse health outcomes even when air pollution exposures fall below the Guideline levels[107]. Children in vulnerable communities in close proximity to persistent polluters, such as the coal-fired power stations and coalmines in Mpumalanga, the petrochemical industries in south Durban and the Vaal areas and rare metals mining in northern KZN and North West, are at excess risk for acute and chronic cardiac, respiratory and neurocognitive outcomes. Risk for exposure commences in utero, and continues in the neonatal, infancy and early childhood. These health impacts influence the growth and development of these children, their long-term health status and ability to escape the poverty.

- A further challenge is that the extent of air pollution-related ill-health among children is poorly documented, as our Health Information Systems do not specifically identify pollution in the aetiology for these problems. While acute outcomes (such as attacks of asthma, presentations of cough, shortness of breath and wheeze) are easily attributable to short-term (generally abnormally high) air pollution, the long-term exposure to persistent pollution that causes more insidious ill-health is not recognized by health services or by communities themselves. For example, the higher than normal exposure to heavy metals, such as mercury, seen in close proximity to coal-fired power stations, are likely to result in lower intelligence quotients (IQ) among exposed children. Similarly, particulate matter pollution could account for 1·96 billion lost IQ points in African children in 2019[108]. Adverse birth outcomes (pre-term birth, low birth weight, small for gestational age etc) have also been strongly associated with air pollution[109]. Because many of these outcomes are also associated with poor socio-economic status, the air pollution risk is often not recognized by affected communities and is subsequently ignored by polluters, and government.

- We are particularly concerned about how the State has recently allowed ESKOM, the world's biggest sulfur dioxide emitter, to apply to bypass pollution abatement equipment at one of its two biggest coal-fired power plants to allow it to restore generation capacity to the electricity grid.[110]

- It is vital that policy makers in South Africa recognize that economic development (efforts to increase electricity, jobs and investment) should not come at the expense of child health and

human rights. And that the long-term costs of weakening health standards will be borne not only by children in affected communities, but by the state over generations to come. It is therefore vital that this 'unfunded liability' is factored into the cost-benefit analysis before granting polluters waivers in emission limits or lowering air quality standards.

Recommendations:

- **adopt and enforce stricter air quality standards**
- **ensure health professionals are educated about air pollution and know how to take environmental health histories.**
- **establish environmental health trusts to redress the long term health effects of air pollution that are likely to persist within affected communities over the generations**.

Impacts of climate change on child health

- Climate change is no longer a distant projection and warming trends are already firmly established with 2—4°C warming expected along the coastal areas of South Africa, and 4—6°C warming inland by 2100 if maximum and immediate mitigation actions are not implemented.[111] As the world and country warm, we will experience rising sea levels, rising temperatures and more extreme weather events (EWE) such as floods, droughts & wildfires. Direct health risks include extreme heat stress, vector-borne diseases, malnutrition, respiratory diseases, chemical exposures, mental stress, violence, injury and allergies, while indirect risks include water scarcity, water-borne diseases, displacement due to EWE, and increased poverty.

- The WHO[112] estimates that approximately 85% of the existing global burden of disease due to climate change occurs in children under the age of five, making climate change the most significant intergenerational justice challenge facing the world today.[113] Climate change has been caused by today's adults and previous generations. Yet it is children —those least responsible for climate change —who will feel the worst impacts —both now and into the future.

- It is therefore of concern that key legislation, plans and strategies do not include specific measures to protect or prioritise children. The Climate Change Bill mentions children only once in its list of people who are particularly vulnerable to the adverse effects of climate change, but it fails to include any specific measures to protect or prioritise children. Similarly, the National Climate Change Adaptation Strategy calls for people to be placed at the centre

of adaptation planning and implementation "with special consideration of vulnerable groups, such as women, the elderly, and children" but it does not include any commitments to prioritise the protection of children from exposure to risk and harm. And while the National Climate Change and Health Adaptation Plan 2020 – 2024 recognises some (but not all) of the potential threats to child health, it does not include any specific actions or strategies to address the specific needs and vulnerabilities of pregnant women, infants, young children, school children or adolescences, nor any child-specific indicators.

The Just Transition and Health

- South Africa's heavy dependence on coal for energy makes it a leading global emitter of greenhouse gases and localised air pollution. Pressures are growing for a transition to renewable energy that minimises the socio-economic impacts and optimises job creation and environmental benefits. The economic and health impacts of the current national energy supply crisis, characterised by frequent 'load-shedding' and polluting diesel generators, make this 'just transition' even more urgent.
- The healthcare sector has a key role to play in reducing emissions and helping societies to adapt and become more 'climate resilient'. Not only is the health sector itself a significant emitter, but health workers are generally well placed and trusted to protect the public health, especially the most vulnerable like children and the elderly. Communities involved in recent national stakeholder engagements on South Africa's Just Transition Framework called for affordable and effective health services to address the widespread health impacts, particularly respiratory conditions, from mining and energy operations.
- The community health burden should therefore be determined, and air pollution data from a properly functioning national network of air quality monitoring should inform public awareness and public health management. Finally, better regulation of mining activities and the provision of free quality healthcare to most-affected communities would help to redress the long and deadly legacy of air pollution in places like the Mpumalanga Highveld coal belt and achieve some restorative justice.

