
HEALTH RIGHTS, ISSUES AND RECOMMENDATIONS

Joint Submission of Health Stakeholders in South Africa to the United Nations Committee on Economic, Social and Cultural Rights, 64th Session, 24 September – 12 October 2018



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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral
CESCR	Committee on Economic, Social and Cultural Rights
CHW	Community Health Worker
CRPD	Convention on the Rights of Persons with Disabilities
CSG	Child Support Grant
DCST	District Clinical Specialist Teams
DR-TB	drug-resistant tuberculosis
ECD	Early childhood development
EMS	Emergency Medical Services
FASD	Foetal Alcohol Spectrum Disorder
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IMCI	Integrated Management of Childhood Illnesses
MDG	Millennium Development Goals
MDR-TB	Multi-Drug Resistant Tuberculosis
NCD	Non-Communicable Diseases
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NHI	National Health Insurance
NMR	Neonatal Mortality Rate
NSP	National Strategic Plan
OHSC	Office for Health Standards and Compliance
PHC	Primary Health Care
PHC-R	Re-engineering of Primary Health Care

PMTCT	Prevention of Mother-to-Child Transmission
PIP	Problem Identification Programme
PPIP	Perinatal Problem Identification Programme
RBA	Rights-Based Approach
SASL	South African Sign Language
SERI	Socio-Economic Rights Institute
STI	Sexually Transmitted Infection
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
U5MR	Under 5 Mortality Rate
UHC	Universal Health Coverage
US	United States
VAT	Value Added Tax
XDR-TB	Extensively Drug-Resistant Tuberculosis
WHO	World Health Organisation
ZAR	South African Rand

TABLE OF CONTENTS

ABBREVIATIONS.....	1
INTRODUCTION.....	5
PART 1: RIGHT TO HEALTH UNDER ARTICLE 12	5
I EMERGENCY MEDICAL SERVICES.....	5
II ACCESS TO MEDICINES	7
III NATIONAL HEALTH INSURANCE.....	10
a Introduction.....	10
b Determinants of Health and the National Health Insurance Scheme	10
c Implementation of the National Health Insurance.....	11
d Financing of the National Health Insurance Scheme.....	13
e Discrimination under the National Health Insurance Scheme.....	15
f Further Issues under the National Health Insurance scheme	17
g Democratic Participation in Decisions About Health	21
IV LACK OF COMPETITION IN THE PRIVATE HEALTH CARE SECTOR.....	24
V SANITATION	25
VI ALCOHOL.....	28
VII LANGUAGE	29
a Introduction to language barriers in relation to the right to health.....	29
b Deaf people and the United Nations Convention on the Rights of Persons with Disabilities 2006 (CRPD).....	29
c Key concerns	30
d The consequences of language barriers	31
PART 2: CHILD HEALTH: FROM SURVIVAL TO OPTIMAL DEVELOPMENT	32
I CHILD DEATHS AND MODIFIABLE CAUSES	32
II PROMOTING EARLY CHILD DEVELOPMENT	36

III	EFFORTS TO PREVENT MALNUTRITION AND STUNTING.....	37
IV	DEFINING NORMS AND STANDARDS TO STRENGTHEN ACCOUNTABILITY AND QUALITY OF CARE	39
V	INVESTING IN COMMUNITY HEALTH WORKERS AND BUILDING CAPACITY FOR MATERNAL AND CHILD HEALTH AT DISTRICT LEVEL.....	41
VI	PRIORITISING CHILDREN IN HIV AND TB PREVENTION AND TREATMENT ...	43
VII	INVESTING IN ADOLESCENT HEALTH	46
VIII	ALCOHOL ABUSE	47
IX	ENDING VIOLENCE AGAINST CHILDREN.....	48
X	Mental health.....	50

INTRODUCTION

1. This submission is a result of collaboration from various health organisations and interested parties. It seeks to bring the pertinent health issues facing South Africa to the forefront of the engagement between the State and the UN Committee on Economic, Social and Cultural Rights. Enforcement of the obligations imposed on the State - by international law and the Constitution of the Republic of South Africa, 1996 – has the potential to address the issues raised below. Recommendations are made for steps and measures that can be taken by the State to comply with the obligations imposed by the right to health.

PART 1: RIGHT TO HEALTH UNDER ARTICLE 12

I EMERGENCY MEDICAL SERVICES

2. The South African Constitution recognises the right to emergency medical services.¹ This right is not subject to progressive realisation or available resources.
3. There is a lack of emergency medical services in rural areas, such as the Eastern Cape province of South Africa. Such rural areas are sparsely populated, underdeveloped, poverty stricken and often lack infrastructure such as viable roads and clinics. In such rural areas, the lack of emergency medical services disproportionately impacts on the most vulnerable.² The elderly, women and girls, pregnant women and mothers, persons with physical and mental disabilities, chronically ill persons, and children are most severely affected by the barriers in access to emergency medical services.
4. The opening paragraph of SECTION27's report on emergency medical services in the Eastern Cape, South Africa, captures the severity of the crisis facing the population:

'Mothers giving birth at home; babies developing disabilities due to difficult unsupervised births; diabetics unable to reach treatment; old women crossing rivers and spending most of their pensions to get to the clinic; a 10-year-old boy dying of pneumonia because his mother could no longer carry him to the hospital; a young woman dying in pain after a 10-day wait for an ambulance. Countless tragedies occurring every day across the Eastern

¹ Section 27(3) of the Constitution.

² Treatment Action Campaign & Section 27 Report *Emergency Medical Services in the Eastern Cape*; South African Human Rights Commission Hearing Report of Inquiry into Access to Emergency Medical Services in the Eastern Cape (2015). See also Rural Health Advocacy Project *National Inquiry into EMS in the Eastern Cape*

Cape and stemming from one cause: an emergency medical services system that has failed.³

5. The cause of the failing emergency medical services can be attributed to historical neglect during apartheid and a continuation of poor planning and budgeting post 1994. Many factors contribute to the lack of emergency services, particularly the lack of road infrastructure (making it physically impossible for ambulances to commute), the inadequate number of ambulances, poor reception services, limited ability to contact and request emergency medical care, and lack of emergency services personnel. Due to these factors, the lengthy response times (if even) are death sentences in some instances.
6. The human dignity of the vulnerable in this context is blatantly disregarded by the neglect perpetuated by the ongoing poor governance.
7. The poor state of roads in the rural areas (not only the Eastern Cape) was noted as a major concern by the Human Rights Commission, because it makes it physically impossible for ambulances to reach people in need and impacts financially on those living in poverty, perpetuating financial devastation, hunger and ill health.⁴
8. The fact that it is the most vulnerable, poorest, most ill segment of the population makes this issue a priority to be addressed with urgency. There is much that can be done immediately that will provide some relief in this context. Fundamentally, making the roads drivable for the few ambulances that are available will have a significant impact. Once this physical barrier is overcome, greater issues of resources, personnel, call centres and response times can be addressed.
9. We would like to draw the Committee's attention to the applicability of paragraph 5 of General Comment 14:

'The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.'

³ Treatment Action Campaign & Section 27 Report *Emergency Medical Services in the Eastern Cape*.

⁴ South African Human Rights Commission Hearing Report of Inquiry into Access to Emergency Medical Services in the Eastern Cape (2015).

10. We urge the State to take into account that, although there are certain persistent inequalities in access to emergency medical services that will take time to resolve and address, the issue of physical access regarding road infrastructure in rural areas is an immediate step which can be taken.

Recommendations

11. For the state of the road infrastructure to be immediately addressed under the States' obligation to take immediate steps and to prioritise the most vulnerable;
12. For emergency medical services in the Eastern Cape to be prioritised as a budgetary and governance issue to enable rapid relief – such as providing incentives to attract and retain personnel to ensure sufficient human resources, and providing and maintaining adequate emergency services vehicle;
13. For the social determinants of health implicating the need for emergency medical services to be addressed, such as health education, sanitation, environmental health and nutrition; and
14. That the State engages the communities on their health needs and the barriers faced in adequately addressing the situation of access to emergency medical services, as guaranteed by the Constitution of South Africa.

II ACCESS TO MEDICINES

15. International law, and South African law, recognises the right to health to include the right to access to medicines.⁵
16. While the State rightly acknowledges increased access to HIV/AIDS medicines, many other medicines remain inaccessible. A recent study found that 17 out of 24 cancer medicines, including four WHO essential medicines, were not available in the public sector. High prices, caused by poor quality patents, likely precluded access.⁶
17. Access to new tuberculosis medicines remains similarly constrained. Tuberculosis remains the leading cause of death in South Africa, and drug-resistant TB (DR-TB) is rising.⁷ But the

⁵ In terms of ICESCR article 12, General Comment 14, and South African law, see *Minister of Health and Others v Treatment Action Campaign 2002 (5) SA 703*; Medicines and Related Substances Control Amendment Act 90 of 1997; *Pharmaceutical Manufacturers Association of South Africa and Another: In re Ex Parte President of the Republic of South Africa and Others 2000 (2) SA 674 (CC)*.

⁶ Cancer Alliance and Fix the Patent Laws, Exploring Patent Barriers to Cancer Treatment Access in South Africa: 24 Medicine Case Studies (October 2017). (Of the 24 medicines, 15 were available in India—which better incorporates TRIPS flexibilities—for less than half of the price offered to the South African private sector.)

⁷ World Health Organization, GLOBAL TUBERCULOSIS REPORT 45 (2017).

introduction of a new DR-TB treatment, Bedaquiline, offered hope. It was the first TB drug developed with a new mechanism of action in over 40 years and was quickly added to the WHO essential medicines list. Older DR-TB regimens require painful injections, thousands of pills, and have serious potential side effects, including hearing loss and psychosis.⁸ Most concerning, only approximately half of all patients who start the older multi-drug resistant (MDR-TB) therapy are treated successfully, with the success rate dropping to 11-33% for those with extensively drug-resistant TB (XDR-TB).⁹ But, despite its improved efficacy and safety profile, access to the Bedaquiline remains limited, in part, due to excessive pricing.

