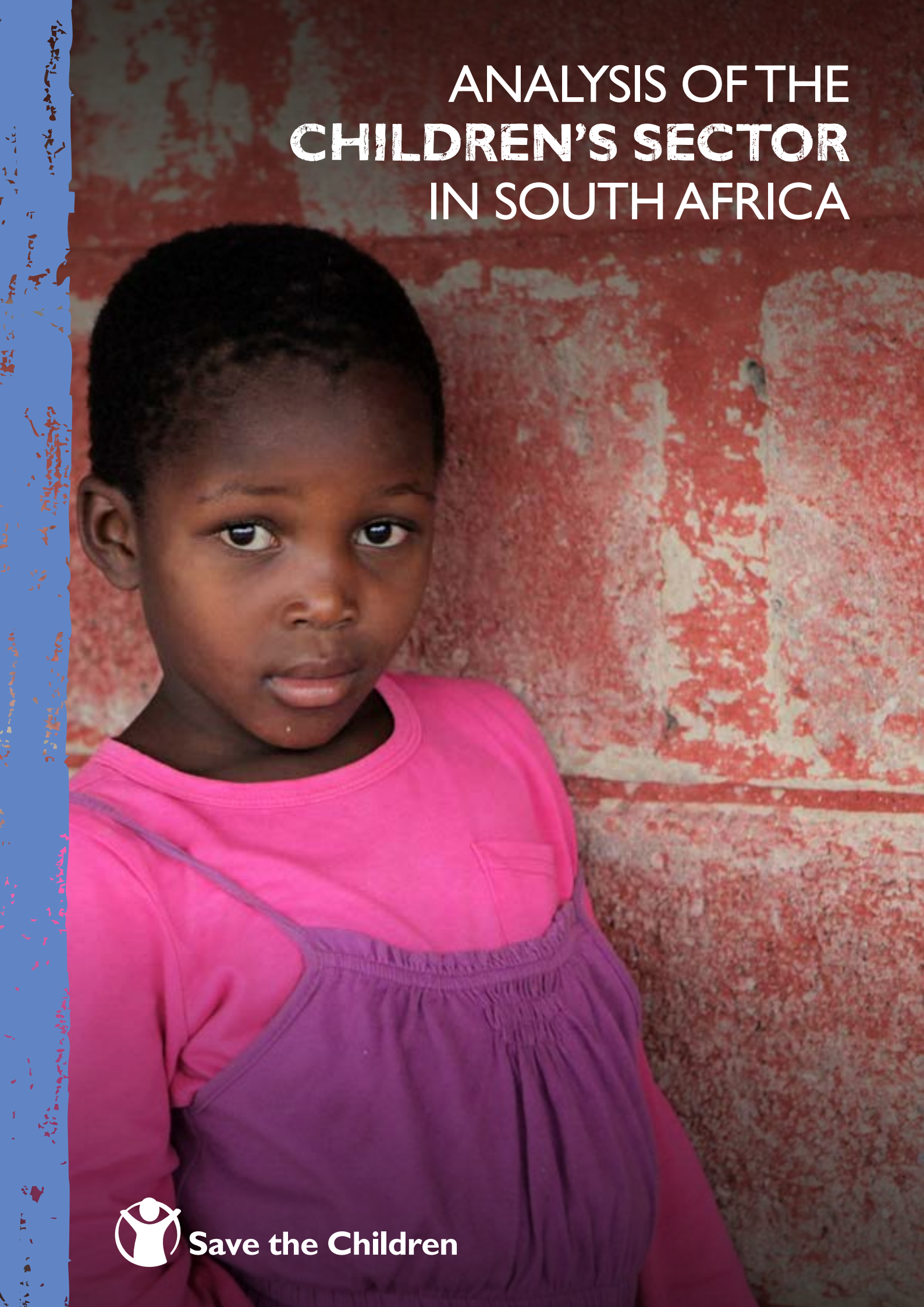
ANALYSIS OF THE **CHILDREN'S SECTOR** IN SOUTH AFRICA



Save the Children

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Acknowledgements
Save the Children South Africa (2015)
Analysis of the Children's Sector in South Africa
Pretoria, South Africa
This report was written by Patricia Martin
Photos byJenn Warren/Save the Children
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Cover photo: A child at the Save the Children Sizolomphakathi Drop-in Centre in Mpumalanga Province waits in line for her hot meal of the day. Many children in the area live in single-parent households, either due to separated parents, a deceased parent or an absent father. In early 2010, Save the Children recognised the need to open a drop-in centre for children in the area, which now serves over 133 children.
(Photo: Save the Children)

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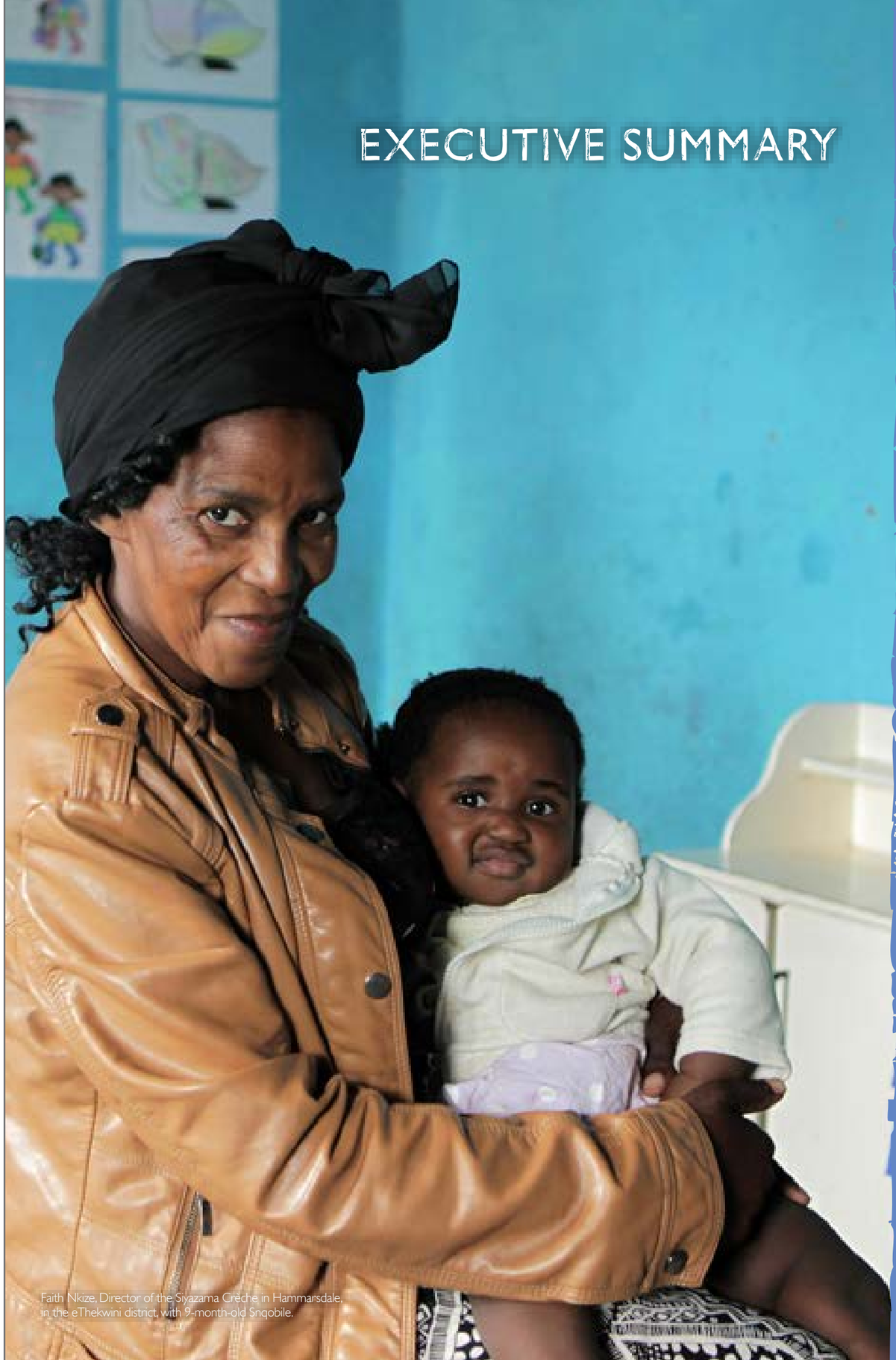
ABBREVIATIONS AND ACRONYMS

ACRWC	African Charter on the Rights and Welfare of the Child
ART	Antiretroviral treatment
BANC	Basic antenatal care
CYCCs	Child and youth care centres
CRPD	Convention on the Rights of Persons with Disabilities
CRC	Convention on the Rights of the Child
DSD	Department of Social Development
DART	Disability Action Research Team
EPI	Expanded Programme on Immunisation
GRSA	Government of the Republic of South Africa
IMR	Infant mortality rate
IMCI	Integrated Management of Childhood Illness
MDG	Millennium Development Goa
NPA	National Plan of Action
NCDs	Non-communicable diseases
NGOs	Non-governmental organisations
PMTC	Prevention of mother-to-child transmission
RtHB	Road to Health Booklet
SGB	School Governing Body
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
TOC	Theory of Change
U5MR	Under-five mortality rate

EXECUTIVE SUMMARY



Faith Nkize, Director of the Siyazama Crèche in Hammarsdale, in the eThekwini district, with 9-month-old Snqobile.

EXECUTIVE SUMMARY

INTRODUCTION

Save the Children South Africa, as part of the global Save family, is required to develop a country strategy to promote public child-sensitive health, nutrition, and education policies, programmes and budgets which are responsive to local risks and protective factors and achieve the following breakthrough or priority outcomes:

1. Health and nutrition: No child under 5 should die from preventable causes and public attitudes will not tolerate high levels of child deaths
2. Child protection: All children thrive in a safe family environment and no child is placed in harmful institutions
3. Education: All children can read by the time they leave primary school
4. Governance: Greater investment and better use of public resources to realise children's rights, especially the most marginalised children (Save the Children, 2010).

The strategy must be rights-based and catalyse strategic change which will bring about lasting and sustainable solutions for children.

Save the Children South Africa commissioned a mapping of the children's sector in South Africa as at June 2014 to provide an information platform to inform its strategic reflection and planning process.

The brief for the mapping exercise, the results of which are documented in this paper, was to work within Save the Children's global strategic framework of priority rights and breakthrough outcomes to identify:

1. catalytic issues impacting on children's constitutional rights to health and nutrition, education, protection and child rights governance;
2. who the various role players are that are working on the issues and what issues are currently being pursued by the sector; and
3. where the strategic gaps are that Save the Children South Africa should fill. That is to say, what catalytic issues are being inadequately addressed or not addressed at all.

HEALTH AND NUTRITION

The strategic outcomes and objectives of the Save's health and nutrition programme: No child under 5 should die from preventable causes and public attitudes will not tolerate high levels of child deaths. Priority objectives:

1. Universal access to quality health services *(associated with the prevention of the leading causes of child mortality and morbidity);* and
2. Universal access to adequate nutrition.

Child health issues and concerns in 2014

1. A growing incidence non-communicable diseases (NCDs) aggravated through poor health care and development in infancy
2. Child survival rates remain comparatively low, especially the neo-natal mortality rate
3. The maternal mortality ratio has increased
4. A substantial number of child deaths in South Africa are preventable and/or treatable
5. High levels of preventable childhood disability
6. The nutritional status of children in South Africa is poor
7. Significant provincial and district inequities in the distribution of maternal and child deaths and the burden of childhood diseases, disabilities and poor nutrition.

Immediate preventable causes of child death and poor nutrition among children

South Africa's public health system provides a wide range of policies and programmes aimed at securing the healthy development and survival of its children, many of which target the key issues identified in the previous paragraph. The mapping exercise identified a number of immediate supply and demand-side issues associated with the poor health outcomes for children in South Africa. These include the following:

1. Late access to, and poor quality of basic antenatal care (BANC) services for pregnant women
2. Late testing of HIV-exposed infants
3. Low coverage of routine post-natal 6 day visits by health care workers
4. Poor coverage of the Vitamin A supplementation programme
5. Inadequate immunization coverage
6. Poor implementation of the Integrated Management of Childhood Illness (IMCI) programme by health care professionals
7. Inadequate implementation and monitoring of coverage and quality of integrated growth monitoring, nutritional counselling and support, and screening for and early treatment of developmental delays and disability components of the Primary Health Care (PHC) package
8. Parents and caregivers lack of knowledge
9. Inaccessible youth-targeted sexual and reproductive health services
10. Pregnant women, infants and young children do not accessing enough food and nutrition

Underlying systemic causes

There are a number of underlying systemic causes driving the preceding deficiencies in the current health system.

1. Whilst South Africa's public health policies and programmes are comprehensive, there are a number of gaps. For example:
   a. Mental health and substance abuse screening
   b. Parenting support programmes targeted at vulnerable caregivers, for example, caregivers of children with disabilities and teen mothers
   c. No national multi-sectoral prevention of stunting and child obesity policy
   d. No programme addressing food security of vulnerable pregnant women
   e. Inadequacies in the labour law framework
   f. No comprehensive childhood-specific disability policy and programme
2. Inadequate quantities and quality of infrastructure, human resources and supplies to support the provision of quality services.
3. Inadequate child health and nutrition behaviour change / communication / education initiatives.
4. Inadequate coordination within, and across the health and other sectors.
5. Insufficient political will to support a paradigm shift to a child-health promotive system (rather than a child-survival focused system).

Summary of priority child-health areas not receiving adequate attention

NGO activity in the health sector is weighted in favour of system's strengthening at a facility level to address child survival issues. In the main, community-based, nutritional and sexual and reproductive health programmes at a community and behaviour change / advocacy level are inadequately covered.

This does leave a number of strategic gaps and inadequacies, including the following:

1. Insufficient advocacy for a child-health development, rather than a child-survival agenda
2. Insufficient advocacy advancing a comprehensive multi-sectoral maternal and child nutrition and food security agenda and associated programmes.
3. Insufficient support and advocacy for developing and rolling out scaled-up parenting support and public education programmes.
4. Duplication and limited focus of community-based maternal and infant health and nutrition initiatives
5. Insufficient evidence-based advocacy for scaling up and integration of maternal screening, treatment and education for depression and substance abuse into health-care programmes
6. Limited cohesion within the disability sector and as a result little, if any advocacy driving a comprehensive child-focused disability prevention, early screening and treatment strategy
7. Sexual and reproductive health advocacy is pursued within a limited HIV and AIDS context
8. Few organisations are pursuing the social and economic determinants of health
9. NGOs in the health sector appear to be operating independently of each other, with little coherence and coordination to ensure that the most common and pressing child health issues are addressed and to optimize coverage.

CHILD PROTECTION

The strategic outcomes and objectives of the Save's child protection programme: All children thrive in a safe family environment and no child is placed in harmful institutions. Priority objectives:

1. Children in, or at risk of requiring alternative care
   a. Children at risk benefit from appropriate care / good quality services either in the family or in family or community-based alternatives
   b. Children on the move have better access to care and protection systems
2. Physical and humiliating punishment – violence against

children in the home, community and institutions
   a. Government bans physical and humiliating punishment in all settings
   b. Public attitudes no longer accept physical and humiliating punishment
   c. Parents / caregivers and teachers practice positive discipline
3. Children and work / child labour the elimination of harmful work and economic exploitation of all children, particularly children involved in, or at risk of harmful domestic and agricultural work through:
   a. Access to services and support for children at risk of harmful domestic work to minimise risk factors
   b. Access to education for children involved in agricultural work
   c. Engagement of the private sector as a partner.

Child protection issues and concerns in 2014 and their immediate causes

South Africa has one of the most comprehensive and progressive child protection statutory frameworks in the world. Despite this, there are a number of serious and long-standing child protection issues that plague the system. These include the following:

1. High levels of violence, abuse and exploitation of children in their homes and institutions, particularly among particularly vulnerable children such as young children, children with disabilities, and migrant children.
2. High levels of public, community and household acceptance (and practice) of violence against children.

The immediate causes of these issues include the following:

1. Inadequate prevention, early intervention and other statutory services including protection, therapeutic services and prosecution of offenders
2. Poor quality, safety and inappropriate duration of alternative residential care
3. Inadequate protection for especially vulnerable groups, notably unaccompanied or separated refugee children and children with disabilities

Underlying causes of key child protection issues

1. South Africa has a relatively comprehensive legal framework underpinning its child protection system. There are however a few policy / legislative gaps which contribute to the high levels of violence and inadequate provision of services for children. These include the failure to:
   a. Prohibit corporal punishment in the home setting
   b. Provide legislative clarity related to the prevention of child labour
   c. Regulation of onerous domestic responsibilities
   d. Finalization of a national prevention, early identification and intervention strategy
   e. Provincial strategies for child and youth care centres
   f. Weak regulatory framework for the protection of unaccompanied / separated refugee children

2. Implementation challenges impact on the adequacy of the coverage and quality of the many policies and programmes in place. These include:
   a. Insufficient human and financial resources
   b. Poor coordination and integration of services
   c. Lack of clarity among role players on how to fulfil responsibilities
   d. Poor population-based planning
   e. Weak institutional and accountability mechanisms
   f. Poor data collection and management of information
   g. A regulatory rather than developmental approach adopted with regards to alternative care
   h. Insufficient political will and leadership, particularly in relation to prevention and early intervention
   i. Weak advocacy

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Tebogo, his two siblings and his mother are enjoying a whole new life, thanks to Save the Children South Africa's support

   j. Poor communication and education of decision-makers, the public, parents and other responsible role players

Summary of priority child protection issues not receiving adequate attention

Generally, it would appear that NGO activity in the child protection sector is weighted in favour of the direct provision of services to children who have been abused, neglected or sexually exploited. Advocacy initiatives appear to be limited in number and scale and focus on community, school, family and peer-based behaviour change and educational advocacy.

There appears to be limited research and evidence-based advocacy campaigns aimed at securing:

1. Publicly provided prevention and early intervention initiatives and services
2. A developmentally-oriented registration and quality assurance framework for child and youth care centres, or for the compliance by the State with its obligations to children in alternative residential care facilities
3. Enhanced child-protection systems for especially vulnerable groups such as children with disabilities, very young children and undocumented minors.

This does leave a number of areas requiring support and attention, including:

1. Testing of, and advocacy for effective models of prevention and early intervention strategies and services
2. Corporal punishment and violence in schools is well-covered, but not corporal punishment and violence against children in the homes
3. The mapping exercise was not able to identify meaningful organisational support for addressing child labour in South Africa
4. Systemic and focused advocacy aimed at the improved prevention of violence and protection of young children, children with disabilities, and unaccompanied refugee children against neglect, abuse and exploitation.
5. Advocacy for systemic responses to the problems experienced by Child and Youth Care Centres (CYYCs), notably problems of registration and quality and DSD's compliance with its statutory responsibilities to children in alternative care.

EDUCATION

The strategic outcomes and objectives of the Save's education programme: All children can read by the time they leave primary school.

Priority objectives: Improve access and quality:
1. In teaching and learning
2. The learning environment
3. Early childhood care and development
4. Particularly for marginalised children.

Key issues impacting on children's literacy outcomes

The South African education system is beset by a number of well-documented challenges. There are however a number of these which are particularly pertinent to the literacy outcomes for children in South Africa. These include the following:

1. Exclusion of especially vulnerable children from early and primary education, notably:
   a. Low enrolment rates of the youngest vulnerable children living in poverty and in under-serviced areas in early childhood education programmes
   b. Children living in poverty continue to be at a higher risk of exclusion from school
   c. Children with disabilities are at higher risk of exclusion
   d. Children of refugees, migrants and asylum seekers, notably those who are separated from their parents are at a greater risk of exclusion from schooling.
2. The low quality of teaching and learning in public schools means that many children are not acquiring basic numeracy and literacy skills, notably in their foundation and primary school years.
3. There are massive inequities in learning opportunities and outcomes among children in South Africa along racial, socio-economic and geographic lines.

Underlying reasons for inequitable exclusion of vulnerable children

1. As in the other domains of child development, basic education is supported by a sophisticated policy and programmatic framework. There are however a number of policy and legislative gaps, notably with regard to the inclusion of vulnerable children. For example:

a. The policy and legal underpinnings of early childhood education are weak. There is currently no national ECD policy which articulates and drives the public provision of early childhood development and education (although one is in development)
b. A number of policy gaps and disjunctures in the current school-fee exemption policy serve to exclude children living in poverty
c. The commitments made by the Government of the Republic of South Africa (GRSA) to include children with disabilities in the governing policy have not been translated into a law which creates difficulties in holding the Department of Basic Education to account for taking all necessary steps.
d. The Schools Act and the Refugee laws contradict each other making access to documents necessary to register migrant children impossible.

2. Implementation challenges also serve to exclude vulnerable children. Poor knowledge of rights and responsibilities as well as prejudicial attitudes and practices by school principals and governing bodies contributes to low levels of implementation and respect for the rights of refugee children, children living in poverty and children with disabilities.

Underlying reasons for poor and inequitable educational outcomes

Much attention has been paid to the underlying systemic causes of poor and inequitable educational outcomes for children in South Africa. There is agreement that the following are leading underlying causes:

1. Poor and inequitable access to quality early childhood care and education
2. The poor quality of early childhood education, pre-school and primary education
3. The inefficient use of education resources contributes to inadequate infrastructure and an enabling school environment in the poorest areas, overcrowded classrooms, inadequate learning and teaching support materials such as textbooks and workbooks, laboratories and libraries, poor teacher knowledge and skills, notably the quality of reading instruction and content knowledge, and poor curriculum coverage
4. The poor quality of literacy teaching and learning in the classroom and lack of understanding of what is required to change the status quo.
5. Poor implementation of the language of learning and teaching policy resulting in a substantial number of children not being taught in their home language in the foundation phase
6. Weak management skills, leadership, knowledge, and accountability mechanisms, notably in the positions of school principals and School Governing Bodies contribute to inefficiencies in the system
7. Insufficient support for parental participation in education.

Summary of priority education issues not receiving adequate attention

There are many organisations that are actively engaged in the promotion of the realisation of the rights of children under the heading of the various priority issues, leaving few unique spaces for involvement. However there are a number of strategic entry points for Save the Children.

These include the following areas which are not receiving adequate attention:

On the whole, there are huge numbers of organisations active in the education sector, leaving few unique spaces for involvement. However there are a number of strategic entry points for Save the Children. These include the following areas which are not receiving adequate attention:

1. A national campaign supporting the adoption of a comprehensive ECD policy and programme of action capable of ensuring universal availability and equitable access to quality ECD and ECCE services.
2. Systemic campaigns for an effective and legally enforceable inclusive education system which guarantees access to quality education for all children affected by disabilities, poverty and displacement, etc.
3. Poverty-related barriers are no longer receiving the advocacy attention necessary to overcome remaining hurdles.
4. There is a need for focussed research and advocacy for the identification and implementation of measures capable of bringing about improvements in the quality of teaching and learning in the classroom.
5. Advocacy for sustainable and effective measures to improve the knowledge, quality of, and accountability of SGBs.
6. Advocacy for stronger government-driven support for parental and community involvement in education as a key accountability mechanism.

CHILD RIGHTS GOVERNANCE

The strategic outcomes and objectives of the Save's child rights governance programme: Greater investment, better use, and stronger accountability for the use of public resources to realise children's rights, especially the most marginalised children.

Priority objective: To strengthen governance mechanisms and structures in government and civil society that impact on the fulfiment of children's rights and ensure children voices are heard.

Responsibilities of the GRSA

Operating as it does within a child rights-based framework, the GRSA is required to develop a country-wide child rights governance system which:

1. Articulates the common child rights goals and objectives into a National Plan of Action (NPA)
2. Articulates the roles and responsibilities of different stakeholders
3. Makes provision for mechanisms to hold stakeholders to account
4. Makes provision for measurement of progress against child rights goals and targets
5. Makes provision for an independent coordination and oversight body
6. Establishes mechanisms to coordinate interventions
7. Makes provision for child-friendly and accessible rights-enforcement mechanisms
8. Systematises the participation of children and civil society in the development, implementation and monitoring of all policies and programmes.

Measures taken to date

South Africa has taken a number of steps towards fulfilment of its preceding obligations. These include the legislative protection of the participatory rights of children, the development of a NPA, the establishment of dedicated oversight and coordinating ministry and department, and the establishment of various sector-specific coordination structures.

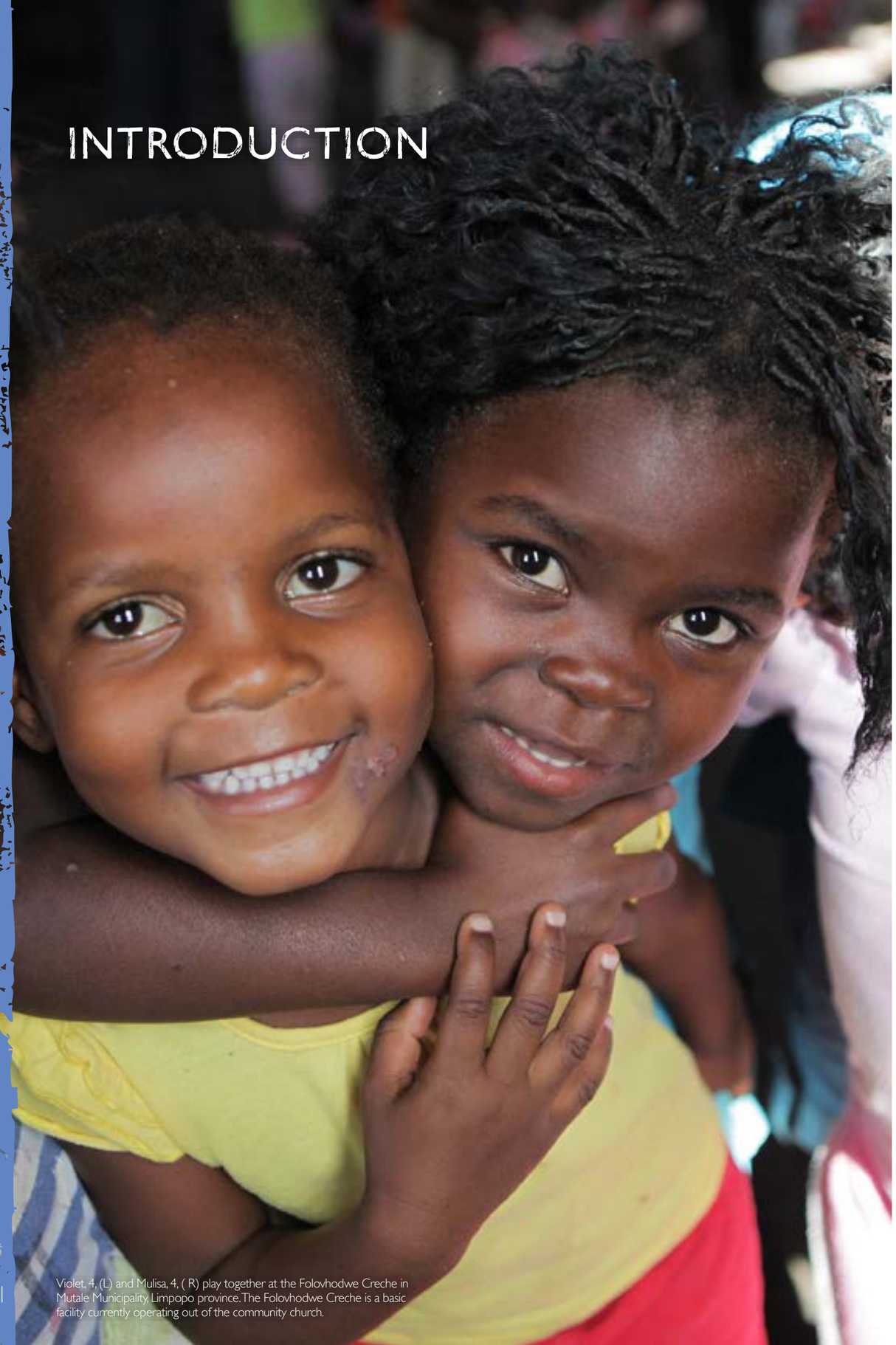
Key concerns with the child rights governance system

1. The recent dissolution of the ministry and department responsible for child rights oversight and coordination
2. The failure to mainstream children's rights at all levels of government resulting in a failure of children's rights in marginalised areas, especially in particularly weak provinces and communities governed by weal local government
3. The absence of an independent child-friendly rights-abuse reporting mechanism
4. Children's participation is recognised in law, but has not been systematised across all decision-making domains, including the home, school and government.
5. There are a multitude of cross-cutting issues which underlie transgressions of rights in all child rights domains or which have the potential to promote realisation of multiple rights. Tackling these cross-cutting systemic issues require appropriately comprehensive and systemic solutions across all sectors and within all relevant departments; this in turn requires organised advocacy campaigns driven by stakeholders across the sub-sectors targeting the resolution of the common underlying issues. There is however a stark absence of coordinated advocacy across the children' sector to address common cross-cutting issues.
6. Funding constraints have severely curtailed the ability of NGOs to organise themselves and engage in advocacy, with the result that there are few, if any, successful system-wide advocacy campaigns and no identifiable children's sector voice championing children's rights in South Africa.

CONCLUSION

International, regional and national rights and development initiatives recognise that the realisation of children's rights in the period leading up and beyond 2015 requires the development of a strong accountability framework. This in turn requires increased investments in strong child rights governance systems that ensure coordinated civil society and that the voices of children are heard (ACPF and ODI, 2013).

Given the slippage of the political prioritisation of children in South Africa alongside the reduced resources and capacity of the children's sector, attaining the post-2015 child rights and development goals requires a child rights champion in South Africa. There is a need for a strong child-rights organisation to support the coordination and resourcing of the child rights sector and champion the development of systemic and collaborative solutions to the persistent and emergent risks and opportunities which impact on children's rights in South Africa. This is a unique and much needed role that Save the Children South Africa should consider stepping into.



INTRODUCTION

Violet, 4, (L) and Mulisa, 4, (R) play together at the Folovhodwe Creche in Mutale Municipality, Limpopo province. The Folovhodwe Creche is a basic facility currently operating out of the community church.

A. INTRODUCTION

1. SAVE THE CHILDREN'S VISION AND MISSION

Save the Children's vision is a world in which every child attains the right to survival, protection, development and participation. Its mission is to inspire breakthroughs (innovations) in the way the world treats children and achieve immediate and lasting change in their lives (Save the Children, 2010).

Save the Children pursues its vision within a rights-based framework of action which unites all Save members across the world, and differentiates it from other International NGOs (Save the Children, 2010).

1.1 What is a rights-based framework?

A child-rights framework of action is one which recognises that all children are entitled to the rights guaranteed by international, continental and legal instruments; and that for each right there is a correlating legally enforceable obligation on the State to take action to respect, protect and promote the right in questions. A rights-based approach measures State action against this normative framework of obligations; holds it to account for fulfilment of its responsibilities; supports it to take the requisite action; and enables and empowers rights-holders to claim their rights (United Nations Development Programme, 2003).

Thus, for Save the Children, a rights-based framework of action is aimed at ensuring that duty-bearers take all necessary action (prescribed by international, regional and national laws) to secure fulfilment of their responsibilities (Save the Children Sweden, 2005).

Legal instruments such as the United Nation's Convention on the Rights of the Child (CRC), its various optional protocols, the Convention on the Rights of Persons with Disabilities (CRPD) and the African Charter on the Rights and Welfare of the Child (ACRWC) recognise and call for the realisation of many inter-dependent rights; all of which are foundational to children's survival, protection, development and participation. The primary duty bearer responsible for ensuring realisation of children's rights is the State. Whilst parents are duty-bound to ensure their children's survival, development and participation, where they lack the skills, knowledge and resources to do so, the State is obliged to support them through public programmes.

2. SAVE THE CHILDREN SOUTH AFRICA'S STRATEGIC PLANNING OBLIGATION AND FRAMEWORK

Save the Children's global strategy for the period 2005 - 2010 calls on all of its members to develop rights-based country-strategies which prioritize the realisation of a select number of children's rights. The priority rights which are especially at risk and which harbor significant potential to secure children's overarching rights to survival, development, protection and participation are:

1. Health and nutrition
2. Child protection
3. Education, and
4. Child rights governance and participation (Save the Children , 2010).

Whilst children across the world are equally entitled to these rights, the particular protective factors and risks that impact on their attainment differ from country to country. So too the State responses required, in terms of programme design, budgets and delivery mechanisms will differ, depending on what is necessary to minimize the particular risks and maximize protective factors at a country level.