Preparing for El Nino and Extreme Heat

- Temperatures are currently soaring in the global north, and El Nino is likely to bring extreme heat to South Africa in the summer. It is therefore encouraging that the *National Heat Health Action Guidelines October 2020 Guide to Extreme Heat Planning in South Africa for the Human Health Sector*, recognises that children under five are at highest risk of mortality due to extreme heat and acknowledged that heat exposure can cause substantial mental stress

and increase levels of violence in homes and society. It also acknowledges that infants and young children are also sensitive to the effects of high temperatures because they rely on others to regulate their thermal environments and to provide adequate fluids for hydration, and that older children and adolescents may be vulnerable to heat stroke during school sports or extra-mural activities, or due to inadequate fluid intake or inappropriate clothing.

- So, it is reassuring to see that some child centred measures have been included in the plan including reviewing the thermal comfort of classrooms and school uniforms, ensuring access to drinking water at schools, and including heat health education in the curriculum.
- These measures need to be fast tracked in collaboration with the Department of Basic Education, and similar specifically tailored measures and health messages need to be developed to safeguard the health of adolescents, pregnant women, infants and young children in homes and ECD centres – especially those living in informal settlements and shacks where the internal temperatures can be a full 10% hotter than outdoors.
- Similarly measures need to be put in place to strengthen child protection systems to respond to the threat of increased violence, and to ensure women and children are prioritised and safeguarded in disaster mitigation plans.

Recommendations

- **take more proactive steps to protect children's health, including steps to both mitigate and adapt to climate change.**
- **ensure children's health and best interests are clearly and concretely articulated in policy, plans and strategies, including actions and health messages that are specifically tailored to address the specific needs and vulnerabilities of pregnant women, infants, young children, school children and adolescents;**
- **include child-specific indicators to monitor impacts and the effectiveness of interventions.**

Nutrition and food security

A double burden of malnutrition

- South Africa is faced with a double burden of malnutrition. The most recent national data from the 2016 South African Demographic and Health Survey[114] found that:
- 1 in 4 young children are stunted or too short for their age, because they are not getting enough nutrients for healthy growth and development.
- 1 in 8 young children are overweight or obese. They are too fat because they are eating foods low in nutrients and high in energy from sugar and fat.
- Stunting rates have remained stubbornly unchanged for the past 20 years, and our child obesity rates are double the global average, with overweight and obesity increasing rapidly across the life course and affecting 27% of adolescent girls and 62% of women.[115]

An apparent increase in severe acute malnutrition

- Malnutrition is also a key driver of under-five mortality: About 45% of children who died in hospital in 2022 were either moderately or severely malnourished.[116] A recent NDoH response to a parliamentary question indicates that the national incidence of severe acute malnutrition (SAM) was 2,4% for the 2022/23 financial year. [117] This indicator measures the number of children under five years of age who are diagnosed with severe acute malnutrition (SAM) per 1,000 children in this age group.
- SAM increased by 23% from 2018/19 to 2022/23.[118] While some of this increase may be linked to improved surveillance systems, it is likely that the increase is primarily caused by high unemployment, rising food and fuel prices and a decline in the uptake of the Child Support Grant for children under 1 years of age.

Increasing poverty and inequality

- Malnutrition has its roots in high levels of poverty and inequality. Significant progress was made by the state in reducing the rate of child food poverty from 53% in 2003 to 33% in 2013.[119]. This period of improvement mirrors the same time period in which the Child Support Grant (CSG) was expanded in reach. The pace of progress in reducing child food poverty slowed down after 2013, with the child food poverty rate hovering around the 33% mark for the next seven years. It then shot up to 39% in 2020 and 37% in 2021. The upper-bound poverty rate shows a similar trend until 2018 and 2019 when improvements start to show. While the UP Rate was 65% in 2017, it decreased to 56% in 2019. However, this

progress was reversed after COVID-19 to 62% of children of children living below the upper-bound poverty line.[120]

- The Food Poverty Line (FPL) represents the minimum income required for daily energy needs and was R663/child/month in 2022. It does not ensure sufficient income for dietary diversity or nutrient dense food. Children living below this line are therefore highly likely to be suffering either from undernutrition or obesity or both. In 2021, 37% of all children in South Africa fell below this line – amounting to 7,7 million children.
- Poverty is also gendered with individuals in female dominated households 4 times more likely to be living in poverty than those in male dominated HH[121]. In addition, only 1 in 3 children live with their biological fathers, leaving the majority of mothers and many grandmothers to carry the burden of childcare.
- High income poverty also compromises children's access to safe drinking water, basic sanitation and health care services giving rise to frequent infections that further undermine child health and nutrition.[122] In 2021, 30% of children did not have access to safe drinking water and 20% did not have basic sanitation in their households, while I in 5 had to travel more than 30 minutes to access health care services,