18. The government is currently purchasing 6150 six-month courses of Bedaquiline per year for ZAR 33 million. Despite some recently announced discounts, at current prices, adding Bedaquiline to the regimen of all laboratory confirmed drug-resistant TB cases in 2016 (20 040) would cost ZAR 75 million. This is more than double the current yearly amount spent on Bedaquiline, and would require immense spending increases from an already under-resources tuberculosis response. Every dollar spent on high-priced treatment is a dollar taken away from strengthening the TB response, including hiring more health care workers, and conducting contact-tracing to close the gap of 4.1 million undiagnosed people with TB, including over 78% of people globally with drug-resistant TB who are not identified and receiving appropriate therapy.
19. Researchers have estimated that a 6-month course of Bedaquiline could be profitably produced at US \$64 - \$102 (ZAR 770 – 1230)—which is nearly a fifth of the current cost provided by the originator company, Janssen.¹⁰ Treating all laboratory confirmed DR-TB cases with Bedaquiline would cost between ZAR 15 million and 25 million at these prices. Securing these prices—and therefore making universal access to an essential medicine possible—requires increasing generic competition.
20. In its state party report, the State highlights specific price reductions for medicines, but overlooks the structural barriers that drive excessive pricing. South African patent law does not take advantage of public health flexibilities contained in the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). A patent law reform process began in 2009,

⁸ A Reuter et al., The devil we know: is the use of injectable agents for the treatment of MDR-TB justified? *International Journal of TB and Lung Disease* (2017) (Injecting agents 'are administered intramuscularly for 4–8 months, cause a great deal of pain and distress for patients, and are associated with frequent, serious adverse effects. Perhaps the most serious problem associated with IAs is permanent hearing loss in as many as 50% of persons receiving them for MDR-TB').

⁹ World Health Organization, *GLOBAL TUBERCULOSIS REPORT 45* (2017). SD Ahuja SD et al. Multidrug resistant pulmonary tuberculosis treatment regimens and patient outcomes: an individual patient data meta-analysis of 9153 patients. *PLoS Med* 2012; 9: e1001300.; E Pietersen et al., Long-term outcomes of patients with extensively drug-resistant tuberculosis in South Africa: a cohort study. *Lancet* 2014; 383: 1230–39.

¹⁰ D Gotham et al., Estimated generic prices for novel treatments for drug-resistant tuberculosis. *J Antimicrobial Chemotherapy*. 2017 Apr 1;72(4).

but nearly a decade later, no new legislation has been enacted. Patent legislation that protected public health could help facilitate generic competition, cut prices and increase access to essential medicines.

21. In General Comment No. 24, the Committee has recognised that the right to health must inform the design of an intellectual property system.¹¹ As the Committee states, in part:

‘In designing a framework on intellectual property rights, for instance, that is consistent with the Universal Declaration of Human Rights and with the right to enjoy the benefits of scientific progress stipulated in article 15 of the Covenant, States parties should ensure that intellectual property rights do not lead to denial or restriction of everyone’s access to essential medicines necessary for the enjoyment of the right to health.’

Recommendations

22. The Human Rights Council, the Special Rapporteurs in the field of cultural rights and health, and the UN Secretary General’s High-Level Panel on Access to Medicines have recognised *TRIPS flexibilities* as a necessary measure to fulfil its obligations regarding the right to health.¹² Therefore, South Africa must pursue patent law reform and introduce legislation to incorporate *TRIPS flexibilities* and use these flexibilities to promote greater access to medicines; and

23. The current DR-TB approach—exposing poor people to the risk of deafness and psychosis, with less effective treatments—violates South Africa’s obligations under the Covenant. Therefore, South Africa must scale up access to new, more effective essential medicines by using *TRIPS flexibilities*, including compulsory licensing.

¹¹ UN Committee on Economic, Social and Cultural Rights, General Comment No. 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities, E/C.12/GC/24 (Aug. 10, 2017), para. 24.

¹² See Human Rights Council, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, A/HRC/RES/12/24 (Oct. 12, 2009), para 6. U.N. GAOR, 70th Sess., 3rd Comm., Item 69(b and c), Statement by Ms. Farida Shaheed, Special Rapporteur in the Field of Cultural Rights as the 70th session of the General Assembly (Oct. 26 2015). Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development, UN Doc. A/HRC/11/12, para. 94, 102 (Mar. 31, 2009). Report of the United Nations Secretary General’s High-Level Panel on Access to Medicines, Sept. 2016, 9.

III NATIONAL HEALTH INSURANCE

a Introduction

24. South Africa is seeking to implement a National Health Insurance (NHI) scheme as a financing mechanism to achieve universal health coverage. There is concern that the NHI scheme in its current form is likely to entrench the disparities in access to and quality of care. South Africa currently has a two-tier health care system consisting of the private sector and the government-funded public sector. While exorbitant prices in the private sector is concerning, so is the current state of the public sector. The public sector has been repeatedly criticised for its inadequate provision of health care services. The problem with the current two-tier system is that the private sector is unaffordable to the majority of the population while the standard and quality of care in the public sector is deteriorating. The NHI scheme seeks to address the inequities in the health system and the current lack of access to quality health care services.
25. The NHI has been developed as a policy by the National Department of Health over the past 7 years starting with a Green Paper in 2011, a White Paper in 2015 and a Policy White Paper in 2017 linked to an Implementation Plan issued in a Government Gazette in July 2017. The policy process finally culminated in the release of the NHI Bill in June 2018. These comments take account of the changing emphasis in the various policies over time and respond specifically to the NHI Bill of June 2018 and the Implementation Gazette of July 2017 as the most recent formulations of the NHI policy.
26. The NHI scheme as per the National Health Insurance Bill 2018 proposes a financing system for universal health coverage in South Africa. The NHI scheme seeks to address the structural problems in the health care system, and the burden of disease in South Africa. The NHI scheme reflects the State's commitment to take reasonable legislative and other measures, within available resources, to progressively realise the right of access to health care as provided for in section 27 of the Constitution.

b Determinants of Health and the National Health Insurance Scheme

27. Universal Health Coverage (UHC) 'means a service that is available to all persons, including promotive, preventative, curative, rehabilitative and palliative health services, regardless of socio-economic or health status of those persons.'¹³. Fundamentally, it recognises health as

¹³ National Health Insurance Bill GG 41725 of 21-06-2018 s2.

a human right and protects persons from financial hardship in seeking health care. Health is more than just health care services, and has interrelationships with the environment, water and sanitation, food and nutrition, education, and standards of living, *inter alia*. However, the NHI scheme does not specifically concern itself with addressing the social determinants of ill health, despite it being an objective of the NHI White Papers of 2015 and 2017.

28. The NHI scheme, as per the previous policy paper in 2017, notes that:

‘Health is influenced by the environment in which people are born, grow up, live and work, and societal risk conditions are also more important than individual ones in the spread of disease. This includes exposure to polluted environments, inadequate housing and poor sanitation. Health is shaped by multiple epidemics, as well as powerful historical and social forces, such as vast income inequalities, unemployment, poverty, racial and gender discrimination, the migrant labour system, the destruction of the family life and extreme violence.’¹⁴

29. Despite the recognition of the fundamental influence of the social determinants of health, the NHI scheme, as reflected in the Bill, does little to provide for how these will be addressed.

c Implementation of the National Health Insurance

30. South Africa’s health system is characterised by deep inequalities between public and private care, urban-rural discrepancies and rich-poor discrepancies. These inequalities present ongoing challenges to the ability of people living in South Africa to realise their right to the highest attainable standard of health.

31. The NHI scheme adopted by government ‘is intended to move South Africa towards Universal Health Coverage (UHC) by ensuring that the population has access to quality health services and that it does not result in financial hardships for individuals and their families.’ Since UHC is argued to be ‘a practical expression of the concern for health equity and the right to health’¹⁵, the NHI has the potential to advance the right to health.

32. However, the approach to implementing the NHI scheme proposed by the Department of Health in its Gazette of 7th July 2017 threatens to undermine key aspects of the right to health:

¹⁴ Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 40.

¹⁵ World Health Organization: *Positioning Health in the Post-2015 Development Agenda*. Geneva: World Health Organization; 2013. <http://www.worldwewant2015.org/bitcache/7c4f4f265f3d2dfdfed54c06afee939039865522?vid=302852&disposition>

- i. In its implementation strategy, the NDoH has signalled its intention to consolidate current medical insurance funding pools by creating five different domains – with separate funds for large formal sector workers; for workers in small businesses; for government employees; for informally employed and for the unemployed – and mandating medical insurance membership for all workers in the formal sector.
- ii. This is a substantial breach from earlier versions of the NHI scheme which envisioned cross-risk and cross-income pooling. It is further reinforced by correspondence from the Director General indicating that the NHI involved moving through a process of a contributory funding scheme towards more equitable funding arrangements.
- iii. Consolidation of financing arrangements must be viewed in the context of the whole system with universal access in mind, rather than from the viewpoint of the separate schemes. As stated by Kutzin¹⁶:

‘The unit of analysis for goals and objectives must be the population and health system as a whole. What matters is not how a particular financing scheme affects its individual members, but rather, how it influences progress towards UHC at the population level. Concern only with specific schemes is incompatible with a universal coverage approach and may even undermine UHC, particularly in terms of equity. Conversely, if a scheme is fully oriented towards system-level goals and objectives, it can further progress towards UHC. Policy and policy analysis need to shift from the scheme to the system level.’
- iv. Where health insurance schemes begin by covering the formal sector, they tend to concentrate resources on a relatively small and economically advantaged part of the population. Such schemes do not naturally ‘evolve’ to include the rest of the population. Instead, the initially covered groups, who tend to be well organized and influential, use their power to increase their benefits and subsidies, rather than to extend the same benefits to the rest of the population.’
- v. The proposed NHI transitional arrangement, which start by focusing on formal sector employees and on government employees, indicate that public servants and those in formal employment will be first priority. Prioritising coverage for formal sector workers is likely to have a disproportionately negative impact on

¹⁶ Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. Bull World Health Organ 2013; 91: 602–611

vulnerable groups such as children and women – particularly Black women, who are overrepresented amongst the unemployed, in informal work, and in precarious formal sector work.¹⁷ This approach to phasing in the NHI is inconsistent with the obligation that government should prioritise the most vulnerable groups in society.