Each Save member, including Save the Children South Africa, is required to develop a country strategy to promote the development, funding and monitoring and evaluation of public child-sensitive health, nutrition, and education policies, programmes and budgets which are responsive to local risks and protective factors and achieve the following breakthrough or priority outcomes:

1. Health and nutrition: No child under 5 should die from preventable causes and public attitudes will not

tolerate high levels of child deaths
2. Child protection: All children thrive in a safe family environment and no child is placed in harmful institutions
3. Education: All children can read by the time they leave primary school
4. Governance: Greater investment and better use of public resources to realise children's rights, especially the most marginalised children (Save the Children, 2010).

Save the Children South Africa's strategy must promote the adoption of policies and implementation of sustainable programmes at scale which will bring about lasting change in the lives of children which will contribute to attainment of the breakthrough outcomes (Save the Children , 2010).

In terms of Save the Children's Theory of Change, through its chosen issues, strategies and methodologies it must catalyse strategic change. This requires:
1. The pursuit of Innovative initiatives: The development and provision of evidence-based, replicable breakthrough solutions to problems facing children
2. Advocacy for stronger policies and practices to better realise children's rights and ensure that children's voices, especially the most marginalised are heard, and
3. Leveraging knowledge within Save the Children to support the effective implementation of proven policies and programmes to ensure sustainable impact at scale.

To develop the prescribed rights-based strategic and catalytic plan of action, Save the Children South Africa must identify:
1. Locally prevalent protective and risk factors which impact on the enjoyment of the children's rights prioritised by Save the Children (health, nutrition, education, protection, and participation (inclusive governance))
2. Measures taken by the State to address risks and promote protective factors impact on the rights in question through effective child rights policies, programmes and budgets
3. Gaps and inadequacies in the current national child protection framework
4. Within the wide range of resultant child rights issues, it must identify the catalytic issues and possible solutions falling within the framework of breakthrough priority areas / outcomes
5. Strategies and actions that may promote lasting, sustainable and scalable solutions to the catalytic issues, and
6. The most strategic and innovative role that Save the Children South Africa may play and partnerships it may enter into in order to address the identified issues.

3. MAPPING OF THE CHILDREN'S SECTOR: A FRAMEWORK AND OBJECTIVES

Save the Children South Africa commissioned a mapping of the children's sector in South Africa as at June 2014 to provide an information platform to inform its strategic reflection and planning process.

The brief for the mapping exercise, the results of which are documented in this paper, was to work within Save the Children's global strategic framework of priority rights and breakthrough outcomes to identify:
1. The key catalytic issues impacting on children's constitutional rights to health and nutrition, education, protection and child rights governance
2. Who the various role players are that are working on the issues, what issues are currently being pursued, and what NGOs are doing to address the identified issues, and
3. What the strategic gaps are that Save the Children South Africa should fill. That is to say, what catalytic issues are inadequately addressed or not addressed at all.

3.1 Methodology

The mapping exercise has drawn on a variety of sources of information which were analysed within a framework informed by Save the Children's global strategy to identify:
1. National priority issues impacting on children's rights which resonate with the goals, objectives and priorities of Save's Global Strategy as well as with international, continental and national child rights priorities
2. The underlying causes of the identified issues emerging from a rights-based analysis; that is causes associated with failures of responsibilities of obligated role players
3. Potential solutions which resonate with Save the Children's Theory of Change (TOC). That is possible catalytic actions and interventions with the potential to leverage scaled-up sustainable and lasting change for children in South Africa, and
4. Issues and causes that are not being adequately addressed by the sector, leaving unique spaces that Save the Children South Africa could fill or provide additional strategic support for through its programmatic work.

Information sources drawn on include:

A. Literature
1. Save the Children's global and thematic strategy documents
2. International, continental and national rights and development documents identifying priority child rights and related development issues in the period remaining until 2015 and beyond
3. Reports documenting the status of children's rights, progress made as well as gaps and inadequacies and required solutions developed by the GRSA as well as research institutions, independent human rights institutions and NGOs
4. National survey and other data reports documenting children's demography, access to services and outcomes in key areas produced by Statistics South Africa, government departments, research institutions and NGOs;
5. Government departments' and NGO's websites, strategic plans and annual reports documenting the issues prioritised by the sector and the strategies adopted to address these.

B. Save the Children South Africa's programme staff knowledge and expertise

The mapping process engaged with the Save the Children's programme staff for guidance in shaping and informing the mapping exercise. For example, a workshop with the staff distilled out, with greater clarity, criteria for determining what constitutes a catalytic issue and responses (documented in the following paragraphs) and identified potentially catalytic issues not identified in the initial stage of the mapping process.

C. Interviews and correspondence with key role players in the NGO sector

Key role players with knowledge and expertise in the relevant children's rights domains were identified and interviewed so as to obtain their perspectives on the key catalytic issues, solutions and strategies required to ensure improved realisation of children's rights to health, nutrition, protection, education and to improved child rights governance in South Africa.

3.2 What is a catalytic issue?

To support the construction of the analytical framework for the mapping exercise, the author and Save the Children South Africa's programme staff distilled out the following characteristic features of a catalytic issues and strategic responses which are aligned with Save's TOC. These features informed the analysis documented in this paper and are intended to further guide the Save the Children South Africa team in mapping out their national five year strategic plan.

A catalytic issue is one that if addressed:
1. Will bring about lasting and sustainable change
2. Will improve the lives of a substantial number of children
3. May impact on fewer children, but will equalise opportunities for the survival and development to their full potential of socially, economically and otherwise marginalised children
4. Will have a multiplier / developmental impact. That is to say, will, if addressed, not only improve access to the immediately relevant service, but will, in so doing catalyse reductions in poverty and inequality
5. Will resonate across and possible pioneer replicable solutions the continent or similarly placed middle-income countries marked by high levels of child poverty and inequality
6. Will mark an innovation in an area of concern, providing replicable evidence, based solutions that may be taken to scale through a public programme
7. Will advance attainment of international, continental, regional and or nationally prescribed developmental and child rights priorities. For example, it may
   a. Accelerate the attainment of 2015 MDGs
   b. Advance the post-2015 child rights agenda for sustainable development which prioritises improved quality of services alongside improved access, reduced inequality, inclusion of the most marginalised children, and improved accountability of duty bearers for the realisation of rights through the design and implementation of developmental programmes
   c. Accelerate the attainment of the goals and objectives of the National Development Plan: Vision 2030, notably the reduction of poverty and inequality as well as the national sectoral goals and priorities as set out in the Medium Term Strategic Framework (MTSF), the various sectoral delivery agreements and sectoral strategic plans.

3.3 What is catalytic action and the associated strategic role/s for Save the Children South Africa?

The Save the Children South Africa programme team further distilled out key elements for defining / identifying strategic roles for Save the Children SA to address catalytic

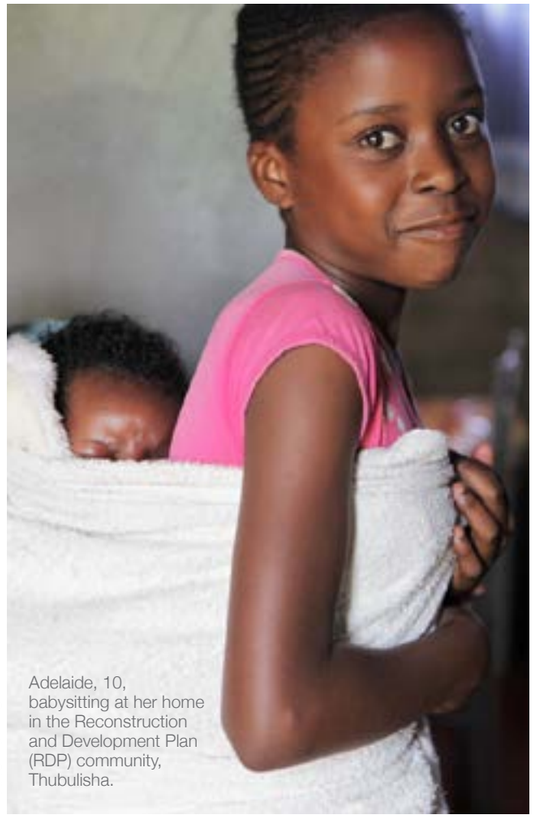
issues within a rights-based framework founded on Save's TOC.

Given that rights-based programming is founded on ensuring accountability for fulfilment of legal obligations imposed on responsible role players to realise children's rights, the role of Save the Children South Africa within a rights-based strategic plan is:

1. To hold government accountable for fulfilment of its responsibilities and support parents to be able to fulfil their responsibilities
2. Catalytic in the pursuit of advocacy initiatives and change capable of driving change that will achieve lasting results for children
3. Innovative in its promotion of evidence-based breakthrough solutions to support effective implementation of proven strategies and programmes at scale
4. To advocate for strengthened public policies and practices to ensure that children's rights to health, nutrition, education, protection and effective child rights governance are better respected, protected and promoted.

Strategies that are well suited to driving catalytic, sustainable and lasting change include:

1. Entering into strategic partnerships and the facilitation of collaboration and coordination amongst duty bearers and role players
2. Researching, documenting and supporting the development of innovative, evidence-based programmes and strategies that can be taken to scale through public programmes
3. Documenting successful signature programmes for sharing with wider audiences which may use the information to replicate piloted solutions / benefit from the lessons learned to improve the realisation of rights of similarly placed children
4. Advocacy directed at the GRSA for the development, funding and implementation of improved public policies, budgets and quality programmes
5. Strategic litigation against the GRSA for fulfilment of its legal duties to children
6. Social change advocacy for better practices, attitudes, behaviours and improved knowledge of duty bearers, including parents, caregivers, families, community members and government role players responsible for the survival, development and participation of children.



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Adelaide, 10, babysitting at her home in the Reconstruction and Development Plan (RDP) community, Thubulisha.

4. THE DEMOGRAPHY OF CHILDREN AND CHILD RIGHTS IN SOUTH AFRICA

In 2011, South Africa had a total child population of 18, 5 million, constituting just over 35 percent of the total population of 51, 7 million (Statistics South Africa, 2012).

Almost half of the child population lives in three provinces which formed part of the former apartheid homelands. These are KwaZulu-Natal (23%), the Eastern Cape (14%) and Limpopo (12%); provinces that are marked by high levels of poverty and unemployment, a predominantly rural geography, and backlogs in infrastructure development and service provision(Statistics South Africa, 2013). The provinces with the largest numbers of children are KZN and Gauteng. The Gauteng child population (18%) has grown substantially by more than 20 percent; growth that is attributed to increasing rural – urban migration in the country (Meintjies & Hall, 2013). The majority of children, nearly 70 percent, live in the poorest 40 percent of households (Meintjies & Hall, 2013).

Only 35 percent of children in South Africa live with both of their parents. 23 percent live with neither of their parents, 3 percent lived with their father only and almost 30 percent live only with their mothers, whilst almost 8 percent live in skip-generation households with their grandparents (Statistics South Africa, 2012 (b)). The majority of children not living with their parents are not orphans but in the care of extended family members. 90 percent of children live in households where there are two or more adults in residence, often however the adults are extended family members such as grandparents, aunts and uncles who play a caregiver role in relation to the children (Meintjies & Hall, 2013). The most common type of family in which children reside in South Africa is not nuclear, but the extended family. 64 percent of children live in extended families and 33 percent in nuclear families. 8 percent of children live in households with their grandparents (Statistics South Africa, 2012 (b)). A much larger percentage of black African and Coloured children and children living in poverty live in extended families rather than with their biological parents. This is a result of a number of factors, including poverty, labour migration, educational opportunities and cultural practice (Meintjies & Hall, 2013).

Not all children who do not live with their parents are orphans. Nonetheless, the rate of orphaning remains high in South Africa. In 2012, 4 percent of children were double orphans, just over 10 percent were paternal orphans and 3 percent were maternal orphans (Statistics South Africa, 2013). The majority of orphaned children are found in two provinces; KZN and the Eastern Cape and more than half of the orphans in South Africa live in the poorest 20 percent of households (Meintjies & Hall, 2013).

In 2011, approximately 82,000 children lived in 47,000 child-only households. This number has not, despite earlier predictions to the contrary, increased since 2002 and the majority of the children in these households are not orphans (Meintjies & Hall, 2013).

Given the fact that South Africa has the highest number of person with HIV and AIDS in the world, with an estimated 6,1 million people living with HIV in 2012, a substantial number of children in South Africa live in households affected by HIV and AIDS. Over 2,5 million children have been orphaned by HIV and AIDS and many more live in households with caregivers who are ill or disabled as a result of HIV and AIDS (AVERT, n.d.).

There is little reliable data as to the number of children in South Africa with disabilities. Available data from the 2009 General Household Survey indicates that more than 2 million children in South Africa are living with disability (including mild, moderate and severe disabilities). Children living in poverty, orphans, children with HIV, children living on the streets and children living in rural areas are at a greater risk of disability (DSD, DWCPD and UNICEF, 2012) (Department of Women, Children and People with Disabilities, 2013).

When South Africa became a democracy in 1994, the Government of the Republic of South Africa (GRSA) inherited, as a legacy of apartheid policies, a child rights landscape marked by the systemic exclusion of the majority of children from basic quality services, geographical marginalization of children in the former under-serviced homeland areas, high levels of child poverty, low education among children and their parents and caregivers, poor health and nutrition, and fractured families. The Constitution of the Republic of South Africa recognised and sought to address the plight of children by guaranteeing the full complement of rights protected by child rights instruments such as the CRC and the ACRWC. The protected rights includes a bundle of socio-economic rights including health care and nutrition, protection and education, which unlike the comparable rights for adults, were not made subject to progressive realisation and available resources.

The GRSA subsequently adopted and enacted a range of child-specific policies, laws and programmes aimed at respecting, protecting and promoting children's constitutionally protected rights. These targeted children formerly marginalized by apartheid policies – that is to say Black African and Coloured children, children living in poverty, those living the former, predominantly rural homelands, and children with disabilities and have provided a strong foundation for substantial improvements in the living conditions of the majority of its children and their families in the past twenty years.

4.1 Children's rights in post-apartheid South Africa

The ensuing twenty years of social development has substantially improved the realization of the rights and the lives of Black African, Coloured and Indian children; children in rural areas (especially the areas falling into the former homelands); children living in poverty; and children affected by HIV and AIDS.

Notable progress has been made in the following domains:

1. Child poverty has reduced. Analysts estimate that income poverty has reduced by between 15 and 25 percentage points over the last decade. The Children's Institute estimates it to have dropped from 73 percent in 2003 to 58 percent in 2011 (Hall, 2013). Van den Berg estimates it to have dropped from 76

to 40 percent between 2000 and 2010 as a result of stronger economic development and rapid expansion of the Child Support Grant (CSG) (SAHRC and UNICEF, 2014). The drop in child-poverty has largely been driven by the roll out of an extensive social security programme which includes the Child Support Grant (CSG). The CSG, a monthly grant of R 300 per month is paid to the caregivers of children who live in poverty below an income threshold which is ten times the value of the grant. In 2013 the CSG reached more than 11,3 million children (SASSA, 31 March 2013).

2. Access to health care facilities has improved as a result of the PHC clinic expansion programme (SAHRC and UNICEF, 2014). The percentage of children living far from their nearest health facility improved by more than 10 percentage points between 2002 and 2011 (from 36, 4 to 23,9 percent) (K Hall, 2013). Similarly, access to basic health services such as immunization has improved considerably over the last decade.
3. Access to early childhood education programmes for children aged 4 – 5 years almost doubled between 2000 and 2011 to reach a total of 90 percent (over two million) children (Statistics South Africa, 2013).
4. Children's access to water on site increased from 60 to 66 percent between 2002 and 2011 and their access to basic sanitation improved by almost twenty percentage points from 47,4 % to 69,1 percent in the same time period (Hall K. , 2013).

4.2 Persistent historical and emergent risks and protective factors

Despite the progress made, in 2014 South Africa continues to face a number of historically persistent and emerging risks that are not adequately addressed by the current child protection system and which continue to present a challenge to the realization of children's rights. At the same time, there are a number of protective factors with proven, but as yet not fully realised potential to advance the realisation of the rights of the most vulnerable children.

4.2.1 Persistent child poverty and inequality

Whilst poverty levels have reduced in the past twenty years, a disproportionately large number of children continue to live in households where poverty levels are high and impact significantly on enjoyment of their rights and quality of life. Whilst there is agreement that child poverty levels have dropped, there is some difference of opinion as to the extent of the reduction. Using a poverty line of between R 575 and R 604 per capita per month, analysts such as Hall and Van den Berg calculate a reduction of between 6 and 16 percent. Using different data sets, they estimate that the number of children living in poverty dropped from approximately 14 million in 2003 to between 10 and 11 million in 2011/ (Hall K. , 2013) (SAHRC and UNICEF, 2014).

Despite the differences in calculations, there is agreement that:

- The number of children living in poverty is higher than adult-poverty levels in the country;
- children experience the adverse effects of poverty more aggressively than adults; and
- child-poverty is unequally distributed across historical inequity fault lines – children living in the former homelands, in rural areas, in female-headed households and Black and Coloured children bear a disproportionate share of the poverty burden in South Africa (Hall K. , 2013) (SAHRC and UNICEF, 2014)

South Africa's historically marginalized children remain trapped in a poverty cycle. Some twenty years after democracy, historically marginalized Black children in rural areas, the youngest children (0-4 years), and children in provinces falling within the former homelands (notably the Eastern Cape, KZN and Limpopo) are less likely to escape living in poverty because they remain excluded from essential quality services and programmes necessary to break the chains of the South African child poverty trap (SAHRC and UNICEF, 2014).

The structural nature of child poverty has trapped poor and socially marginalised children in an inter-generational cycle of poverty. 40 percent of the children that were living in poverty in 2001 continue to live in poverty more than a decade later. Similarly, the majority of those born into poverty in 2014 are likely to remain trapped and continue to feed the poverty cycle because the social protection framework has not adequately addressed the mechanisms that keep children trapped in poverty – notably the poor quality of early childhood care and education, poor quality of schooling, poorer access to quality health care, and high levels of violence and abuse experienced by children living in poverty (SAHRC and UNICEF, 2014).

This points to a fundamental failure in the national child protection system[1]: it is inadequately designed, targeted and implemented so as to enable the most vulnerable children in South Africa to escape the poverty trap. South Africa continues to face the challenge of developing measures capable of addressing and dissolving the structural determinants of poverty. Success in this regard is key, not only to reducing poverty, but also attaining equality (SAHRC and UNICEF, 2014).

[1] The term child protection system is used widely to connote the full spectrum of measures which serve to address children's rights and developmental needs.

4.2.2 Socially excluded and vulnerable families and children

Poverty and social exclusion combine in South Africa to create a nexus of poor social and economic living conditions which hamper the survival and development of children. Remediation of the situation is hampered by their lower access to public services which are often of too low a quality to compensate for their low socio-economic status and equalise their developmental opportunities.

To ensure that child poverty and inequality are systemically and sustainably addressed requires the development of programmes ensuring the universal provision of quality services appropriately designed and delivered to reach socially excluded and vulnerable families and children.

A number of identifiable groups of children have and continue, as a result of South Africa's political and development history, to be socially excluded and additionally vulnerable. These include children living in rural areas and areas falling within the former apartheid homelands, orphaned children, children living with older caregivers such as grandparents, children affected by HIV and AIDS, children living in child-headed households, and children with disabilities. These children are in the main, at a greater risk than others to neglect, abuse, poor health outcomes, poor educational outcomes, economic and sexual exploitation and to exclusion from participation in decisions that impact on their lives.

The national child protection system has long recognised the particular vulnerabilities of these children and has developed a rich tapestry of social protection interventions which make additional and compensatory provision for services to realise their rights. As a result, there has been progress in reducing their vulnerabilities. However, the work in this regard is not complete as is evidenced by the historically persistent fault lines in access to quality services and support and children's survival and development. Children living in rural areas, in areas falling within the former homelands, children affected by HIV and AIDS, orphaned children and children with disabilities continue to access fewer essential services and where they do, of a lower quality, including early childhood development services, education, child protection services, health care, and food and nutrition (Department of Women, Children and People with Disabilities, 2013) (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

4.2.3 Emergent risks and vulnerabilities

In addition to the persistent historical patterns and causes of child deprivation, a number of more recent or emergent risks brought about by global, regional and national pressures and developments are creating additional groups of vulnerable children. Many of the emerging risks present a significant crisis in terms of scale and impact on the lives of children in the here and now. However, they are projected to escalate significantly in the years ahead, with comparably dramatic consequences for children.

The South African national child protection system has been fundamentally shaped, in terms of targeting and design, to respond to historical / legacy risks and vulnerable groups and is thus at times out of synch and incapable of ensuring the rights of emerging vulnerable groups.

For example, significant investments have been made in the development and funding of essential service programmes such as social grants and education so as to ensure that they reach the historically geographically marginalized rural children of South Africa, especially those living in the former homelands. Whilst these have made a positive difference, the overall programmatic framework has neglected children in urban and metro areas, resulting in unchecked levels of deprivation in these sites of increasing child poverty, giving rise to an emerging vulnerable group of children in urban informal areas (UNICEF, 2013).

4.2.3.1 Increasing rural / urban migration

As previously mentioned, children (under the age of 18 years) total 18, 5 million, constituting 37 percent of the total population. The number of children in the country has grown by about 6 percent since 2001 (by approximately one million) (Meintjies & Hall, 2013 based on Stats SA's 2011 General Household Survey data).

The largest numbers of children live in KwaZulu Natal (4,2 million), Gauteng (3,3 million), the Eastern Cape (2,7 million), Limpopo (2,2 million). There has been a significant increase in the child population in Gauteng (21,7 percent) and the Western Cape (14 percent) between 2002 and 2011 and a reduction in the child population in the North West and Limpopo provinces (of just over 10 percentage points) and the Eastern Cape (5,3 percentage points) (Meintjies & Hall, 2013).

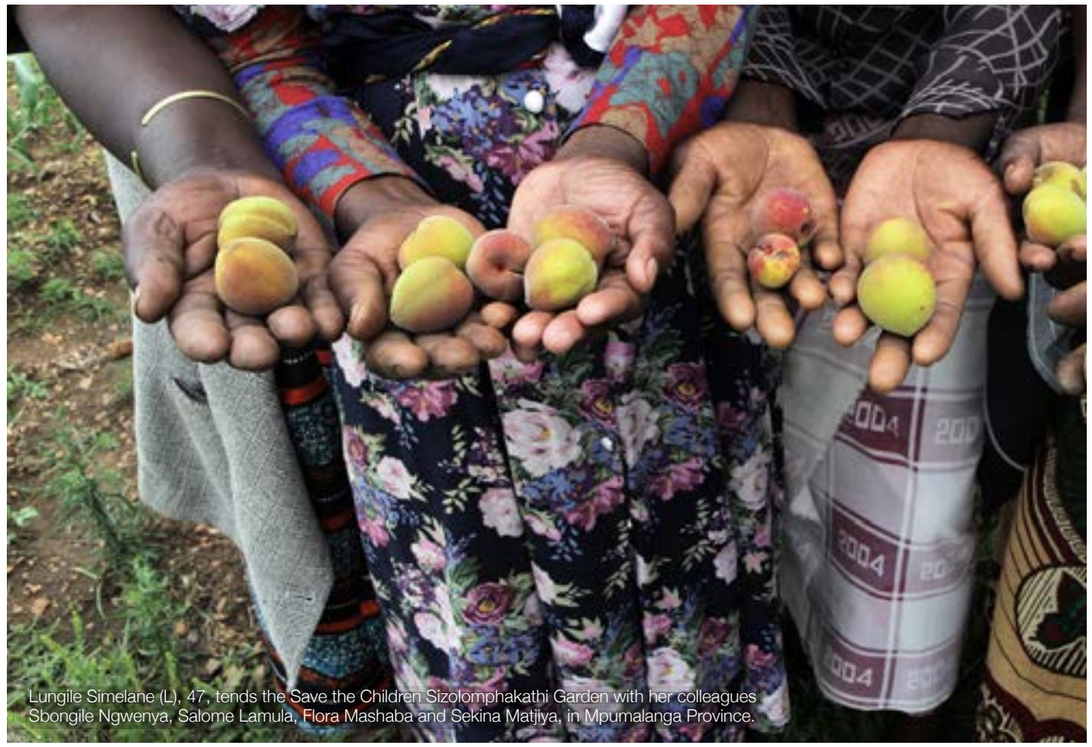
These shifts represent a growing trend of migration from rural to urban areas, with labour migration and pursuit of a better standard of living driving growth in the overall and child populations in provinces such as Gauteng and the Western Cape – both of whose share of the total population increased. Gauteng from 19,3 and the Western Cape from 9,7 in 1996 to 23,7 and 11,2 percent respectively in 2011 (Statistics South Africa, 2012). Gauteng shows the highest levels of in-migration (901 622), followed by the Western Cape which gained 192 401in 2011. Eastern Cape, Limpopo and KZN show the biggest losses in 2011 of between 325 078 and 109 889. Other provinces with notable losses include the Free State (59 800) North West province (31 700), Mpumalanga (21 700), and the Northern Cape (15 200). Thus there is a clear and consistent pattern of migration from predominantly rural provinces to the urban industrialized areas of Gauteng and the Western Cape (Statistics South Africa, 2012).

This trend has seen rapid growth in the urban populations in South Africa – to the detriment of children in urban areas and those remaining behind in rural areas. By 2011, almost 63 percent of the population were residing in towns and cities, with the trend expected to continue (President Jacob Zuma, 17 June 2014).

The rural / urban shifts have resulted in the equally rapid growth of informal urban settlements at a pace which outstrips urban development initiatives and budget, resulting in poor provision of essential services in these areas.

In addition, the migration trend aggravates the risks faced by children remaining in rural areas as it contributes to the ongoing fracturing of families and separation of parents and children. In addition, it lowers the capacity and resilience of rural communities to improve their social and economic circumstances as the economically active and productive leave behind the youngest and the oldest (SAHRC and UNICEF, 2014).

This trend and the emerging challenges is receiving priority attention. It was recognised as a priority concern by the President in his State of the Nation address (made at the start of the new administration after the 2014 (Statistics South Africa, 2011) is developing an Integrated Urban Development Framework (scheduled for completion by the end of July 2014) (President Jacob Zuma, 17 June 2014). It is critical that the situation of urban children and their rights feature prominently in the Framework.



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Lungile Simelane (L), 47, tends the Save the Children Sizolomphakathi Garden with her colleagues Sbongile Ngwenya, Salome Lamula, Flora Mashaba and Sekina Matjiya, in Mpumalanga Province.

4.2.3.2 Youth unemployment

South Africa has one of the highest youth unemployment rates of all developing countries and is set to increase in the years ahead. In 2011 almost 50 percent of young people between the ages of 15 and 24 years were unemployed (Statistics South Africa, 2011). It is estimated that between 25 and 30 percent of school-leavers have never entered the job market and will never be formally employed for the full duration of their lives (National Treasury, 2011). The extended duration of youth unemployment is a key contributor to the growing numbers of discouraged young people who have simply given up looking for work.

This growing phenomenon has potentially significant consequences for the well-being of children. The young population of today are the parents of the next generation of children, many more of whom are likely to live in households with unemployed adults. Children who live in households with unemployed caregivers are at a greater disadvantage and risk of poor health, educational and nutritional outcomes (Meintjies & Hall, 2013) (Statistics South Africa, 2012 (b)). Given the increasing numbers of unemployed young people and the growing number of young people who have given up looking for work, the current number of 6,5 million children living in households where no adult is employed (in 2011) is likely to increase.

4.2.3.3. Increasing cross-border migration

In recent years, growing continental and regional economic and safety pressures have increased the number of refugees from other African countries crossing South Africa's borders. These include children. Children and adolescents constitute the majority of migrants in Africa, a substantial number of whom are not accompanied by an adult (Schreier, 2011).

These children, especially those who are unaccompanied by an adult are very vulnerable to abuse, neglect and exploitation as well as failure to access education, health care and other services for their survival and development (Schreier, 2011) (Centre for Education Rights and Transformation, University of Johannesburg, June 2012) (UNICEF , 2009).

4.2.3.4 Climate change

South Africa's climate is changing and this is likely to result in significant increases in annual rainfalls in certain regions with sharp decreases in other areas, alongside increasing temperatures. These changes are likely to impact on water, sanitation, health, agriculture and food and nutrition outcomes for the country. Children are more vulnerable to the impacts of climate change because of their physical, social and emotional make-up and their heightened sensitivity to high-impact events (UNICEF South Africa, 2011).

4.2.3.5 Local emergencies / humanitarian crises

In recent years, South Africa has been confronted with a number of national emergency scenarios. These include violent and disruptive industrial action which has resulted in disruptions to essential services, loss of lives and property as well as local service delivery protests which has also disrupted services and created unsafe local communities.

Whilst the impact of these events on children has not been fully explored, it is clear that they pose a particular risk to the protection, health and educational rights of children in the affected communities.

4.2.4 Protective factors in South Africa

Children in South Africa undoubtedly face a number of risk factors. However, the child protection framework has institutionalized a number of fundamental protective elements which are proven counterbalances for the many risks. Two notable elements are the near universal, well-resourced basic education system and the child-specific cash transfer system. Both elements are proven to hold the potential to address the structural drivers of poverty and inequality at source, provided they are universal in their reach, reach the most vulnerable and are of a high quality. Both elements have however not yielded their full potential because of a combination of access and quality impediments.

4.2.4.1 Education

A quality education is perhaps the most catalytic intervention of all, given its potential to break the intergenerational cycle of poverty that has trapped so many children in South Africa and in so doing drive the realisation of a more equal society (The National Development Plan 2030: Our future - make it work, 2012) (SAHRC and UNICEF, 2014).
Education has a profound multiplier effect, especially for vulnerable children. It leads to, inter alia, improved health and nutritional outcomes, improved gender equity, greater employment levels and increased earnings, as well as lowering risky adolescent behaviour, including drug

abuse and risky sexual behaviours (Department of Basic Education , 2013) (Pufall, et al., July 2014).

The full potential of education for founding the stronger realisation of rights, children's development and reductions in poverty and inequality has not been realised in South Africa because of inefficiencies in the use of the substantial education budget and the resulting poor quality of education provided to the most vulnerable children in the country (SAHRC and UNICEF, 2014).

4.2.4.2 Access to the CSG and other forms of social protection

South Africa has an expansive child focused cash transfer system which provides monthly support to the caregivers of vulnerable children. Numerous studies have shown that grants such as CSG fundamentally strengthen the resilience of vulnerable children to local risk factors. Notably, child focused cash transfers:

- Improve food security, reduce hunger and improves the quality of food in households and on children's nutritional status (Delany et al (2008), De Koker Et al (2006), Van der Berg et al (2010) and Aguero et (2006) in (Martin, Children's right to social assistance: A review of South Africa's Child Support Grant, 2014)
- Improve access to health services (Department of Social Development, South African Social Security Agency and UNICEF, 2010)
- Improve access to early childhood care and education (Department of Social Development, South African Social Security Agency and UNICEF, 2010)
- Improve school enrolment, attendance and learning outcomes (Budlender et al (2010) in (Martin, Children's right to social assistance: A review of South Africa's Child Support Grant, 2014) (Department of Social Development, South African Social Security Agency and UNICEF, 2010)
- Reduce the likelihood of child labour (Department of Social Development, South African Social Security Agency and UNICEF, 2010)
- Substantially reduce risky sexual behaviour in girls which is associated with high levels of HIV-transmission such as transactional sex and age-disparate sex (Cluver, et al., July 2014) (Department of Social Development, South African Social Security Agency and UNICEF, 2010)
- Reduce poverty and contributes to breaking the chain of intergenerational poverty (Woolard et al (2010) in (Martin, Children's right to social assistance: A review of South Africa's Child Support Grant, 2014).

The national child social security system is well-targeted and efficiently administered. However, a number of design, targeting and administrative barriers contribute to the exclusion of a number of the most vulnerable children from its protective ambit (SASSA and UNICEF, 2013).

5. CHILD PROTECTION CHALLENGE AND PRIORITIES 2015 AND BEYOND

South Africa ranks as the second most child-friendly country in Africa. Its high ranking is largely attributable to their advances in social protection measures benefitting children such as protection, health and nutrition policies and social protections and adequate budget allocations to sectors targeting children as well as having measures in places to ensure effective use of resources to ensure better child outcomes (The African Child Policy Forum, 2013).

However, despite gains, South Africa, along with its other African counterparts, cannot rest. There remains an urgent need for "accelerated and sustained efforts … in terms of legal reform, investment of resources and policy implementation" (The African Child Policy Forum, 2013).