Unhealthy food environments

- Individual food choices are shaped in powerful ways by local food environments and the broader food system which is increasingly profit-driven.
- Global food corporations are expanding their markets in the global South, directly targeting children as consumers, and flooding local markets with cheap ultra-processed foods.[123]
- These foods – low in micronutrients, high in sugar, salt and saturated fats– are fuelling a rapid rise in obesity and NCDs – with many of SA's children living in 'food deserts' where healthy foods are unaffordable or unavailable.

COVID-19 further intensified these challenges

- Rising unemployment coupled with food price inflation pushed families even deeper into poverty: By November/December 2020, 1 in 6 households reported that a child went to bed hungry in the week before the NIDS-CRAM survey.
- Yet child hunger is just the tip of the iceberg. Mothers attempted to shield their children from hunger by eating less and purchasing cheaper, less nutritious meals, but these empty calories are likely to further exacerbate already high rates of stunting, micronutrient deficiencies and obesity.

- In addition, over 9 million children were denied access to school meals following the closure of schools and early childhood development (ECD) centres; and the disruption of routine health care services made it harder to identify and support children at risk of malnutrition. This raises concerns about how the rights of vulnerable children are sidelined in emergencies such as COVID, civil unrest, climate change and the current economic recession.

Rising unemployment and food insecurity

- A 2021 nationally representative survey found that 20% of households were food insecure, with families eating less, borrowing or using credit, and even begging for food, and experiencing higher levels of anxiety and depression.[124]
- This is not surprising as with the war on Ukraine, food and fuel prices continued to soar, with food price inflation standing at 13.5% in January 2023, at a time when the official unemployment rate stood at 32.9%, and the expanded unemployment rate (which includes discouraged work seekers) at 42.4%.[125]
- Yet, the Child Support Grant (R480/child/month in March 2023) continues to fall way below the Food Poverty Line (R663 in 2022), and austerity budgets are eroding expenditure on health services threatening to further compromise children's health and nutrition as evidenced by suboptimal immunisation and measles outbreaks across the country.

Leadership and political will

- The National Nutrition Directorate has lost several mid-level managers due to resignations, retirement and death. None have been replaced crippling its capacity to address any nutrition priorities
- The National Food and Nutrition Security Council which is responsible for driving the implementation of intersectoral National Food and Nutrition Security Plan has still not been appointed raising questions about a lack of political will to address these key challenges.

➢ **Address the capacity constraints in the national nutrition directorate, and establish the NFNS Council as a matter of urgency to strengthen leadership and drive the nutrition agenda in South Africa**

Maternal health and nutrition

- Women's nutritional needs increase dramatically during pregnancy, and food insecurity, micronutrient deficiencies, overweight, gestational diabetes and pre-eclampsia pose a threat to the health of both mother and unborn child. It is therefore essential to adopt a double-duty approach and not only provide micronutrient supplements, but also monitor weight

gain and integrate dietary counselling into routine antenatal care with an emphasis on nutrient density and dietary diversity. Yet, the 2012-2016 Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition makes no mention of maternal nutrition, and while the maternal care guidelines speak to the identification of malnutrition, they don't include any actionable measures to address the problem. This must be remedied to enhance outcomes for mothers and children.

- In addition, food insecurity also increases the risk of domestic violence, depression and anxiety that can further compromise mothers' capacity to feed and care for their children.[126]

➢ **Adopt an integrated approach: extend social assistance to pregnant women, integrate mental health screening and support into antenatal and postnatal care, and scale up efforts to prevent teenage and unwanted pregnancies.**

Infant and young child feeding

Only 32% of infants in SA are exclusively breastfed during the first six months of life, and only 23% of children 6 – 23 months are fed a minimum acceptable diet.[127] Greater efforts are therefore needed to promote optimal infant and young child feeding practices as this is when children are most vulnerable to stunting and severe acute malnutrition.

➢ **scale up support for all breastfeeding women (eg parental leave, child care and breastfeeding breaks) including those working in the informal sector,**
➢ **improve health workers' nutrition knowledge and counselling skills,**
➢ **promote local, nutrient-dense and affordable complementary foods.**
➢ **Strengthen surveillance and support systems at facility and community level to identify and support children at risk of malnutrition.**

Early childhood development programmes

Early learning programmes offer a platform for supporting nutrition of preschool children. While registered ECD centres qualify for a subsidy of R15 - R17 per child per day, 40% of which is earmarked for nutritious food, stringent registration requirements exclude centres serving those communities most in need. As a result, only 10% of young children benefit from the subsidy – in marked contrast to the National School Nutrition Programme (NSNP) which supports 77% of learners.[128]

➢ **Increase access to ECD subsidy and increase its value to meet nutritional and educational needs of young children.**

School nutrition

The NSNP provides a daily meal to over 9 million learners but there are concerns that rising food prices are eroding both the quantity and quality of school meals. Schools should also be used as a platform for nutrition education, food gardens and school health services.