- vi. Central to a Rights-Based Approach (RBA) to health is the importance of prioritising the most vulnerable in society. Paragraph 44 of General Comment 14 indicates that when devising, adopting and implementing a national public health strategy and plan of action, states must ‘give particular attention to all vulnerable or marginalized groups.’
- vii. This is further emphasised by the former Special Rapporteur on Health, Paul Hunt, who notes that the right to health implies ‘a preoccupation with disadvantaged groups, participation, and accountability¹⁸’ and that the planning process should give attention to the health needs of disadvantaged individuals, communities, and populations¹⁹.
- viii. The Bill indicates that the current Implementation Phase will include ‘interim purchasing of personal healthcare services for vulnerable groups such as children, women, people with mental health disorders, people with disability and the elderly.’ This is to be welcomed but there is no workgroup or task team under the implementation framework that will strengthen the public sector on which the most vulnerable populations, such as the unemployed or informally employed, depend.

d Financing of the National Health Insurance Scheme

33. The 2018 NHI Bill provides that the sources of income for the NHI will include:

- a) Money appropriated by parliament;
- b) Interest of return on an investment made by the Fund;
- c) Any bequest or donation received by the Fund;
- d) Moveable or immovable property purchased or otherwise acquired by the Fund; and any other money to which the Fund may become legally entitled to.

¹⁷ Valodia, I. Economic Policy and Women’s Informal Work in South Africa. *Development and Change* 2001, 32.5: 871-892;

¹⁸ Hunt P. Right to the highest attainable standard of health. *Lancet* 2007; 370: 369-371

¹⁹ Hunt P, Backman G. Health Systems and the Right to the Highest Attainable Standard of Health. *Health and Human Rights* 2008; 10(1):81-92

34. This is vague and ambiguous – especially considering the amount of finances required for the implementation of the NHI and full coverage.
35. The 2017 NHI Policy Paper elaborated more on possibilities of funding, especially regarding taxation. The central purpose of progressive taxation and redistributive policies is to allow governments to address inequalities in the distribution of income and provide services to the people, such as public health, education, housing programmes and affordable public transport.⁸ In common with most countries personal income taxation in South Africa is essentially progressive, where those with higher incomes contribute a larger proportion of their income to tax than those with lower incomes. Everyone in South Africa pays value-added tax (VAT), a retrogressive tax since it imposes a larger burden on poor people because they have to spend a greater proportion of their already low income on VAT. Until 2018 VAT was set at 14%, although certain items, including 19 staple foods and paraffin (but not electricity) are exempt. In 2018 VAT was increased to 15% and hence the poor will inevitably become poorer and their health will inexorably deteriorate, thus impacting negatively on both their economic rights and their health rights.⁹
36. Progressive taxation coupled with state expenditure targeted at reducing inequity, building infrastructure and expanding social investment spending, such as the proposed NHI funded universal health care, would reduce economic inequalities as well as improve the health of the population. Thus, pairing progressive taxation with the NHI produces synergy towards realising economic, social and health rights. The proposed NHI notes that: ‘The three main sources of general tax revenue in South Africa are personal income tax, value-added tax and corporate income tax’¹⁰; and further notes that: ‘However, from an equity perspective, there is concern that value-added tax is regressive.’¹¹
37. Despite noting the above, the NHI scheme proposes that funding of the NHI be derived from a mix of personal income tax via an added flat rate surcharge across all income bands; using a payroll tax, again via a flat rate across all wage bands; and an increase in value added tax (VAT).¹² All of these options have potential retrogressive implications.
38. In addition to reducing tax evasion and tax avoidance, funding the NHI via progressive taxation methods such as increasing the tax rate on high income earners via personal income tax, increasing corporate income tax rates and introducing a wealth tax, is a clear alternative which would reduce inequalities.
39. However, it seems that the South African Government has rigidly pegged the Tax:GDP ratio at 25% and hence is reluctant to increase this ratio for the purpose of increased social

investment spending, by instituting higher progressive taxation.²⁰ Why it refuses to progressively increase the Tax:GDP ratio, when doing so would reduce inequity in the world's most inequitable society, is unclear, and requires answering.

40. The Tax:GDP ratio is a key measure of indicating what a government's ambitions are for the quality and size of public services. It is also a key measure of how much of the whole economy the government allows to be placed under private control and production for profit. A policy of maintaining a low Tax:GDP ratio limits the financing of all public services and programmes, such as health, education and housing. For the majority, a low-tax society means a poor level of public services, whether for health or other services, and a denial of their democratic aspirations. It means that millions of citizens will continue to live in informal settlements, only having access to bucket toilets. It means poor quality education. It means failing housing programs, a lack of safe public transport, and that there won't be affordable electricity or piped water to all households. It means poor health for the poor, even if the proposed NHI is realised, as funding that very NHI would push low income earners into a worsened economic environment wherein their health will deteriorate.

e Discrimination under the National Health Insurance Scheme

41. Access to health care for refugees and migrants under the NHI is potentially problematic. The 2015 NHI policy paper sets up a clear distinction between migrants with status, migrants who have applied for status, and undocumented migrants, a distinction that is not always a justified distinction on which to base differential access to health care. However, the 2018 NHI Bill is confusing about health care entitlements for non-South Africans, implying that both refugees who have been granted asylum and those awaiting a decision on their asylum application are entitled to only a selected set of services under the NHI: ((a) emergency health care services; (b) services for notifiable conditions of public health concern; and (c) paediatric and maternal services at primary health care level.) For undocumented migrants without any refugee status, there is no entitlement under the NHI Bill. Thus, while the 2015 NHI White Paper states clearly that the NHI is intent on 'ensuring progressive realisation of the right to health by extending coverage of health benefits to the entire population...' to the NHI Bill commits to providing UHC only for South African citizens and permanent residents. The commitment to the 'entire population' is lost in the NHI Bill.

²⁰ Dick Forslund at <http://aidc.org.za/download/taxation/Taxation-booklet-AIDC-FINAL.pdf>

42. This two-tier system with one set of benefits for South Africans and a lower level of benefits for refugees and asylum seekers is prima facie discriminatory. The language of the Refugees Act (section 27(b) and 27(g)) describes an entitlement of refugees to the rights set out in the Bill of Rights in the Constitution which includes access to health care, and specifically notes that refugees are 'entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time'. Setting up different packages of care appears to contradict the very basis of universal access.
43. Further, the NHI scheme implies that the health services to be afforded to migrants with legal status will not be equivalent to South Africans and permanent residents because they will be provided with 'basic health coverage' rather than equivalent coverage under universal health care. Far from complying with section 27 (g) of the Refugees Act 130 of 1998 as amended, it seems the NHI scheme seeks to establish exceptional status for legal migrants with reduced coverage – which would appear to be in violation of Section 27(g) and international human rights commitments with regard to refugees. There has been no mention of health care coverage to undocumented migrants and, given the number of undocumented migrants in South Africa, this is concerning due to potential discrimination and denial of access to health care.
44. A further contradiction is that the NHI scheme states that asylum seekers would be entitled to emergency care (paragraph 122), but that undocumented migrants would have to pay for their emergency care. Since the South African Bill of Rights frames access to emergency medical services as a right for 'everyone' (not just citizens or those who have been officially recognized as refugees), imposing the cost for emergency medical care on undocumented migrants appears to be highly discriminatory, as most undocumented migrants will likely not be able to pay for services essential to preserve their lives. Despite the fact that there is considerable research into the number of migrants in South Africa, their socio-economic status, their health care utilization and obstacles to care,²¹ none of these data are presented in the NHI policy as a basis for deciding on benefits for refugees.
45. In a South African Constitutional Court case, *Khosa v The Minister of Social Development*, the court held that a reasonable measure cannot unfairly discriminate against a group. Whilst citizenship is not a listed ground of discrimination under section 9(3) of the South

²¹ For example, Zihindula et al, Access to Health Care Services by refugees in Southern Africa: A Review of Literature, South African Journal of Demography 2015; 16 (1): 7-35; Landau LB. Protection and Dignity in Johannesburg: Shortcomings of South Africa's Urban Refugee Policy. Journal of Refugee Studies (September 2006) 19 (3): 308-327; Nkosi G. Influences of xenophobia on accessing health care for refugees and asylum seekers in Johannesburg. MA thesis (Wits). Walls et al. Understanding healthcare and population mobility in southern Africa: The case of South Africa. S Afr Med J. 2015 24; 106(1):14-5; Vearey J. Healthy migration: a public health and development imperative for south(ern) Africa. S Afr Med J. 2014; 104(10):663-44.

African Constitution, the Constitutional Court held that the legislation limiting access to social assistance grants to citizens amounts to unfair discrimination as it impacts on the group's human dignity.²² In light of this precedent, and the fact that under General Comment 14 non-discrimination is recognised as an aspect of accessibility, the NHI scheme should not exclude groups unfairly.

46. The NHI Bill does not provide for coverage of migrants in detention centres, some of whom are minors and who have received inadequate access to care at South Africa's main detention centre for migrants, the Lindela Repatriation Centre.²³ Given the fact that immigration legislation has been changed to make it more difficult for non-citizens to enter the country legally and speedily, which has led to huge backlogs in processing applications,²⁴ this is likely to be an important issue in years to come.²⁵

f Further Issues under the National Health Insurance scheme

47. Further weaknesses in the state NHI policy that potentially threaten the realisation of the Right to Health include:

- i. Access to NHI services will be contingent on registration at designated health facilities and South Africans will be able to access personal health services covered by NHI closest to where they reside. However, residential location in South Africa remains deeply tied to apartheid planning and the poorest residential areas are associated with poor infrastructure and poor service provision, such as water, electricity, roads and public transport, in addition to poor quality health care services. People living in low income historically racially designated and separated black areas would then be forced to register for poorer quality and limited access health care services, than those living in higher income (previously white) residential areas. These differentials would be particularly acute in rural and peri-urban areas. This poses a risk to violating the right of access to health care, which, according to the General Comment 14, must be delivered without discrimination.
- ii. This inequality may be further exacerbated by the requirement for health facilities to achieve certification by the Office of Health Standards Compliance (OHSC) in order to be accredited by the NHI Fund as part of strategic purchasing. Currently,

²² 2004 4 SA 505 (CC) para 72.