The challenge in South Africa is for the child protection system to evolve sufficiently to address the persistent historical inequities and exclusions, with a focus on the social exclusions which sustain the poverty trap in which South Africa's most vulnerable children live, whilst also addressing emerging risks and maximizing the potential of proven protective factors.

There are a number of gaps and inadequacies in the current system, and it is the role of civil society and international NGOs like Save the Children to take action to ensure, that in moving to 2015 and beyond, the State develops, implements and maintains (with the support of relevant stakeholders) an adequately responsive and strong legal, institutional and accountability framework to secure the rights of all children in South Africa.

This report aims to provide some guidance in navigating the path forward by providing information that may help in the making of decisions as to which of the many possible issues to support in moving the child rights agenda forward.

Lungile Simelane, 47, tends the Save the Children Sizolomphakathi Garden in Mpumalanga Province.

B. HEALTH AND NUTRITION

1. SAVE THE CHILDREN'S HEALTH AND NUTRITION BREAKTHROUGH / PRIORITY OUTCOMES

Breakthrough / priority outcomes for Save the Children:
1. No child under-5 should die from preventable causes; and
2. Public attitudes should not tolerate high levels of child deaths (also Save's One Goal campaign objective).

Priority objectives:
3. Universal access to quality health services *(associated with the prevention of the leading causes of child mortality and morbidity);* and
4. Universal access to adequate nutrition.

2. LEGAL OBLIGATIONS AND COMMITMENTS

The international, regional and national legal and developmental framework obligates the government to take all necessary measures to ensure the highest attainable standard of health care for all children.

Health is defined as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1946).

This translates into an obligation to take steps to ensure, not only the survival of children, but to ensure that they grow and develop to their full potential. This requires the provision of a comprehensive suite of health promotive, preventative and curative health and nutrition services, including:

- Timely and appropriate
  - prevention,
  - health promotion,
  - curative,
  - rehabilitative
  - palliative services; and
- Social protection services to address the social and economic determinants of health such as water, sanitation, social security and related support (UN Committee on the Rights of the Child, 2013).

With specific reference to Save's priority outcomes, the government is duty-bound by a number of international, continental, regional and national instruments to:

1. Ensure that every child has access to basic nutrition, basic health care services and social services (UN CRC Article 24(1); ACRWC, Article 14(1) and section 28(2)© of the Constitution of the Republic of South Africa, 1996);
2. reduce the infant, under-5 and maternal mortality rates (UN CRC (article 24(2)(a); AU ACRWC, article 14(2)(a); UN Millennium Development Goal 1);
3. intensify cost-effective actions against disease and malnutrition which are proven to reduce child morbidity and mortality, with a special focus on children under the age of 2 and 5 years (UN General Assembly's: A World Fit for Children, 2002);
4. Provide quality medical care, with a focus on Primary Health Care (PHC), pre-natal, post-natal, essential obstetric care and care for newborns, especially for marginalised families (UN CRC, article 24(2)(B); ACRWC, article 14(2)(b); A World Fit for Children, paragraph 37(2) and (6));
5. Eliminate hunger (MDG 1)
6. Provide adequate food and nutrition for pregnant women and children (ACRWC, article 14(2)©; A World fit for Children; MDG 4);
7. Promote exclusive breastfeeding and provide infant-feeding counselling (A World Fit for Children, paragraph 37; Innocenti Declaration on Infant and Young Child Feeding; Tshwane Declaration of Support for breastfeeding in South Africa, 2012);
8. Provide education about child health and nutrition to parents, communities and others caring for children (UN CRC, article 24(2)(e); ACRWC, article 14(2)9e); A World Fit for Children, paragraph 37);
9. Combat malaria, HIV and AIDS and other diseases (MDG 6);
10. Ensure full immunization of children under the age of 1 year (A World Fit for Children);
11. Provide clean drinking water, basic and hygienic sanitation and a clean environment (ACRWC, article 14(20©; MDG; A World Fit for Children, paragraph 36); and
12. Provide social and other forms of assistance to enable parents to provide their children with an adequate standard of living to ensure their development (UN CRC, article 27(4)).

3. NATIONAL GOALS AND COMMITMENTS

The Constitution of the RSA: S28 of the Constitution provides that every child has the right to basic nutrition, shelter, basic health care services and social services

The National Department of Health's Strategic Plan and Annual Performance Plan 2014 – 2017 recognises that the right to health care encompasses the right to good health and not just an absence of disease or treatment when ill. Its mission is to "improve the health status through the prevention of illness, disease and the promotion of healthy lifestyles, and to consistently improving the health care delivery system by focusing on access, equity, efficiency, quality and sustainability."

Its strategic goals include the prevention of disease and the promotion of health, alongside improving the quality and accessibility of health care services (NDOH, 2014).

The National Department of Health's Strategic Goals for the period 2014/15 – 2016/17 include, inter alia, the prevention of disease and he promotion of health; the re-engineering of PHC by increasing the number of ward-based outreach teams and expanding school health services; and improving the quality of care through norms and standards and strengthened governance (DOH (APP), 2014).

Its strategic objectives that relate specifically to infant and child health and nutrition include the following:

1. Reduce the maternal mortality ratio to under 100 per 100,000 live births, focusing specifically on increasing the rate of 1st antenatal care visits before 20 weeks from 37 percent in 2011 to 75 percent by 2016 /17; and increasing the postnatal visit for mothers within 6 days from 27 percent in 2010/11 to 90 percent in 2016/17;
2. Reduce the neonatal mortality rate to under 6 per 1 000 live births;
3. Increase access to sexual and reproductive health services by expanding the availability of contraceptives;
4. Expand PMTCT coverage from 79 to 98 percent
5. Reduce the under-five mortality rate to less than 23 per 1,000 live births by promoting early childhood development. The performance indicators are all linked to disease prevention (rather than health promotion) and include the reduction of fatality rates in facilities as a result of diarrhea and severe acute malnutrition and increasing immunization coverage for children under 1 year from 89 to 97 percent and the measles 2nd does from 81 percent to 93 percent;
6. Improve health and educational outcomes for children of school-going age by rolling out the ISHP measured by the rate of Grade 1 and Grade 8 screening coverage.
7. Organise health services in the community and primary health care facilities to meet standards and to achieve population health outcome targets. Specifically by increasing the number of ward based primary health care outreach teams (WBPHCOTs)
8. Strengthen the provision of environmental health services
9. Improve access to and the quality of mental health services, notably by increasing and treating the number of people screened for mental disorders
10. Improved access to disability and rehabilitation services through the implementation of the framework and model for rehabilitation and disability services (notably key indicator is the cataract surgery rate) (DOH (APP), 2014).

South Africa's National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) aims to accelerate implementation of evidence-based interventions essential to improve maternal health and child survival, notably through effective advocacy for quality maternal and child health care, health system strengthening, community empowerment and involvement and effective collaboration with partners and relevant stakeholders. Key targets include the reduction of the under-five mortality rate through the provision of quality child survival services; reducing the maternal mortality ratio by increasing access to quality maternal health services and reducing the adolescent birth rate. With regards to the latter, the strategic plan aims to achieve universal access to reproductive health with family planning and youth-friendly sexual and reproductive health services identified as key strategies for attainment of the MDGs (DOH (CARMMA))

The Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 -2016

To reduce the IMR from 40 to 36 per 1,000 live births by 2014 and to 32 by 2016

To reduce the U5MR from 56 to 50 by 2014 and to 40 by 2016

To reduce the neonatal mortality rate from 14 to 11 per 1,000 live births by 2016 (The Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 - 2016).

The plan commits to the delivery of a suite of priority services as part of a comprehensive package at community level through ward-based PHC outreach teams, primary health care and hospital levels, including:

- Promotion of early and exclusive breastfeeding
- Provision of PMTCT services
- Newborn care as per protocols
- Promotion of Kangaroo Mother Care
- 6-day postnatal visits
- Increased access to contraceptive services and youth-friendly counseling and reproductive health facilities and through school health services
- Provision of preventive services such as immunization, growth monitoring, Vitamin A supplementation and deworming
- Correct application of the IMCI protocol
- Early identification and appropriate management of HIV-infected children
- Expand and increase school health services
- Increasing provision of MNCW and Nutrition services at a community level

DOH Service Delivery Agreement, Output 2.1 Decreasing maternal and child mortality

By 2016:

Decrease IMR to 18 per 1,000 live births

Decrease U5MR to 20 deaths per 1,000 live births

National Development Plan: Vision 2030 commits to ensuring quality health and nutrition services and support for especially young children as a key intervention of attaining reduced poverty and equality. It prioritises, inter alia, the reduction of maternal, infant and child mortality; the reduction of injury, accidents and violence by 50 percent; universal health care coverage and the provision of PHC to families and communities through PHC teams. The NDP further prioritises a number of strategies that are essential to achieve the stated goals by 2030. These include inter alia, addressing the social determinants of health and disease, strengthening the health system, and improving quality by using evidence.

4. EXISTING AND EMERGENT RISK FACTORS IMPACTING ON THE HEALTH RIGHTS OF CHILDREN IN SOUTH AFRICA

1. High levels of child poverty and inequality: Children living in poverty are at a greater risk because of the associated social and economic deprivations which determine poor development and health outcomes. For example, lower levels of access to water, sanitation, a safe source of energy and a hygienic environment experienced by children living in poverty and in underserviced areas such as rural areas and informal settlements are key drivers of poor health, development and survival rates of historically marginalised children (NDOH, 2014).
2. High levels of unemployment: In 2011, 35 percent of children in South Africa lived in households where there was no employed adult in residence (Hall K. , 2013). This impacts on their health and nutritional status. Children living with employed adults are more likely to benefit from the higher quality health care associated with belonging to a medical insurance fund. In addition, children living in households with no employed adults are more vulnerable to hunger. In 2010, 27 percent of children in households with no employed adult, compared to 14 percent with at least one employed adult experienced hunger (Statistics South Africa, 2012 (b)).
3. Distance, cost and safety concerns remain a barrier to access to health care services (McClaren, Ardington, & Leibbrandt, 2013). Despite a number of policies to expand the health care footprint into marginalized areas, there is still notable inequity in access for people living in poverty and African people (15% of Black African, compared to 7 % Coloureds and 4% Whites live more than 5 km from the nearest facility (McClaren, Ardington, & Leibbrandt, 2013). It is particularly money and travel time costs that inhibit access. This impacts negatively on access to key maternal and child health services such as having a skilled birth attendant, an immunization record and a growth chart for children (McClaren, Ardington, & Leibbrandt, 2013). Distance is a particularly important predictor of health care utilization for high risk births. For every additional kilometer from a clinic, the probability of attended birth for older mothers (over 35 years) decreases by 2,2 percentage points. It also, impacts on access to immunization record and road to health card – for children under the age of 5 years, each kilometre further from the nearest health facility is associated with a 0,2 percentage point reduction in the probability of having a road to health card (McClaren, Ardington, & Leibbrandt, 2013).
4. High levels of HIV: Whilst South Africa has made progress in reducing its HIV incidence levels it remains the country with the highest numbers of people living with HIV (DOH (APP), 2014). HIV-prevalence amongst the general adult population (15 – 49 year olds) has remained stable at approximately 17 percent since 2005. The rate amongst pregnant women is however much higher at 29 percent (DOH, 2011). High levels of HIV prevalence, notably among young women and pregnant women in South Africa create a risk of transmission to infants and young children during labour and after through breastfeeding (K Hall, 2013).
5. High levels of pregnancy in young women / girls under the age of 18 years: Whilst there is a general downward trend in the fertility rate among teenage girls (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014), the rate of teen pregnancies (under 18 years) in facilities remains substantial at 7.7 percent in 2012/13. Provincially the largest number is in the Eastern Cape (10,3 percent) and the lowest in Gauteng (4,8 percent) (Massyn, et al., October 2013). Children born to teen mothers are at greater risk of adverse neonatal outcomes such as low birth weight, preterm delivery and are more likely to be stunted than other children (Reddy et al (2010) and Branson, Ardington and Leibbrandt, 2011 in (H Saloojee, 2012).
6. Substance abuse: South Africa has the highest prevalence of foetal alcohol syndrome (FAS) in the world. In some areas, the rates are high as 67-100 per 1,000 children which leads to cognitive and physical developmental difficulties and/or disability (Urban et al, 2008 in (H Saloojee, 2012). There are however no surveillance systems to routinely collect data and the true scale of the problem is not known – but prevalence studies in high risk areas has shown rates as high as 119/1000 in one particular site (MRC; University of Pretoria; University of Cape Town, 2009). FAS is the most common form of intellectual disability in the world – it is preventable simply be ensuring that women do not drink alcohol during pregnancy (SANCA Western Cape, 2014). Smoking significantly increases the risk of two leading causes of perinatal death (Saloojee, 2014).
7. Maternal depression: Maternal mental illness, most commonly in the form of anxiety and depression, affects 40 percent of women during and after pregnancy, with long-term consequences for the physical, emotional and cognitive development of infants and young children. The rate is higher than in developed countries (10 – 15 percent). One in three women in South Africa suffers from depression during and/or after pregnancy. It affects the most vulnerable women and thus serves to fuel the intergenerational transmission of poverty and poor development. It impacts the most on women living in poverty, affected by HIV, those affected by violence and abuse and social exclusion. Many refugee women fall within the group of affected mothers (Perinatal Mental Health Project, 2014). Not only do the social and economic conditions in which women at risk of depression fuel their heightened risk; it also means they have limited, if any access to mental health services. 75 percent of people in South Africa needing mental health services do not get what they need (Perinatal Mental Health Project, 2014). The impact of maternal depression, before and after the birth of an infant has proven adverse impacts on the health and well-being of the mother as well as the development and health of the young child. Depression during or after the pregnancy is associated with poor mother-infant bonding, less optimal mother-infant interactions and insecure infant attachment (Meintjies, Heyningen, & Field, 2012). Women experiencing depression or anxiety during or after birth are at a greater risk of "self-medication with alcohol and drugs; reduced sleep and appetite; poor antenatal weight gain; increased risk of pre-term birth and low-birth weight and increased risk of emotional and behavioural problems in the child" (Surkan et al, 2011 in (Meintjies, Heyningen, & Field, 2012).
8. Climate change: The changing climate in South Africa will have an impact on the health and nutritional status of children. Increasing temperatures and droughts in some areas, and increased rainfall in others, combined with existing vulnerabilities such as poverty, high levels of unemployment and HIV and AIDS and poor access to basic services may lead to increased food insecurity, higher levels of malnutrition and increased infections, vector and water-borne diseases such as diarrhea, cholera, bilharzia and Malaria (UNICEF South Africa, 2011)

5. SITUATIONAL ANALYSIS: THE ENJOYMENT OF THEIR RIGHTS TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH AMONG CHILDREN IN SOUTH AFRICA

The GRSA has put in place a comprehensive policy and programmatic framework to prevent and / or treat the leading clinical causes of child morbidity and mortality. At present, the following package of health care services is available for pregnant and lactating women and children at community, primary and hospital levels of care:

1. Free health care for pregnant women, young children and children with disabilities
2. Basic Antenatal Care (BANC)
3. Emergency and specialist obstetric care
4. Post-delivery 6 day visits
5. PMTCT
6. Immunisation
7. IMCI – Integrated Management of Childhood Illnesses
8. TB treatment
9. Growth monitoring and developmental screening
10. Food and nutritional support programmes (such as breastfeeding counselling, food fortification, micronutrient supplementation, the provision of fortified food, food parcels, the SROD).

In addition, the GRSA has recently engaged in wide-scale strengthening of the health system to improve coverage and the quality of care at community, clinic and hospital levels. Measures include:

- The introduction of National Health Insurance (NHI) with the objective of making affordable, quality health care universally available.
- A PHC re-engineering initiative has been developed to strengthen the PHC system with a focus on delivering promotive and preventative health services at a community level and household level. The initiative centres around district health teams made up of district specialist teams, health facility teams and ward-based outreach teams of community health workers (Government of the RSA: Delivery Agreement Outcome 2, 2010). Ward-based outreach teams will provide a range of health promotive and preventive services for pregnant women and young children (DOH (APP), 2014).
- Focused infrastructure development initiatives based on findings of the 2012 health facility audit commissioned by the DOH (Health Systems Trust, 2012).
- Human resource strengthening with a focus on the numbers, qualifications and skills of maternal and paediatric health workers, especially in rural areas (DOH (HRH Strategy), 2012).

5.1 Progress in 2014

A number of key health indicators have shown positive developments over the last few years. Life expectancy has increased from 59 to almost 63 years between 2009 and 2011 (MRC, 2012). South Africa has recently succeeded in reversing its previously increasing levels of infant and under-five mortality rates. These were estimated by UNICEF (2010) to have increased from 44 to 48 and from 56 to 67 infant and under-five deaths per 1,000 live births between 1990 and 2008.

Between 2009 and 2011 the Infant Mortality Rate (IMR) reduced from 40 to 30 deaths per 1,000 live births and the Under-Five Mortality rate (U5MR) reduced from 56 to 42 deaths per 1,000 live births (Department of Health, RSA, 2013):

The significant improvements in adult and child mortality rates are largely attributable to South Africa's strengthened HIV and AIDS policies and programmes, notably its Prevention of Mother to Child Transmission (PMTCT) Programme (K Hall, 2013) (Saloojee, 2014). South Africa continues to be confronted with "serious generalized HIV and TB epidemics" and remains home to the world's largest number of people living with HIV – an estimated 6,4 million in 2012 (Spectrum policy modelling system, Statistics South Africa 2013 in (NDOH, 2014). However, South Africa is making notable gains in stabilizing the epidemic among pregnant women, reducing it among younger women, men and children and reducing the number of deaths caused by or linked to HIV and AIDS among adults and young children alike. This is largely because of the focused "integrated and concerted efforts at all levels to reduce MTCT through high-level commitment to a number of strategic plans and action frameworks" (Massyn, et al., October 2013).

South Africa has the largest ARV programme in the world. More than 2 million people are on treatment and 15 percent of these are children (Saloojee, 2014). The number of children on ART increased from 4,200 to 152,000 between 2004 and 2011 (Government of the Republic of South Africa, 2013). Prevalence among pregnant women has stabilized at around 29 percent after increasing between 2000 and 2007 and as a result of the near-universal roll-out of the PMTCT programme and its effective design almost 100 percent of pregnant women are tested and 92 percent of HIV positive pregnant women receive ARV treatment or prophylaxis. This has resulted in a significant reduction in pregnancy and intrapartum transmission rates from mothers to infants down to 2,7 percent in 2011 (Goga, et al., 2012)

5.2 Child health issues and concerns in 2014

Whilst life expectancy and child survival rates have improved, these gains are offset by a number of issues relevant to Save's key objectives of preventing avoidable deaths of children under 5 and access to adequate nutrition for all children.

These include:

1. A **growing incidence of life-style-related non-communicable diseases (NCDs)** such as diabetes, hypertension, cancer and other chronic conditions alongside the burden of communicable diseases (mainly HIV, AIDS and TB) (NDOH, 2014). Whilst NCDs are primarily found among adults, the risk of developing an NCD is **aggravated through poor health care and development in infancy** – thus poor health and development in the earliest years of life drives the growing adult NCD prevalence (Fellitti & Anda, 2009).

2. Whilst the IMR and U5MRs have come down, there are a number of abiding concerns with child survival rates.
   2.1 Despite the reductions, the **IMR and U5MR remain high and South Africa will not meet MDG 4 by 2015**. By comparison, South Africa's rates remain higher than similarly place countries. It is between 4 times higher than countries with comparable economic status (Saloojee, 2014).

   2.2 **The neonatal mortality rate (NNMR) increased over the last 5 years** from 9, 9 per 1,000 live births in 2007/8 to 12, 3 in 2011/12 (Department of Health, RSA, 2013). The 2013 District Health Barometer records a slightly lower rate of 10,2 per 1 000 live births, and recognises that between 2011/12 and 2013 the rate has remained static (Massyn, et al., October 2013). Whilst it remains unclear if the increase between 2007 and 2012 was a result of better reporting or of a deterioration in health services, the numbers recorded remain cause for concern. The number of infant deaths within the first 28 days after birth accounts for 1/3 of under-five deaths (Department of Health, RSA, 2013). Thus, the attainment of U5MR goals depends on reducing the NNMR. The leading causes of neonatal deaths are:
      2.2.1 Labour-related complications (asphyxia and birth trauma)
      2.2.2 Spontaneous pre-term birth
      2.2.3 Placental diseases (R C Pattinson (Ed) , 2009).

   There are wide provincial and district variations in the neonatal death rate. The worst rate is in the Eastern Cape (16,4) and the best in the Western Cape (6,2). Within provinces there is massive district variation – with the worst recorded rate in the Nelson Mandela Bay district (27,2) and the best in Amajuba in KZN (2,9) (Massyn, et al., October 2013).

   2.3 **The maternal mortality ratio has increased:** The risk of a child dying before the age of 5 years doubles if his or her mother dies during childbirth and at least one fifth of child morbidity is associated with poor maternal survival (Lule et al, 2005 in (H Saloojee, 2012)). South Africa's maternal mortality rates are between 6 and 8 times higher than countries with a similar economic development profile (Saloojee, 2014). The population (as opposed to facility-based) maternal mortality ratio in South Africa increased from 248 per 100,000 to 333 in 2009. The 2011/12 facility-based maternal mortality ratio is 144,9 per 100,000 with a high of 199.1 in the Free State and a low of 28,6 in the Western Cape (Department of Health, RSA, 2013).

   2.4 **A substantial number of child deaths in South Africa are preventable and/or treatable** through the application of cost-effective interventions. 26 percent of child deaths recorded between 2005 and 2009 were avoidable (L Bamford, 2011) (Department of Health, April 2011). 40 percent of neonatal deaths caused by labour related complications in 2007 were avoidable (R C Pattinson (Ed) , 2009).

   2.5 **The leading clinical causes of child mortality** in South Africa are HIV and AIDS, non-HIV and AIDS pregnancy and child-birth complications, newborn illness, childhood illness and malnutrition (L Bamford, 2011).

      2.5.1 **Avoidable and treatable newborn and childhood illnesses which cause the most deaths** among children are
      2.5.2 Acute respiratory infections

2.5.3 Diarrhea
2.5.4 Infection
2.5.5 TB
2.5.6 Meningitis

Despite the gains made through South Africa's multi-sectoral HIV and AIDS policies and programmes, HIV and AIDS remains a major contributor to under-5 deaths. The deaths of over half of the children who die in hospitals are linked with HIV and AIDS (NDOH Committee on Morbidity and Mortality in Children under 5 Years, 2013).

2.5.7 **Under-nutrition is a leading cause of morbidity and mortality** with over 60 percent of child deaths in hospitals in South Africa associated with malnutrition (CR Stephen, 2011).

2.5.8 **Injuries and trauma** contribute significantly to the number of avoidable child deaths, including poisonings, burns, falls, car accidents and abuse (Government of the RSA: Delivery Agreement Outcome 2, 2010). These are the foremost cause of death in children older than 1 year and all children older than 5 years (Saloojee, 2014).
Road accident injuries in children aged 1-4 was recorded in 2011 as the leading cause of death among children aged 1-4, especially in certain districts such as Sedibeng in Gauteng[2] (Day, et al., 2011).

3. Whilst the numbers are not clear (because of poor data collection and management), high levels of preventable **childhood disability are closely associated with the infant mortality and morbidity.** Many of the children who do not die as a result of the preceding list of preventable causes of mortality and morbidity are left with preventable developmental delays and / or disability. These children are in turn at a greater risk of dying before the age of 5 years. Whilst there is no data in South Africa, in a number of developing countries, mortality rates for disabled children under the age of five years can be as high as 80 percent (DFID, 2000). In 2011, an estimated 474,000 children were living with a severe disability (using 2011 mid-year population estimates) (Slemming, 2014). This does not reflect the full picture as many more children live with mild to moderate disabilities, but are not counted by the current national data collection surveys. It is estimated that 40 percent of disabilities affecting children are attributable to preventable causes (Slemming, 2014) (DFID, 2000).

4. **The poor nutritional status of children in South Africa – notably, comparatively and persistently high levels of under nutrition and obesity** - impact significantly, not only on children's right to survival, but also to develop to their full potential.

4.1 **High levels of under-nutrition among children is contributing to the high morbidity rate as well as poor developmental outcomes for children and the country as a whole.** Under-nutrition is the leading cause of child mortality and morbidity in sub-Saharan Africa, including South Africa. In South Africa, malnutrition is associated with 60 percent of all child deaths in hospitals (Hendricks, Goeiman, & Hawkridge, 2013). As in the case of other forms of childhood diseases, historically marginalised children are at greater risk of under-nutrition (Shisana, et al., 2013). In addition, under-nutrition is a key poverty trap which drives and perpetuates historical patterns of inequity and exclusion some 20 years after the dissolution of apartheid (SAHRC and UNICEF, 2014).

4.1.1 **Currently, the most significant and damaging form of under-nutrition among children in South Africa is chronic malnutrition or stunting** (low height for age) rather than acute malnutrition (underweight and wasting).

Stunting occurs when children do not receive adequate the minerals and vitamins they need for their minds and bodies to grow adequately. They enjoy a carbohydrate-rich diet and are thus not underweight. However the micronutrients and growth nutrients (zinc, sulphur and magnesium) required for growth and developing are missing in commonly consumed foods such as maize. Thus while this form of stunting does not result in distended bellies and glassy eyes as in the case of acute malnutrition it does not receive the same attention; yet the effects are equally, if not more devastating for children. This form of under-nutrition impacts negatively (and often irreversibly) on the child's cognitive development, resulting in educational deficits and low productivity in adulthood – thus fuelling poverty and inequality amongst historically marginalised families (Draft National ECD Policy and Programme (RSA) , 2014). The negative effects of stunting are most extreme where children are stunted in the first 2 – 3 years of life as it is during this crucial developmental period that cognitive development, fuelled by sufficient and adequate nutrition, takes place.

Researchers and development organisations all agree; stunting is the most pressing post-2015 nutritional issue among children. It must be prevented through the provision of adequate maternal, infant and child food and nutritional support, starting during pregnancy and continuing until the child is at least 2 or 3 years old (the first 1000 days) (Hendricks, Goeiman, & Hawkridge, 2013) (Draft National ECD Policy and Programme (RSA) , 2014) (Save the Children , 2012) (Shisana, et al., 2013). The importance of the issue has received the highest national attention. The reduction of stunting through targeted measures for children in the 1st 1000 days is recognised and prioritised by South Africa's National Development Plan: Vision 2030, given its fundamental linkages with obtaining the dual national goals of reduced poverty and inequality.

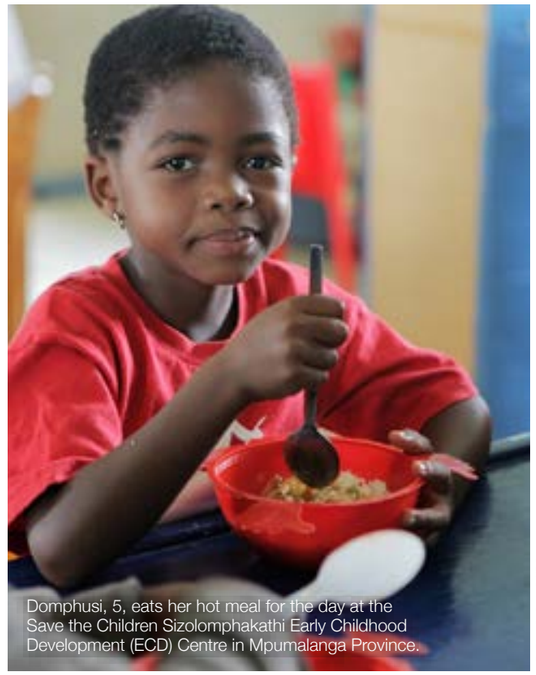
Stunting rates among children between the ages of 1 and 3 years have increased by 3 percent since 2005. Whilst malnutrition rates have improved since 2005, with 15,4 percent of children 0- 14 stunted and 5,4 percent underweight, the problem remains particularly acute and is more common-place among the youngest children (0-3 years). In this age group 27 percent of boys and 26 percent of girls are stunted. (Shisana, et al., 2013).

4.1.2 **Across all age groups and across all provinces, there are high levels of micronutrient deficiency.** There is a national prevalence of 43,6 percent Vitamin A deficiency. Within the sampled group, 10,5 percent were anaemic, 11 percent were iron deficient, and 2,1 percent were suffering from iron deficiency anaemia. Zinc deficiency levels are as high as 45 percent and iodine deficiency 15 percent (Shisana, et al., 2013).

4.1.3 **Acute malnutrition – that is underweight and wasting remains a problem for a minority of children – but they are the most vulnerable.** The rate of severe acute malnutrition is increasing among children under the age of one year and high rates of wasting and underweight are found in certain provinces (North West, the Free State and the Northern Cape) (Shisana, et al., 2013). Nationally, 2,2 percent of children aged 0-3 are wasted and 6 percent are underweight.

4.2 Under nutrition is not the only problem. Across all age groups, there are increasing rates of **overweight and obesity**, especially amongst girls (16,5 and 7,1 percent) compared to boys (11,5 and 4,7 percent (Shisana, et al., 2013) ((Hendricks, Goeiman, & Hawkridge, 2013)

5 There are significant **provincial and district inequities in the distribution of maternal and child deaths and the burden of childhood diseases, disabilities and poor nutrition.** Generally, the burden is higher among poorer, predominantly rural provinces and districts marked by high levels of poverty and historical legacies of poor infrastructure and administration and management skills. However, urban areas are emerging as problems in some areas.



Domphusi, 5, eats her hot meal for the day at the Save the Children Sizolomphakathi Early Childhood Development (ECD) Centre in Mpumalanga Province.

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[2]The drafters do caution about the quality/reliability of data. But there is a trend across the country for high levels of road accident-related deaths

5.1 **The IMR varies across provinces**, with the lowest rates recorded in the wealthier more urban provinces of the Western Cape (19) compared to the worst performing province – the Eastern Cape, where the rate is more than double at 47 (Department of Health, RSA, 2013). Similar patterns are found in the case of the U5MR with the Western Cape at 27 and the Eastern Cape at 65 (Department of Health, RSA, 2013).

5.2 In addition, there are **marked differences in survival rates between rural and urban** areas and between African children and other race groups. In 2011 the IMR in urban areas was 52,6 compared to 32 per 1000 live births, jumping as high as 70 in some rural districts in the Eastern Cape (Department of Health , 20 January 2012). White children have a 30 percent greater chance of surviving to the age of 5 years compared to African children (Heaton & Amoateng, 2007).

5.3 **Children in rural areas are significantly more likely to have a serious disability** than their urban counterparts (2,7 versus 2,3 percent) primarily because of their lower social and economic living conditions and poorer access to social protection and quality health services (DSD, DWCPD and UNICEF, 2012).

5.4 **Children in rural areas are at a greater risk of under nutrition, whilst children in urban areas are at a greater risk of being overweight or obese** (Shisana, et al., 2013).

5.5 **Children born to younger / teen mothers** are, as previously mentioned, at a greater risk of poor health and nutritional outcomes and their mothers are more likely to experience poor health, educational, social and economic outcomes themselves. The close association between teen pregnancy and its association with poor health and educational outcomes for mothers and their children is the reason for a recent study on social exclusions to identify early pregnancy as a mechanism driving poverty and inequality in South Africa (SAHRC and UNICEF, 2014)

6. IMMEDIATE AND UNDERLYING REASONS FOR POOR HEALTH AND NUTRITIONAL OUTCOMES AND STATUS OF CHILDREN IN SOUTH AFRICA

Given the expansive policy framework, maternal and child health programmes and PHC-focused health-system strengthening initiatives targeting access barriers and improving the quality of public health, the question is why then do we continue to see poor and inequitable health outcomes for so many children in South Africa. The causes, as identified and described below, reside at both a health-system's supply, as well as demand-side.

6.1 Immediate causes of preventable cause of child death and poor nutrition children

6.1.1. **Late access to ANC:** Despite the availability of BANC and the near-universal access to services (with almost 95 percent of women accessing ANC services), less than half of all pregnant women access these services early enough (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014) (Saloojee, Haroon, 2014).

In 2012, only 44% percent of women accessed BANC services before 20 weeks of gestation. Only 19 out of 52 districts have reached the national target of 50 percent and two districts have rates below 30 percent (Alfred Nzo and OR Tambo in the EC) (Massyn, et al., October 2013) .The lowest rate of access is in the Eastern Cape where only 33,6 percent of women enjoy early access. The highest is in the Western Cape (56,2 percent) (Department of Health, RSA, 2013).