SA's children are increasingly sedentary: Less than half of learners get enough exercise to promote health and prevent chronic disease, and one in three schools are without sporting facilities.[129]

- **Monitor and enforce the Department of Basic Education's guidelines to improve the nutritional quality of school meals and limit the marketing and sale of unhealthy, obesogenic foods;**
- **Scale up the National School Sport Programme and provide safe spaces for physical activity – especially for adolescent girls.**

The food system

Direct intervention by the state is needed to ensure that the food system supports, protects and promotes children's health, nutrition and food security. We therefore welcome the state's efforts to introduce regulations to protect children from the marketing of unhealthy foods; front-of-pack labelling to enable consumers to make informed choices; and taxes to limit the consumption of unhealthy foods – through the Health Promotion Levy, Audio and Audio-Visual Content Services Bill, Regulation R991 relating to Foodstuffs for Infants and Young Children, and draft Regulation R3337 relating to the Labelling and Marketing of Foodstuffs Harmful to Health.

- **Strengthen monitoring, enforcement and sanctions to ensure compliance with marketing restrictions.**
- **Subsidise the costs of a basic healthy food basket to help make healthy foods more affordable.[130]**

Social protection

- The Child Support Grant (CSG) provides a lifeline for 13 million children and over 7 million caregivers.[131] But the grant amount (R480 a month/ R16 a day in March 2023) is not enough to meet children's dietary needs. Pre-COVID with a child food poverty rate of 33%, the State was advised by three international human rights committees to increase the CSG amount[132]. However, this advice was not heeded and the grant has remained at its pre-COVID low value. Recently the state took decisions to reduce the real value of the CSG by allocating below

headline inflation annual increases in the last three financial years [2021/22, 2022/23 & 2023/24][133]. The gap between the CSG value and the FPL (R663 in 2022) is now at 28%.

- Despite impressive reach, the low value of the grant and recent reductions to its purchasing power limit its ability to further reduce child food poverty. Increasing its value to the FPL will significantly reduce the number of children living below the food poverty line which in turn will have a positive impact on child health and nutrition indicators.
- Take-up of the grant is over 80% of poor children, however for infants under 1 year of age, only 64% of the eligible population were receiving a social grant in 2017.[134] Since 2020 there has been a real decrease in CSG take-up among infants. The first sharp drop occurred between March 2020 and March 2021, with a decrease of over 100,000 infants receiving the CSG. Although the rate of decline slowed subsequently, the number of infants receiving the CSG has continued to decline each year, by another 1% in 2022 and by 6% in 2023. At the end of March 2023, there were 150,000 fewer infants receiving the CSG than there had been in March 2020, just before the COVID-19 lockdown. This represents a decrease of 23% in early CSG uptake.[135]
- This trend is worrying as infants are particularly vulnerable to the immediate shock and long-term effects of malnutrition. The downward trend in under 1 CSG uptake is likely caused by a similar downward trend in current year birth registration, and backlogs in access to IDs for young mothers.[136] Home Affairs services were reduced during the two-year state of disaster and have also been negatively affected by austerity budgeting and loadshedding and this has resulted in a backlog in access to Home Affairs documents.

Recommendations:

- **Increase the value of the CSG and the Social Relief of Distress Grant for unemployed adults to the food poverty line.**
- **Design and implement a joint catch up strategy to ensure all pregnant women have IDs before they give birth and all babies are registered as soon as possible after birth in order to increase early uptake of the CSG**
- **in the meantime, SASSA should pro-actively promote the use of its 'alternative document' policy which allows mothers without IDs and infants without birth certificates to access the CSG as outlined in Regulation 13(1) of the Social Assistance Act, SASSA officials are however reluctant to utilise the policy and the take-up is low compared to the numbers of children in need.**

Austerity cuts to health and social spending

- We also wish to raise concerns about government's cuts to social spending in its October 2022 Medium Term Budget Policy Statement. This includes cuts to health, social services and social assistance, which threaten to undermine the provision of essential child health and child protection services whilst simultaneously pushing more of South Africa's children even deeper into poverty.[137]
- Consolidated spending on health was R259 billion in 2022/23 and will remain at this level for 2023/24. And in the context of consumer price inflation, this equates to a real reduction on health care spending of 4.9% - while inflationary pressures are even higher in the region of +40% on imported medicines and medical equipment.
- In addition, the number of people without medical aid is increasing at a rate of 2.2% per year which means that spending per health care user reduced from R5,028 in 2022/23 to R4,605 in 2023/24. These extreme austerity measures are set to continue in 2024/25, with a further reduction in spending per health care user to R4,453.
- These cuts prompted the Child Health Priorities Association, together with all the major child advocacy organisations in South Africa, academics and paediatric departments of five South African universities and more than 100 professors, doctors and other allied health workers with an interest in child health and well-being to issue a call to protect child health services from budget cuts ,[138] yet they received no response from national government, nor any commitments from the state to safeguard and protect human resources for child health from these austerity measures.