²³ <https://sahrc.org.za/home/21/files/Gauteng%20-%20Investigative%20Report%20-%20Lindela%20-%20201%20September%202014.pdf>

²⁴ pmg-assets.s3-website-eu-west-1.amazonaws.com/160308Asylum.pdf.

²⁵ <http://bhekisisa.org/article/2017-05-24-00-rough-welcome-could-south-africas-new-border-detention-centres-turn-deadly>;

only 46% of public health facilities comply with the quality standards set by the Office of Health Standards and Compliance.²⁶ The worst quality hospitals are in the poorest parts of South Africa serving the most vulnerable populations. For example, all 6 predominantly rural and poorer provinces in South Africa had average scores on the 2016/17 OHSC audit of less than 50%, which noted that '[P]rovinces have not demonstrated expressive improvement of performance scores over time.' This means that the poorest, rural and most marginalised populations are serviced by facilities least likely to achieve accreditation. In the absence of a clear programme to assist these facilities to improve the quality of services, poor communities are likely to be further marginalised. The preliminary reports of the OHSC do not suggest that public sector facilities are ready for the NHI and it is unclear how the OHSC reports are being used to improve services.'

- iii. General Comment 14 provides that health investments 'should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population' but should rather build up 'primary and preventive health care benefiting a far larger part of the population.' The NHI policy signals that 'Central hospitals will be transformed into national assets operating as training platforms research hubs and centres of excellence locally, regionally and internationally' but makes no mention of Primary Health Care (PHC) services provision requiring similar levels of investment to achieve PHC management excellence and research, even though it is said in the NHI Policy that 'Primary Health Care will form the heartbeat of NHI.' Similarly, the Implementation Structures speak only to establishing a commission for tertiary hospital services. In 2013 Operation Phakisa Ideal Clinic Realisation Programme was launched to improve services in PHC facilities.²⁷ The Ideal Clinic programme can strengthen the service delivery of PHC services and provide a foundation for further service provision if actively pursued.
- iv. Article 3 of the ICESCR places an obligation on governments to ensure equality between men and women in enjoying the economic, social and cultural rights set forth in the present Covenant. It is important to note that the effects of under-investment in the public health system are not gender neutral. Women are

²⁶ <http://ohsc.org.za/wp-content/uploads/OHSC-2016-17-ANNUAL-INSPECTION-REPORT-FINAL.pdf>; See also Section 27 Submission on the White Paper <http://www.nhisa.co.za/B_submissions.asp> (accessed 10 June 2016) para 6.1.

²⁷ Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 13.

disproportionately responsible for caring for the sick, elderly, and young or weak.²⁸ A dysfunctional public health system will effectively increase their burden of care work and impede their equal enjoyment of the rights stipulated in the Covenant.

- v. The NHI Bill is more or less silent on prevention, mentioning prevention only once in relation to Phase 2 services. Whereas the 2015 NHI White Paper references the growing Non-Communicable Diseases (NDCs) burden facing South Africa and provided for the establishment of a National Health Commission to promote health and wellness, with a focus on diseases of lifestyle and effecting required multi-sectoral collaboration involving government and non-government sectors, the 2018 NHI Bill has omitted any reference to this Commission or the critical need for prevention and health promotion. General Comment 14 refers to the elements of the right to health as including (not limited to) ‘... improving all aspects of environmental and industrial hygiene; preventing, treating, and controlling epidemic, endemic, occupational, and other diseases.’ The NHI does not provide any indication of improving environmental and industrial hygiene; or preventing occupational diseases and give no account of any attention to the prevention of communicable and non-communicable disease, other than this being the responsibility of the Department of Health under the National Health Act of 2003. While the 2015 NHI White Paper referred to Primary Health Care (and its emphasis on prevention) as the heartbeat of the NHI, the Bill has removed any reference to the establishment of a National Health Commission, not how it will address preventative care.
- vi. South Africa has a huge burden of HIV/AIDS. Despite this, the NHI policy does not address recent criticisms that the current National Strategic Plan (NSP) on HIV, Tuberculosis (TB) and Sexually Transmitted Infections (STIs) inadequately protects vulnerable groups such as sex workers, young women aged 14-25 who are disproportionately affected by HIV/AIDS.²⁹
- vii. As Paul Hunt, former UN Special Rapporteur on the Right to Health, has illustrated, the Right to Health is integrally dependent on the participation of communities in overseeing how health services and health goods are delivered³⁰. General

²⁸ Budlender, D. Time Use Studies and Unpaid Care Work. Harare: UNIFEM, 2004.

²⁹ <https://www.dailymaverick.co.za/article/2017-06-20-groundup-former-aids-council-head-criticises-government-plan/#.WogwpYLLi8o>;

³⁰ Hunt 2008, *ibid*; Hunt and Backman, 2008, *ibid*.

Comment 14 notes that, under the right to health, 'the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations'. While the 2015 White Paper referred to clinic committees as community participation structures established by the National Health Act, it well recognised that less than 50% of facilities have health committees and less than 50% of committees are at all functional, reflecting a lost opportunity to ensure community voice in the health system. The 2018 NHI Bill makes no reference to how such committees will be supported to ensure the NHI is informed by strong community participation.

viii. Paul Hunt and Gunilla Backman have pointed out that a human rights approach to health systems implies that 'communities are entitled to active and informed participation on issues bearing upon their health' which includes 'participation in identifying overall strategy, policy-making, implementation, and accountability.' This implies that 'states have a human rights responsibility to establish institutional arrangements for the active and informed participation of all relevant stakeholders, including disadvantaged communities.'³¹ To date, there is wide policy variability across South Africa with regard to health committees, inconsistent roles and functions, poor support and unclear mandates that hamper effective community participation in health³².

ix. Article 7 of the ICESCR protects the right to enjoy just and favourable conditions of work. The NHI scheme recognises the importance of community health workers in expanding access to Primary Health Care services. However, the existing national regulatory framework for CHWs³³ does not sufficiently protect and advance this right and many CHWs experience precarious employment conditions.³⁴ The White Paper does not indicate how this oversight will be

³¹ Hunt and Backman, 2008, *ibid*.

³² See Levendal E, English R, Schneider H, London L, Haricharan H. Health governance. In: Eds Frytatt RJ, Andrews G, Matsoso MP. South Africa health reforms 2009 – 2014: Moving towards universal coverage. Juta, Cape Town, 2015: 244-280.

³³ Department of Health. 2018. Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams. 2018/19 - 2023/24. Accessed 9th August at <https://rhap.org.za/wp-content/uploads/2018/04/Policy-WBPHCOT-4-April-2018-1.pdf> See Part II V for more on CHW regarding child health.

³⁴ Munshi S. Exploring the Municipal Ward Based Primary Health Care Outreach Teams Implementation in the context of Primary Health Care Re-engineering in Gauteng. Research Report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfillment of the requirements for the degree of: Master of Public Health (MPH) University of the Witwatersrand 19 June 2017; <http://wiredspace.wits.ac.za/handle/10539/23346>; See also WHITE, Meghan S.; GOVENDER, Pragashnie; LISTER, Helga E.. Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal. *African Journal of Disability*, [S.l.], v. 6, p. 8 pages, aug. 2017. ISSN 2226-7220. Available at: <https://ajod.org/index.php/ajod/article/view/294/625>. Date accessed: 09 aug. 2018. doi:<https://doi.org/10.4102/ajod.v6i0.294>.

addressed and the NHI bill does not mention CHWs at all. It is worth noting that a vulnerable population, i.e. women, are disproportionately employed as CHWs and many of them will be adversely affected if the NHI expands the CHW labour force without also securing stronger labour rights and improved conditions of employment for these workers.

g Democratic Participation in Decisions About Health

48. South African law regards participation and engagement as integral to the realisation of socio-economic rights. 'Meaningful engagement' is required throughout policy development and thus the NHI scheme must facilitate such participation. PHC also requires participation and engagement. The NHI policy provides that '[t]he success of NHI will require building a responsive health care system that is people-centred. Community involvement will be essential at all levels of the transformed systems to ensure that there is participatory governance, and accountability.'³⁵

49. However, despite recognising the importance of participation, there are no measures provided for facilitating stakeholder engagement in the development and implementation of the NHI. It is therefore necessary for the State to facilitate participatory decision-making and engagement with stakeholders and communities.³⁶

50. The NHI will require high levels of management capacity at all levels of the South African health system. However, the weakness of management and leadership capacity in the South African health system remains a major challenge³⁷. Yet the success of the NHI in providing equitable access to health care will rely on the establishment of Contracting Units for Primary Health Care at local level, responsible for complex planning, contracting, monitoring and enforcement functions. Given the weakness of management capacity in the current health system, introducing ever-more complex systems requiring high degrees of management skills, risks failure of implementation.

<https://www.health-e.org.za/2018/03/15/struggle-continues-for-gauteng-health-workers/>
<https://www.health-e.org.za/2016/11/12/community-health-workers-protest-better-working-conditions/>
<https://www.soulcity.org.za/news/why-policy-is-failing-community-health-workers>

³⁵ Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 345.

³⁶ L London 'Comments on the White Paper on a National Health Insurance for South Africa' *Report to the Foundation for Human Rights* (2016) <http://www.nhisa.co.za/B_submissions.asp> (accessed 10 June 2016).

³⁷ PASSCHIER, R V. Exploring the barriers to implementing National Health Insurance in South Africa: The people's perspective. *SAMJ, S. Afr. med. j.* [online]. 2017, vol.107, n.10 [cited 2018-08-09], pp.836-838. Available from: <http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742017001000010&lng=en&nrm=iso>. ISSN 2078-5135. <http://dx.doi.org/10.7196/samj.2017.v107i10.12726>; Gilson L, Daire J. Leadership and Governance within the South African Health System. In (Eds: Padarath A, English R) *South African Health Review 2011*. Chapter 6; pp 69-80. Health Systems Trust: Durban

Recommendations

Determinants of Health and the National Health Insurance Scheme

51. The NHI should specifically provide societal level preventive, promotive, rehabilitative and palliative health services, including an adequate deployment of properly trained and supported community health workers, in order to reduce inequitable social determinants of health.