This results in the late diagnosis of many preventable or manageable conditions and low access to early access to essential ANC services such as PMTCT and nutritional support which impact on the health and well-being of the infant, child and later adult (Saloojee, Haroon, 2014).

6.1.2. **Poor quality of BANC services:** There is also wide variation in the quality of BANC services provided. Thus whilst the majority of women deliver in a facility (more than 90 percent in 2012 – ranging from 79,8 percent in the Free State to more than 100 percent in Limpopo) the level of poor maternal and neonatal outcomes indicate a serious concern with the quality of care provided in facilities (Department of Health, RSA, 2013) (Massyn, et al., October 2013). The poorest and most rural areas are often the most problematic in terms of the quality of services provided (Saloojee, 2014). For example, a health system's crisis in the Eastern Cape has left many women and infants at risk in facilities (TAC and Section 27, 2014) (Human Rights Watch, 2011).

It is estimated that 2/3rds of child deaths between 2005 and 2009 were linked to poor quality clinical practices and in 2007, 44 percent of neonatal deaths were linked to avoidable inappropriate health care provision (R C Pattinson (Ed) , 2009).

6.1.3. **Late testing of HIV-exposed infants:** It is critically important that HIV-exposed infants receive a PCR test in early infancy (by six weeks) to secure early initiation of treatment, survival and development of the child. Whilst the rate of early testing has improved substantially over the last five years from 30 percent in 2007/8 to 63,3 percent in 2011/12, this is still substantially below the national target of 95 percent. The highest coverage is in the Western Cape (79 percent) and the lowest in the Limpopo (50 percent). However the district with the lowest coverage is OR Tambo in the Eastern Cape and the highest in Xariep in the Free State (over 100 percent) (Department of Health, RSA, 2013).

6.1.4. **Low coverage of a post-natal 6 day visit:** A recent innovation introduced by the Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa (2012) is the provision of postnatal visits within 6 days of birth to secure the mother and infant's survival, health and nutrition. These are ideally home-based, but can also be facility-based. Community health workers play a key role in the provision of this service. The national target is 75 percent for 2012/13. Coverage is below this target as 62,7 percent in 2011/12, with a low of 43 percent in the Northern Cape and a high of 82 percent in the Free State. At a district level, the lowest coverage is in the O R Tambo district (24 percent) and the highest is in Bojanala in the North West (93 percent) (Department of Health, RSA, 2013). In addition, there is little clarity, and some concern, about the quality of the support and services provided given that the CHWs and ward-based outreach teams are limited in number and have to provide a full basket of services to adults and children alike. These limitation leave little space for the in-depth and specialist support required by, especially vulnerable, new mothers and infants (Saloojee, 2014) (Draft National ECD Policy and Programme (RSA) , 2014).

6.1.5. **Poor coverage of the Vitamin A supplementation programme:** The Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa (2012) aims to achieve 80 percent coverage of one dose of Vitamin A per year for all children aged 12 – 59 months (although the policy provides for two doses per year). Vitamin A coverage has declined from 43,4 to 42,8 percent between 2011 and 2013 with a low of 35,8 percent in the North West and a high of 50 percent in the Free State (Massyn, et al., October 2013). Low coverage contributes to infant morbidity, mortality and disability in the form of blindness (Massyn, et al., October 2013) (Department of Health, RSA, 2013) (Martin, P, 2014).

This is attributable largely to the failure to provide Vitamin A supplements as part of the routine health services. The DOH conducts ad hoc rather than annual routine Vitamin A supplementation campaigns (Massyn, et al., October 2013).

6.1.6. **Inadequate immunization coverage:** Immunizations are key to preventing many of the causes of child death and disability. The Expanded Programme on Immunization (EPI) provides a comprehensive suite of immunizations, including the rotavirus and pneumococcal vaccines. Children receive the full dose before they turn one year and receive a further measles vaccination at 18 months.

Immunization coverage reached a national average of 94 percent in 2012/13. However, the rate is lower in certain provinces, notably Mpumalanga and the Eastern Cape (83 percent) and drops down to as low as 70 percent in districts such as Alfred Nzo in the Eastern Cape and Dr Kenneth Kaunda in the North West. Moreover, two districts have recorded substantial reductions in coverage – OR Tambo (EC) dropped by 17 percent and Tshwane (GP) by 16 percentage points (both are NHI districts) (Massyn, et al., October 2013).

In addition to variable rates for children under one year, there is a significant and increasing drop-out rate between the first and second measles dosages. It increased from 9 percent to 17 percent between 2009 and 2012, with the highest drop-out rates recorded in the Western Cape (23%) and the lowest in KZN (10%) (Massyn, et al., October 2013).

6.1.7. **Inadequate quality of IMCI by health care professionals:** The Integrated Management of Childhood Illnesses (IMCI) programme makes provision for facility care and treatment of common childhood illnesses, including diarrhea, pneumonia, measles, rubella and malnutrition. There have been concerns about the quality of IMCI care, particularly at a PHC level (Thandrayen & Saloojee, September 2010). The DOH has responded to these concerns with efforts to improve the management of common illnesses driving infant and child mortality rates such as pneumonia. These have yielded positive results, as is evidenced by improvements in the case fatality rates of diseases such as pneumonia and severe acute malnutrition. In 2012/13, the average case fatality rate for pneumonia in children under 5 years was 3,8 percent "which continued the downward trend evident since 2009/10 when it was 6,6 percent" (Massyn, et al., October 2013).

However, given the fact that common childhood illnesses – notably pneumonia, TB, diarrhea and acute malnutrition remain a leading cause of all child deaths - there are ongoing issues with the quality of the management of these illnesses at a facility level (Saloojee, 2014). There are a number of reasons, including failure to follow protocols and to implement guidelines such as those governing the inpatient and community-based management of severe acute malnutrition at a district-level (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

6.1.8. **Inadequate implementation of nutritional and disability prevention interventions through the Road to Health Booklet (RtHB):** The PHC package for children makes provision for PHC workers to undertake routine growth monitoring and screening for developmental delays and disabilities, and to provide care and, where necessary, referrals to higher levels of care to access therapeutic, clinical and rehabilitative care and devices. The tool for managing these services is the RtHB which children receive at birth. At each subsequent PNC clinic visit, clinic health-care workers are required to assess the child's developmental progress and nutritional well-being through measuring and recording the child's weight. At the same time, health-care workers are required to provide counselling and support on nutrition and development, and where problems are picked up, provide clinical support or refer the caregiver and child to a higher level of care.

There is however inadequate implementation and monitoring of coverage and quality of integrated growth monitoring, nutritional counselling and support, and screening for and early treatment of developmental delays and disability components of the Primary Health Care Package for South Africa.

There is little, if any formal monitoring of implementation of these roles and tasks, but it would appear that PHC workers are not fulfilling their assigned screening and counselling roles, particularly in the case of disability screening (Slemming, Developmental difficulties and disabilities: Background paper for draft national ECD programme, 2014) (Slemming & Saloojee, Beyond survival: The role of health care in promoting ECD, 2013) (Martin, P, 2014) (H Saloojee, 2012) (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014). Monitoring is critical, not only to assess if screening is taking place, but also to ensure quality – the quality of developmental and nutritional screening is critical for the intervention to have the necessary prevention results (interview, Sue Philpott, Disability Action Research Team).

Where growth faltering is picked up, many children do not access therapeutic services because of stock outs. Children identified with developmental delays and disabilities are not accessing therapy and assistive devices because these are not available at PHC level and referral systems are inadequate (Thandrayen & Saloojee, September 2010) (Martin, P, 2014) (Interview, Wiedaad Slemming, Department of Community Paediatrics, University of the Witwatersrand). At the same time, there is little, if any tracking within the health system, of where identified children go and the services they are receiving (interview, Sue Philpott, Disability Action Research Team).

6.1.9. **Caregiver behaviour and knowledge deficits:** Parents and caregivers lack knowledge, and at times the will, to use available services and appropriate health promotive practices to ensure the health and nutritional well-being of their children. One third of all child deaths between 2005 and 2009 were linked to caregiver behaviour in the home and community, including delays in seeking care, lack of recognition of danger signs, the provision of insufficient food and inappropriate treatment (L Bamford, 2011). In 2012, 44,5 percent of child deaths occur in the health system, but many more (54,5) percent occur in the community pointing to demand-side failures (interview, Dr Neil McKerrow, Head: Paediatrics & Child Health, Department of Health, KwaZulu-Natal and chair of the Ministerial Committee on Child Mortality).

Caregivers' low levels of appropriate practices and the timely use of services is attributable to a number of factors. These include lack of knowledge of signs of illness requiring medical care and lack of knowledge about appropriate practices, cultural and social factors, difficulties in accessing health facilities, and unwillingness to use facilities because of poor quality, judgmental care and long waiting times (DOH; DSD; DPME, 2014) (interview, Dr Neil McKerrow, Head: Paediatrics & Child Health, Department of Health, KwaZulu-Natal and chair of the Ministerial Committee on Child Mortality).

The problem of early recognition of symptoms and use of services is particularly problematic amongst parents of children with disabilities. Often parents with children with disabilities do not acknowledge the disability and are reluctant to take their child to a health facility. Part of the problem is the lack of positive education and messaging for these caregivers on the symptoms, the importance of early recognition and that they are welcome to use the services available (interview, Sue Philpott, Disability Action Research Team).

6.1.10. **Inaccessible youth sexual and reproductive health services:** Whilst the GRSA has developed an expansive policy framework governing the provision of youth-friendly health services, including sexual and reproductive health services, many young women and men fail to access these because of poor knowledge of services, lack of information, cultural attitudes and beliefs and hostile attitudes among health care professionals (O'Reilly & Washington, 21 August 2012) (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

Thus many young women and men do not use contraceptives, despite high levels of early initiation of sexual activity; many are reluctant to attend on clinics to obtain contraception services and support; and many young pregnant women and mothers delay their antenatal and post-natal visits (Health Systems Trust; The Atlantic Philanthropies; DOH North West Province, 2012). In 2008, 37,5 percent of learners reported having had sex. 12,6 percent reported having engaged in sexual activity before the age of 14 years. 19 percent had been or had made someone pregnant. 18 percent of learners that had engaged in sexual activity had not used any form of contraception to prevent an early pregnancy (Medical Research Council, 2010).

6.1.11 **Pregnant women, infants and young children are not accessing enough food and nutrition in the right quantities and diversity for a number of reasons:**

6.1.11.1 **Inadequate nutritional counselling, support and education through the health system:** Poor infant feeding practices are a cause of the increasing severe acute malnutrition rates among children under 1 year (Hendricks, Goeiman, & Hawkridge, 2013). In the case of stunting, dietary diversity levels – which is essential for preventing stunting – are low. In 2012, across the country, the mean dietary diversity score was 4,2 (scores less than 6 are poor) with scores lower than 4 found in rural informal areas (Shisana, et al., 2013).

The national exclusive breastfeeding policies and programmes, the re-engineered PHC package and PMTCT programme make provision, in principle, for pregnant women and mothers of young children to receive counselling and education on feeding options, breastfeeding and good nutritional practices for children whose weight falters through some individual and group counselling at clinics and the CHWs.

In practice however, generally there is inadequate provision of nutritional information, education and support as a matter of course to healthy people. There is little proactive under-nutrition prevention and health promotion activity through the health system (DOH; DSD; DPME, 2014).

There has been a significant improvement in the amount and quality of breastfeeding counselling provided and the district health system monitors breastfeeding rates ate 12 – 14 weeks. As a result, there has been a huge improvement in exclusive breastfeeding rates. In 2010, only 12 percent of children were exclusively breastfed at the age of 2 months and 2 percent at the age of 4 – 6 months. At the age of 23 months only 13 percent are breastfed (Shisana, et al., 2013). Exclusive breastfeeding rates were also low amongst women who are HIV positive (Massyn, et al., October 2013). In 2012, the rate has increased to 44 percent at 12 weeks (interview, Dr Neil McKerrow, Head: Paediatrics & Child Health, Department of Health, KwaZulu-Natal and chair of the Ministerial Committee on Child Mortality).

In practice, beyond breastfeeding counselling, there is little, if any, education for families on appropriate feeding options (interview, Dr Neil McKerrow, Head: Paediatrics & Child Health, Department of Health, KwaZulu-Natal and chair of the Ministerial Committee on Child Mortality). Notably, there is little meaningful effective child-nutrition-focused community-based outreach taking place, other than in KZN (DOH; DSD; DPME, 2014). It is not only the DOH's outreach workers that are not providing sufficient child-nutritional support, education and counselling. The same criticism applies DSD and the DOA's outreach workers (DOH; DSD; DPME, 2014).

There is also little monitoring of the coverage and quality of the nutritional education, counselling and support provided at clinics and by CHWs. The data that is available points to poor implementation of the policies and programmes.

6.1.11.2 **Inadequate access to social protection services to address the social and economic determinants of health and to ensure food security:** 45 percent of households are food insecure, 28 percent are at risk of hunger and 26 percent experience hunger (Shisana, et al., 2013). There is poor access, among especially vulnerable children, to key national social protection services to support food security. For example, access to the CSG is low (and has been for a number of years) among poor caregivers of children under the age of one year and other vulnerable children (SASSA and UNICEF, 2013).

6.2 Underlying systemic issues

There are a number of underlying systemic causes driving the preceding deficiencies in the current health system.

The health system is not merely the country's health facilities and health professionals. A health system is defined by the WHO as consisting of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence the determinants of health as well as more direct health-improving activities. [It] is therefore more than a pyramid of publicly-owned facilities that deliver personal health services. It includes for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control programmes; health insurance organisations; occupational health and safety legislation. It includes intersectoral action by health staff, for example encouraging … female education – a well-known determinant of better health (WHO, 2007)

To address the rights of children to the best attainable standard of health requires the provision, through the public health system, of a comprehensive suite of health promotive, preventative, curative and palliative services which are appropriately designed and targeted to respond to the needs of especially vulnerable children. To meet this requirement, the services in question must be:

1. Available through the national health legal, policy and programmatic framework and health system infrastructure and resources
2. Accessible to all, including the most marginalised – meaning that the system must recognise and address barriers to access
3. Adaptable in terms of their design to meet the needs of children's different circumstances and associated risks
4. And of a sufficiently high quality (UN Committee on the Rights of the Child, 2013).

Ensuring universal availability and equitable access to a comprehensive suite of curative and promotive health care services requires their sustained availability, quality control and public resourcing. This in turn depends on the services in question being fully integrated / embedded within the national health system – within the operational foundations of the health system as identified by the WHO (WHO, 2007):

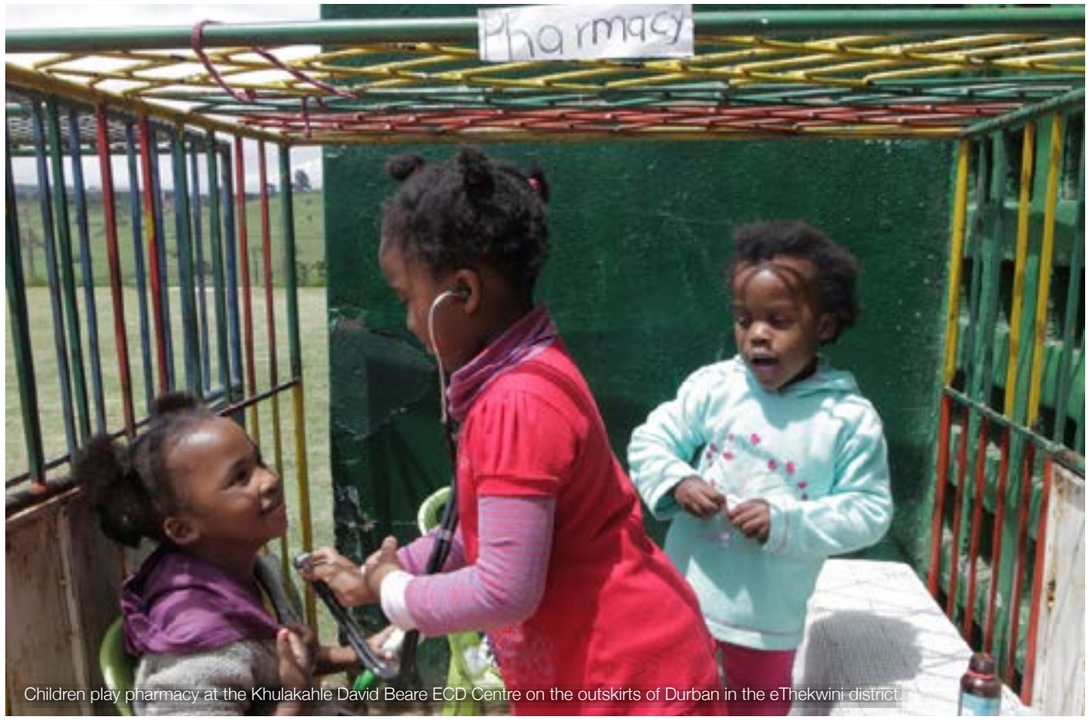
- Service delivery platforms (especially PHC platform)
- Health workforce
- Information systems
- Medical products, technologies and infrastructure
- Funding and budgets
- Leadership and governance

Measured against these criteria, the following policy and programme gaps and implementation deficiencies drive the current poor and inequitable health outcomes for children in South Africa:

6.2.1 Policy and programme gaps:

Whilst South Africa does have a comprehensive policy and programmatic framework in place (on paper) and the bulk of the child health and nutrition deficits are attributable to implementation challenges, there are a number of policy and programme content gaps. A number of essential services are not available through the public health system. These include:

1. Screening for maternal mental health, substance abuse and abuse of women and children and accompanying referral protocol, follow-up and monitoring (Draft National ECD Policy and Programme (RSA) , 2014) (Saloojee, 2014) (MRC; University of Pretoria; University of Cape Town, 2009).
2. Focussed community-based parenting support programmes aimed at ensuring the health, nutrition and development of young children of especially vulnerable caregivers – those of children with disabilities, teen mothers, mothers with substance abuse problems, those living in extreme poverty (Draft National ECD Policy and Programme (RSA) , 2014).
3. A national multi-sectoral prevention of stunting (chronic under nutrition) and prevention of child overweight and obesity policy and supporting programmes (DOH; DSD; DPME, 2014) (Draft National ECD Policy and Programme (RSA) , 2014).
4. A maternal feeding policy and programme to address the food security of vulnerable pregnant women (H Saloojee, 2012).
5. Inadequacies in the labour law framework protecting and supporting the rights of working women to continue breastfeeding once they return to work.
6. A multi-sectoral comprehensive and dedicated childhood disability prevention, screening and rehabilitation policy and programme for children (Slemming, Developmental difficulties and disabilities: Background paper for draft national ECD programme, 2014).



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Children play pharmacy at the Khulakahle David Beare ECD Centre on the outskirts of Durban in the eThekwini district.

7. The Integrated Nutrition Policy for South Africa is not supported by a programme outlining the roles and responsibilities of different sectors to preventing under-nutrition in children and there are no budgets and accountability mechanisms to ensure fulfilment of responsibilities. It is also not aligned to the Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa. As a result, there is:
    i. No clarity on the role of different departments identified in the INP for securing the nutritional well-being of pregnant women and children;
    ii. no overarching policy / programme of action governing the health and nutrition role of health and non-health sector community outreach workers and no common training curriculum for all maternal and child community workers to secure the comprehensive health of pregnant women and young children;
    iii. no standard referral protocol (and systemic partnerships other than in KZN) aligned with other household profiling initiatives (such as War Room on Poverty) for the identification of vulnerable households with pregnant women and young children and to ensure their food security and access to nutritional support and services.

6.2.2 Inadequate quantities and quality of infrastructure, human resources and supplies

Coverage and quality deficiencies are driven by human and financial resource and management deficits. Deficiencies are particularly problematic at PHC and community outreach level resulting in:

1. Inadequate skilled professionals such as paeditricians, therapists, and nutritionists places an onerous burden on nursing staff. The problem is particularly acute in rural areas.
2. PHC staff lack the time and skills to provide essential maternal and child health, development and nutrition (notably screening and prevention) services in the right quantity and quality. Poor quality is aggravated by lack of human resource systems for monitoring quality, quantity and coverage of relevant prevention and screening services as part of the performance management and improvement system (Martin, P, 2014).
3. The attitudes, lack of knowledge of young people's rights, prejudices and discriminatory practices of health care professionals in relation to the provision of sexual and reproductive health care services to young people is a key barrier to access to these services (O'Reilly & Washington, 21 August 2012).
4. Community health workers have been introduced to augment human resource deficits. However their case load and spread of responsibilities may be too onerous to allow for effective provision of quality community-based child-health promotive and preventative health and nutrition support and services for vulnerable caregivers and children. Their performance is not monitored and improved (Draft National ECD Policy and Programme (RSA) , 2014).
5. Inadequate budgets and supplies result in stock-outs and few, if any community-based services or the provision of rehabilitative nutritional and disability services and assistive devices (TAC and Section 27, 2014) (Martin, P, 2014).

6.2.3 Inadequate development and implementation of programmes supporting key maternal and young-child nutritional health and development

Whilst there are many recent policies aimed at improved nutritional health and well-being of young children, such as the Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa (2012), these have not been adequately translated into well-articulated, evidence-based, and adequately resourced programmes.

Current programmes neglect education at a home and community level, and in terms of current messaging, are limited in the main, to issues of exclusive breastfeeding. There is no evidence-based, adequately funded and monitored comprehensive (public and parenting) child health and nutrition behaviour-change /education campaign.

In addition to the absence of a dedicated campaign, there are many missed opportunities for education and behaviour change advocacy given the failure to integrate routine education and awareness-raising on maternal self-care, hygienic practices at home, breastfeeding and nutrition, the importance of the 1st 1000 days, recognition of the signs of childhood illness and appropriate responses into all maternal and child-health services of (DOH; DSD; DPME, 2014) (Draft National ECD Policy and Programme (RSA) , 2014)

What is required is the development of a comprehensive Infant and Young Child Feeding (IYCF) programme which has an evidence-based Information, Education and Communication strategy focused on behavior change

in homes and communities (Correspondence, Chantell Witten, UNICEF nutrition specialist) interview, Dr Neil McKerrow, Head: Paediatrics & Child Health, Department of Health, KwaZulu-Natal and chair of the Ministerial Committee on Child Mortality).

6.2.4 Inadequate collaborative institutional and governance arrangements to secure coordination within and across the health and other sectors.

Fulfilment of the GRSA's obligation to ensure that the health system is capable of, not only securing the absence of disease, but also children's optimal requires a multi-faceted health system which addresses not only the clinical, but also the social and economic determinants of health and developmental and health promotive interventions such as education and awareness-raising. This in turn requires a comprehensive health system which provides a holistic suite of services through integrated health delivery platforms – an outcome which is only possible through effective and strong coordination mechanisms and collaborative institutional arrangements.

The inadequacy of the current collaborative institutional arrangements, governance and accountability mechanisms results in insufficient integration of essential promotive and preventative services into routinely available child-health services (Massyn, et al., October 2013). There are few, if any examples of integrated interventions that have been taken to scale. Integration is largely NGO-driven on a small-scale (Slemming & Saloojee, Beyond survival: The role of health care in promoting ECD, 2013).

It further results in little collaboration with NGOs and CBOs and government to secure community-based nutritional support for pregnant women and children (DOH; DSD; DPME, 2014).

6.2.5 Insufficient political will to support a paradigm shift to a child-health promotive system

The national health system has focussed almost exclusively on improving its child survival rates – given the pressure brought to bear through the MDGs and related global and continental initiatives which have prioritised child survival over and above child development. Child health has thus remained largely trapped within the "absence of disease" paradigm. There has been a neglect and resultant failure to integrate and take to scale many child-health promotive and well-being interventions. As a result, the more clinical health services are better mainstreamed and prioritised than health promotive parent support and behavioural change interventions (DOH; DSD; DPME, 2014) (Slemming & Saloojee, Beyond survival: The role of health care in promoting ECD, 2013) (interviews, Wiedaad Slemming, WITS University & Sue Philpott, DART).

This is in itself fuelling the intergenerational cycle of poor health – poverty- low literacy – poor personal growth and development – poor national development - persistently high infant and child morbidity and mortality rates (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014) (Slemming & Saloojee, Beyond survival: The role of health care in promoting ECD, 2013).

Whilst there are a number of principled statements at a health policy level acknowledging the importance of, and committing to a health promotive system, there has been little legislative, programming and budgetary support translating these sentiments into concrete action. Thus, for example, whilst the National Development Plan as well as the national Department of Health's Strategic Plan recognise the importance of refocussing the health system within a child-health promotive framework, the realisation of this broad goal is not reflected at the highest political level. The DOH's Strategic Plan and Annual Performance Plan identifies the overarching purpose of the HIV/AIDS, TB, Maternal and Child Health Programme as, not only reduced maternal and child mortality, but also securing the optimal good health of children, adolescents and women. Yet when one turns to the key indicators of the Plan and national political platforms supporting priorities, child development and optimal health measurements (and hence resources and accountability) for improved child development outcomes are absent. For example, the GRSA's recently published Medium Term Strategic Framework which highlights the priority issues, interventions and goals for the next five year period across all relevant sectors, including health. The targets for child health in the MTSF remain focussed on child survival (reduced mortality), with no child development targets identified.

A recent diagnostic of early childhood development in South Africa noted that a key impediment to an effective multi-sectoral and comprehensive ECD system in South Africa is the health sector's failure to align itself with the broader ECD imperative (The Presidency: Department of Performance, Monitoring and Evaluation, 2012). Whilst South Africa has a national integrated ECD plan with cross-sectoral objectives, outcomes and indictors, including for the health sector; health sector policies, plans and reports make no mention of the integrated plan and

showed no evidence of planning and accounting within the national ECD framework.

It is increasingly recognised that for a meaningful shift towards a child health promotive paradigm to take place, the child health system must identify with, and support the realisation of the objectives of the broader national early childhood development framework. This may be achieved through the "hearts and minds" integration of interventions within the health system which are promotive of the optimal development of young children so as to make them universally available, adequately resourced and of routinely evaluated to ensure coverage and quality. The Department of Health should, as should all other role players responsible for ECD, be a party to, and be held accountable within the ECD framework for promoting the optimal physical, mental, social, emotional and cognitive health and development of young children, and not merely their survival (Slemming & Saloojee, Beyond survival: The role of health care in promoting ECD, 2013).

7. PRIORITISING HEALTH CARE SERVICES FOR CHILDREN

As we approach the 2015 MDG deadline there are clearly multiple gaps, issues and concerns contributing to the avoidable deaths and poor health of children in South Africa as well as their rights to health care services and adequate nutrition. The question for Save the Children South Africa is which of these issues merit support; which of the issue are catalytic, innovative and likely to yield lasting and sustainable results for the survival and development of children in South Africa.

Guidance may be sought from the issues prioritised by the GRSA as well as the international and continental development community on the grounds of their ability to drive the survival and development of children as well as the broader post-2015 goals of reducing poverty and inequality.

A number of common priorities emerge from various rights and development documents charting the way forward to 2015 and beyond. They all contribute to the overarching post-2015 Sustainable Development Goal (DSG) recently articulated by the UN General Assembly – that is ensuring healthy lives and promotion of well-being for all at all ages by 2030 (United Nations General Assembly Working Group on Sustainable Development, 2014).

There is growing consensus that attainment of this development-focussed goal for children requires that:

a. Health systems must be strengthened to accelerate attainment of the child survival MDGs such as reductions in the infant, neonatal, child and maternal mortality rates. This requires increased investments and accountability of the GRSA for improved and equitable access, improved quality and efficiencies in health services which address avoidable causes of child and maternal morbidity and mortality (United Nations General Assembly Working Group on Sustainable Development, 2014) (The Global Thematic Consultation on Health, April 2013) (The Consultative Group on Early Childhood Care and Development, 2014) (The African Child Policy Forum, 2013).
b. Strengthening clinical programmes will not however be sufficient to sustain development and reduce poverty and inequality. Health systems must also be strengthened to secure universal quality health promotive services for optimal child development and the prevention of diseases, with a particular focus on the social, economic and environmental determinants of child health mortality (United Nations General Assembly Working Group on Sustainable Development, 2014) (The Global Thematic Consultation on Health, April 2013) (DOH (APP), 2014) (Draft National ECD Policy and Programme (RSA) , 2014) (The African Child Policy Forum, 2013).
c. Progress must be made on reducing health inequities, including the provision of tailored programmes to compensate for deficits of children who are especially vulnerable children to poor development and health outcomes. This includes children with disabilities, children of teenage mothers, and children of mothers with substance abuse problems or suffering from a disability or chronic illness, including mental illness and HIV and AIDS (The Global Thematic Consultation on Health, April 2013) (The Consultative Group on Early Childhood Care and Development, 2014) (The African Child Policy Forum, 2013) (Draft National ECD Policy and Programme (RSA) , 2014) (The National Development Plan 2030: Our future - make it work, 2012).
d. The post-2015 agenda continues to highlight the need to address malnutrition. It not only emphasises the eradication of starvation and acute malnutrition, but places the spotlight on the prevention of stunting and interventions to secure sufficient daily food to ensure the development of children, pregnant women and adolescent girls mortality (United Nations General Assembly Working Group on Sustainable Development, 2014) (The Global Thematic Consultation on Health, April 2013) (DOH (APP), 2014) (Draft National ECD Policy and Programme (RSA) , 2014) (The African Child Policy Forum, 2013) (The National Development Plan 2030: Our future - make it work, 2012).
e. There is an increasing recognition that sustaining the developmental benefits of increased investments in health care requires the provision of support and services within the first 1000 days – the period from conception until children reach the age of two years. That is to say, that health services must secure optimal early childhood development (The National Development Plan 2030: Our future - make it work, 2012) (Draft National ECD Policy and Programme (RSA) , 2014) (The Global Thematic Consultation on Health, April 2013) (The African Child Policy Forum, 2013) .
f. Furthermore, alongside the emphasis on promotive and preventative health care, there is a recognition that universal access to these services requires a strong and well-resourced PHC system delivered at a home and community-level (DOH (APP), 2014) (GRSA MTSF, 2014).
g. Notable promotive, preventative and curative interventions highlighted include parenting support and education, environmental health services such as water and sanitation, the identification and provision of treatment of substance abuse and mental illness, the provision of sexual and reproductive health services notably aimed at preventing teen pregnancies, and nutritional and food security services.

7.1 Key post-2015 child-health rights and development documents and their priorities

Key Un General Assembly's health and nutrition SDGs: By 2030

- Reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- End preventable deaths of newborns and children under five
- End the AIDS epidemic, TB and combat water-borne diseases
- Strengthen prevention and treatment of substance abuse
- By 2020, halve deaths and injuries from road traffic accidents
- End hunger, achieve food security and improved nutrition and sustainable agriculture.
- All people, in particular children and infants must have access to safe, nutritious and sufficient food all year round
- All forms of malnutrition must be eradicated, especially stunting and wasting in children under 5 years (with all targets met by 2025) and the nutritional needs of adolescent girls, pregnant and lactating women must be met.

The UN Platform on Social Determinants of Health and the Global Thematic Consultation on Health:
Accelerate initiatives to achieve reduced maternal and child mortality, but also focus on development of children for long term resolution of the issue, particularly with a focus on social and economic determinants of health and development (The Global Thematic Consultation on Health, April 2013) (UN Platform on Social Determinants of Health).

The UN Consultative Group on Early Childhood Care and Development:
Early Childhood Development (ECD) is the foundation of Sustainable Human Development for 2015 and beyond. Whilst progress has been made to increase child survival, child development has been neglected on the development agenda. Young children have the right beyond survival to thrive and contribute to sustainable communities and workforce. The post-2015 agenda must address this gap. ECD is the foundation of sustainable development and is not a single intervention – it includes health, education, and nutrition. It is provided through, inter alia, parenting support services, early detection and intervention to address developmental delays and disabilities, targeted health, nutrition and social protection as well as early learning (The Consultative Group on Early Childhood Care and Development, 2014)

The African Child Policy Forum:
In Africa, in moving beyond 2015, governments need to scale up universal access to public health services to reduce, especially preventable child deaths and must address the socio-economic determinants of child health, notably water and sanitation services. In addition, priority must be given to reducing the prevalence of stunting through multi sectoral actions. Governments must invest, not only in maternal and infant nutrition, but also "hidden hunger" – stunting due to insufficient vitamins and minerals) and must ensure that child nutrition is integrated into, not only health's, but other sectoral interventions, such as agriculture, education and social protection (The African Child Policy Forum, 2013).