➢ It is currently impossible to disaggregate current spending on child health services, meaning that many of the decisions on how budgets were cut, would have been devolved to district and facility level making it incredibly difficult to monitor and/or advocate on the ground to pre-empt cuts to children's services.

A call to safeguard child health in times of crisis

- The UN Secretary General and Committee on the Rights of the Child called on states to prioritise children in their COVID-19 response plans, and to "activate immediate measures to ensure that children are fed nutritious food during periods of emergency, disaster or lockdown".[139]
- In addition, the Gauteng High Court in its judgement calling for the reinstatement of the National School Nutrition Programme during COVID-related school closures, upheld the UN Committee on the Rights of the Child's stipulation that "even in an economic crisis, the State may only introduce regressive measures as a last resort and must ensure that children are the last to be affected"[140].

Recommendations

In the context of extreme inequality, rising food insecurity, austerity and climate change, we call on the Committee to remind the State that:

- **it has an immediate obligation to respect, protect, promote and fulfil children's right to basic nutrition and basic health care services as outlined in section 28 of the Constitution and that these are not subject to progressive realisation.**
- **It may not introduce retrogressive measures and should take proactive steps to safeguard children's health and nutrition during the current economic recession, and from the potential impact of El Nino and rising temperatures on child health, and food production in SA.**

We also call on the State to:

- **Expand social protection including an increase in the value of social grants to better protect children and families from rising unemployment, poverty and hunger.**
- **Put in place real time surveillance and strong referral systems to identify and support children in need of food, care, protection, and psychosocial support.**
- **Strengthen leadership, representation and advocacy for children in all decision-making fora, to ensure that children's best interests are proactively addressed and prioritised in our response and recovery plans.**
- **Build more resilient and responsive systems that are better equipped to cope with future shocks and challenges.**
- **Seek the perspective and participation of children, to ensure that their concerns and the solutions they offer, guide our efforts to protect and support them**

Annex 1: List of endorsements and contributors

Endorsements

Organisations

1. Children's Institute, University of Cape Town
2. Child Health Priorities Association
3. Advocacy Committee, Department of Paediatrics and Child Health, University of Cape Town
4. Centre for Environmental Rights
5. Healthy Living Alliance (HEALA)
6. Adolescent Accelerators Hub, Centre for Social Science Research, University of Cape Town
7. Patch SA
8. SAMRC Centre for Health Economics and Decision Science PRICELESS SA
9. South African Association of Child and Adolescent Psychiatry and Allied Professionals
10. Rural Health Advocacy Project
11. SECTION27
12. Southern African Alcohol Policy Alliance – South Africa
13. South African Civil Society Organisation for Women, Adolescent and Child Health (SACSOWACH)
14. People's Health Movement – South Africa

Individuals

1. Professor Ashraf Coovadia, Department of Paediatrics and Child Health, University of the Witwatersrand
2. Dr Nomlindo Makubalo, Chairperson of the Ministerial Committee on Mortality and Morbidity in Children under five, and Eastern Cape Department of Health
3. Associate Professor Maylene Shung-King, School of Public Health, UCT
4. Professor Mignon McCullogh, Department of Paediatrics and Child Health, UCT
5. Professor Linda Theron, Department of Educational Psychology, University of Pretoria
6. Dr Gabriel Urgoiti
7. Dr Dave le Roux, Department of Paediatrics and Child Health, University of Cape Town
8. Professor Ute Feucht, Department of Paediatrics and Child Health, University of Pretoria
9. Russell Rensburg, Rural Health Advocacy Project

10. Jane Booth, Department of Paediatrics and Child Health, UCT
11. Dr Scott Drimie, Division of Human Nutrition, University of Stellenbosch & leadership collective South African Food Lab
12. Nzama Mbalati, Healthy Living Alliance
13. Maria van der Merwe
14. Dr Yogan Pillay, South African Civil Society Organisation for Women, Adolescent and Child Health
15. Dr Sara Jewett, School of Public Health, University of the Witwatersrand
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18. Professor Steve Reid, Primary Health Care Directorate, University of Cape Town
19. Professor Louis Reynolds, Department of Paediatrics and Child Health, UCT
20. Lori Lake, Children's Institute, University of Cape Town