Implementation of the National Health Insurance

52. The pathway to a UHC under the NHI should avoid at all costs any balkanisation into discreet funding pools which afford different contributor groups different packages of benefits and which will be difficult to reverse once implemented. Transitional arrangements to an NHI should focus on enhancing access first for the most vulnerable populations and ensure a common set of benefits for all beneficiaries of an NHI. Hidden subsidies to the private sector (e.g. tax rebates for medical scheme contributions) should be gradually phased out to release funds for strengthening the public sector.

53. A clear and coherent national plan to improve the quality of public sector services in the most under-developed areas of the country serving the most marginal and vulnerable populations must precede any accreditation of facilities. To do so requires both an investment of resources and sound management to ensure the investments translate into sustainable improvement in the quantity and quality of services for those dependent on public sector services. This should be the focus of the early stages of the NHI. In the same way that the NHI Bill envisages establishing structures for Health Technology Assessment, for Tertiary Services and for Human Resource Development, the NHI should set up an intersectoral Task Team under the Presidency to strengthen the public sector health services for an NHI to function. This task team should have the mandate and capacity to ensure that public sector services, particularly those in rural and underserved areas, are able to meet accreditation requirements under the OHSC audits.

54. The NHI must have a preventative focus structured into its operations and governance; otherwise, it risks reverting to a model dominated by curative care. Preventative care should be reflected in the financing of the NHI since improved prevention services should deliver reduced health care costs.

55. The role of statutory structures for community participation (Health Committees, hospital boards) should receive much greater amplification in the policy – both in terms of strengthening their governance roles, but also in terms of strengthening the articulation of participation structures at all levels of the health service and in resourcing the structures needed for community participation.

Financing of the National Health Insurance Scheme

56. Noting that paying for the NHI via progressive taxation would reduce economic inequity in the world's most unequal society, it is strongly recommended that the NHI be funded through increasing the tax rate on high income earners via personal income tax, increasing corporate income tax, and introducing a wealth tax.

Discrimination under the National Health Insurance Scheme

57. The NHI must rethink its position on migrants. The current position is neither tenable or practical to implement. Rather than continuing to treat migrants differentially, concrete entitlements should be articulated for equal access for all, as required by the Constitution.

Further Issues under the National Health Insurance scheme

58. The NHI should formally include sufficient numbers of well-trained, adequately remunerated and appropriately supported CHWs within its ambit, and hence explicitly within its expenditure include them and afford them the same labour rights and conditions of employment as other health staff.

59. To meet its obligations to deliver equitable quality care to all without discrimination, the state must ensure that its managers at all levels of the health system have the skills and capacity to steward the NHI appropriately. A coherent human resource development plan is a key element of state obligations for the right to health and should include not only appropriate clinical skills but also managerial and leadership skills to effect the intent of the NHI.

Democratic Participation in Decisions About Health

60. The NHI funding mechanisms should be decided by a transparent, participatory and evidence-based process that is insulated from the private sector influencing decision-making.

Engagements with all stakeholders – communities, civil society, private sector, research institutions and others – should be consistent with transparency and democratic principles. Participation, particularly of vulnerable communities, should be actively sought in the policy making process.

61. Where conflicts of interest exist, the government should have processes to ensure that such CoIs are managed without allowing the private sector and other vocal sectors to decide the NHI policy directive. The current work of WHO to manage conflicts of interest could be used in this regard.

IV LACK OF COMPETITION IN THE PRIVATE HEALTH CARE SECTOR

62. The Competition Commission recently inquired into the private health care sector. The inquiry was sparked by concern for the high prices and drastic increases in private health care. The Competition Commission has found that a feature of the private sector prevents and restricts competition.

63. The Inquiry concluded that the public health sector ‘does not pose a significant competitive constraint to the private sector for patients or for service providers’.

64. The Competition Commission describes the health care sector:

‘Overall, the market is characterised by high and rising costs of healthcare and medical scheme cover, highly concentrated funders’ and facilities’ markets, disempowered and uninformed consumers, a general absence of value-based purchasing, ineffective constraints on rising volumes of care, practitioners that are subject to little regulation and failures of accountability at many levels.’

65. Additionally, the Inquiry concluded that there ‘is no measure of cost-effectiveness’ in the private sector and that there is evidence of ‘supply induced demand’.

66. The lack of competition implicates access to health care. It also implicates State obligations to protect rights from third party interference. The State is obliged to protect the right to health by ensuring that the private sector prices do not hinder economic accessibility and thereby violate the right to health under the Covenant. General Comment 14 explains the framework of obligations between the State and private entities as follows:

'While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society – individuals, including health professionals, families, local communities, intergovernmental organizations and non-governmental organizations, civil society organizations, *as well as the private business sector* – have responsibilities regarding the realisation of the right to health. States Parties should therefore provide an environment which facilitates the discharge of these responsibilities.'

67. Even more directly, the findings of the Competition Commission in this Inquiry resonate with the Committee's General Comment 24 on socio-economic obligations in the context of business activities. General Comment 24 provides that the obligation on States to respect will be violated if business interests are prioritised over socio-economic rights without proper justification. General Comment 25 further provides that the obligation to protect 'at times necessitates direct regulation and intervention'. In the context of the right to health, the State has an obligation to ensure that the private sector does not hinder access to affordable and adequate health care services.

68. The lack of competition – which is caused by business monopolies and lack of transparency and access to information – results in diminished access to health care and thereby is in conflict with General Comment 24.

Recommendations

69. In light of the Inquiry by the Competition Commission it is recommended that:

- a) General Comment 24 be used in guiding regulatory changes in the private health care sector;
- b) That the Inquiry be followed-up on with due diligence;
- c) That information regarding the private sector be made more accessible; and
- d) That the State take the necessary regulatory measures to ensure increased competition and/or increased accessibility.

V SANITATION

70. Whilst the South African Constitution does not explicitly recognise the right to sanitation, the right is implicit under the right to basic municipal services under section 152(1)(b) of the

Constitution. The right to basic municipal services obliges local government to 'ensure the provision of services to communities in a sustainable manner' and the local government is also obliged to 'promote a safe and healthy environment'.

71. Sadly, lack of sanitation services mirror apartheid spatial geography³⁸ and disproportionately impact on the most vulnerable.³⁹
72. Sanitation also has interrelationships with other fundamental rights. Sanitation is integral to the right to health, the right to water and the right to a healthy environment. Sanitation forms part of the Committee's understanding of the right to an adequate standard of living. Importantly, sanitation is fundamental to the right to human dignity. The interrelationships between sanitation and other rights and health issues, are captured in a report by SERI:⁴⁰

'Access to adequate sanitation is fundamental to personal dignity and security, social and psychological well-being, public health, poverty reduction, gender equality, economic development and environmental sustainability. Poor sanitation promotes the spread of preventable diseases like diarrhoea and cholera, places stress on the weakened immune system of HIV positive peoples and has a major impact on the quality of life of people living with AIDS.'⁴¹

73. The right to sanitation includes a toilet that is safe, reliable, easy to keep clean, private, protected from the elements, well ventilated and free from flies, pests and diseases.⁴² Only 59% of people in South Africa have access to flush toilets. 2.4% of the population have no access to any form of toilet.⁴³
74. However, despite legislation providing for this right to basic municipal services,⁴⁴ many people (30% of the population) are still living with pit latrines. A pit latrine 'consists of a rudimentary top-structure built over a pit which collects waste. Pit latrines generally do not have adequate ventilation (i.e. are unimproved) and are susceptible to odours and flies. They are not an

³⁸ South African Human Rights Commission Report on the Right to Access to Sufficient Water and Decent Sanitation in South Africa (2014).

³⁹ South African Human Rights Commission Report on the Right to Access to Sufficient Water and Decent Sanitation in South Africa (2014).

⁴⁰ Socio-Economic Rights Institute of South Africa *Basic Sanitation in South Africa: A Guide to legislation, Policy and Practice* (2011).

⁴¹ Socio-Economic Rights Institute of South Africa *Basic Sanitation in South Africa: A Guide to legislation, Policy and Practice* (2011) 13.

⁴² Socio-Economic Rights Institute of South Africa *Basic Sanitation in South Africa: A Guide to legislation, Policy and Practice* (2011).

⁴³ Available on https://wazimap.co.za/profiles/country-ZA-south-africa/#service_delivery.

⁴⁴ Section 73 of the Municipal Services Act provides for the right to basic municipal services and section 251(1)(b) of the Constitution.

acceptable form of basic sanitation.⁴⁵ Many schools have pit latrines. These, despite policies and promises, are not 'serviced' or 'maintained' by local government.

75. There have been two reported incidents of deaths related to young children and pit latrines. In 2014, five-year-old Micheal Komape died falling into a pit latrine at school in Limpopo province. Earlier this year, 2018, five-year-old Lumka Mketwa drowned in a pit latrine in Eastern Cape province. These tragedies illustrate the risks and ultimate lack of dignity associated with government's failure to provide adequate basic sanitation services such as safe toilets.⁴⁶ These deaths, as well as illnesses and ill-health caused by and affected by poor sanitation, are avoidable.

76. Furthermore, the issues pertaining to sanitation are not gender-neutral yet are treated as such by government policies. Women and girls are exposed to greater risks of danger when using the pit latrines, especially at night. Girls miss school when they menstruate due to their reluctance to use these facilities.⁴⁷

77. The National Department of Water and Sanitation released a National Sanitation Policy in 2016 seeking to develop national sanitation standards reflective of a human rights approach to sanitation.⁴⁸ Despite this policy, little action has been taken to address the dire sanitation crises subjecting vulnerable groups such as children to danger.⁴⁹

Recommendations

78. We are concerned that the gap between policy and implementation results in little to no change. Thus, we make the following recommendations to address the issue of sanitation, especially regarding access to adequate toilets:

- i. That the government take immediate steps to prioritise the vulnerable groups disproportionately affected by poor sanitation services such as children (therefore schools), girls and women, persons living with HIV and AIDS, disabled persons *inter alia*;
- ii. That a gendered approach to addressing the lack of access to sanitation is taken;

⁴⁵ Socio-Economic Rights Institute of South Africa *Basic Sanitation in South Africa: A Guide to legislation, Policy and Practice* (2011).9

⁴⁶<https://www.dailymaverick.co.za/article/2018-03-20-op-ed-pit-toilet-school-deaths-and-human-dignity/#.WvVIFExuLOY>; <https://www.timeslive.co.za/news/south-africa/2018-03-16-human-rights-investigation-into-eastern-cape-schools-after-girl-drowns-in-pit-toilet/>; <https://citizen.co.za/news/south-africa/115488/equal-education-saddened-pupils-death-pit-toilet/>.