The National Development Plan: Vision 2030
Focusses on health promotion as the foundation for sustainable development, notably through interventions

to improve the nutritional well-being (with an emphasis on the prevention of stunting) and addressing social and economic determinants of poor health, notably in the first 1000 days.

The Medium Term Strategic Framework 2014 – 2019: The MTSF emphasises the need to accelerate interventions to reduce infant and child mortality through, inter alia:

- Improved access and quality of child-health services
- Expanded and re-engineered PHC, including the acceleration of pace and increase in numbers of ward-based PHC outreach teams
- Strengthened HIV and AIDS and TB prevention and management programmes
- Expanded access to sexual and reproductive health through improved availability of contraception
- Reduced unwanted pregnancies, with a special focus on teenage pregnancies (GRSA MTSF, 2014).

8. ORGANISATIONS ENGAGING WITH THE ISSUES

A number of the priority issues and underlying causes are currently addressed by various civil society organisations.

Focus areas of organisations working in the relevant areas of maternal and child health include:

1. **Systems and infrastructure monitoring and strengthening to improve access to and the quality of essential clinical services at a facility-level for treating avoidable causes of infant and child-death.**

Large organisations such as PATH (sites.path.org), the WHO (WHO, 2013), UNICEF and USAID are supporting systems strengthening in the way of infrastructure, capacity building, management of the IMCI protocol and neonatal care.

PATH supports the reduction of maternal and child mortality through improved technology and systems strengthening at public health facilities. It focusses on the use of technology in labour, effective management of 3rd stage labour, and the introduction of cost-effective and simple neonatal resuscitation devices.

The WHO works closely with the national DOH to strengthen systems and resources to improve the quality of services for women and children at a facility level. It supports the implementation of the NHI, the development of the national health regulatory authority and improvements in the numbers, skills and distribution of human resources. For example, it has strengthened human resources by providing on-line training on the IMCI protocol.

At a programme level, the WHO focuses on strengthening HIV and AIDS interventions and immunization coverage.

Organisations such as S27 and TAC monitor infrastructure and resources in the health system. This is not however specifically for children.

USAID's ASSIST project – Applying Science to Strengthen and Improve Systems supports the strengthening of health systems, health environment and behaviour change in the areas of maternal, newborn and child health, HIV and AIDS, Reproductive health and family planning, food and nutrition, and vulnerable children and families.

In the areas of maternal and child health its supports the strengthening of facility-based care and systems to improve neonatal care.

Zoé-Life focuses on infant and child feeding, IMCI and HIV and AIDS systems strengthening specifically within the context of supporting the DOH to implement and scale up the MCWH programme.

At a facility-level, it supports improved implementation of the IMCI protocol through training and technology. In terms of infant and young child feeding, it has supported UNICEF and the KZN DOH to roll out the Infant and Young Child Nutrition Guidelines. It has supported this through the development of training material and monitoring and evaluation system to train and mentor 3 800 health care practitioners from the DOH to implement the guidelines at a facility level.

2. **Developing and piloting integrated community- and home-based programmes for the provision of health promotive and preventative health and nutrition services to pregnant women and young children**

Zoé-Life supports the scaled up implementation of the infant and child feeding, IMCI and HIV and AIDS components of the DOH's MCWH programme at a local level through the development and implementation of integrated community responses involving households, schools, health facilities and children that are drawn in project planning and implementation.

PATH's Window of Opportunity Project is a collaborative initiative involving government and civil society aimed at improving the quality and range of clinical and community-based services in the first 100 days through integrated inter-sectoral models of care to support the health and nutritional development of children.

Ilifa Labantwana in KZN, the North West and the Eastern Cape is working to systematize and provide training and support to specialist maternal and child health workers and achieve better integration of maternal and child health services, including nutrition, parenting support and maternal mental health and developmental screening into health and other ECD programmes.

UNICEF has supported the DOH to build the skills of community based workers to deliver Road to Health Booklet health services and improve referrals to fixed health facilities.

The Philani Maternal, Child Health and Nutrition Project has developed a home-based maternal, child health and nutrition model, the Philani Mentor Mother Project. It has been piloted in the Eastern Cape to test its effectiveness. It targets pregnant women and children up to the age of 6 years. Malnourished children are identified by the Mentor Mothers who provide home-based health, nutritional and protective care to the families and communities.

Mothers 2 Mothers trains, employs and empowers mothers living with HIV. It is establishing a mentor mother programme in 7 districts in 5 provinces which will be run by local communities. Whilst it previously focused on HIV and AIDS, the new programme will expand beyond HIV to include the provision of education, support and referrals on a wider range of health issues including TB, malaria, cervical cancer, immunizations, family planning, reproductive health, nutrition and GBV.

3. **Developing and piloting integrated maternal screening, treatment and education programmes for mental illness and substance abuse**

SANCA Western Cape runs a FAS programme which reaches about 6000 women and children in vulnerable high risk communities – living in poverty in predominantly farming and rural areas. Social workers that provide information to affected women and mobilizes and capacitates community service providers and members to spearhead information and community advocacy (SANCA Western Cape, 2014).

The Perinatal Mental Health Project is working partnership with the DOH in KZN to develop and pilot a mental health screening tool to be integrated into maternal health services.

Nutrition Information Centre, University of Stellenbosch provides evidence-based information on issues such as FAS (NICUS, Undated)

4. **Behaviour change and communication campaigns to advance maternal and child health and nutrition**

MAMA – Mobile Alliance for Maternal Action – launched a project in 2013 using mobile technology to reach women with appropriate age and stage-based health messaging for their and their children's benefit. IT promotes ANC, HIV treatment, the prevention of HIV transmission to babies, encourages health household practices during pregnancy and the first year of life. The project aims to reach 500 000 mothers.

The DOH has recently announced that it is launching a similar cell-phone based information service called MomConnect. It is expected to register all pregnant women in the country for an SMS service which provides information and advice on pregnancy, encourages early ANC, as well as a channel to notify the department about poor service (http://www.health.gov.za).

The WHO promotes the adoption of cost-effective behaviour-change measures for the promotion of healthy dietary choices and weight reduction (not specifically for children)

5. **Sexual and reproductive health for adolescents, with a focus on preventing risky behaviour, HIV and AIDS and teen pregnancies**

Pathfinder International (http://www.pathfinder.org) promotes access to youth-friendly sexual and reproductive health services through increasing availability, advocacy to address community and cultural norms and attitudes, and building local capacity.

Lovelife has a number of programmes, largely within the context of HIV and AIDS aimed at promoting access to youth-friendly sexual and reproductive health services.

Sonke Gender Justice runs a programme on sexual and reproductive health which focuses on awareness-raising and behaviour change advocacy aimed at the prevention of teenage pregnancy.

6. The integration and strengthening of programmes aimed at the prevention and treatment of HIV and AIDS in children

Many of the child-health programmes have a stronger focus on integration of services into the health system, from primary through to tertiary levels, of interventions to prevent the transmission and treatment of HIV and AIDS in children.

For example, PATH's Khusela project in the Eastern Cape involves working with the DOH to integrate PMTCT into routine antenatal, maternal and paediatric care.

The WHO is supporting the NDOH to develop a National Strategy on Community Mobilisation for PMTCT to address late ANC booking.

UNICEF supports the integration of PMTCT into maternal and neonatal care. It works with the DOH and other partners to develop a comprehensive programme of services to protect children from HIV and prolonging their lives.

MatCH – the Maternal, Adolescent and Child Health Divisin of the WITS Health Consortium provides evidence-based information and support for health system's strengthening, capacity building and technical support for the provision of HIV and AIDS programmes for the benefit of children. Initiatives include:

- Supporting delivery of ARVs at PHC level
- Integration of PMTCT into maternal and child health services
- Training on HIV
- Infant feeding in the context of HIV
- Outreach programmes for HCT, TB and CD4 screening
- Training to community based caregivers on HIV, TB and STIs.

AMREF Health Africa provides care and support for children made vulnerable by HIV and AIDS in Limpopo and KZN. It works with traditional healers and provides training to community based organisations promoting HIV support.

Kheth 'Impilo (formerly ARK) provides support for the implementation of the child-specific components of the NSP.

The Yezingane Network is a network of organisations that engages in monitoring and advocacy on numerous issues related to HIV and AIDS and children.

Priceless SA does research on cost-effective infant feeding practices to prevent the transmission of HIV to infants.

Lovelife has a number of behaviour-change programmes, largely within the context of HIV and AIDS aimed at, preventing risky behaviours and promoting health and positive practices to prevent the transmission of HIV.

7. Initiatives aimed at integration of quality disability prevention, screening and treatment services within the health system

PATH is developing a model package of evidence-based interventions which includes child development assessments (and is rolling out in districts in 4 provinces Gauteng, KZN, Mpumalanga and the NC)

Orbis Africa is advocating for a national prevention of childhood blindness programme which includes relevant advocacy.

Deaf SA conducts research and advocacy for support and services for children who are deaf.

8. Research into health issues and solutions and advocacy for evidence-based policy change

PATH is conducting an assessment of maternal and child health problems and needs in 4 selected provinces and districts (Gauteng, KZN, Mpumalanga and the Northern Cape).

The Child Health Unit within the Department of Paediatrics and Child Health ay UCT (www.uct.ac.za/depts/chu/nut.htm) conducts research and provides evidence and engages in advocacy in the areas of child disability and nutrition. Specifically in the areas of nutrition, its aim is to ensure that policies and programmes promote the nutrition of women and children in South Africa. Its focus is on action research to inform the development of cost effective nutrition policies and programmes integrated within the PHC context.

Perinatal Mental Health Project (UCT) conducts research and engages in advocacy for the provision of quality and accessible mental health services for vulnerable women, including pregnant women.

WITS Paediatric Unit has some PHD students doing studies on implementation of developmental screening, but this is not part of a broader systemic review and monitoring of integrated developmental screening.

9. SUMMARY OF PRIORITY CHILD-HEALTH AREAS NOT RECEIVING ADEQUATE ATTENTION

Generally, it would appear that NGO activity in the health sector is weighted in favour of system's strengthening at a facility level to address child survival issues. At the same time, this is where government's energy has also been directed, with a variety of programmes and significant budgets directed at strengthening health system inadequacies.

On the whole, inadequate attention has been paid, at an NGO and government-level to the development, implementation, monitoring and resourcing of home and community-based programmes targeting the leading causes of child morbidity and mortality – notable nutrition, common childhood illnesses, disability and sexual and reproductive health programmes outside of the HIV and AIDS context.

This does leave a number of gaps in the broader child health advocacy arena with key developmental issues not receiving sufficient attention. Strategic gaps include:

1. Insufficient advocacy for raising the political profile and support for a child-health development, rather than a child-survival agenda as the foundation of the health system. There is a need for advocacy across the sector for the reorientation of the health system to serve as a primary vehicle for early childhood development.

2. A focused multi-sectoral maternal and child nutrition and food security agenda and associated programmes (including parenting support, education, communication, technical support, social and economic support) which promote the optimal nutritional well-being of pregnant women and children, with a specific focus on the first two years, so as to prevent wasting, stunting and promote the optimal growth and development of young children. Current NGO nutritional interventions are embedded within multi-focused community-based programmes which address multiple issues, resulting in child nutrition becoming lost or losing meaningful focus. Where it is a primary focus area, it is often within the limited context of PMTCT.

3. Parenting support and public education programmes for optimal health and nutrition of children have not been developed, piloted and scaling up pursued through evidence-based advocacy.

4. There are a number of programmes supporting the strengthening of the quantity and quality of community-based maternal and infant health and nutrition support and services. However they seem to be duplicating efforts, focusing on a limited number of services and issues, and not feeding into a broader national framework for the regulation and provision of quality specialised maternal and child services.

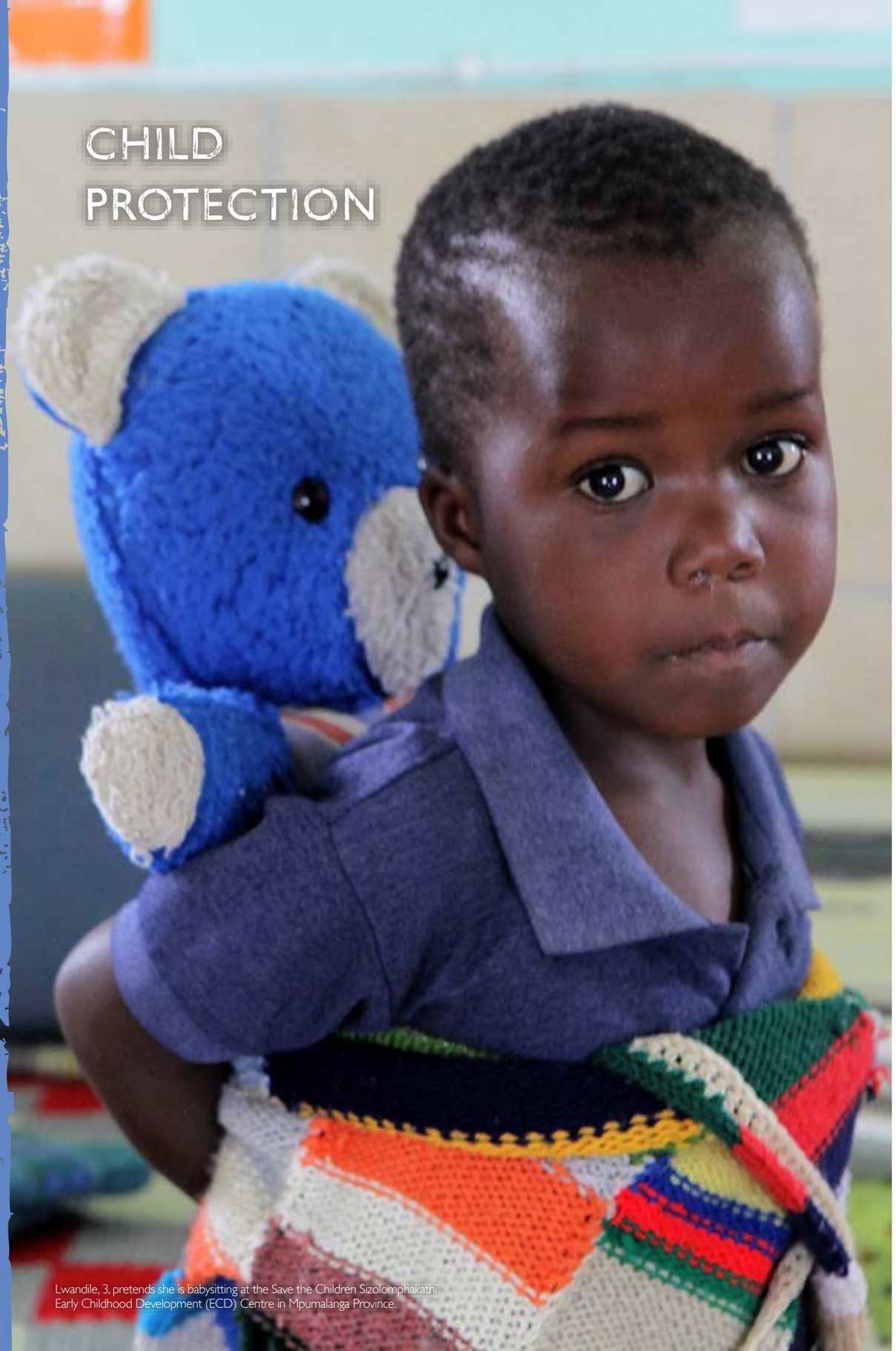
5. Whilst there are a few pilot projects for maternal screening, treatment and education for depression and substance abuse, there appears to be inadequate monitoring of programmes, results and advocacy for scaling up and integrating these interventions by the NDOH.

6. The prevention, early screening and treatment of developmental delays and disability in children from before birth and in the first years of life is dealt with in a piece-meal fashion, with advocacy revolving around specific forms of disability. There appears to be an advocacy gap in driving a child-focused disability prevention, early screening and treatment strategy as an integral and effective part of the health system at all levels.

7. A number of organisations are pursuing youth-friendly sexual and reproductive health. However, this is often within the context of HIV and AIDS, rather than the family planning and rights-based context.

8. Few organisations are pursuing the social and economic determinants of health, such as improved access to water, sanitation and appropriate social grants such as the CSG and CDG within the health context.

9. The non-government health sector organisations appear to be operating independently of each other, with little coherence and coordination to ensure coverage and synergy to address the most common and pressing child health issues. There is a need for better coordination and synergy among NGOs in the sector, with NGOs form other sectors and government departments.



Lwandile, 3, pretends she is babysitting at the Save the Children Sizolomphakathi Early Childhood Development (ECD) Centre in Mpumalanga Province.

C. CHILD PROTECTION

1. BREAKTHROUGH / PRIORITY OUTCOMES AND OBJECTIVES FOR SAVE THE CHILDREN

Breakthrough / priority outcome for Save the Children: All children thrive in a safe family environment and no child is placed in harmful institutions

Priority objectives:

1. Children in, or at risk of requiring alternative care
    a. Children at risk benefit from appropriate care / good quality services either in the family or in family or community-based alternatives
    b. Children on the move have better access to care and protection systems
2. Physical and humiliating punishment – violence against children in the home, community and institutions
    a. Government bans physical and humiliating punishment in all settings
    b. Public attitudes no longer accept physical and humiliating punishment
    c. Parents / caregivers and teachers practice positive discipline
3. Children and work / child labour – the elimination of harmful work and economic exploitation of all children, particularly children involved in, or at risk of harmful domestic and agricultural work through:
    a. Access to services and support for children at risk of harmful domestic work to minimise risk factors
    b. Access to education for children involved in agricultural work
    c. Engagement of the private sector as a partner.

2. RESPONSIBILITIES OF THE GOVERNMENT OF THE REPUBLIC OF SOUTH AFRICA

2.1 Legal obligations and commitments

National Plan of Action for Children 2012 – 2017, RSA's goal: To create and sustain a safe, supportive and caring environment for all children in their homes, communities, schools and within institutions.

The international, regional and national legal framework obligates the government to take all necessary steps to ensure that children are protected from all forms of abuse, neglect, violence and or exploitation while the child is in care of his or her parents or any person who has the care of the child.

Such steps include legislative, administrative, social and educational measures and must include[3]:

1. Laws that prohibit, criminalize and sanction abusive, exploitative and neglectful behavior in all settings
2. Primary prevention measures that address the underlying social and economic causes of violence, neglect and exploitation in the home and other care settings. This includes the provision of material support to address poverty and other stress factors in the home and measures to reduce the availability of weapons and reduce levels of alcohol and substance abuse in homes and communities.
3. The provision of educational and psychosocial support to parents caregivers to enable them to know and respect, protect and fulfil their children's rights to protection and to practice positive parenting and care-giving
4. Education of the public, community members, parents, other caregivers of children promoting positive protective care practices and that address harmful attitudes, practices, customs, and behaviours which drive abuse and exploitation of children through public information campaigns and specific training of persons working with / or caring for children
5. A child protection system that protects children

[3]The state's obligations are documented in, inter alia, the UN CRC, the ACRWC, the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography; The UN Committee on the Rights of the Child's General Comment 13, The Rights of the Child to Freedom from all Forms of Violence and General Comment 8 (2011), The Right of the Child to Protection from Corporal Punishment and other forms of Degrading Punishment (2006) and ILO's Convention on the Elimination of the Worst Forms of Child Labour (199), and the Constitution of the Republic of South Africa.

who have experienced abuse, neglect or exploitation from further harm through the provision of early identification, intervention and child protection services, as well as a justice system to prosecute offenders

6. The provision of therapeutic services to victims of violence to restore their physical and psychological health, and
7. Special programmes protecting children whose circumstances make them additionally vulnerable to violence, abuse and exploitations, such as those living without parental care, on the streets, children on the move, children with disability, and children in conflict with the law.

2.2 Key factors driving the risk of neglect, violence and exploitation of children

A host of, often underlying co-occurring factors, create potentially unsafe home, community and institutional environments where there is a high risk of abuse, neglect and exploitation of children. These include:

- Poverty
- High unemployment levels
- High levels of substance abuse
- High levels of gangsterism and availability of weapons
- Gender inequality and harmful stereotypes
- Harmful cultural and religious beliefs, attitudes and practices
- Fractured families with high numbers of children living without their biological parents
- High numbers of refugee children entering the country, many without adult caregivers
- Societal acceptance of violence and authoritarian discipline

(Department of Women, Children and People with Disabilities and UNICEF, 2012) (Pan: Children, 2012) (Ward, Dawes, & Merwe, 2011) (Jewkes, et al., 2009) (Martin & Mbambo, 2011) (Townsend & Dawes, 2004).

2.3 Required ecological response

An effective response to the underlying and interrelated matrix of social, economic, cultural and related causes requires the development, resourcing and implementation of an ecological child protection system (Jewkes, et al., 2009) (Ward, Dawes, & Merwe, 2011). That is to say, a system that cuts across sectors to provide the necessary continuum of services and support to children, families, communities and care-givers in institutional settings such as schools and residential facilities to:

- Increase the capacity of caregivers to provide positive care and protection
- Minimize the social, economic, psychosocial and cultural risks associated with high levels of child maltreatment
- Facilitate early identification and intervention
- Provides quality therapeutic and reintegration services; and
- Justice for child victims.

3. SITUATIONAL ANALYSIS: PROGRESS MADE/ LACK OF PROGRESS IN THE PROTECTION OF CHILDREN IN SOUTH AFRICA

3.1 Legislative measures taken

Various laws and policies have been developed in furtherance of the preceding obligations. These include the:

- Children's Act No. 38 of 2005
- Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007
- Child Justice Act No. 75 of 2008
- Domestic Violence Act No 116 of 1998
- Prevention of Family Violence Act No. 133 of 1993
- The South African Schools Act No. 84 of 1996
- The Abolition of Corporal Punishment Act No. 33 of 1997
- Basic Conditions of Employment Act No. 75 of 1997
- Integrated Social Crime Prevention Strategy, 2011
- Green Paper on Families, 2011

The resultant legal framework creates a national child protection system in terms of which:

- ⇨ Most forms of violence against, and the neglect, abuse and exploitation of children in the home and all other settings is criminalised.
- ⇨ The only form of violence not outlawed in all settings, is corporal punishment. It is outlawed in schools, in the justice system and in all institutions, but not in the home-setting.
- ⇨ There is policy recognition that violence and exploitation of children is driven by underlying social, economic, cultural and religious factors and that to protect children requires the provision of appropriate material, social, educational and psychosocial support to families, communities and in institutional settings.
- ⇨ Legislative provision is made for the development and delivery of appropriate prevention interventions including a duty to register all offenders in national child protection registers, the prohibition of employment of registered offenders in positions involving children, the regulation of the use of firearms, the regulation of the use of and support for substance abusers, and the provision of material, educational and psychosocial support to families and children at risk of violence, neglect and exploitation.
- ⇨ The child protection system obliges duty bearers in positions of care and authority over children to identify children whose home, community or other circumstances place them at risk and to refer them to the formal protection system. These children are defined by the Children' Act as children in need of care and protection and includes, inter alia, children:
  - That have been abandoned or orphaned and are without any visible means of support;
  - Who live on the streets or beg for a living;
  - Are addicted to dependence-producing substances and have no support to obtain treatment;
  - That have been exploited or live in circumstances which may expose the child to exploitation;
  - Who live in circumstances that may seriously harm the child's physical, mental or social well-being;
  - Who are physically or mentally neglected;
  - Who are being maltreated, abused, deliberately neglected or degraded by their parents, a care-giver, or a family member, or a person under whose control the child is.

  Child victims of child labour and children in child-headed households may be, but are not automatically regarded as being in need of care and protection (section 150 of the Children's Act).
- ⇨ Children in need of care and protection and their parents / caregivers are required in terms of the Children's Act and other laws to receive material, social, health and legal services (including early intervention, therapeutic and reintegration services) appropriate to their needs and circumstances to ensure their health, well-being and development.
- ⇨ Where it is deemed necessary by a court of law, children in need of care and protection may, as a measure of last resort, be removed from their families and placed in a residential care setting which is termed a child and youth care centre (CYCC) by the Act (s 158(1).
- ⇨ In terms of the Children's Act, a child may only be placed in a CYCC that is registered with the national Department of Social Development and complies with the norms and standards governing the safety, quality of care and therapeutic programmes provided by the centre to ensure the child's well-being, safety and development.
- ⇨ The Children's Act further aims to secure the protection of children in residential care and their rights to live with and be cared for by their families by limiting the permissible duration of the child's residency. Court orders placing children in residential care may be for no longer than two years and must be reviewed by a court after every two years. Jamieson notes that this "provides a transparent accountability mechanism aimed at ensuring that family reintegration services are being provided and that children are placed back with their families if the reason for their removal has been addressed." (Jamieson, 2014) In addition, in terms of the Norms and Standards, all CYCCs must engage in an internal review of the child's placement every six months to assess if the child's therapeutic programme should be changed or if the child should be reunited with his or her family.
- ⇨ The Act requires that the national and provincial DSDs work together to develop strategies which identify and meet the numerical and geographical need for CYCCs (s 192) and provincial DSDs are required to provide and fund sufficient CYCCs based on their strategies (s 193).
- ⇨ Moreover, in terms of the Children's Act and the CRC's General Comment on Treatment of Unaccompanied and Separated Children outside their Country of Origin, the CYCC strategies must make special provision to secure the rights to alternative / residential care and appropriate material, social, therapeutic and legal support of especially vulnerable groups (Committee on the Rights of the Child, 2005). This includes children with a disability, children with chronic illnesses (s 192(1)) and unaccompanied or separated foreign children outside of their country (Committee on the Rights of the Child, 2005).
- ⇨ The South African courts have ruled that where a child is placed in alternative residential care, the State, rather than the parent is the primary duty-bearer responsible for the rights, care and needs of the child. The State is required to ensure that that their basic needs (such as food, clothing, hygiene and safety) as well as their psychosocial and therapeutic needs are met (Centre for Child Law and Another v Minister of Home Affairs and Others 2005 (6) SA 50 (T) & Centre for Child Law and Others v MEC for Education Gauteng and Others 2008 (1) SA 223 (T) in (Jamieson, 2014).
- ⇨ The criminal justice system provides various forms of protection for children at risk of, or experiencing abuse, including child-friendly and protective investigative and prosecution processes, protection orders, child-friendly courts and aggravated sentences for offenders.

- ⇨ Provision is made in terms of the Child Justice Act for children in conflict with the law to be diverted away from the formal justice / correctional system so as to ensure their protection and development. Children who have been diverted from the justice system or who are awaiting trial may be placed in a CYCC which must provide appropriate material, safety and therapeutic services. In addition, children under the age of 14 years may not be imprisoned, and those older than 14 may only be imprisoned as a measure of last resort.

Thus, it is apparent that, in principle the legal framework makes provision for, and obligates the development and implementation by the State of a range of programmes necessary to cover the legally prescribed child protection elements, including:

1. Prohibitory and regulatory laws
2. Prevention initiatives including the provision of material, psychosocial support and information to raise awareness around rights, remedies and practices related to child abuse, neglect and exploitation
3. Parenting programmes
4. Therapeutic programmes which are responsive to the specific care and development needs of children in different circumstances and at different ages and staged of development
5. Regulated residential care to ensure the safety and development of all children, including those made additionally vulnerable by their circumstances
6. Family reunification and reintegration services, and
7. Protective and prosecutorial processes for victim of abuse, neglect and exploitation through the justice system.

3.2 Key concerns with the national child protection system

3.2.1 High levels of violence, abuse and exploitation of children

Despite the sophisticated legal framework in place, in 2014 South Africa is marked by **very high levels of violence against, and the exploitation of children.** Notably, most incidences of violence, neglect and exploitation of children are perpetrated against them in their homes, communities and schools by the very people obligated to care for and protect them (Department of Women, Children and People with Disabilities and UNICEF, 2012).

3.2.2 Inadequate prevention, early intervention and other statutory services

Prevention, early intervention and other statutory services are inadequate and many children who are at risk of, or who have experienced maltreatment cannot access the child protection system, perpetrators are not prosecuted and children and their families do not receive the necessary health, psychosocial and other therapeutic services necessary to prevent secondary and long-term harm (Proudlock, Mathews, & Jamieson, 2014).

3.2.3 Quality, safety and appropriate duration of alternative residential care

The focus of the child protection system in South Africa is to ensure that children and their families are, as far as possible, provided with the necessary support so that children may remain in their home environments. Where this is not possible and children are at risk of abuse, neglect and exploitation (that is to say, in need of care and protection), the placement of children in alternative residential care is intended to provide a temporary safe solution leading to reunification with their families, or where this is not possible, to place the child in foster care or facilitate the permanent adoption of the child. There are however, significant concerns with the **quality and safety of residential care provided to children removed from their families, as well as the frequency with which children are placed and the long-term duration of their placements** (Jamieson, 2014).

3.2.4 Inadequate protection for especially vulnerable groups

Moreover, a number of groups o**f especially vulnerable children at high risk and in urgent need of child protection services are inadequately protected by the current system.** Notable in this regard are unaccompanied or separated refugee children and other foreign migrant children, as well as very young children and children with disabilities (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014) (DSD, DWCPD and UNICEF, 2012).

3.3 Routine practice and acceptance of violence in homes and institutions

Current statistics reveal very high levels of violence, abuse and exploitation of children. The reported numbers do not reflect the full extent of the problem as many cases of violence, neglect and exploitation are never reported. The data points to:

1. **Very high levels of violence and exploitation among particularly marginalized and vulnerable groups, notably among:**

   - Children in poorer households and communities (Department of Women, Children and People with Disabilities, 2013) (SAHRC and UNICEF, 2014);
   - younger children, especially those under the age of five years (Proudlock, Mathews, & Jamieson, 2014) (Dawes, Kropiwnicki, & Richter, 2005);
   - children in the predominantly rural provinces coinciding with the former apartheid homelands (Department of Women, Children and People with Disabilities, 2013) (SAHRC and UNICEF, 2014); and
   - children with disabilities (DSD, DWCPD and UNICEF, 2012).

2. **High levels of violent crime against children. In 2011/12:**

   - 50 688 children were victims of violent crime
   - 793 children were murdered
   - 758 were victims of attempted murder
   - 12,645 were victims of assault and a further 10,630 were victims of assault with grievous bodily harm (South African Police Service, 2012).

   Many child murders take place in the context of child abuse (including cases of physical and sexual violence and child abandonment), with younger children (under the age of 5 years) especially vulnerable to being killed in the context of child abuse (Mathews S et al (2013) in (Proudlock, Mathews, & Jamieson, 2014).

3. **High levels of violence against children in their homes and schools**

Children in South Africa face routine violence at the hands of their parents, teachers and their peers, especially younger children, children in poorer communities and children living in predominantly rural former homelands (Department of Women, Children and People with Disabilities, 2013).

Corporal punishment is routinely used in homes and schools in South Africa in contravention of the constitutional right to protection and the legislative prohibition against the use of the practice in schools.

A 2005 study found that 57 percent of parents in South Africa used corporal punishment to discipline their children and 33 percent used severe corporal punishment (Dawes, Kropiwnicki, & Richter, 2005). This means that at least one in five children experience corporal punishment in the home and one in three parents uses severe corporal punishment (UNICEF, 2011) (Jewkes, et al., 2009).

Younger children (under the age of five years) are at the greatest risk of being beaten at home (Dawes, Kropiwnicki, & Richter, 2005).

Domestic abuse of women is rife in South Africa. It is estimated that between one third and one half of women have experienced domestic violence and that between 35 – 40 percent of children have witnessed their mothers being beaten and are thus co-victims (Machisa, M et al (2011) and Seedat M et al (2009) in (Proudlock, Mathews, & Jamieson, 2014).

Corporal punishment is a common occurrence in schools affecting millions of children. In 2012, 15, 8 percent of children (approximately 2,2 million) reported having experienced corporal punishment at schools (Statistics South Africa, 2013). Whilst this reflects a slight decline in the practice nationally since 2011 (16, 3 percent), the practice increased in a number of provinces (where the problem has remained persistently high and increased annually since the prohibition). In the Eastern Cape it increased from 25, 2 to 30, 3 percent and in Mpumalanga from 8 to 11, 5 percent. The practice is the highest in predominantly rural provinces falling into former homelands – Eastern Cape (30, 3 percent); KZN (21, 4 percent), Free State (18, 4 percent). It is the lowest in the urban provinces of Western Cape (4, 5 percent) and Gauteng (4, 6 percent) (Statistics South Africa, 2013). A 2012 School Violence in South Africa study found the numbers of affected children to be higher. It found that almost 50 percent of children were beaten at school (Burton & Leoschut, 2013). A local study in the Eastern Cape found that, on average, 90 percent of girls and boys experienced harsh physical punishment before they reach the age of eighteen years (Jewkes et al, 2010 in (Proudlock, Mathews, & Jamieson, 2014).