21. Dr Tim De Mayer, Department of Paediatrics and Child Health, University of the Witwatersrand
22. Associate Professor Wiedaad Slemming, Children's Institute, University of Cape Town
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33. Professor Andrea Rother, School of Public Health, University of Cape Town,
34. Dr Catherine O. Egbe, Mental health, Alcohol, Substance use and Tobacco Research Unit, Medical Research Unit
35. Paula Proudlock, Children's Institute, University of Cape Town
36. Dr Lungi Hobe, Rural Doctors Association of South Africa
37. Associate Professor Michael Hendricks, Department of Paediatrics and Child Health, UCT

Annex 2: Recommendations

Health data

The current gaps and delays in mortality data are unacceptable, and we call on the State strengthen health data systems for children:

- Make ChildPIP and Perinatal Problem Identification Programme audits mandatory in all public sector health facilities and ensure these programmes are adequately resourced.
- Ensure that medical electronic birth registration is done at all public and private hospitals, with electronic linking of mother–infant pairs, so that cohort monitoring can be done in order to improve perinatal, neonatal and child health outcomes.
- Ensure Statistics South Africa addresses the inordinate delay in the analysis and release of mortality data and ensures a turnaround time of under 24 months moving forward.

Child survival

- As there has been no improvement in neonatal mortality in over two decades new innovations are required in neonatal care including greater emphasis on Kangaroo Mother Care, the implementation of non-invasive respiratory support in district hospitals and an increase in the number of regional and tertiary level neonatal ICU beds.

- Initiatives are required to promote child safe homes and community initiatives to prevent burns, falls, drowning and poisoning, and reduce non-natural deaths in preschool children.

- All provinces need to develop accessible and capacitated critical care services for children and neonates.

From Survive to Thrive: The First 1 000 Days

- Allocate dedicated funding to support the delivery of an expanded package of services so that infants and young children not only survive, but thrive.
- Strengthen care and support for women during the antenatal and perinatal period including mental health screening, social protection and respectful maternal care.
- Ensure that these key interventions in the first 1000 days of life are prioritised in the proposed review of the ECD Policy.

Children with disabilities and long term health conditions

- Develop an overarching policy to guide the delivery of services to children and adolescents with disabilities and long term health conditions.
- Address data gaps in order to improve the identification and management of children with LTHCs and disabilities.
- Develop an essential package of care tailored to meet the specific needs of this large and diverse group of children.
- Strengthen early identification and intervention services for preschool children.
- Deliver on the commitments to inclusive education as outlined in White Paper 6.
- Review the CDG assessment criteria to enable earlier and equitable access to social assistance for children with 'invisible disabilities' and LTHCs.
- Rewrite the rules for admission to hospital to better support adolescents with LTHCs and disabilities' transition to adult services.

Health care services

Access and quality of care

- Prioritise the needs of children in the strengthening of district health services including greater access to comprehensive primary health care services including oral health and rehabilitation services.
- Introduce innovative strategies to ensure more equitable access to specialised care across district and provincial boundaries – using outreach clinics and digital platforms to build capacity, support task shifting and mentor staff working in primary care.
- Strengthen local referral systems between Health, SASSA and DSD to fast track access to social assistance and child protection.
- Intensify efforts to enhance quality of care and compliance with the Ideal Hospital and Ideal Clinic Norms and Standards.
- Build leadership for child health to drive quality improvement at district and provincial level.

National Health Insurance and Universal Health Coverage

- Ensure that the packages of care for children are defined as a matter of urgency in a way that meets the needs of all children in the country including those with disabilities and LTHCs.
- Be more transparent about progress toward PHC reengineering, including ward-based outreach teams and school health services, given the lack of clarity at present beyond the identification of facilities as being in the "ideal clinic" programme.
- Ensure that the transition to NHI is laid out clearly in a way that secures continuous and improved access to health care services for all children.

Human resources and leadership for child health

- Build leadership within each cadre of staff ie nursing, medical and allied professions and at provincial, district and facility levels. This includes the urgent appointment of provincial and district specialists who are responsible for the quality of services and driving intersectoral collaboration to improve the health of all children in their province or district.
- Adopt staffing norms for all cadres of health staff so that we know if sufficient human resources are in place to provide quality care and to assist in the equitable allocation of resources.
- In the context of current fiscal constraints, ensure staff shortages are distributed equitably across services & programmes.
- Avoid rotation of staff to ensure continuity of care and the development of institutional memory in paediatric and neonatal wards.

Participation

- Respect and enable children's right to participate in health care decision-making and provide child and youth friendly materials to support informed consent.
- Actively include children and adolescents in the evaluation of health care services to enhance the quality of care.

Core health services

Community based services

- Increase investment in the numbers, training and supervision of community health workers.
- Ensure maternal and child health is given greater priority in the package of community based services.
- Strengthen data systems to monitor implementation.