⁴⁷ <http://thoughtleader.co.za/readerblog/2016/03/31/theres-no-dignity-in-education-without-proper-sanitation/>.

⁴⁸ Department of Water and Sanitation *National Sanitation Policy* 2016.

⁴⁹ Socio-Economic Rights Institute of South Africa *Basic Sanitation in South Africa: A Guide to legislation, Policy and Practice* (2011).

- iii. That resources be directed to ensuring at the very least the safety of persons who do not have access to safe toilets;
- iv. That alternatives to pit latrines be explored; and
- v. That local government facilitates community participation in seeking to implement the 2016 policy and address sanitation issues.

VI ALCOHOL

1. There are clear evidence-based links between alcohol use and health issues, HIV/AIDS and Gender-Based Violence, as well as crime, road accidents and interpersonal violence.⁵⁰ Alcohol advertising and marketing is a key influencer of consumption patterns and behaviour. Adolescent alcohol consumption is a public health concern.⁵¹ Excessive alcohol consumption has been found to be a driver of poor health in South Africa.⁵²
2. The Control of Marketing of Alcohol Beverages Bill of **2013**, has not been made public for comment. This key piece of legislation is necessary to address the causal link between the marketing of alcoholic beverages and alcohol abuse and alcohol-related issues.⁵³
3. The Bill seeks to ban alcohol advertising in South Africa. However, the Bill has not been released for public comment. The South African Constitution protects the right to access to information, and the right to public participation and consultation. By denying public access to this Bill, for over five years, the government is violating constitutional rights and international obligations under the ICESCR.

⁵⁰ Numerous studies support this link. See note 2 above.

⁵¹ D Jernigan et al. 'Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008' (2016) *Addiction* 112 7-20. See also note 2 above.

⁵² C D H Parry et al. 'Support for alcohol policies from drinkers in the City of Tshwane, South Africa: Data from the International Alcohol Control Study' (2017) *Drug and Alcohol Review*; C D H Parry et al. 'Support for alcohol policies among drinkers in Mongolia, New Zealand, Peru, South Africa, St Kitts and Nevis, Thailand and Vietnam: Data from the International Alcohol Control Study' (2017) *Drug and Alcohol Review*.

⁵³ See T Pikanen et al. 'Age of Onset of Drinking and the Use of Alcohol in Adulthood: A Follow-Up Study from Age 8-42 for Females and Males' (2005) 100 *Addiction* 652-661; A E Martin et al. 'Alcohol Advertising and Youth' (2002) 26 *Alcohol Clin Exp Res* 900-906; J W Grube & E Waiters 'Alcohol in the Media: Content and Effects of Drinking Beliefs and Behaviours Among Youth' (2005) 16 *Adolescent Medicine Clinics* 327-343; M Chesish & H Rees 'Causal Links Between Binge Drinking Patterns, Unsafe Sex and HIV in South Africa: Its Time to Intervene' (2010) 21 *International Journal of STD & AIDS* 2-7; J W Miller et al. 'Binge Drinking and Associated Health Risk Behaviours Among High School Students' (2007) 119 *PEDIATRICS* 76-78; P L Ellickson et al. 'Does Alcohol Advertising Promote Adolescent Drinking? Results from a Longitudinal Assessment' (2005) 11 *Addiction* 235-246; R L Collins et al. 'Early Adolescent Exposure to Alcohol Advertising and Its Relationship to Underage Drinking' (2007) 41 *Journal of Adolescent Health* 527-534; H Amanuel et al. 'The Health and Social Impacts of Easy Access to Alcohol and Exposure to Alcohol Advertisements Among Women of Childbearing Age in Urban and Rural South Africa' (2018) *Journal of Studies on Alcohol and Drugs* 302-308; C Probst et al. 'HIV/AIDS Mortality Attributable to Alcohol Use in South Africa: A Comparative Risk Assessment by Socioeconomic Status' (2018) 8 *BMJ Open* 1-11; C Parry et al. 'A Total Ban on Alcohol Advertising: Presenting the Public Health Case' (2012) 102 *SAMJ* 602-604; M Windle et al. 'Transitions Into Underage and Problem Drinking: Developmental Processes and Mechanisms Between 10 and 15 Years of Age' (2008) 121 *PEDIATRICS* 273-289; BMA Board of Science *Under the Influence: The Damaging Effect of Alcohol Marketing on Young People* (2009).

Recommendations

4. It is strongly recommended that the Bill be released for public comment, as per the constitutional and international law obligations.
5. Additionally, it is recommended that the State takes steps to facilitate public participation and participation among stakeholders to address the relationship between alcohol consumption and advertising.

VII LANGUAGE

a Introduction to language barriers in relation to the right to health

79. The South African Constitution entrenches the right of access to healthcare on the basis of equality and freedom from any form of unfair discrimination on a number of grounds, including race, gender, sex, disability and language (Sections 9 and 27 of the Constitution).

80. The South African National Health Act (61 of 2003) on the issue of language states that:

‘The health care provider concerned must, where possible, inform the user ... in a language that the user understands and in a manner which takes into account the user’s level of literacy’.

81. The Patients’ Rights Charter also states that: ‘health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient’. The Patients’ Rights Charter also includes rights such as the right to confidentiality, informed consent, right to health information and participation in decision-making.

b Deaf people and the United Nations Convention on the Rights of Persons with Disabilities 2006 (CRPD)⁵⁴

82. In 2007, South Africa signed and ratified the United Nations Convention on the Rights of Persons with Disabilities 2006 (CRPD). States are bound to take appropriate measures to

⁵⁴ Haricharan, H.J., and M. Heap. 2009. ‘Feeling freedom’: An anthropological perspective from Cape Town on the right of access to health care for Deaf people who use South African Sign Language (SASL). Oral presentation at The Fifth International Congress of Qualitative Inquiry (QI2009): Advancing Human Rights through Qualitative research, May 20–23, in University of Illinois, Urbana-Champaign.

promote accessibility of information and communication services. These shall include, inter alia, forms of live assistance and intermediaries, readers and professional sign language interpreters (Article 9). In order to be able to exercise the right to information through all forms of communication of a person's choice, states shall accept, facilitate and promote the use of sign languages (Article 21).

c Key concerns

83. Despite the promise of the right of access to health care at both national and international level, gaps in legislation and policy have enabled government to defer responsibility for implementation. For example, the phrase 'where possible' in the National Health Act has been relied upon by the government to justify lack of language accessibility.
84. General Comment 14, an important guide for implementing the ICESCR includes accessibility as a criterion for meeting the right to health but is silent on language.
85. The CRPD states that in order to promote equality and eliminate discrimination of persons with disabilities, states shall take appropriate steps to ensure that reasonable accommodation is provided to cater for their special needs (Article 5, CRPD). This obligation must be implemented by the public authorities unless this would lead to a disproportionate or undue burden; for example, excessive costs. The CRPD is a step forward in at least recognising the special needs of Deaf people who are dependent on sign language, but the relevant provisions do not contain hard obligations for government that can be enforced immediately.
86. It has been argued that in South Africa if we are serious about the right of access to non-discriminatory health care then interpretative and translation services within the health system should be an integral and indispensable component to the provision of access to health care services on the basis of equality.⁵⁵ In South Africa, however, professional interpreting services in healthcare are generally lacking, and always have been despite the country's 400-odd years of plurilingualism.⁵⁶ In all the years leading up to 1994 there were no official interpreter posts in the public service, outside of the judiciary. In post-apartheid South Africa, no provision was made for official interpreter posts in healthcare in the only post-apartheid revision of the

⁵⁵ Pillay, K. (1999) Access to health care services: language as a barrier. *Socio Economic Rights Newsletter*. Community Law Centre. University of the Western Cape, September.

⁵⁶ Crawford, A. 1999. We can't all understand the whites' language: An analysis of monolingual health services in a multilingual society. *International Journal of Sociology of Language* 136: 27–45; Deumert, A. 2010. 'It would be nice if they could give us more language' – Serving South Africa's multilingual patient base. *Social Science and Medicine* 71: 53–61; Shell, R.C.-H. 1994. *Children of bondage: A social history of the slave society at the Cape of Good Hope, 1652–1838*. Johannesburg: Witwatersrand University Press.

public service post structure.⁵⁷ Language barriers within the health system clearly do not allow for full and equal access to health care services as they discriminate unfairly on the ground of language against patients who are unable to communicate effectively in the dominant languages of the health care system, namely English and Afrikaans.

d The consequences of language barriers

87. Language differences are an important factor contributing to adverse health outcomes. Three studies focus on (1) the magnitude of the problem; (2) the contribution of differences in use of terminology by doctors and patients and; (3) the effects of an intervention program addressing communication in medical settings.⁵⁸
88. Intervention by language and cultural awareness courses can go a long way to improving patient-doctor interaction and job satisfaction but cannot replace the skilled use of well-trained interpreters by HCWs who have, in turn, been trained how to use them effectively.
89. In general language barriers and a lack of professional interpreting services violate a number of rights for Deaf people who used South African Sign Language (SASL)⁵⁹ – including the right to health, right to information, to participate in decisions, to give informed consent, to confidentiality and to be treated with respect and dignity.
90. An intervention that provided professional SASL free-to-patient medical interpreting services as part of research projects has demonstrated that these services can advance access to health care on the basis of equality – as well as better health because they improve communication – the key to effective health care.

Recommendations

⁵⁷ Beukes, A.-M. 1996. Language in the public service. In Towards a national language plan for South Africa. Final report of the Language Plan Task Group. Pretoria: Ministry of Arts, Culture, Science and Technology, Pretoria.