4. **High levels of sexual violence against children**

Children in South Africa experience very high levels of sexual violence, especially by adults responsible for their care and protection in the home and in schools.

In 2011/12, 25,862 children were victims of sexual offences (40% of all sexual offences) (South African Police Service, 2012).

Many sexual offences take place against children in schools. One in five incidents of sexual abuse take place in schools, with children in rural areas most at risk. One third of rapists are teachers and older children are also often perpetrators of sexual violence at schools (Department of Women, Children and People with Disabilities, 2013) (Centre for Applied Legal Studies and Cornell Law School's Avon Global Center for Women and Justice and International Human Righst Clinic, 2014).

5. High levels of exploitation – children involved in labour

Almost a quarter of South Africa's children are involved in child labour (economic activities) and over 40 percent of them are exposed to hazardous conditions. It is particularly older children between the ages of 12 and 17 years that are involved in these activities (Statistics South Africa, 2011).

In addition, many children are engaged onerous (unpaid) domestic work such as fetching fuel, water and caring for younger siblings. Statistics are not available as to the numbers of affected children. However, it is notably girl-children, especially those in rural areas and in households with ill or deceased caregivers where domestic responsibilities are so severe that they impact negatively on children's other rights, such as the right to education (Department of Labour, 2007 in (Martin, Government-funded programmes and services for vulnerable children in South Africa, 2010).

6. High levels of public, community and household acceptance (and practice) of violence against children

Poor parenting practices, attitudes and beliefs create an environment where children are not adequately protected from harm and support and legitimize the use of violence in the home and other settings such as schools (SAHRC and UNICEF, 2014) (Pan: Children, 2012) (Proudlock, Mathews, & Jamieson, 2014).

More comprehensively, the broader public's attitudes and beliefs are marked by widespread acceptance of violence against children and acceptance that child maltreatment cannot be prevented (Makoae, Roberts, & Ward, 2012).

3.4 Unavailability of prevention, early intervention and other statutory services

3.4.1 Insufficient prevention interventions

Prevention interventions are key to the successful realization of the protection rights of children in South Africa given the fact that many of the causes are modifiable social, economic and cultural factors.

Prevention, early identification and intervention programmes are key to an ecological child protection system, offer a more sustainable and effective solution to the high levels of violence against children in South Africa, and are required by the Children's Ac. However, there are very few, if any, systemic prevention programmes implemented at scale in South Africa (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012).

The few programmes that exist are localized, with limited coverage and implemented by organizations with specific goals. They are not systemic and/or designed, developed, funded and/or implemented to ensure population coverage (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012) (Proudlock, Mathews, & Jamieson, 2014).

Notably lacking, given the high levels of violence and exploitation experienced in the home and communities in which children live, are parent support and education programmes and public mass media and awareness-raising interventions targeting the relevant domestic stress factors and poor knowledge, practices and attitudes that drive the use of violence, abuse and exploitation of children (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012) (Giese, 2010) (Department of Performance, Monitoring and Evaluation, 2012).

In addition, whilst the system requires the early identification and referral of children at risk, there are low levels of identification of children at risk, and low levels of their referral to social workers for services. Notably, the South African police and labour inspectors fail to identify children in need of care and protection (Proudlock, Mathews, & Jamieson, 2014) (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

3.4.2 Bottlenecks prevent access to the child protection system for children at risk

Many children who are in need of child protection services because of their risk of neglect, abuse and/or exploitation are not able to access the social workers and courts that serve as gatekeepers of the system. This is largely because of the inappropriate use of the child protection system as a vehicle for accessing material support by the many extended family members caring for children whose parents have died or abandoned them.

There are approximately 1,5 million orphans living with extended family members and a further 3,4 million children who are not orphans also living with or in the care of extended family members for a number of reasons, including cultural and economic reasons. As such, extended family care is a common occurrence in South Africa and not an indication that the affected children are at risk or in need of care and protection. The reality is that the many children – orphans and non-orphans in the care of their grannies and aunts do not require protection services. What they do need is material support; and this need is forcing them into the child protection system. There are two grants available for these children and their caregivers. The first is the Child Support Grant (CSG) in the amount of R 300 per month and the other is the foster child grant (FCG) which is R 800 per month. Poverty drives the majority of caregivers to seek the FCG given the inadequacy of the amount of the CSG to cover children's needs. Accessing the FCG requires a formal court-based child protection inquiry and a court order placing the child in foster care (Proudlock, Mathews, & Jamieson, 2014).

The need for material support rather than protection services has overwhelmed the child protection system. The current foster care system is designed to accommodate 50,000 children in need of temporary care and protection with no other care alternative available. It is stretched beyond capacity and currently accommodates 550,000 children, many of whom do not need child protection. This has two implications. The first is that the many orphan children (one third) that are unable to access the system are denied access to social assistance. The second is that many children who are in urgent need of protection services cannot access the system because of the huge backlog (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

3.4.3 Insufficient therapeutic and social services for child victims and witnesses

For those children that are able to access the child protection system, there is a marked lack of sufficient quality therapeutic programmes within the justice and social development sectors to counsel, support healing and prevent secondary trauma of child victims and their caregivers and to secure reintegration with their families. Children and their caregivers are thus not able to access services, and the insufficiency is particularly pronounced in rural areas (Proudlock, Mathews, & Jamieson, 2014) (SAHRC and UNICEF, 2014) (Giese, 2010).

In addition to the lack of counselling, material support in the form of shelter for victims of domestic abuse are insufficient. In 2011, there were only 98 shelters across the country. The majority of these are in urban areas, leaving women and children in rural areas with little, if any alternatives but to remain in their harmful home environments (Proudlock, Mathews, & Jamieson, 2014).

3.4.4 Low levels of prosecution / sanction of cases of violence and exploitation of children

There are low levels of criminal prosecution and labour-related sanctions completed against perpetrators of sexual violence, physical violence, including corporal punishment against children. Where processes are completed, often the sentences and penalties imposed are very lenient (Vetten et al (2008) in (Proudlock, Mathews, & Jamieson, 2014) and (Veriava, 2014).

3.5 Inadequate safety, quality and inappropriate duration of alternative residential care

The Children's Act provides a comprehensive framework to secure the availability of and regulation of the quality, safety and appropriate duration of residency in alternative care institutions for children at risk of abuse, neglect and/or exploitation, This is achieved through a number of measures, including the required registration of residential care facilities and their compliance with norms and standards relating to the content of therapeutic programmes and length of residency of children.

There is however poor compliance with the provisions which results in:

1. An insufficient spread of registered centres to cover areas of need and to ensure children are placed in centres close to their homes and communities. This contributes to the placement of children, even by government officials, in unregistered centres;
2. large numbers of unregistered and non-compliant centres;
3. unsafe conditions in many centres (including those that are run by the GRSA), inadequate provision of basic services and support such as bedding, clothes and recreational equipment, and inadequate therapeutic programmes; and

4. long-term residency of children with little, if any routine review of their progress or possibility of reunification (Jamieson, 2014) (Interviews, Centre for Child Law, Kidshaven and Epworth Children's Village).

3.6 Exclusion of especially vulnerable groups of children from the child protection system

3.6.1 Unaccompanied or separated refugee children

Unaccompanied or separated refugee children and other foreign migrant children are in particular need of child protection and other services, such as health care, education and grants. During 2008/09 it was estimated that nearly 4,000 migrant children were living in South Africa without their parents / close relatives (Department of Women, Children and People with Disabilities, 2012). They face a number of problems in accessing protection services because of multiple factors, including lack identification documents and institutional difficulties with obtaining these, lack of clarity about processes, as well as xenophobic attitudes by officials (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014) (Schreier, 2011).

3.6.2 Children with disabilities

The Children's Act specifically obliges the GRSA to prioritise the development, implementation and provision of prevention, parenting support and other child protection services specifically designed to meet the heightened risk and special need of children with disabilities. Whilst research on the child protection needs and adequacy of the responses for children with disabilities is limited, it is apparent that the GRSA has not complied with its prescribed responsibilities (DSD, DWCPD and UNICEF, 2012).

For example, there are few, if any, scaled up parenting support programmes for parents of children with disabilities (Slemming, Developmental difficulties and disabilities: Background paper for draft national ECD programme, 2014). In addition, whilst many children with disabilities are living in alternative residential care, very few of these centres are equipped to provide the services and support required by these children (DSD, DWCPD and UNICEF, 2012).

3.6.3 Young children

As previously noted, the youngest children under the age of five years, are at the greatest risk of violence in the home. There are however, few, if any parenting support programmes targeting the parents and caregivers of very young children, promoting positive parenting practices and discouraging the use of corporal punishment as a form of discipline (Department of Performance, Monitoring and Evaluation, 2012).

3.7 Underlying reasons for key issues with the national child protection system

3.7.1 Policy and legislative gaps

On the whole, South Africa has a relatively comprehensive legal framework underpinning its child protection system. There are however a few policy / legislative gaps which contribute to the high levels of violence and inadequate provision of services for children in need of care and protection. These include:

1. The failure to prohibit corporal punishment in the home setting (African Union Committee of Experts on the Rights of the Child, 2014)
2. The failure to provide legislative clarity and arrangements for effective accountability of multi-sectoral role players responsible for measures to prevent and remediate child labour in terms of the national Child Labour Programme of Action (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014)
3. The failure to regulate onerous domestic responsibilities (Martin & Mbambo, An exploratory study on the interplay between African Customary Law and practices and children's protection rights in South Africa, 2011)
4. A national prevention, early identification and intervention strategy to be developed by the DSD in terms of the Children's Act remains to be finalized and implemented (Proudlock, Mathews, & Jamieson, 2014)
5. The national and provincial strategies for the development and funding of an adequate spread of child and youth care centres required by the Children's Act have not been developed (Jamieson, 2014) (Interview, Centre for Child Law)
6. The regulatory and operational framework governing access to the child protection system for unaccompanied / separated refugee children requires strengthening in terms of clarity of roles and responsibilities and operational norms and standards (Schreier, 2011) (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014)
7. The failure to integrate child protection interventions, notably prevention and early interventions, into the national ECD framework of action, and the resultant failure to provide focused policy direction on prevention and early interventions to protect young children from violence and abuse in their homes.

3.7.2Implementation challenges

The largest challenge is in implementation of the various laws, interventions and programmes at sufficient scale in areas of greatest need for various reasons, including the following:

3.7.2.1 Insufficient resources

Across the country there are insufficient national, provincial and resources (human and financial) to develop, implement and monitor quality prevention, therapeutic and justice services at sufficient scale, particularly in areas of greatest need.

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Enhle, 4, completes a sewing puzzle at the Khulakahle David Beare ECD Centre on the outskirts of Durban in the eThekwini district.

The inadequacy of resources includes insufficient budgets, insufficient infrastructure, insufficient numbers of personnel and insufficient specialization and expertise necessary to meet the protection challenges faced by children in South Africa (SAHRC, 2013) (Proudlock, Mathews, & Jamieson, 2014) (Department of Performance, Monitoring and Evaluation, 2012).

3.7.2.2 Poor coordination and integration of services

Poor coordination and integration of protection (notably prevention, identification and early intervention) services across all sectoral service delivery platforms results in responsible role players failing to fulfil their responsibilities, inefficient use, waste and duplication of resources, poor data collection and management (Proudlock, Mathews, & Jamieson, 2014).

By way of illustration of the consequences:
The health sector has failed to integrate child protection screening, support and referral services into its core maternal and health services. This represents a key missed opportunity given that the health sector sees the most children and women from an early stage in life and personnel have the potential screening and referral skills and networks at their disposal (Makoae, Richter, & Jubber, Maltreatment prevention and the ethic of care., 2012)

Child labour is not addressed holistically. The Child Labour Programme of action is multi-sectoral plan of action requiring many government departments to act to address child labour. These responsibilities of departments are widely misunderstood and disregarded (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014)

3.7.2.3 Lack of clarity on how to fulfil responsibilities

There is a lack of clarity by key responsible role players on how to fulfil their protection responsibilities, how to identify children at risk of being in need of care and protection, and the measures that they must take once identified (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

3.7.2.4 Poor population-based planning

Poor population-based planning by the national and provincial departments of social development, notably in the case of prevention programmes and the provision of an adequate spread of alternative residential care facilities results in ad hoc programmes that are not implemented at the scale required or in areas of greatest need (Proudlock, Mathews, & Jamieson, 2014) (correspondence, Carol Bower, child protection consultant).

3.7.2.5 Weak institutional and accountability mechanisms
The DSD is not adequately maintaining the National Child Protection registers recording of all cases of child abuse and neglect and the names of all persons guilty of child abuse (SAHRC, 2013).

In addition, institutions responsible for ensuring accountability for actions are weak resulting in poor levels of prosecution and weak sanctions. For example, there is no national mechanism for reporting all cases of child violence; institutions such as the South African Council of Educators are inadequately mandated and resourced to pursue prosecutions; and labour relations officials are inadequately trained in child protection to pursue labour sanctions effectively (Veriava, 2014) (Proudlock, Mathews, & Jamieson, 2014) (Centre for Applied Legal Studies and Cornell Law School's Avon Global Center for Women and Justice and International Human Righst Clinic, 2014).

3.7.2.6 Poor data collection and management of information
Poor data collection and information management systems, insufficient evidence collection and evaluations, and evidence-based planning of prevention programmes (Proudlock, Mathews, & Jamieson, 2014).

3.7.2.7 A regulatory rather than developmental approach adopted with regards to alternative care
A key reason for the failure of many child and youth care centres to register is the difficulty of the process and the cost and complexity of complying with a number of onerous conditions (Jamieson, 2014)(interviews, Centre for Child Law, Kidshaven and Epworth Children's Village).

The DSD adopts a punitive or regulatory, rather than a developmental approach to the registration and quality control of alternative care services provided by child and youth care centres. It is not supporting organisations to register and there is a looming crisis. All centres must be registered by 31 March 2015. There are many that remain unregistered and face insurmountable obstacles to registration. If they are closed, this will leave a service delivery vacuum. The DSD has not adopted a pro-active stance to registration or developed population based plan for the provision of an equitable spread of centres (interviews, Centre for Child Law, Kidshaven and Epworth Children's Village).

A further barrier in the registration of centres are the complex and often expensive and contradictory local government requirements. Local municipalities are gatekeepers to registration, yet they do not know their roles and responsibilities adequately and obstruct the registration of many centres with unhelpful attitudes and practices (interviews, Centre for Child Law, Kidshaven and Epworth Children's Village).

3.7.2.8 Insufficient political will
Lack of political will and meaningful leadership to prioritise, develop, fund and hold officials accountable for the delivery of, notably, prevention and early identification and intervention services as well as safe registered centres is a leading cause of issues in the child protection sector (Makoae, Richter, & Jubber, Maltreatment prevention and the ethic of care., 2012). There is widespread belief that there is a lack of political will and commitment to place child protection sufficiently high on the political agenda and to ensure the investment of adequate resources and ensure that decision-makers are held accountable for effective child protection measures. This is particularly so in the case of commitment to long-term prevention measures. The lack of political will and leadership is attributable to a number of issues, including the pressing number of priority issues and the lack of understanding as to why child protection should be elevated when competing with many demands, as well as political leaders not knowing what to do to reverse the rates of child maltreatment (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012)

3.7.2.9 Weak advocacy
There is weak advocacy advancing the development of the necessary laws, allocation of resources and development of systems and programmes for the implementation of prevention, early identification and intervention programmes as well as compliance with residential care requirements (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012) (interviews, Centre for Child Law, Kidshaven and Epworth Children's Village).

Reduced funding has reduced the capacity of child protection non-profits to engage in organised and strategic advocacy at the scale and with the consistency necessary to address key gaps in the child protection system (Interview, Joan van Niekerk, Childline, SA).

3.7.2.10 Poor communication and education
There is insufficient effective and communication and education of decision-makers, the public, parents and others targeting fulfilment of responsibilities, harmful public attitudes accepting of violence against children and high levels of public perception that violence/ maltreatment cannot be prevented; as well as harmful cultural, religious and other practices and attitudes which legitimize and aggravate the incidence of violence against children in South Africa (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012) (Department of Performance, Monitoring and Evaluation, 2012). Education and awareness-raising interventions are not systemic; rather they are, in the main, ad hoc interventions implemented on a project-basis (rather than scaled-up systemic programmes) implemented by NGOs with project-specific and limited objectives and reach. There are few nation or province-wide departmental education programmes or mass media campaigns implemented at scale. The few that have been implemented are plagued by low coverage and impact (SAHRC, 29 and 30 May 2014) With the focus on statutory services, there is little, if any budget in protection programmes for education and awareness-raising aimed at appropriate behaviour and attitudinal change (Giese, 2010) (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012). Departments rely heavily on NGOs and NGOs in turn have faced severe financial constraints, thus reducing this domain of activity to negligible and ineffective quantities (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012) (Proudlock, Mathews, & Jamieson, 2014).

In addition to education and awareness-raising campaigns not being systemic, those that are implemented are generally not evidence-based. Programmes are not designed around what works to bring about the necessary behavioral and attitudinal changes. This is because there is little information on what works to effectively educate and raise awareness (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012). Linked to this is the fact that there is little, if any research on what works in the South African context, monitoring and evaluation of education and awareness-raising programmes or documentation and dissemination of effective best practices (Makoae, Roberts, & Ward, Child maltreatment prevention readiness assessment: South Africa, 2012). There is thus little to draw on in the development of evidence-based education and awareness-raising interventions.

4. PRIORITISING CHILD PROTECTION ISSUES

Form the preceding analysis, there are clearly multiple gaps, issues and concerns undermining the realisation of Save the Children's priority child protection breakthroughs. The question for Save the Children South Africa is which of these issues merit support; which of the issue are catalytic, innovative and likely to yield lasting and sustainable results for the protection of children in their homes and institutions.

A number of common child protection priorities emerge from various rights and development documents charting the way forward to 2015 and beyond. These include:

1. Adequate child protection is gaining increasing recognition as central to the development, and as such, the movement of vulnerable children out of poverty (Draft National ECD Policy and Programme (RSA) , 2014) (The National Development Plan 2030: Our future - make it work, 2012) (United Nations General Assembly Working Group on Sustainable Development, 2014) (The African Child Policy Forum, 2013). Recognition of the fundamental link between child protection and development gives rise to the need for the location of child protection on the development agenda and allocating it appropriate national priority status and funding. Moving towards 2015 and beyond, strengthened child protection services must be an integral part of broader social protection platforms for children, notably for those made additionally vulnerable because of their lack of parental care, such as children separated from their parents and orphaned children.
2. The recognition of child protection as a developmental issue requires that greater priority be given to the prevention of violence, especially against women and girls in the post-2015 development agenda (The African Child Policy Forum, 2013) (United Nations General Assembly Working Group on Sustainable Development, 2014). The GRSA's most recent Medium Term Strategic Framework (MTSF) recognises that South Africa's levels of crime are unacceptably high and that children, amongst others constitute highly vulnerable groups. The focus in the medium term will be on preventing crimes against women and children, improving the efficiency of the justice system and improving conviction rates for serious offences (Government of the Republic of South Africa, 2014). Notably, the MTSF highlights the need to prioritise preventative action through violence prevention and dialogue campaigns.
3. The National Department of Social Development's strategic priorities echo global and national priorities and prioritises the strengthening of a responsive and inclusive social protection system through measures targeting the prevention of violence against children in their homes and improving the safety and quality

of residential care, notably for the most vulnerable of children. Departmental priorities include, inter alia:

3.1 The prevention of violence against children through the programme of action on no violence against children
3.2 Strengthening support provided to families
3.3 The development, implementation and oversight of a transformation plan for child and youth care centres
3.3 The implementation of a national register of Child-headed households and the roll out of community-based services for orphans and vulnerable children through the Isibindi model
3.4 Increasing human resources, notably social workers, to support a stronger child protection system (Department of Social Development, 2014).

4. The Department of Labour has prioritised addressing child labour. It has launched a national multi-sectoral Child Labour Programme of action for South Africa: Phase three 2013 –which more clearly defines the roles and responsibilities of multi-sectoral stakeholders

5. ORGANISATIONS ENGAGING WITH THE ISSUES

A number of the priority issues and underlying causes are currently addressed by various civil society organisations.

Focus areas of organisations working in the relevant areas of child protection include:

5.1 The prevention of violence, abuse and exploitation of children

Prevention of violence

UNICEF South Africa launched an End Violence against Children campaign in July 2014 to:

- Ensure effective actions are developed, implemented and monitored
- Make every day a child protection day
- Facilitate coordinated multi-sectoral action through the development of a multi-stakeholder action plan
- Advocate for prioritised resource allocation
- Develop and roll out a multimedia communication campaign (http://www.unicef.org

RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect) works to promote the protection rights of children through advocacy for a strongly preventative-focused child protection system. Its strategic objectives include the promotion of primary and secondary prevention in the child protection system (http://www.rapcan.org.za)

Childline South Africa works across the provinces collectively to protect children from all forms of violence. In addition to the direct counselling and support provided to children in need of care and protection, Childline engages in training and advocacy to promote a strengthened child protection system which secures the prevention of violence against children. It also engages in behavior change advocacy and education to promote knowledge of children's rights, prevention of violence against children in homes, schools and institutions (http://www.childlinesa.org.za).

Prevention of violence in homes and schools, including corporal punishment

Sonke Gender Justice has an active campaign against the use of corporal punishment and promoting the use of positive discipline by parents and caregivers (http://www.genderjustice.org.za/sexual-reproductive-health/children-s-rights-and-positive-parenting.html).

The Teddy Bear Clinic provides support to abused children. In addition, it engages in community, school and family-based behaviour change advocacy and education to prevent violence against and abuse of children (http://ttbc.org.za/).

There are many organisations engaged in activities to prevent and prosecute cases of corporal punishment and other forms of violence in schools, including bullying and sexual violence. Their range of activities includes, research, advocacy, training and strategic litigation. Organisations include:

1. The South African Human Rights Commission
2. The Center for Child Law
3. The Centre for Justice and Crime Prevention
4. MIET Africa
5. Section 27
6. Lawyers for Human Rights
7. Active Schools Initiative
8. Project for Conflict Resolution and Development (EC)
9. Gauteng Children's Rights Committee
10. GM South Africa Foundation (EC)
11. Ithemba Life Skills Programme
12. Proudly South Africa
13. Quaker Peace Centre
14. RAPCAN
15. Teddy Bear Clinic
16. UNICEF South Africa

5.2 The provision of adequate prevention, early intervention and other statutory services

Childline South Africa provides counselling and therapy for children who are victims of abuse, neglect and exploitation.

Child Welfare South Africa provides community-level safety and support for abused, neglected and exploited children (http://www.chidwelafresa.org.za).

RAPCAN provides support to child witnesses and victims in preparation for court proceedings.

Teddy Bear clinic provide support, counselling and therapy for abused children.

Molo Songololo provides support and empowerment to victims of sexual abuse, sexual exploitation and trafficking. It also conducts education, awareness-raising and research in this regard (http://www.molosongololololo.com)

The National Association of Child Care Workers (NACCW) has developed and is rolling out to scale, with the DSD, the Isibindi community-based child-protection model which seeks to identify families and children at risk / in need of care and protection and the provision of support and services, and referrals to the child protection system.

5.3 Quality, safety and appropriate duration of alternative residential care

The Centre for Child Law supports the registration of Child and Youth Care centres and the provision of safe and quality services at the relevant centres through research into registration challenges, education and the provision of support to unregistered centres to become registered and strategic litigation (interview, Centre for Child Law).

Kidshaven and Epworth Children's Village, in collaboration with the Centre for Child Law, provide support to a number of unregistered centre to become compliant with requirements and navigate the CYCC registration process.

5.4 Improved child protection framework and services for especially vulnerable groups

Children with disabilities

DICAG (Disabled Children's Action Group) engages in advocacy among all relevant stakeholders and parenting support and education to promote the effective realisation of the rights of children with disabilities in all policies and programmes and to empower parents and caregivers to respond to the rights and needs of their children. It is not clear from DICAG's website if it engages in advocacy specifically with regards to the protection needs of children with disabilities (hhtp://www.dicag.co.za).

Unaccompanied refugee children

The Scalabrini Centre located in the city of Cape Town offers welfare, development and advocacy support for refugees, asylum seekers, migrants and their children (Scalabrini Centre of Cape Town, 2014). It provides legal advice, assistance to access services as well as advocacy through lobbying and strategic litigation aimed at systemic change. Key advocacy initiatives relate to:

1. The DOHA's immigration system
2. Vulnerable foreign minors
3. Access to health, education and grants

Refugee Rights Centre, Nelson Mandela Metropolitan University is located in the university's law faculty and offers legal support, advice and information to asylum seekers and refugees on accessing documents and applying for asylum status and residency permits (Nelson Mandela Metropolitan University Refugee Rights Centre).

The Refugee Rights Unit, University of Cape Town provides direct legal advice, conducts research into the rights of refugees in South Africa and conducts advocacy and education aimed at government officials. Many of its research projects, advice services and advocacy address the rights of refugee children, including the protection rights of unaccompanied minors (Refugee Rights Unit, UCT).

The Refugee Children's Project engages in advocacy for improved policies and laws to protect the rights of refugee and internally displaced children. It has specific projects on the rights of unaccompanied minor children (Refugee Children's Project). There is no indication on the organisation's website as to whether it addresses protection right specifically.

6. SUMMARY OF PRIORITY CHILD PROTECTION CONCERNS NOT RECEIVING ADEQUATE ATTENTION

Generally, it would appear that NGO activity in the child protection sector is weighted in favour of the direct provision of services to children who have been abused, neglected or sexually exploited.

Advocacy initiatives appear to be limited in number and scale and focus on community, school, family and peer-based behaviour change and educational advocacy.

There appears to be limited organised and focused research and associated issue-driven evidence-based advocacy campaigns aimed at a policy-level for:

1. The development, resourcing, monitoring and evaluation of prevention and early intervention initiatives and services
2. For a more developmentally-oriented and constructive registration and quality assurance framework for child and youth care centres, or for the compliance by the State with its obligations to children in alternative residential care facilities
3. Enhanced child-protection systems for especially vulnerable groups such as children with disabilities, very young children and undocumented minors.

The withdrawal of development funding from South Africa as a middle income country and the inadequate public funding of NGOs (as well as the requirement that public funding is to be used in the provision of statutory services rather than advocacy) means that NGOs have little human and financial capacity to engage in systemic advocacy to drive the development, adequate funding and implementation of public provided prevention and early intervention services.

This does leave a number of gaps, including:

1. Advocacy for and the piloting / research into effective models of prevention and early intervention strategies and services. The emphasis seems to be on the provision of statutory services to child-victims. This is understandable as the lack of prevention and early intervention services leads to higher levels of abuse, neglect and exploitation. The affected children cannot access services because of resourcing inadequacies in public programmes, leaving an urgent gap that is being met, as a matter of necessity by NGOs. The capacity of NGOs to advocate for strong prevention and early intervention programmes is limited by their limited resources.
2. Corporal punishment and violence in schools is well-covered, but not corporal punishment and violence against children in the homes. There also seems to be a general lack of activity around piloting, monitoring and advocating for effective broader parenting support programmes with the objective of strengthening knowledge and protective practices in homes and communities.
3. Child labour. This mapping exercise was not able to identify significant organisational activity around the issue of child labour in South Africa.
4. Child protection for unaccompanied refugee children. Whilst there are a number of organisations working on projects related to the rights of unaccompanied refugee children, their focus, in the main, appears to be on documentation issues and education rights. The Child Rights Unit at UCT is the exception, having conducted research on these protection rights. It is not clear however to what extent the evidence gathered is driving a focused advocacy campaign for the realisation of the recommendations for policy and administrative changes which emerged from the research.
5. Child protection for children with disabilities, including research and advocacy appears to be an area that receives little, if any attention in South Africa.
6. There is little systemic advocacy within the ECD sector for targeted prevention and early intervention efforts to secure the protection of the youngest children in the home and their communities.
7. Similarly, there is little advocacy for systemic responses to CYYC problems of registration and quality and compliance by the DSD with its responsibilities to children in alternative care.

Faith Nkize operates the Siyazama Crèche in Hammarsdale, in the eThekwini district. She first opened as a crèche in 1994, responding to the need for children to be cared for while their parents were at work.

EDUCATION

The Grade RR class at the Zamani ECD Centre on the outskirts of Durban in the eThekwini district. Principal Ethel Ngcobo first opened as a crèche in 1995, responding to the need for children to be cared for while their parents were at work.

D. EDUCATION

1. BREAKTHROUGH / PRIORITY OUTCOMES AND OBJECTIVES

Breakthrough / priority outcome for Save the Children: All children can read by the time they leave primary school.

Priority objectives:
Improve access and quality:
1. In learning
2. The learning environment
3. Early childhood care and development
4. Especially for marginalised children (Save the Children, 2010).

2. RESPONSIBILITIES OF THE GOVERNMENT OF THE REPUBLIC OF SOUTH AFRICA

2.1 International and regional legal obligations and commitments

South Africa is a party to a number of international, continental and regional legal instruments and development initiatives which recognise education as a fundamental human right as well as a developmental priority. [4]

The rights and development rationale for the prioritisation of investments in education is that it is a gatekeeper right. The realisation of many other rights depends on the prior realisation of the right to education. Education has a "tremendous multiplier effect that brings lasting benefits to individuals and communities. Education is intrinsically linked to all development goals, such as supporting gender empowerment, improving child health and maternal health, reducing hunger, fighting the spread of HIV and AIDS and diseases of poverty, encouraging economic growth and building peace. Therefore, opening classroom doors to all children, especially girls, helps to break the inter-generational chains of poverty" (Department of Basic Education , 2013).

The GRSA is duty-bound to take all legislative, administrative and other steps necessary to ensure:
1. Universal access to quality early childhood care and education, especially for the most vulnerable and marginalised
2. Universal access to free and compulsory primary education
3. Quality education at all levels, from early childhood through to secondary education which is capable of ensuring children's measurable competencies and skills in literacy, numeracy and other learning domains such as problem solving, science, technology and life skills to enable to live and work in dignity and realise their full potential (UN Committee on the Rights of the Child, 2001), and
4. That the most marginalised and vulnerable children, including children with a disability, children living in poverty, orphaned children, refugee / unaccompanied children (Committee on the Rights of the Child, 2005), children in prisons, and working children are guaranteed access to high quality education which meets their learning needs and vulnerabilities.

Summary of the obligations of the GRSA in relation to Save the Children's Breakthrough priority

Save the Children's priority breakthrough is to ensure that all children can read by the time they leave primary school. This that the GRSA guarantee universal access to early learning and primary education for all children, including vulnerable and marginalised children, as well as access to teaching and learning of a sufficiently high quality which addresses learning barriers which impact on the child's ability to learn to read and write.

[4]Rights instruments include the Universal Declaration on Human Rights (1948); the United Nations Convention on the Elimination of Discrimination Against Women (1979); the UN Convention on the Rights of the Child (1989); the UN Convention on the Rights of Persons with Disabilities (2006); the African Charter on the Rights and Welfare of the Child (1990); and the International Covenant on Social, Economic and Cultural Rights (1996) – the latter has not yet been ratified by the GRSA, but is in progress at Cabinet level (Department of Women, Children and People with Disabilities, 2013). Development initiatives include the UNESCO's World Declaration on Education for All and the UN's Millennium Development Goals.

2.2 The GRSA's national responsibilities, commitments and goals

Constitution of the RSA: S29 of the Constitution provides that everyone has the right to basic education and the right to receive education in their official language of choice in public education institutions.

The National Plan of Action for Children in South Africa 2012 – 2017 commits to, inter alia:
1. Ensure universal access to effective, integrated, quality early childhood development interventions responsive to the needs of South African children from birth to school-going age;
2. Ensure universal access to quality Grade R for all children in South Africa by 2015;
3. Ensure the improve quality of education in all schools in South Africa;
4. Ensure that every schools is rights-based and inclusive, effective and provides quality education, is safe, protective and supportive, gender sensitive and promotive of equity and equality, and is building linkages and partnerships with the community;
5. Increasing the number of children who have acquired minimum language competencies in the foundation phase and at the end of primary school (Grade 6);
6. Increasing the skills and capacities of teachers and preventing overcrowded classrooms
7. Ensuring all teachers and learners have access to essential learning and teaching materials
8. Improve parent and community participation in the governance of schools; and
9. Ensuring adequate and transparent funding for schools (Department of Women, Children and People with Disabilities, 2012).