School health services

- Clarify roles and responsibilities to improve delivery and coordination between the departments Health, Education and Social Development.
- Put in place the necessary human and financial resources to expand the programme to all schools.
- Develop mechanisms for following up on referrals to ensure that children access treatment and support.

Neonatal care

- Ensure compliance with the norms and standards outlined in the Neonatal Essential Package Toolkit for staff, infrastructure, equipment and patient care.
- Strengthen leadership and accountability by establishing clinical governance structures, hosting regular mortality and morbidity meetings.
- Ensure all decisions are evidence-based and data driven to improve quality of care.

Emergency and intensive care

- Increase investment in paediatric critical care services, including the number and proportion of ICU beds dedicated to children and neonates, and the number of paediatric critical care nurses.
- Ensure EMS teams have the necessary equipment and training to transport sick and injured children and provide life support.

Palliative care

- Reinstate the National Palliative Care Coordinator post.
- Draft a revised policy to guide delivery over the 2025 - 2030 term.

- Develop a separate Palliative Care Policy for Children to ensure children's needs do not or children lags behind.
- Include more palliative care indicators to enable monitoring through the District Health Information System

Critical conditions: HIV, TB and mental health

Tuberculosis

- Strengthen efforts to protect children from infection when family members are either short on treatments options (extreme drug resistance) or not adherent to treatment that should and could work.
- Include screening for TB should in the assessment of all children with acute lower respiratory tract infections.
- Provide point of care diagnostics to maximise diagnosis and early treatment.
- Ensure more equitable access to paediatric TB drug formulations for the treatment of TB in children.
- Follow up all children after completion of TB treatment to ensure that those with post tuberculosis lung disease (PTLD) access appropriate care.

HIV

Prevention

- Increase access and utilization of HIV prevention interventions such as PrEP, particularly amongst vulnerable groups such as young women and adolescent girls by integrating these interventions into family planning and antenatal clinics and peer support groups.
- Identify and close the gaps in the treatment and care of women and children living with HIV by supporting community and health facility-based peer mentor groups.
- integrate HIV care in all reproductive and sexual health and maternal and child health services to Improve monitoring and timely access to care for women at risk of HIV infection, those living with HIV and their children.

Access to condoms

- Produce and distribute one hundred million "youth" condoms each year that are especially designed to appeal to young people.

- Introduce measures to ensure that schools implement the structured lesson plans for comprehensive sexuality education including the condom education.
- Put in place accessible, confidential condom distribution systems for young people, including at schools and other places where young people routinely congregate.

Testing, treatment and adherence

- Educate and support health workers, parents and caregivers so that they better equipped to talk to children about their HIV status and the need to take their medication.
- Intensify efforts to provide child/adolescent friendly clinics that treat young people with care and respect their confidentiality.
- Greater focus on life skills education in the curriculum, taught by competent and knowledgeable educators.
- Establish more support groups to encourage adherence and support.
- Work with boys and men to prevent violence against women and girls.

Integrated support for adolescents living with HIV

- Strengthen collaboration between stakeholders both within and beyond the health care system to provide healthcare services are tailored to the needs of a growing cohort of adolescents living with HIV, including young parents living with HIV.
- Integrate HIV, mental health support services and violence prevention services including parental monitoring to support prevention and early diagnosis and adherence to treatment.
- Provide accessible and youth-friendly healthcare services offering confidential HIV testing, counselling, treatment, and support.
- Continue advocacy against HIV-related stigma, and provide comprehensive sexual and reproductive health education.
- Support access to existing poverty reduction programs such as HIV-sensitive social protection to enhance ART adherence.

Sexual and reproductive health services

- Transparently report on progress on the school- and community-based provision of sexual and reproductive health services.
- Monitor, adjust and improve the provision of adolescent and youth friendly health services which are at their core respectful and confidential in an age and life-stage appropriate way.

- Put in place accessible, confidential, high quality contraceptive services for adolescent girls, including measures to prevent stockouts and ensure access during future humanitarian/ pandemics/ climate/ or conflict crises.
- Supporting highly vulnerable sub-groups of adolescents and young people to access sexual health services, for example how is HIV prevention integrated in existing SRHS and antenatal and perinatal care.
- Establish, refine and monitor the linkages between schools, social protection programmes, and SRH services and products/technologies.
- Assess children's access to Thuthuzela Centres and the quality of medical treatment and mental health care for child survivors of sexual and physical abuse.

Mental health

- Close the treatment gap and radically increase the number of facilities offering child and adolescent mental health services.
- Ensure these services are private, confidential and open at times that work for children and adolescents.
- Invest in the training, supervision and support of health workers at primary levels of care so that they can screen and treat children with common mental disorders and refer those requiring more specialised care.
- Scale up specialized training of child psychiatrists, child psychiatric nurses and psychologists and social workers, and ringfence budgets to drive the implementation of CAMH services on the ground.