⁵⁸ Levin, M. E. Editorial. *South African Medical Journal*. 2006, 96, 10: 1058–1060; Levin, M. E. Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *South African Medical Journal* 2006, 96, 10: 1076-1079; Levin M. E. Different use of medical terminology and culture-specific models of disease affecting communication between doctors and patients at a South African paediatric teaching hospital. *South African Medical Journal*. 2006, 96, 10: 1080-1084; Hunter-Adams, J. and Rother A. Qualitative study of language barriers between South African health care providers and cross-border migrants. *BMC Health Services Research*. 2017, 17:97 DOI 10.1186/s12913-017-2042-5; Haricharan, H.J., Heap, M., Cooman, F., & London, L. (2013): Can we talk about the right to healthcare without language? A critique of key international human rights law, drawing on the experiences of a Deaf woman in Cape Town, South Africa, *Disability & Society*, 28:1, 54-66 <http://dx.doi.org/10.1080/09687599.2012.699277>.

⁵⁹ Haricharan, H.J., and M. Heap. 2009. 'Feeling freedom': An anthropological perspective from Cape Town on the right of access to health care for Deaf people who use South African Sign Language (SASL). Oral presentation at The Fifth International Congress of Qualitative Inquiry (QI2009): Advancing Human Rights through Qualitative research, May 20–23, in University of Illinois, Urbana-Champaign.

91. In light of the key issues raised we make the following recommendations:

- i. That government implement free-to-patient professional medical interpreting services, which are now available in Cape Town, across the country;
- ii. That accredited training of medical interpreters be addressed in health education;
- iii. That health care staff be trained to work with interpreters; and
- iv. That health care education include education on human rights, including language rights.

PART 2: CHILD HEALTH: FROM SURVIVAL TO OPTIMAL DEVELOPMENT

I CHILD DEATHS AND MODIFIABLE CAUSES

1. This part focuses on health issues pertaining to children. These extend beyond just article 12 of the ICESCR, but also pertain to articles 10, 11, 13 and others regarding standard of living, neonatal health, environmental health, nutrition and standard of living and education pertaining to health information. As such this part is framed per issue, not per article as they intersect and are inherently interdependent and for this submission, integral to realising the highest attainable standard of health for children.
2. South Africa has made significant progress in reducing under-five mortality (U5MR) over the past decade but failed to achieve its Millennium Development Goals (MDG) target of 20 deaths per 1000 live births and U5MR remains unacceptably high for a middle-income country. In 2015 the official U5MR stood at 37 deaths/1000 live births,⁶⁰ and the latest demographic health survey suggests that this may be even higher at 42 deaths/1000 live births.⁶¹ Despite significant gains following the rollout of PMTCT, and pneumococcal and rotavirus vaccines there has been little progress since 2011. Similarly, District Health Information Systems data suggests that the neonatal mortality rate (NMR) has remained constant at 12 deaths per 1000 live births for 2014 and 2015,⁶² yet the 2016 Demographic

⁶⁰ Dorrington, R, D Bradshaw, R Laubscher and N Nannan (2016) *Rapid Mortality Surveillance Report 2015*. Cape Town: South Africa Medical Research Council.

⁶¹ National Department of Health, Statistics South Africa, Medical Research Council and ICF (2017) *South African Demographic Health Survey 2016. Key Indicator Report*. Pretoria: NDOH, Stats SA, MRC & ICF.

⁶² Dorrington RE, Bradshaw D, Laubscher R, Nannan N (2016). *Rapid mortality surveillance report 2015*. Cape Town: South African Medical Research Council. ISBN: 978-1-928340-17-1.

Health Survey suggests NMR may be nearly double this figure at 21 deaths/1000 live births.⁶³ Stark variations persist between districts and provinces.

3. In addition, variations across different data sources raise concerns around data quality and contribute to uncertainty around the extent, trends and causes of child mortality. And there are a number of areas – such as children with disabilities and chronic health conditions – where there is a critical lack of data.
4. Most child deaths are preventable. The most recent (2012) National Burden of Disease study⁶⁴ identified neonatal causes (27.5%); HIV/AIDS (19.5%); diarrhoeal diseases (16%); lower respiratory infections (12.3%); other childhood conditions (6.6%); injuries (5.5%); malnutrition (4.9%); congenital disorders (2.8%) and TB, meningitis and septicaemia (all under 2% of the total) as the key drivers of under-five mortality.
5. HIV and malnutrition continue to be underlying risk factors associated with 36% and 31% of deaths in hospital.⁶⁵ In addition, the role of non-natural deaths is under-recognised: these now account for 20% of deaths in the 1 – 4-year age group, and injuries/motor vehicle accidents and violence are the leading cause of death in adolescence,⁶⁶ yet there has been no obvious advocacy from the NDoH to promote child safety.
6. The Child Healthcare Problem Identification Programme (Child PIP) and Perinatal Problem Identification Programme (PPIP) audit hospital deaths and identify modifiable factors at hospital, clinic and community levels,⁶⁷ helping to inform planning at national level, and reducing mortality and morbidity at implementing hospitals, but the programmes have yet to be implemented countrywide.
7. Preventable factors associated with in-facility deaths include: delay in seeking care, failure to recognise danger signs, failure to identify or respond to growth problems, inadequate assessment of HIV and a lack of high care facilities for children.⁶⁸

⁶³ National Department of Health, Statistics South Africa, Medical Research Council and ICF (2017) *South African Demographic Health Survey 2016. Key Indicator Report*. Pretoria: NDOH, Stats SA, MRC & ICF.

⁶⁴ Msemburi, W, V Pillay-van Wyk, RE Dorrington, I Neethling et al. 2016. Second National Burden of Disease Study for South Africa 1997-2012. Cape Town: South Africa Medical Research Council.

⁶⁵ Child PIP 2015 data.

⁶⁶ Statistics South Africa (2017) *Mortality and causes of death in South Africa, 2015: Findings from death notification. Statistical Release P0309.3*. Pretoria: Stats SA. P. 37.

⁶⁷ See: www.childpip.org.za

⁶⁸ Stephen CR. 2016. *Saving Children 2012-2013: An eighth survey of child healthcare in South Africa*. Pretoria: Tshepesa Press, MRC, CDC

8. Yet just over half of child deaths occur outside hospitals.⁶⁹ Poor access to health care services is compounded by poor quality of care and communication within the health sector – and many caregivers either don't know when to return, don't want to return or can't afford to return. For example, lower respiratory tract infections are the leading cause of out of facility deaths – almost half associated with preterm birth, and many occurring soon after discharge from hospital.⁷⁰ Early entry to the health sector and better care on presentation is therefore critical, as one third of child deaths in hospital occur within 24 hours of admission.⁷¹
9. In 2015, the SA Human Rights Commission released a damning report on emergency medical services (EMS) in the Eastern Cape noting how poor management, shortages of staff, ambulances and medical supplies, and an inability to navigate long distances and difficult terrain, resulted in often fatal delays and/or forced poor families to shoulder the high costs of public or private transport driving them deeper into poverty.⁷² We also note with concern that ambulance crews have extremely limited training in the management of paediatric emergencies and most EMS services do not carry the necessary equipment to manage the resuscitation and safe transport of children.
10. Perinatal asphyxia and preterm birth and infection are the leading causes of neonatal death. And while roll out of three neonatal interventions targeting early neonatal deaths⁷³ is ongoing, provinces are struggling to achieve adequate coverage as they have insufficient funds to take these interventions to scale. Key recommendations of the National Perinatal Mortality and Morbidity Committee include: a) allowing community health workers to manage pneumonia; b) rolling out additional antenatal visits; and c) allowing the District Clinical Support Teams (DCSTs) to lead and track the quality of neonatal care at district level (as the quality of neonatal care in districts with both a paediatrician and paediatric nurse, has improved by up to 30%).⁷⁴ A further recommendation is for community health workers to visit all neonates within one week of delivery to ensure early identification of sick new-borns and to reinforce mothers' recognition of danger signs.

⁶⁹ Committee on Mortality and Morbidity in Children under 5 years, personal communication, Neil McKerrow.

⁷⁰ Mathews S, Martin L, Scott C, Coetzee D & Lake L (2015) *Every child counts: Lessons learned from the South African Child Death Review pilot. A research brief*. Cape Town: Children's Institute, University of Cape Town.

⁷¹ Child PIP data.

⁷² South African Human Rights Commission (2015) *Hearing report of the South African Human Rights Commission inot Access to Emergency Medical Services in the Eastern Cape. 24 – 25 March 2015*.

⁷³ Helping Babies Breathe, management of the small and sick neonate, and the implementation of non-invasive ventilation to address respiratory distress in preterm neonates

⁷⁴ Data extracted from Perinatal Problem Identification Programme 2013 - 2016.

11. While there has been a slow but steady decline in child poverty, 62% of South Africa's children still lived below the poverty line in 2015, 30% of children living in unemployed households, with many continuing to live in households with inadequate water (30%), sanitation (26%), electricity (21%), and overcrowding (18%). Stark racial and spatial inequalities persist, with Black African children in rural areas experiencing multiple deprivations. These living conditions have an adverse impact on children's health, safety, survival and development, and it is vital that the NDoH initiates intersectoral action at national, provincial and district level.

Recommendations

12. We therefore call on the State to improve the quality of paediatric emergency services by scaling up training in paediatric emergency care and triage and ensuring that paediatric staff and equipment are specified in the national standards.

13. Ongoing mortality reductions to reach the Sustainable Development Goals (SDGs) target require a review of each child death both within and outside of hospital – which should result in immediate action to address any modifiable factors. Child PIP and PPIP should therefore be mandatory and extended to all facilities and accompanied by Child Death Review teams which have proven effective in investigating the circumstances surrounding out-of-facility deaths and improving intersectoral collaboration across health, social development and the criminal justice system.⁷⁵

14. Early entry into the health system, better implementation of the Road to Health Book and IMCI, together with timely referral to higher levels of care is essential, as is better assessment and care on arrival in hospital.