Delivery Agreement for Outcome 1: Improved Quality of Basic Education (2010) recognises the fundamental link between realisation of the GRSA's legal commitments and its development objectives and the provision of quality basic education. It further recognises that the most pressing challenge is the poor quality of education in South Africa and identifies improving "educational quality in schools in the sense of improving learning outcomes" as the greatest challenge. It commits to achieve this priority outcome through prioritisation of investments in expanded and improved ECD and strengthening of the teaching and learning environment.
The National Department of Basic Education's Action Plan to 2014: Towards the Realisation of Schooling 2025

Goals 1 and 2: Increase the number of learners in Grades 3 and 6 who, by the end of the year, have mastered the minimum language and numeracy / mathematics competencies for Grades 3 and 6
Goals 7 and 8: Improve the average performance of Grade 6 learners in languages and mathematics
Goal 11: Improve the access of children to quality Early Childhood Development (ECD) below Grade 1

National Development Plan: Vision 2030 recognises that education is central to South Africa's long-term development; that it is core to eliminating poverty and reducing inequality, and is foundational to an equal society. It further recognises that the realisation of education's potential depends on the adequacy of foundational skills, including language skills and competencies. It identifies a "strong educational system spanning early childhood development, primary, secondary, tertiary and further education" as crucial to attaining the goals of addressing poverty and inequality.

The foundation of a strong educational system is guaranteed universal access to high quality education at all of the relevant levels. To achieve this requires:
1. The development of a comprehensive system of early childhood development from birth
2. Improvements in the quality of education, notably the qualifications and skills of teachers
3. Effective governance and managements
4. Involved parents
5. Accountable schools
6. Accessible learning materials
7. Enabling school environments with adequate infrastructure (The National Development Plan 2030: Our future - make it work, 2012).

The Medium Term Strategic Framework 2014 – 2019 recognises that education "plays an important role in equalizing individual's chances, promoting economic mobility, advancing economic growth, creating employment, eradicating poverty and reducing inequality. Improving the quality of education is the first priority outcome identified in the MTSF, notably through improved access to and quality of education and outcomes at a foundational level. Strategies for achieving improved educational quality and outcomes which will be prioritised by the GRSA in the medium term include:

1. Measures to improve school governance, leadership and accountability
2. Improving the teaching and learning environment, with a specific focus on infrastructure and textbooks
3. Teacher development and training
4. Further expansion of ECD programmes, including for age groups 0-4, a pre-Grade R programme and improving the quality of Grade R
5. Implementation of school safety programmes to prevent bullying and abuse of learners

The Minister of Basic Education's budget vote speech (2014) commits to focusing the Ministry's resources and energies in the 2014 – 2019 period on "consolidating achievements made so far and then driving home the theme of improvement on quality and efficiency … with a renewed emphasis on curriculum coverage, and the need to strengthen quality, efficiency and accountability in our provinces, districts and schools." An amount of R 30 million has been allocated to improve the quality of education through the National Initiative to improve Learning Outcomes.

Quality will be improved through, inter alia:
1. Expanded access to and the improved quality of Early Childhood Development, notably the introduction of two years compulsory pre-school
2. Improved infrastructure and access to learning and teaching materials
3. Teacher development
4. Strengthened and regular learner assessments (Motshekga, 15 July 2014).

3. RISK FACTORS AND OPPORTUNITIES IMPACTING ON LITERACY OUTCOMES OF CHILDREN

There are a number of risk factors which impact negatively on the educational opportunities and outcomes of children in South Africa. These include:

Low socio-economic status: Poverty presents a globally common risk for the attainment of quality educational outcomes. It impacts, not only on access, but also learning attainments. Various studies, including the regionally comparative Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) III study, show a marked difference in literacy levels (reading scores) between rich and poor children in countries in the southern and eastern African region, including South Africa (where the difference between the groups was significantly higher than in other participating African countries (Hungi, N, 2011a).

Poverty remains the most common reason cited for children dropping out of school or failing to attend (Global thematic consultation on education in the post-2015 development agenda, 2013). The cost of schooling, notably no money for fees, but also transport costs, the costs of uniforms and stationery is cited as the primary reason for children's failure to enroll or attend school in South Africa (Gustafsson, M (2011) and Strasburg S, Meny-Gibent S and Russell B (2010) in (Martin, P, 2014a).

Over and above the lack of cash for opportunity costs, the low parental literacy levels and lack of books and other learning and teaching materials in poor households impacts on parents' ability to support children's learning activities at home (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012) (Hungi, 2011). Children who are supported with home work at home and who have many books at home achieve better in maths and reading (Hungi, N, 2011a).

Home language: Children who speak a language at home which differs from the language of teaching and learning perform worse in reading and mathematics (Hungi, N, 2011a).

Learning materials and sole ownership of textbooks: Pupils with access to basic learning materials achieve better learning outcomes (Hungi, N, 2011a).

Pre-school attendance: Children who participate in pre-school for two or more years before Grade 1 perform better in reading and mathematics (Hungi, N, 2011a)

Teacher qualifications and skills: In South Africa, children taught by more skilled and knowledgeable teachers did better than those who were not (Hungi, N, 2011a).

Bullying and school violence, including corporal punishment: Unlike the situation in other countries, more than half of the Grade 4 South African learners in the PIRLS assessment experienced bullying on a weekly basis and this impacted on their learning outcomes. Children who were bullied weekly tended to achieve 50 points fewer than those who were not bullied as often (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012).

Failure to diagnose developmental difficulties and delays and provide support for children, in their foundation phase. Where children with developmental difficulties and delays are not identified and given appropriate support in their early educational years, this impacts on their literacy outcomes (interviews, Nikki Steyn and Faranaaz Veriava, Section 27).

In addition to the risk factors, there are a number of protective factors which facilitate better learning outcomes.

Various studies show that **parental interest and involvement in children's studies** and the governance of schools result in better educational outcomes than for children whose parents are uninvolved or show little interest (Singh, Mbokodi, & Msila, 2004) (Hungi, N, 2011a).

The provision of food: Studies have shown a positive association between the number of meals eaten per week by children and their academic achievement. An analysis of Kenyan data, using SACMEQ II data found that children who ate more meals per week were more likely than their counterparts who are less to perform better in mathematics and reading (Hungi and Tuku (2010b) and Mukudi (2003) in (Hungi, 2011).

4. SITUATIONAL ANALYSIS: PROGRESS MADE / LACK OF PROGRESS IN THE REALISATION OF THE CHILDREN'S RIGHT TO EDUCATION, NOTABLY THEIR ABILITY TO READ

The government of the RSA has put in place a comprehensive policy and programmatic framework which is supported by a large, pro-poor budget to support the realisation of the rights of children to basic education. It is directed at addressing the multiple risk factors faced by historically marginalised children and maximizing proven protective factors so as to protect and promote the right of children in South Africa to basic education.

4.1 Legislative measures taken

The GRSA has developed an extensive policy and legislative framework which forms the bedrock of the basic education system in South Africa, the aims of which are furthered through a host of supporting strategy and programme. Laws, programmes and strategies include:
- The South African Schools Act 84 of 1996
- The National Education Policy Act 27 of 1996
- National Norms and Standards for Public School Funding (1998)
- Exemption of parents form payment of school fees in public schools (2006)
- Regulations relating to the minimum uniform norms and standards for public school infrastructure
- The Admission Policy for Ordinary Public Schools
- Education White Paper 5: Early Childhood Education (2001)
- Education White Paper 6: Special Needs Education – Building an Inclusive Education and Training System (2001).

These policies and laws are supported by a number of planning and programming documents, including the Delivery Agreement for Outcome 1: Improved Quality of Basic Education (2010); Action Plan to 2014: Towards the Realisation of Schooling 2025 (2010); and the Integrated Strategic Planning Framework for teacher Education and Development in South Africa (2011).

Accumulatively the governing legal framework makes provision for, inter alia:
1. The prohibition of discrimination so as to exclude children from education based on their socio-economic and other circumstances
2. Universal access to one year of pre-school (Grade R)
3. Compulsory basic education from Grade 1 to 7 (ages 7 – 15 years)
4. Subsidized early childhood care and education for children living in poverty
5. A pro-poor funding model that results in the allocation of more operational funds to schools serving poor communities
6. Free schooling for children living in poverty at "no-fee" schools and through a system of fee exemptions for parents sending their children to fee-charging public schools
7. A National School Nutrition Programme (NSNP) which provides daily meals to children living in poverty
8. The provision of improved school infrastructure and learning materials, with priority given to the poorest schools, to create an enabling learning environment
9. The provision of education to children in their home language in the foundation phase
10. Improving the qualifications of teachers and the quality of teaching through curriculum and teacher development, annual learner assessments, and targeted support for under-performing schools
11. The inclusion of children with disabilities and other learning barriers in the education system and the provision of infrastructure, learning materials and teaching suited to their needs.

4.2 Progress in 2014

There has been substantial progress made in improving

access to basic compulsory education as well as equalizing access for historically marginalised children living in poverty. Enrolment of children in pre-school / Grade R increased from 15 percent in 1999 to 75 percent in 2012 with equal enrolment rates for boys and girls DBE, Education Statistics in South Africa, 1999 – 2012 in (Department of Basic Education , 2013). Enrolment is near-universal (99 percent in 2012) for the compulsory basic education years (Grades 1 – 9 or aged 7 – 15 years) and as in the case of Grade R, gender parity has been achieved at this level of education (Statistics South Africa, 2013). In 2011 28,4 % of the population have completed Grade 12, compared to 20,4% in 2001 and the net enrolment rate among Black children has increased from almost 71% in 1996 to 74,5% in 2011 (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012).

By mid-2014 the NSNP was providing daily meals to more than 9 million children in 21 000 schools in quintiles 1-3 (Motshekga, 15 July 2014).

The basic education budget is deliberately pro-poor in design, and "in practice has become increasingly well-targeted." In 2009, 49 percent of the education budget reached the poorest 40 percent of the population (Taylor, Van der Berg, & Burger, 2011).

At a cost of R 8 billion 86 percent of schools are no-fee schools. In addition, learners at no-fee schools receive a higher per learner allocation in the amount of R 1, 059 per year per learner. More than 9 million children are fed through the National School Nutrition Programme (Motshekga, 15 July 2014).

The basic education budget in 2014/15 is R 19, 680 billion (compared to R 17, 592 billion in the previous year), confirming a strong commitment by government to education (Motshekga, 15 July 2014).

4.3 Key issues impacting on literacy outcomes for children in South Africa in 2014

4.3.1 Exclusion of especially vulnerable children from the education system

The first requirement to secure universal literacy of children by the time they leave primary school is to ensure that all children, including the most marginalised are enrolled at and attend pre- and primary school regularly.

Whilst enrolment rates within the compulsory ages of education (Grade 1 – 7) are near-universal (at 99 percent in 2011 compared to 96 percent in 2002), enrolment rates are significantly poorer for especially vulnerable children and at a stage when access is crucial.

- The rate of participation in early childhood care and education (ECCE) programmes for children between the ages of 0-4 years is low, particularly amongst disadvantaged children. In 2012 approximately 37 percent of children aged 0-4 years attended an ECD centre (although not all the centres provided ECD activities) (Statistics South Africa, 2013). The rate of participation is however much lower than the national average among children living in poverty, the very youngest children (under the age of 2), children with disabilities and children in underserviced areas. Only 20 percent of children in the poorest 40 percent of households access ECCE services, with a massive 80 percent exclusion rate; only 18 percent of children under the age of 3 years and fewer than 1 percent of children with disabilities benefit from ECCE services (Department of Performance, Monitoring and Evaluation, 2012).
- Coinciding with the GRSA's policy to universalize Grade R, the rate of enrolment of children Grade R (formal pre-school year) increased from 15 percent in 1999 to 75 percent in 2012 (Department of Basic Education , 2013). This does however mean that 25 percent of children do not have an opportunity to access support to prepare them for acquiring their numeracy and literacy skills once they entre Grade 1.
- Despite the pro-poor bias in the education system, children living in poverty continue to be at a higher risk of exclusion. At an ECCE level, poverty is a key reason for non-enrolment of children in ECD programmes for those under the age of 5 years. Poverty remains the most common reason cited for children dropping out of school or failing to attend (Global thematic consultation on education in the post-2015 development agenda, 2013). The cost of schooling, notably no money for fees, but also transport costs, the costs of uniforms and stationery is cited as the primary reason for children's failure to enroll or attend school in South Africa (Gustafsson, M (2011) and Strasburg S, Meny-Gibent S and Russell B (2010) in (Martin, P, 2014a) Whilst it does not serve to prevent large numbers of children from enrolling at primary school-level, it does nonetheless prevent children who experience multiple deprivations intersecting with poverty from enrolling (such as refugee children, children with disabilities and others), and further is a leading cause of poor or irregular attendance..
- The number of children with disabilities accessing the compulsory years of schooling has increased by more than 20 percent between 2002 and 2010. However, children with disabilities remain at high risk of exclusion and are disproportionately represented in the out-of school population. In 2011, an estimated 8 percent of children with disabilities between the ages of 7 and 15 years were not enrolled and 24 percent of children between the ages of 16 and 18 years were excluded. This amounts to an estimated 400 and 480 000 children (Department of Women, Children and People with Disabilities, 2013).
- Children of refugees, migrants and asylum seekers, notably those who are separated from their parents are at a greater risk of exclusion from schooling. The Constitution of the RSA guarantees the rights of all children in South Africa to basic education and this includes non-citizens. Thus all asylum seeker and refugee children have a right to quality primary education and it is compulsorily. However, a disproportionate number of excluded because of the cost, language and attitudinal barriers, as well as difficulties in complying with documentation requirements. At the ECD level, subsidies are not afforded to migrant children (Centre for Education Rights and Transformation, University of Johannesburg, June 2012) (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

4.3.2 Poor educational outcomes in South Africa's public schools

The right to education encompasses more than access; it is also a matter of quality of content and outcomes. "Getting children into school is a necessary but insufficient condition for achieving the Education for All Goals. The experience of school, what children learn in the classroom and the skills that they emerge with are what ultimately count" (EFA Global Monitoring Report, 2011). The foundation for what and how well they learn is literacy. Reading is the quintessential skill required; without it, learners are doomed to struggle through school and drop out when they are unable to master it adequately" (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012).

Whilst enrolment rates are near-universal, and access barriers have been substantially addressed "Improving the quality of education in schools in the sense of improving learning outcomes stands out as the greatest challenge." In terms of quality of outcomes, "South Africa's performance is the lowest amongst all middle-income countries" (Department of Basic Education, 2011). Moreover, its scores are notable low at primary school-level in literacy and mathematics.

Local, regional and international performance evaluations all show that South Africa's children underperform in core learning areas such as literacy / reading, mathematics and science. In the 2006 PIRLS – Progress in International Reading Literacy Study which measures literacy rates at primary school, South Africa came last out of 40 countries. Whilst there has been a marginal improvement since 2006, the 2011 PIRLS assessment continues to paint a bleak picture.

The 2011 PIRLS results revealed that:

"South African Grade 4 learners, particularly those tested in African languages, achieved well below the international centre point despite having written and easier assessment. They were still performing at a low level overall on an easier assessment compared to their counterparts internationally… Learners tested in Afrikaans and English performed relatively well and above the international centre point. However, those tested in all African languages, despite most writing in their home language, achieved very low outcomes …. Few South African learners (6%) were able to read at an advanced level, although 71 % were able to reach a rudimentary level of reading and attain the Low International benchmark. More than half the learners tested in Sepedi and Tshivenda could not read at a basic level required for successful reading" (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012).

The results were poorer for children in Grade 5. At this level, even the learners tested in English and Afrikaans performed "approximately 80 points below the international average score of 500 fixed for the reading literacy of Grade 4 learners internationally". 43 percent of learners tested in English and Afrikaans were unable to reach the Low International benchmark. Only 4 percent reached the High International Benchmark (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012).

Comparatively South Africa performed slightly below the average of the 14 Southern and East African countries in Grade 6 Maths and reading in the SACMEQ II and III evaluations. Only 71 percent of 13 year old children in South Africa that participated in the SACMEQ III study were functionally literate (in other words, could read for meaning), compared to 87 percent in Kenya and 88 percent in Swaziland (Spaull N. , October 2013)

National assessments confirm that children in South Africa are not acquiring basic numeracy and literacy skills, notably in their foundation and primary school years.

In 2011, the national average score for Grade 3 learners for language was 35 percent and 28 percent for mathematics (Department of Basic Education, 2012). The 2012 and 13 ANA results reflected improvements in key areas, however the extent to which these improvements reflect real improvements in the quality of education is not clear, given that they 2012 ANA tests were not calibrated against the 2011 tests, were not externally audited, and the increases reflect unrealistic jumps in achievement over a period of 12 months (Spaull N. , October 2013).

The national average Grade 3 scores for home language in 2012 and 2013 were 52 and 51 percent respectively, and the percentage of children attaining 50 percent or more was 36 and 50 percent over the two years. First additional language scores (which for most children is the language of teaching and learning) for children from Grade 4 onwards were noticeably lower. For Grade 4s the results were 34 and 39 percent in 2012 and 2013, for Grade 5s, 30 and 37 percent, and for children in Grade 6, 36 and 46 percent (Department of Basic Education, 2014).

The DBE's analysis of the 2011 ANA point to fundamental challenges in the acquisition of necessary literacy skills in the foundation and later primary phases. The examiners found:

- that children's hand writing was illegible as a result of insufficient training and practice
- Children basic literacy skills were sorely deficient, notably the use of correct spelling and proper use of language forms as a result of an insufficient vocabulary and inadequate reading and exposure to new words
- Learners were unable to make meaning of written text and demonstrate comprehension
- An inability to read instructions
- An in inability to translate word problems into numbers (Department of Basic Education, 2012).

4.3.3 Inequities in learning outcomes

There are massive inequities in learning opportunities and outcomes among children in South Africa along racial, socio-economic and geographic lines (Taylor, Van der Berg, & Burger, 2011). Spaull observes that all analyses point to the reality of "two different public school systems in South Africa. The smaller, better performing system accommodates the wealthiest 20-25 percent of pupils who achieve much higher scores than the larger system which caters to the poorest 75-80 percent of pupils." For the latter group, educational outcomes "can only be described as abysmal. These two education systems can be seen when splitting pupils by wealth, socio-economic status, geographic location and language." (Spaull N. , October 2013). Thus it is not just inequities in the children's backgrounds, but also inequities in the schools they attend that are of concern. Children from very disadvantaged backgrounds who enter well-resourced schools do better: the quality of schooling can compensate for disadvantage. However, the majority of schools serving poor communities, exhibit equally depressed socio-economic conditions (Taylor, Van der Berg, & Burger, 2011). There is wide variation in the quality of education in former White Afrikaans and English schools and the historically black and Coloured schools – one year of education in the former is not equivalent to one year in the latter (Taylor, Van der Berg, & Burger, 2011). By "the fifth grade the educational backlog experienced in historically black schools is already equivalent to more than two years' worth of schooling."

Inequality in the basic education system has a significant bearing on Save the Children's education breakthrough priority. Compared to wealthier children who are educated through the better performing education system, the majority of African and Coloured children living in poverty (and who live in rural areas, in the former apartheid homelands, and who have an African home language) and who receive an education through the larger education system accommodating 75 – 80 percent of children, leave primary school unable to "read and write and compute at grade-appropriate levels [and are] functionally illiterate and innumerate" (Spaull N. , October 2013).

The extent of the disparities are starkly evidenced by a socio-economic analysis of a number of learner assessment scores. For example, the average reading score in the SACMEQ III evaluations for the richest 20 percent of learners in Grade 6 was 605, compared to 436 for the poorest 20 percent of learners. The average score for the poorest 80 percent of learners was below the SACMEQ average of 500 across all countries (Spaull N. , March 2011).

95 percent of the children that attained below 35 percent in the 2011/12 ANA results (for reading and mathematics) were in the poorest quintiles compared to only 6 percent on the top quintile schools (Branson and Zuze, 2012 in (SAHRC and UNICEF, 2014).

In 2012, 1 407 schools had a matric pass rate below 60 percent which is the standard used by the DBE to identify underperforming schools. 86 percent of these schools were in quintiles 1,2 and 3 (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

Children in rural areas perform substantially more poorly than their urban counterparts. Grade 4 learners from rural areas achieved more than 100 points less than their urban learners in the 2011 PILRS evaluations (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012).

The prePirls (2011) results show that children in terms of reading levels, Grade 4 children in rural areas and informal urban townships are two to two and half years behind children in urban areas (Spaull N. , October 2013). Whilst the SACMEQ III results show a national average for functional illiteracy amongst 13 year olds of 29 percent, the number is substantially higher amongst 13 year olds in rural areas (58 percent) and those living in poverty in quintile one (44 percent) (Spaull N. , October 2013).

It further shows that the children who learn in an African language achieve significantly lower reading / literacy levels than those taught in English and Afrikaans (Spaull N. , March 2011). Howie et al observe that the 2011 PIRLS results revealed that "South African Grade 4 learners, particularly those tested in African languages, achieved well below the international centre point despite having written and easier assessment. They were still performing at a low level overall on an easier assessment compared to their counterparts internationally… Learners tested in Afrikaans and English performed relatively well and above the international centre point. However, those tested in all African languages, despite most writing in their home language, achieved very low outcomes …. More than half the learners tested in Sepedi and Tshivenda could not read at a basic level required for successful reading" (Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012). On the other hand, only about 10 percent of Grade 4 children whose home language was English or Afrikaans could not read by the end of Grade 4.

5. UNDERLYING REASONS FOR INEQUITABLE EXCLUSIONS AND POOR AND INEQUITABLE EDUCATIONAL OUTCOMES

There are a number of gaps and challenges, and resultant inadequacies in the policy, programmatic, implementation and accountability responses to the risks that exclude children and shape their cognitive and educational development.

5.1 Reasons for inequitable exclusion of especially vulnerable groups

The ongoing exclusion of especially vulnerable groups of children from ECCE programmes and primary school is attributable in large measure to systemic weaknesses in the policy and legislative framework.

5.1.1 Policy and legislative gaps

Poor access to ECCE, especially for marginalised children

The low levels of access to ECCE programmes for children in South Africa, notably children living in poverty, the youngest children, children with disabilities, refugee children and children in underserviced areas is fundamentally linked to the failure, by the GRSA to fulfil its responsibilities to make ECCE universally available for all children and equitably accessible. There is currently no national ECD policy which articulates and drives the public provision of ECCE. At present, ECCE is largely privately provided with no comprehensive policy or law in place articulating the GRSA's responsibilities against which it may be held to account for its ECCE obligations – that is: to undertake the population-based planning, funding, infrastructure development, human resource provisioning and quality control necessary to make ECCE universally available and to resource it in a manner that ensures equitable access for disadvantaged children (Department of Performance, Monitoring and Evaluation, 2012). There is a draft national ECD policy that has been developed and is currently going through consultative processes under the direction of the Department of Social Development which seeks to remedy these deficiencies. The draft policy will be subjected to a number of further processes and there is a risk that a number of the policy proposals which are critical to ensuring universal availability and equitable access may be excised or amended.

Access challenges for children living in poverty

Whilst the basic education's resourcing policy is founded on a pro-poor foundation a number of children living in poverty face school-access challenges because of a number of policy gaps and disjunctures in the school funding and fee-exemption policies. These include:

1. The quintile-based ranking system underpinning the no-fee ranking of schools serves to exclude schools with high numbers of poor learners, but which are situated in the geographical boundaries of the higher quintiles (Martin, P, 2014a).
2. Fee exemptions are not readily granted to learners attending fee-charging schools because the current policy does not make adequate provision for

compensating schools adequately for lost fee-based revenue (Martin, P, 2014a).

3. Transport and school uniforms constitute a significant poverty-related barrier, yet there is no effective policy in place to assist poor children to cover these costs (Martin, P, 2014a). The issue of transport has been aggravated in poor and under-resourced areas by the DBE's school consolidation policy. The DBE has closed down many schools in remote areas servicing few children. The affected children are required to travel much longer distances to schools, but there has been no accompanying programme for the provision of transport (Interview, Doron Isaacs, Equal Education).

Access challenges for children with disabilities

The GRSA, in principle, has committed to the provision of an inclusive education system which guarantees access to education for children with disabilities. The relevant commitments, undertakings and responsibilities are documented in part in the South African Schools Act and White Paper 6 on Inclusive Education. The latter document covers much of the detail of the State's responsibilities and requires that adequate and appropriate infrastructure, schools, teachers and learning and teaching support materials be made available to accommodate all children with disabilities. Many of the access challenges facing children with disabilities relate to inadequate resource allocation and utilization, especially by the provincial departments of basic education. However these challenges in turn are founded on a fundamental weakness in the governing legal framework. The obligations of the departments are founded on White Paper 6 which is not a law, but rather a broad statement of government policy. "Until such time as the policy is reduced to laws it is not actionable and it is difficult to hold government to account for specific commitments and deliverables" (Martin, P, 2014a).

Access challenges for refugee and unaccompanied children

Whilst the Constitution of the Republic of South Africa and the South African Schools Act guarantee the education rights of all children in South Africa, refugee children separated from their parents are prevented from enrolling at school by provisions in the Admission Policy for Ordinary Public Schools, the Refugee Act and policies and practices of the Department of Home Affairs (DHA).

The current admissions policy permits the enrolment of refugee children whose parents have valid temporary or permanent resident permits as well as those who can present proof of having applied to the DHA for the children's legal residency. Migrant children who have been separated from their parents are unable to comply with either of these documentation requirements and are thus prevented by the terms of the admissions policy from registering at South African public schools. In addition, the DHA has pursued an active policy of prohibiting schools from enrolling children in these circumstances and has threatened schools that do so with fines (Veriava, Refugee children win right to learn, 4 July 2014).

The caregivers of children are unable to present legal residency documents for the children or even proof that they have applied to DHA for the said documents. This is because they are unable to apply to the DHA as the Refugee Act does not recognise non-parents as guardians and only guardians may make the necessary applications to DHA. A guardianship application process must be made through the High Courts and is too expensive as a viable option for the caregivers of children in these circumstances.

A recent court case led by the Centre for Child Law and Lawyers for Human Rights on behalf of a number of undocumented children separated from their parents has resulted in a court order for appropriate policy reform. The DBE did not oppose the matter and agreed to amend the Admission Policy. The court order requires that the DBE and DHA amend the Admission Policy and Home Affair's policies and practices within 6 months to allow the registration of this group of children at schools and to facilitate their asylum applications (Bulambo Miakomboka Mubake v Minister of Home Affairs NGHC case no: 72342/2012 as discussed in (Veriava, Refugee children win right to learn, 4 July 2014).

5.1.2 Implementation challenges excluding vulnerable children

Apart from the preceding policy and legislative gaps, the current legislative framework provides a strong protective and promotive environment securing access to school for marginalised and vulnerable children. However, poor knowledge of rights and responsibilities as well as prejudicial attitudes and practices by school principals and governing bodies contributes to low levels of implementation and respect for the rights of refugee children, children living in poverty and children with disabilities.

5.2 Reasons for poor and inequitable educational outcomes

Much attention has been paid to the underlying systemic causes of poor and inequitable educational outcomes of children in South Africa. Across the analytical spectrum there is agreement that the following are the primary causes:

5.2.1 Poor access to quality early childhood care and education

The foundations for and inequitable learning outcomes are laid at birth. The low socio-economic status of children and the associated poor access to basic and essential services and support, starting at birth, exposes them to a number of deficits which undermine their cognitive development. Inadequate nutrition, poor access to health care, toxic stress brought on by poverty, maternal depression and higher levels of alcohol abuse, poor access to basic services and low levels of early learning stimulation, notably in the first 1000 days, inhibit children's development. This leads to lower cognitive and psychological functioning and as a result poor educational attainment. Left unchecked, the differences in ability and outcomes widen over time (Walker, Wachs, & Grantham-McGregor, 2011) (Department of Performance, Monitoring and Evaluation, 2012).

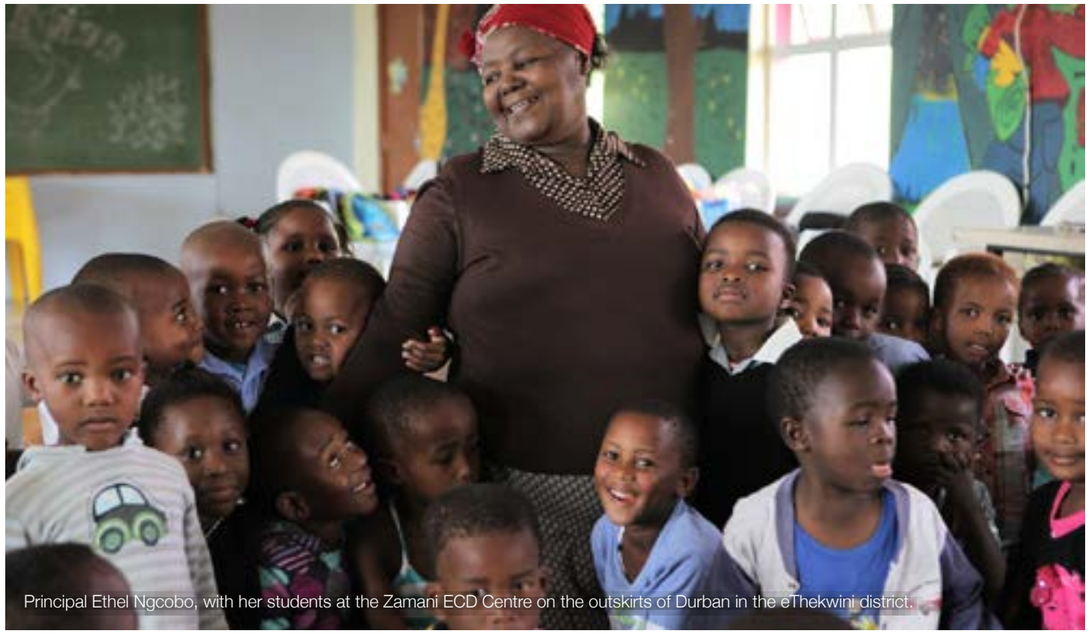
The resulting deficits and inequalities in learning outcomes present very early in children's schooling career – by the age of 8 years there are already substantial inequities in learning outcomes (Spaull N. , October 2013). These accumulate and are magnified over time, with the result that the gaps between children, and the gaps between what disadvantaged children should know and what they do know grow. The negative cycle starts with poor early childhood development which contributes to children not acquiring the levels of foundational literacy skills and competencies in the first few years of schooling. As they move from one grade to the next without the capacities necessary to master the higher grade work, they "fall further and further behind the curriculum leading to a situation where remediation is almost impossible" (Spaull N. , March 2011).

Poor and widening inequities in educational outcomes for children living in poverty and other constrained circumstances is however not inevitable. Access to quality ECD and quality pre and primary education, especially in the foundation phase, can compensate for socio-economic inequities and equalise young children's learning opportunities and their learning outcomes (Department of Performance, Monitoring and Evaluation, 2012) (SAHRC and UNICEF, 2014) (Spaull N. , March 2011) (Engle, 2011).

As previously noted, access to ECCE is severely limited for children who require it most to counter-balance inequities in educational opportunities brought about by constrained socio-economic circumstances at birth.

5.2.2 Poor quality of ECCE, pre-school and primary education

The poor quality of early education is a game changer for education and for achieving broader national developmental goals of reduced poverty and inequality (SAHRC and UNICEF, 2014).



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Principal Ethel Ngcobo, with her students at the Zamani ECD Centre on the outskirts of Durban in the eThekwini district.

There is a growing body of science supporting the conclusion that access to early childhood care, development and education can equalise educational opportunities and outcomes. This includes a comprehensive suite of services from birth, ranging from access to social security from an early age, access to health care, as well as early stimulation and education. Early stimulation and education in the pre-school years is particularly important for laying the necessary foundations for acquiring sound literacy skills – "opportunity for language learning is greatest before children enter school" (Departments of Performance Monitoring and Evaluation & Basic Education, 2014).

However, realizing the full potential of these interventions requires the development and provision of high quality early education, starting at birth until the end of the foundation phase (end of Grade 3) (Department of Performance, Monitoring and Evaluation, 2012). Quality early education and in the foundation phase can compensate for disadvantages attributable to low socio-economic status. Children from disadvantaged backgrounds who receive quality learning stimulation and education from birth, quality pre-school and quality education in the formal foundation phase, from Grades R through Grade 3 do better (Department of Performance, Monitoring and Evaluation, 2012) (Hungi, Characteristics of Grade 6 Pupils, their Homes and Learning Environments, 2011) (Spaull N. , March 2011) (Taylor, Van der Berg, & Burger, 2011).