Risk behaviour and the commercial determinants of health

Alcohol related harm

- Retract the proposed amendments to the Basic Education Law Amendment Bill that allow for the sale of alcohol to ensure that schools remain a safe alcohol-free sanctuary for children.
- Take decisive action and move forward with the 2016 Liquor Amendment Bill and add in measures to better control home deliveries of alcohol**.**
- Take decisive action and move forward with the Control of Marketing of Alcoholic Beverages Bill of 2013 to limit children and adolescents' exposure to alcohol marketing, including sports sponsorship, digital media and cross-border marketing as recommended in the WHO Global Alcohol Action Plan 2022- 2030.

Tobacco and electronic nicotine delivery systems

- Fasttrack the passage of the Tobacco Products and Electronic Delivery Systems Bill.
- Ensure that ENDS and non-nicotine electronic delivery systems are licenced as smoking cessation aids by the South African Health Products Regulatory Authority and can only be prescribed by a doctor as is the case in Australia.
- Educate health workers, the general public and children about the risks and dangers of tobacco and ENDS.

Cannabis

- Prohibit/restrict the marketing of cannabis on radio, television, print media, billboards and social media.
- Educate parents, caregivers, children and adolescents about the harms associated with cannabis use, with a particular focus on child and adolescent physical and emotional development.
- Monitor the use of cannabis by high school students to assess changes over time as well as the potency of cannabis that is being sold and consumed (especially edibles).
- Provide mental health support to parents, caregivers, children and adolescents experiencing problems linked to their use of cannabis.

Climate change and environmental health

Air quality and child health

- adopt and enforce stricter air quality standards.
- ensure health professionals are educated about air pollution and know how to take environmental health histories.
- establish environmental health trusts to redress the long term health effects of air pollution that are likely to persist within affected communities over the generations.

Impacts of climate change on child health

- take more proactive steps to protect children's health, including steps to both mitigate and adapt to climate change.
- ensure children's health and best interests are clearly and concretely articulated in policy, plans and strategies, including actions and health messages that are specifically tailored to address the specific needs and vulnerabilities of pregnant women, infants, young children, school children and adolescents.
- include child-specific indicators to monitor impacts and the effectiveness of interventions.

Nutrition and food security

Maternal health and nutrition

- Adopt an integrated approach: extend social assistance to pregnant women, integrate mental health screening and support into antenatal and postnatal care, and scale up efforts to prevent teenage and unwanted pregnancies.

Infant and young child feeding

- scale up support for all breastfeeding women (eg parental leave, child care and breastfeeding breaks) including those working in the informal sector.
- improve health workers' nutrition knowledge and counselling skills.
- promote local, nutrient-dense and affordable complementary foods.
- Strengthen surveillance and support systems at facility and community level to identify and support children at risk of malnutrition.

Early childhood development programmes

- Increase access to ECD subsidy and increase its value to meet nutritional and educational needs of young children.

Schools

- Monitor and enforce the Department of Basic Education's guidelines to improve the nutritional quality of school meals and limit the marketing and sale of unhealthy, obesogenic foods.
- Scale up the National School Sport Programme and provide safe spaces for physical activity – especially for adolescent girls.

Food industry

- Strengthen monitoring, enforcement and sanctions to ensure compliance with marketing restrictions.
- Subsidise the costs of a basic healthy food basket to help make healthy foods more affordable.

Social protection

- Increase the value of the CSG and the Social Relief of Distress Grant for unemployed adults to the food poverty line.

- DoH and DHA should design and implement a joint catch-up strategy to ensure all pregnant women have IDs before they give birth and all babies are registered as soon as possible after birth.

- In the meantime, SASSA should pro-actively promote the use of its 'alternative document' policy which allows mothers without IDs and infants without birth certificates to access the CSG as outlined in Regulation 13(1) of the Social Assistance Act.

A call to safeguard child health in times of crisis and austerity

In the context of extreme inequality, rising food insecurity, austerity and climate change, we call on the UN Committee to remind the State that:

- it has an immediate obligation to respect, protect, promote and fulfil children's right to basic nutrition and basic health care services as outlined in section 28 of the Constitution and that these are not subject to progressive realisation.
- It may not introduce retrogressive measures and should take proactive steps to safeguard children's health and nutrition during the current economic recession, and from the potential impact of El Nino and rising temperatures on child health, and food production in SA.

We also call on the State to:

- Expand social protection including an increase in the value of social grants to better protect children and families from rising unemployment, poverty and hunger.
- Put in place real time surveillance and strong referral systems to identify and support children in need of food, care, protection, and psychosocial support.
- Strengthen leadership, representation and advocacy for children in all decision-making fora, to ensure that children's best interests are proactively addressed and prioritised in our response and recovery plans.
- Build more resilient and responsive systems that are better equipped to cope with future shocks and challenges.
- Seek the perspective and participation of children, to ensure that their concerns and the solutions they offer, guide our efforts to protect and support them.

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