The quality of education provided through ECCE programmes, at Grade R level and in primary schools is very poor, notably so in programmes and schools serving poor communities (Biersteker, Dawes, Hendricks, & Tredoux, 2010) (Department of Performance, Monitoring and Evaluation, 2012). "All of the available evidence suggest that many South African children are acquiring debilitating learning deficits early on in their schooling careers and that this is the root cause of underperformance in later years. Because they do not master the elementary numeracy and literacy skills in the foundation and intermediate phases, they are precluded from further learning and engaging fully with the grade-appropriate curriculum" (Spaull N. , October 2013).

Whilst there has been massive increased in the enrolment rates of children in Grade R and primary school, the quality of Grade R and the first three years of primary school (the foundation programme) is very poor in the majority of schools serving poor communities. Quality in schools serving the poorest quintiles (75 percent of children), notably in these early years, is too poor to equalise earlier inequities; and indeed serves widen the gap in educational opportunities and outcomes for vulnerable children (Taylor, Van der Berg, & Burger, 2011).

Coinciding with the GRSA's policy to universalize Grade R, the rate of enrolment of children in Grade R (formal pre-school year) increased from 15 percent in 1999 to 75 percent in 2012 (Department of Basic Education , 2013). The massive increase in Grade R enrolments has however made no measurable impact on the learning outcomes of children in the poorest 3 quintiles; instead of reducing inequalities, Grade R "further extends the advantage of more affluent schools." Whilst Grade R has no meaningful impact on improving the learning outcomes of children in the poorest three quintiles, in quintiles 4 and 5 it contributed to a 10 to 20 percent deviation gain in both language and maths (Departments of Performance Monitoring and Evaluation & Basic Education, 2014). The failure to realise the equalizing potential of Grade R is attributed to the poor quality of teaching provided in the reception year. Despite the near-universal roll out of Grade R, approximately 65 percent of Grade R learners enter Grade 1 without the skills necessary to master reading (Departments of Performance Monitoring and Evaluation & Basic Education, 2014).

Quality deficits are not limited to Grade R, but are endemic to the schooling system resulting in poor quality in all years of schooling in the majority of schools serving poor communities. The lasting impact of the low quality in the foundation years does however call for prioritizing quality improvement at pre-school level and in the foundation phase (Taylor, Van der Berg, & Burger, 2011) (Spaull N. , October 2013) (SAHRC and UNICEF, 2014).

5.2.3 Inefficient use of resources

Analysts agree that the poor quality of education in South Africa is not attributable to lack of resources, but rather the inefficient use of resources (Motshekga, 15 July 2014) (Spaull N. , March 2011) (Taylor, Van der Berg, & Burger, 2011) (Spaull N. , October 2013).

Inefficiencies in the allocation and use of resources contributes to the following outcomes, all of which contribute to poor teaching and learning:

1. Inadequate infrastructure and inequitable access to an enabling school environment in the poorest provinces
2. Overcrowded classrooms
3. Inadequate learning and teaching support materials such as textbooks and workbooks, laboratories and libraries
4. Poor teacher knowledge and skills, notably the quality of reading instruction and content knowledge
5. Poor curriculum coverage.

5.2.4 The quality and language of teaching and learning

It is widely recognised that the quality of teaching and learning in South Africa is poor and results in poor literacy outcomes for children. What is not clear is what is required, in the classroom, to improve the quality of learning and teaching taking place to improve literacy outcomes. It is easy to identify and address the environmental and teaching and learning resource deficits, but less clear on what is required to improve literacy teaching and learning in the classroom. As a result there is no clear programme of action to address quality at this level in the classroom (interview, Doron Isaacs, Equal Education).

It is widely recognised that children learn better if they are taught in their home language, especially in the first years of schooling. South Africa's education policy seeks to accommodate this foundation to quality learning outcomes by making provision for teaching and learning to take place in a child's home language in the first three years of formal schooling.

There are however significant impediments to the effective implementation of the policy and as a result, children whose home language is not English or Afrikaans achieve significantly lower literacy scores (Hungi, N, 2011a) (Martin, P, 2014a).

5.2.5 Weak management and accountability mechanisms

Weak management skills, leadership and accountability mechanisms, notably in the positions of school principals and School Governing Bodies contribute to inefficiencies in the system. Whilst the DBE has taken a number steps to address the capacity of school principals, few steps if any have been taken to systemically improve the knowledge and capacity of SGBs, especially those supporting schools in poorer communities to play a constructive role in the management and oversight of the use of resources (Martin, P, 2014a).

Parents that are actively and informed participants in the governance of the school and which play an oversight role over expenditure and school budgeting can exert a positive influence in resolving school challenges (Modisaotsile, March 2012). Similarly, where communities are involved and aware of the school needs and challenges, they are able to articulate community education needs, hold officials accountable and mobilize resources where there are shortfalls. SGBs offer a dedicated space for parental and community participation. However, the weaknesses in the SGB system limit the potential value of this institution for improving educational outcomes. Evidence shows that parent's lack of participation and the weak functioning of school governing bodies (SGBs) contribute to poor teaching and learning experiences – which are among key factors contributing to poor educational outcomes in schools in South Africa (Modisaotsile, March 2012).

Parental and community involvement is particularly important in South Africa in the context improving the inefficient use of resources as a key foundation for the provision of quality education. Accountability for use as required by laws and policies, such as the recently promulgated Regulations relating to minimum uniform norms and standard for public school infrastructure, depends on active compliance monitoring by parents and school communities (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014). This requires that parents and school communities be enabled through knowledge, skills and external legal support to know their children's rights, the school system's responsibilities and the accountability processes available to them. In his concluding observations responding to his analysis of the underlying reasons for, and solutions required to address the poor quality of education in South Africa, Spaull observes that "One of the most pressing needs in South Africa education – and civil society more generally – is a strong commitment to accountability and transparency" (Spaull N. , October 2013). This does not only require strengthening of top-down responsibility, but also a correction of the country's lack of "bottom-up accountability" (RESEP and Oxford Policy Management in (Spaull N. , October 2013).

5.2.5 Insufficient support for parental participation in education

"Parent involvement is an important part of any whole school strategy aimed at school improvement" (Lemmer, 2007). Research suggests that parent involvement in their children's education is a cost-effective way to improve the culture of teaching and learning which is needed in South African schools. Results from the SACMEQ III study confirm that parental support at home with homework and support for, and the cultivation of a culture of learning, improves educational outcomes among children with a low SES (Hungi, N, 2011a).

There are multiple ways for parents (and extended family members) to become involved in schools beyond mere fundraising and participation in school governance (Lemmer, 2007). A study conducted by Lemmer found that parent involvement created a sense of support for teachers under pressure; reduced stress and tension amongst teachers and principals alike; teacher professionalism was strengthened merely by the presence of parents in the school; reduced teacher and learner absenteeism; improved the support provided for learning at home (Lemmer, 2007).

There are however a number of challenges to parent involvement which are not adequately addressed by the current system, especially for parents living in poverty. These include low literacy levels, lack of transport and the cost of participating in school events, lack of child-care facilities, family-unfriendly attitudes at schools, and language barriers (Lemmer, 2007).

SACMEQ analysts recommend the introduction of special home intervention projects which train teachers on how to change parental behaviour in the home so that children receive more support and encouragement for studying. Studies in Malaysia have shown these interventions to be successful in raising the achievement levels of children from disadvantaged backgrounds with poor parents or lower literacy levels. They have also been shown to have the potential to reduce the large inequities in pupil achievement between rich and poor children (Hungi, N, 2011a).

6. PRIORITIZING EDUCATION ISSUES

There are clearly multiple issues underpinning the poor literacy outcomes for children by the end of their primary schools. In moving forward towards 2015 beyond, there is widespread consensus, not only that remedying the quality of education, notably in the earliest years, is foundational to the realisation of the right to education for all children and to sustainable development, but also on the issues and measures that must be prioritized in moving forward towards attainment of these goals.

At an international, regional and national level, rights and development initiatives charting the way forward to 2015 and beyond, there are unanimous calls for the prioritization of improvements in:

- Access to and the quality of early childhood development, including early learning from birth
- The quality of education In the foundation phase (Grades R – 3)
- Access to and the quality of education for especially marginalised children, notably children with disabilities, children living in poverty and migrant and undocumented children
- Government accountability for fulfiment of education rights and development commitments and progress against the prioritized outcomes (United Nations General Assembly Working Group on Sustainable Development, 2014) (Global thematic consultation on education in the post-2015 development agenda, 2013) (UN Special Rapporteur on the right to education, 2013) (GRSA's National Development Plan and the Medium Term Strategic Framework).

The post-2015 development agenda requires an acceleration in progress towards attainment of the EFA and MDG education goals of access, equity and quality. This in turn requires the adoption of a human rights-based approach with a strong focus on equity and quality. This means that the GRSA, as the primary duty bearer, must prioritise and must be held accountable for fulfiment of its duties to ensure universal, equitable public provision and regulation of quality of education for all children, starting from birth (UN Special Rapporteur on the right to education, 2013).

The education agenda leading up to 2015 has driven progress in certain areas. However, as a framework for action, it has neglected core elements of the right to education which are intrinsically valuable and of critical importance to sustained development. The post-2015 agenda must focus on these neglected areas, including the following:

1. Reaching the poor and marginalized and ensuring equity in access and quality for groups such those living in poverty, in remote and rural contexts, children forced to work, migrants and children with disability. Children with disability constitute a significant segment of the out-of-school population and have been systemically excluded in development planning, policies and budgeting.
2. Achieving equity in education and developmental equality requires that the post-2015 education agenda focus on the historical and structural inequalities which drive educational inequities. This requires addressing inequities at source through systemic interventions which recognise and address intersecting inequalities rooted in South Africa's history and socio-economic arrangements (Global thematic consultation on education in the post-2015 development agenda, 2013).
3. A notable systemic solution is universal access to high quality early childhood care and education to equalise deficits in cognitive development rooted in poverty and related socio-economic stresses into which many children in South Africa are born into (UN Special Rapporteur on the right to education, 2013). (Department of Performance, Monitoring and Evaluation, 2012) (The National Development Plan 2030: Our future - make it work, 2012). ECCE is crucial to preparing children for school and for addressing inequities in educational achievement at an early stage (The Consultative Group on Early Childhood Care and Development, 2014) (Global thematic consultation on education in the post-2015 development agenda, 2013)
4. The emphasis on the pre-2015 agenda on primary education has contributed to the neglect of early childhood care and education. Progress on ECCE has been too slow, notably for children in poorer and under-resourced areas. Almost exclusive private provision has impacted on access and quality of pre-school and a neglect of early childhood care and development before pre-primary, starting at birth. This is a particularly important priority in the post-2015 agenda because ECCE is one of the most effective interventions proven to equalise the educational opportunities of children born into poverty and related circumstances which set back their cognitive development.
5. The quality of education has been sorely neglected within the current development framework. The focus to date has been on access at the expense of quality. As a result there is a global literacy crisis, with 250 million 4th graders unable to read and as a result millions of children have been unable to move to higher levels of education and onto meaningful employment (UN Special Rapporteur on the right to education, 2013) (Global thematic consultation on education in the post-2015 development agenda, 2013) (The National Development Plan 2030: Our future - make it work, 2012). "A stronger commitment to good-quality education, with a focus on learning, can be construed as perhaps the most important priority for a post-2015 education agenda" (Global thematic consultation on education in the post-2015 development agenda, 2013). Quality is particularly important in the earliest years of education, notably early childhood and the foundation phase.
6. In all of the neglected areas, including early childhood education, public investments in the financial, human capital and infrastructural resources have been insufficient to ensure access and quality.
7. Strengthened public-private partnerships are critical to addressing resource and quality deficits. However, this is always subject to the proviso that the State remains responsible and accountable for the provision of quality and accessible education at all levels. This requires effective regulation of the role and services provided by the private sector as merely one component of the publicly provided education system guaranteeing universal availability and equitable access, especially for the most marginalised, as well as mechanisms for ensuring accountability by all role players for contributions to education priorities (Global thematic consultation on education in the post-2015 development agenda, 2013).
8. Gender-based violence in schools as well as ineffective sexual and reproductive health education has inhibited girl's participation and educational attainment(Global thematic consultation on education in the post-2015 development agenda, 2013)

These priorities are acknowledge and embedded in the emerging education agenda in South Africa as reflected in the DBE's budget and Strategic Plan and the broader National Development Plan and Medium Term Strategic Framework.

The GRSA has committed to improving access to and the quality of early education through a focus, between 2014 – 2019, curriculum coverage and strengthened efficiency and accountability in the provinces, districts and schools (Motshekga, 15 July 2014). An amount of R 30 million has been allocated to the National Initiative to improve Learning Outcomes, increasing to R 40 million in 2015/16,

In moving forward, priority must be given to ensuring the efficient use of the ever-increasing resources ploughed in to education and this depends on prioritizing strong accountability mechanisms and processes at all levels of the system. The National Development Plan confirms that accountability is the bedrock of achieving the country's education goals in its statement that:
Accountability is essential to democracy. There are several weaknesses in the accountability chain, with a general culture of blame-shifting. The accountability chain has to be strengthened from top to bottom. To begin with, parliamentary accountability is weak, with Parliament failing to fulfil its most basic oversight role. Education outcomes cannot improve unless accountability is reinforced throughout the system, from learner results to the delivery of textbooks.

7. ORGANISATIONS ENGAGING WITH ISSUES

There are many organisations that are actively engaged in the promotion of the realisation of the rights of children under the heading of the various priority issues.

7.1 Improving access to and the quality of early childhood development and education

In the ECD sector there are many non-profits that are involved in the direct provision of ECD services and support. In addition, a number of larger organisations, such as TREE and ELRU and Ilifa Labantwana are engaged in the development and documentation of comprehensive models of ECD provisioning and advocacy for scaling up of tested models. A number of organisations are also involved in building the capacity of practitioners with a view to improving quality, with a number of organisations engaging in advocacy for a stronger and more appropriate qualifications framework.

7.2 The quality of education through improved efficiencies

There are multiple organisations engaging in the provision of support and multi-strategy advocacy initiatives aimed at improving the quality of education. These range from teacher capacitation projects, to curriculum development and support initiatives, to campaigns for improved and equitable infrastructure and teaching and learning support material provision. Organisations driving the quality improvement agenda include the Centre for Child Law, the SAHRC, S 27, Equal Education, Layers for Human Rights and others.

7.3 Access to education for marginalised children

There are a number of organisations which work on aspects of improved accessibility of education for children with disabilities such as Inclusive Education, and for refugee children, such as the Refugee Rights Centre at UCT. However there organisations appear to be addressing discreet issues in a piecemeal fashion, rather than through the strengthening of the whole education system (in all its components) to meet the holistic education needs of vulnerable groups. AS such we are not seeing systemic shifts in the governing inclusive education system in South Africa.

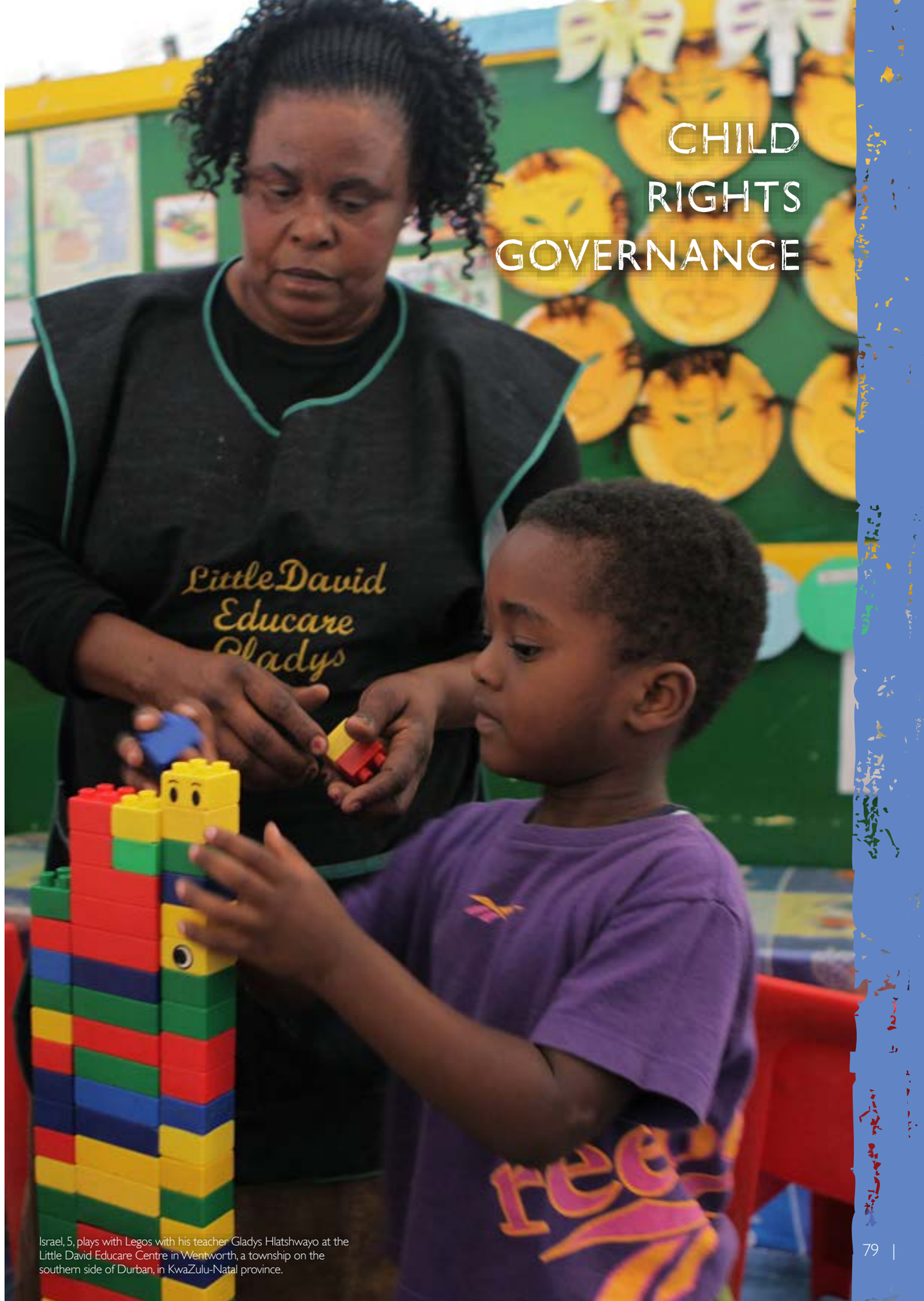
7.4 Governance and accountability

Many organisations are working on supporting the strengthening of school governing bodies, largely through the provision of training and other capacity-building interventions. There appears however to be little advocacy for fulfilment of government's responsibilities to ensure the sustained capacitation of SGBs and parents and communities.

8. SUMMARY OF EDUCATION ISSUES NOT RECEIVING ADEQUATE ATTENTION

On the whole, there are large numbers of organisations active in the education sector, leaving few unique spaces for involvement. However there are a number of strategic entry points for Save the Children. These include the following areas which are not receiving adequate attention:

1. A national campaign supporting the adoption of a comprehensive ECD policy and programme of action capable of ensuring universal availability and equitable access to quality ECD and ECCE services.
2. Systemic campaigns for an effective and legally enforceable inclusive education system which guarantees access to quality education for all children affected by disabilities, poverty and displacement, etc.
3. Given the many developments to address poverty as a barrier to educational access, and given the shift in emphasis in recent years to addressing the poor quality of education, poverty-related barriers, which remain an obstacle to access, no longer receive the advocacy attention necessary to overcome remaining hurdles. These include fee barriers, transport and the cost of school uniforms (interviews, Faranaaz Veriava, Section 27 and Doron Isaacs, Equal Education).
4. There is a need for focussed research and advocacy for the identification and implementation of measures capable of bringing about improvements in the quality of teaching and learning in the classroom (interview, Doron Isaacs, Equal Education).
5. Advocacy for sustainable and effective measures to improve the knowledge, quality of, and accountability of SGBs (interviews, Nikki Steyn and 'Faranaaz Veriava, Section 27).
6. Advocacy for stronger government-driven support for parental and community involvement in education as a key accountability mechanism.



Israel, 5, plays with Legos with his teacher Gladys Hlatshwayo at the Little David Educare Centre in Wentworth, a township on the southern side of Durban, in KwaZulu-Natal province.

E. CHILD RIGHTS GOVERNANCE

1. BREAKTHROUGH / PRIORITY OUTCOMES AND OBJECTIVES SAVE THE CHILDREN

Breakthrough / priority outcome for Save the Children: All children, especially the poorest, benefit from greater public investment and better use of society's resources in realising children's rights.

Priority objective: To strengthen governance mechanisms and structures in government and civil society that impact on the fulfiment of children's rights and ensure children voices are heard (Save the Children , 2010).

2. RESPONSIBILITIES OF THE GRSA

Operating as it does within a child rights-based framework, the GRSA is required to take all necessary measures to ensure the full realisation of the full complement of children's rights protected by international, regional and national instruments. In addition to having to take steps to realise each of the individual rights through the development of sectorally-specific laws, policies and programmes, it is obliged to develop a country-wide child rights governance system. The fact that rights are universal and interdependent means that the realisation of any and the collective body of rights requires collective actions across the full spectrum of the State actors; across all departments, across all levels of government (national, provincial and local), and across all segments, including civil society. The UN Committee on the Rights of the Child thus requires that every country develop a national child rights governance system which:

1. Articulates the common child rights goals and objectives into a National Plan of Action
2. Articulates the roles and responsibilities of different stakeholders
3. Makes provision for mechanisms to hold stakeholders to account
4. Makes provision for measurement of progress against child rights goals and targets
5. Makes provision for an independent coordination and oversight body with the dedicated roles of coordination across sectors and levels of government and monitors and reports on progress made towards realisation of children's rights
6. Establish mechanisms to coordinate State interventions around cross-cutting rights, risks and issues
7. Makes provision for the establishment of child-friendly and accessible rights-enforcement mechanisms
8. Systematises the participation of children and civil society in the development, implementation and monitoring of all steps taken towards realisation of the rights of children (UN CRC) (UN Committee on the Rights of the Child, 2003) (UN Committee on the Rights of the Child, 2002).

3. PROGRESS IN ESTABLISHING CHILD RIGHTS GOVERNANCE SYSTEMS

3.1 Measures taken to date

South Africa has taken a number of steps towards fulfilment of its preceding obligations. These include:

1. The legislative protection of the right of children to participate in the making of decisions that impact on them in the home, school, community and government (Pan Children, 2011).
2. The development of a revised and updated National Plan of Action for Children in South Africa 2012 – 2017 which documents a national common set of goals and objectives and responsible role players and their assigned responsibilities for the protection, promotion and realisation of children's rights in South Africa (Department of Women, Children and People with Disabilities, 2012).
3. The establishment of a dedicated Ministry and Department of Women, Children and People with Disabilities to coordinate State action and monitor and report on progress made on responsibilities to children.
4. The establishment of a number of issue-specific coordinating structures to facilitate State-wide responses to cross-cutting issues such as ECD, children affected by HIV and AIDS and children involved in child labour.

3.2 Key concerns with the child rights governance system

3.2.1 The dissolution of the DWCPD

The advent of democracy in South Africa was complemented by a growing recognition of children's rights and the establishment of high-level structures to pursue realisation of the State's responsibilities to them. Driven by a strong and collective child rights civil society sector which provided a vehicle for children's voices, various structures and processes were developed and implemented, culminating in the establishment of the Ministry and Department of Women, Children and People with Disabilities (DWCPD). Whilst there were a number of capacity constraints in the department, it was able to provide a state-wide vehicle for coordinated development and review of progress against child-rights commitments.

The DWCPD was however disbanded in 2014 and its functions absorbed into the Department of Social Development. This development is contrary to international obligations and marks a worrying trend developing in South Africa which is seeing children slipping off the political agenda. Children, unlike women who retained a dedicated department within the Presidency, are not seen to have political capital and systemic investments have accordingly reduced substantially (discussion group at LINC fellowship, Gauteng, August 2014).

3.2.2 The failure to mainstream children's rights at all levels of government

As can be seen from discussions in the previous sections of the report, the child rights governance system is failing children in marginalised areas, and as a result sustaining high levels of inequity across the country. No matter what right one is dealing with, there is a consistent failure in the fulfiment of responsibilities to children at a provincial and local government level. South Africa has wonderful national policies protecting almost all children's rights. However, the vision of many of the policies is frustrated by the failure at implementation level – that is at provincial and local government level. This is largely the case in the poorest provinces and municipalities and is the result of many factors, including lack of clarity on specific roles and responsibilities, lack of skills and capacities, and mist fundamentally, inadequate accountability mechanisms (Department of Women, Children and People with Disabilities, 2013) (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

3.2.3 No child-friendly rights-abuse reporting and resolution mechanisms

South Africa lacks an independent child-friendly rights-abuse reporting mechanism (Department of Women, Children and People with Disabilities, 2013). Children have to go to extreme lengths to lodge complaints and receive appropriate support (SAHRC workshop on corporal punishment, Gauteng, July 2014). The SAHRC has a dedicated child rights commissioner, but no child-friendly dedicate reporting mechanism and resource constraints inhibit the capacity of the SAHRC to receive and respond to violations (Parliamentary Programme of the Community Law Centre, University of Western Cape & Carol Bower (Ed), 2014).

3.2.4 Children's participation is not systematised

Children's participation is recognised in law, but has not been systematised across all decision-making domains, including the home, school and government. There are ad hoc initiatives in place to facilitate children's input into discreet issues. However there are no systemic procedures and budgets in place to secure consistent participation in, for example, all policies and laws that impact on children (Pan Children, 2011).

3.2.5 Absence of campaigns to address common cross-cutting issues underlying child-rights violations

From the discussions under the preceding sections of this report that there are a multitude of cross-cutting issues which underlie transgressions of rights in all domains or which harbour systemic protective value in the potential to promote realisation of multiple rights.

These systemic issues require appropriately systemic solutions across all sectors and within all relevant departments; this in turn requires organised advocacy campaigns driven by stakeholders across the sub-sectors targeting the resolution of the common underlying issues. There is however a stark absence of coordinated advocacy across the children' sector to address common cross-cutting issues such as:

1. Identification documentation difficulties
2. Access to social security for the most vulnerable children

3. A comprehensive ECD system in South Africa guaranteed access to a comprehensive quality suite of services and support
4. A comprehensive children's disability policy and programme of action addressing the realisation of, and accountability for the realisation of the rights of children with disabilities across all sectors, services and programmes.

3.2.6 Fractured civil society

South Africa has a rich history of a strong and coordinated child rights civil society sector that has organised itself to represent the voice of children and successfully engaged in robust advocacy to drive systemic change in the country for the benefit of children. The children's sector has, in the past, shown tremendous energy in organising itself to work collectively behind systemic issues and has succeeded in driving political change to ensure compliance with the State's institutional obligations. For example, we have had the Children's Bill Working Group which coordinated sectoral inputs into the Children's Act; the Yezingane Network which has facilitated collaboration to drive a child-rights HIV and AIDS agenda in South Africa; and ACESS, an alliance of more than a thousand organisations which substantially influenced the expansion of children's social security in South Africa.

The funding constraints on civil society have severely curtailed its ability to organise itself and engage in advocacy, with the result that there are few, if any, successful system-wide advocacy campaigns and no identifiable children's sector voice championing children's rights in South Africa. By way of illustration; when the DWPCD was dissolved, there was no public response from the sector, unlike the disability sector which has mobilised for the establishment of a dedicated advisory committee within the Presidency.

4. CONCLUSION

International, regional and national rights and development initiatives recognise that the realisation of children's rights in the period leading up and beyond 2015 requires the development of a strong accountability framework. This in turn requires increased investments in strong child rights governance systems that ensure coordinated civil society and that the voices of children are heard (ACPF and ODI, 2013).

Given the slippage of the political prioritisation of children in South Africa alongside the reduced resources and capacity of the children's sector, attaining the post-2015 child rights and development goals requires a child rights champion in South Africa. There is a need for a strong child-rights organisation to support the coordination and resourcing of the child rights sector and champion the development of systemic and collaborative solutions to the persistent and emergent risks and opportunities which impact on children's rights in South Africa. This is a unique and much needed role that Save the Children South Africa should consider stepping into.

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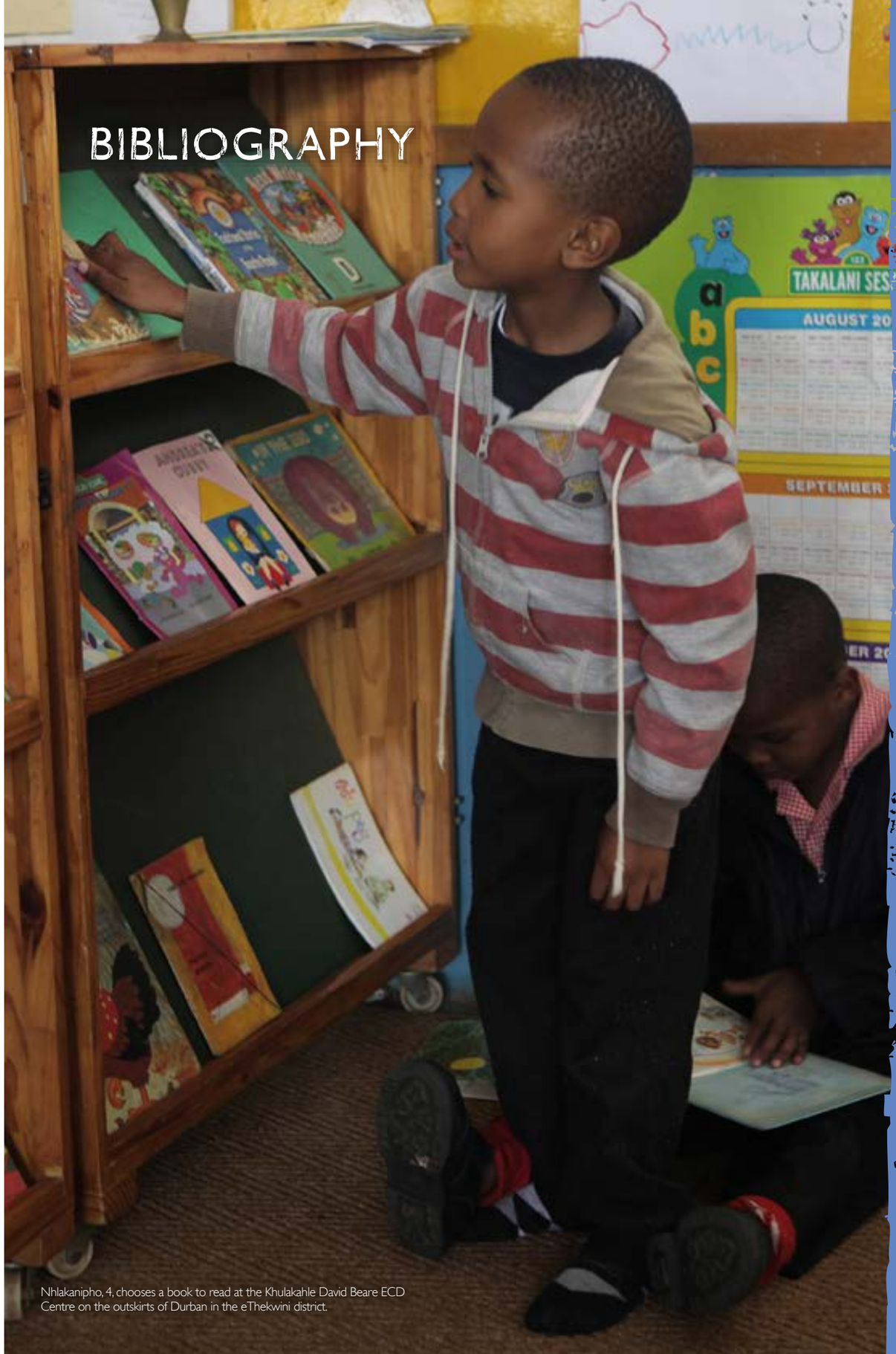

Nhlakanipho, 4, chooses a book to read at the Khulakahle David Beare ECD Centre on the outskirts of Durban in the eThekwini district.

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ANALYSIS OF THE **CHILDREN'S SECTOR** IN SOUTH AFRICA

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