15. Addressing the ongoing shortage of high- and intensive-care paediatric and neonatal facilities at hospitals should be prioritised.

16. The role of community health workers needs to be extended to include not only prevention services, but also treatment of pneumonia and diarrhoea.

17. It is essential to address the underlying social determinants of child health.

⁷⁵ Mathews S, Martin L, Coetzee D, Scott, C & Brijmohun Y. 2016. Child deaths in South Africa: Lessons from the child death review pilot. *South African Medical Journal*, 106(9), 851-852.

II PROMOTING EARLY CHILD DEVELOPMENT

18. The Global Strategy for Women's Children's and Adolescents' Health calls for the transformation of health care services and greater intersectoral collaboration to ensure children not only survive but thrive and reach their full potential. Health has a unique opportunity and responsibility to promote children's optimal development, particularly in the critical 'first 1000 days' when poverty, violence, malnutrition, a lack of care and harsh discipline⁷⁶ can lead to 'toxic stress' and undermine children's long-term physical, cognitive and psychosocial development.
19. Health's expanded role - in identifying risk factors, promoting health and development, supporting mothers and caregivers, and providing a gateway to social grants, child protection and social services - is clearly defined in the 2015 National Integrated Early Childhood Development Policy – including a central role for community-based workers in identifying children most in need of ECD services.⁷⁷
20. Yet for health to fulfil its mandate will require a significant shift in focus, training, and resources and the essential package of services. NDoH has been slow to respond and needs to develop a clear implementation plan to deliver an expanded set of health services. This includes nutritional support and mental health screening for pregnant women, greater efforts to prevent stunting, support breastfeeding and improve complementary feeding; and the promotion of responsive caregiving and early stimulation.

Recommendations

21. The new Road-to-Health Book released in 2018 has the potential to improve communication, guidance and support for caregivers of young children and enhance continuity of care but will require reorientation, training and supervision of health staff to ensure it is used effectively to promote child health and development, and to ensure a more proactive response to growth faltering, developmental delay, domestic violence and other risk factors.
22. Health and nutrition services need to be extended to ECD centres, and the pivotal role of community-health workers in supporting pregnant women and caregivers and promoting

⁷⁶ SP Walker, TD Wachs, J Meeks Gardner, B Lozoff, GA Wasserman and A Pollit. 2007. Child development: Risk factors for adverse outcomes in developing countries. *The Lancet*, 369: 145-157

⁷⁷ Slemming W & H Saloojee H. 2013. Beyond survival: the role of health care in promoting ECD. In: Berry L, L Biersteker, A Dawes, L Lake and C Smith(eds) *South African Child Gauge 2013*. Cape Town: Children's Institute, UCT.

the health and development of young children must be strengthened and matched by investments in training, support and remuneration.

23. Finally, indicators of early childhood development should be included in the core national indicator set to ensure ECD services are prioritized, monitored and protected.

III EFFORTS TO PREVENT MALNUTRITION AND STUNTING

24. Almost one in three children (31%) who died in hospital in 2015 were severely malnourished,⁷⁸ and more than one in four children (27%) aged 0 - 5 years are stunted;⁷⁹ a figure which has remained stubbornly unchanged for the past decade. But malnutrition is not only a key driver of under-five mortality, it also manifests as high levels of stunting which undermine children's education and employment prospects and is driving a growing burden of obesity and non-communicable diseases in adulthood. Household food security is therefore a critical concern given an expanded unemployment rate of 36%,⁸⁰ and a rise in poverty with children hardest hit.⁸¹ In 2016, 20% of households ran out of money to buy food in the previous 12 months,⁸² and only 23% of children 6 - 23 months received a minimum acceptable diet.⁸³ It is therefore not surprising that malnutrition remains a key driver of under-five mortality with 31% of young children who died in hospital in 2015 being severely malnourished. Increasing levels of overweight (15%) and obesity (6%) amongst children are also a concern.⁸⁴

25. Mother-and-Baby-Friendly Hospitals help mothers initiate breastfeeding, but breastfeeding rates remain low, with only 23.7% of infants exclusively breastfed at 4-5 months.⁸⁵ We therefore call on the State to increase investment in community-based

⁷⁸ Unpublished data from the Child Health Problem Identification Programme that audits hospital deaths at 75% of facilities countrywide.

⁷⁹ National Department of Health, Statistics South Africa, Medical Research Council and ICF (2017) *South African Demographic Health Survey 2016. Key Indicator Report*. Pretoria: NDOH, Stats SA, MRC & ICF.

⁸⁰ Statistics South Africa (2017) *P0211 - Quarterly Labour Force Survey, 4th Quarter 2016*. Pretoria: Stats SA.

⁸¹ Statistics South Africa (2017) *Poverty on the rise in South Africa*. <http://www.statssa.gov.za/?p=10334>

⁸² Statistics South Africa (2016) *Community Survey 2016. Statistical Release PO301*. Pretoria: Stats SA.

⁸³ National Department of Health, Statistics South Africa, Medical Research Council and ICF (2017) *South African Demographic Health Survey 2016. Key Indicator Report*. Pretoria: NDOH, Stats SA, MRC & ICF.

⁸⁴ Shisana O, D Labadarios, T Rehle, L Simbayi, K Zuma, A Dhansay, P Reddy, W Parker, E Hoosain, P Naidoo, C Hongoro, Z Mchiza, NP Steyn, N Dwane, M Makoae, T Maluleke, S Ramlagan, N Zungu, MG Evans, L Jacobs, M Faber and the SANHANES-1 Team (2013) *South African National Health and Nutrition Examination Survey (SANHANES-1)*. Cape Town: HSRC Press.

⁸⁵ Tylleskär, T et al. (2011) Exclusive breastfeeding promotion by peer counsellors in sub-Saharan Africa (PROMISE-EBF): a cluster-randomised trial *The Lancet*, Volume 378(9789): 420- 427.

breastfeeding support and to strengthen support for working mothers to ensure breastfeeding is sustained.⁸⁶

26. More effective use of the Road-to-Health Book is needed to promote optimal nutrition, identify and support children whose growth is faltering, and refer children with moderate and severe malnutrition.⁸⁷ These efforts need to extend beyond growth monitoring and ensure hungry and malnourished children are linked to food provision, community health services and social assistance, and the management of Severe and Acute Malnutrition at community level needs to be strengthened.

27. The Child Support Grant (CSG), valued at R400 /month in 2018, reaches about 12 million / 60% of children, yet a lack of documentation prevents up to 18% of eligible children from accessing the CSG, with take-up rates particularly low amongst infants who are most in need of nutritional support. The grant is associated with improved health and nutrition outcomes,⁸⁸ but its value falls below the food poverty line (valued at R531 in 2017), and it is failing to keep pace with food inflation. For example, the cost of a basic food basket increased by 15% between September 2015 and 2016, yet the CSG increased by only 6% over the same period.⁸⁹ The 1% increase in VAT introduced in 2018 is likely to further increase inflation and put further pressure on poor households.

Recommendations

28. We therefore call on the State to introduce measures to improve employment, social assistance, land and agrarian reform. This includes increasing the value of the Child Support Grant to the food poverty line; addressing the systemic barriers in birth registration law and practice that prevent many children from accessing social assistance; introducing early registration for the CSG in the antenatal period; and exploring the possibility of including a maternity benefit in the context of comprehensive social security.

29. We also call on the State to regulate the aggressive marketing of unhealthy foods. We welcome Regulation 991 (R991) that regulates the marketing of breastmilk substitutes, yet note with concern widespread ignorance amongst health professionals, and continued

⁸⁶ For example, by amending the basic conditions of employment act to guarantee paid maternity leave for 6 months, guaranteeing breastfeeding breaks as currently provided for in the Code of Good Practice on the Protection of Employees during Pregnancy and after the Birth of a Child, and encouraging employers to introduce flexible working hours, child care facilities and breastfeeding rooms.

⁸⁷ Recommendation of COMMIC drawing list of modifiable factors identified in Child PIP.

⁸⁸ Delany A, Jehoma S & Lake L (2016) *South African Child Gauge 2016*. Cape Town: Children's Institute, University of Cape Town.

⁸⁹ National Treasury and South African Revenue Service (2016) *2016 Budget: People's Guide*. Pretoria: NT & SARS.

violations by industry, and therefore call on government to strengthen efforts to promote, monitor and enforce R991.

30. The 2018 tax on sugary beverages is also welcomed, but it exempts many sugary products and is low. Revenues from this tax should be ring-fenced to subsidise basic, healthy foods and promote healthy behaviour possibly through funding a Health Promotion Foundation. Taxes on ultra-processed foods driving the obesity epidemic must now be considered.⁹⁰

IV DEFINING NORMS AND STANDARDS TO STRENGTHEN ACCOUNTABILITY AND QUALITY OF CARE

31. While children's right to basic health care services is guaranteed by section 28 (1)(c), the state has yet to define a package of basic health care services for children, making it difficult to hold government accountable. In addition, it is not possible to disaggregate the budget for child health or establish whether children are receiving their fair share of resources.
32. The NDoH has adopted well-recognised child survival programmes which are appropriate and relevant for the South African setting and its burden of disease. However, implementation is flawed, and provinces and districts are not held accountable: for example, only two provinces have appointed provincial paediatricians, despite numerous National Health Council resolutions recommending this.
33. Quality of care remains a concern. In 2011, the NDoH introduced National Standards for Health Care Facilities which offer a potentially powerful mechanism for driving quality improvement processes. Similarly, we welcome the vision of an ideal clinic which 'opens on time', 'is very clean', and 'treats people with dignity'. While the needs of adolescents are now being considered, there is little attention paid to children and what is needed to develop child and family-friendly services at clinics and community health centres and hospitals. It is therefore vital that the Norms and Standards for Health Care Establishments, Ideal Clinics and other guidelines such as the proposed 'comprehensive package of health services' and 'essential drug list' explicitly factor in children's needs and

⁹⁰ Monteiro, C., Cannon, G., Moubarac, J., Levy, R., Louzada, M., & Jaime, P. (2017). The UN Decade of Nutrition, the NOVA food classification and the trouble with ultra-processing. *Public Health Nutrition*, 1-13. doi:10.1017/S1368980017000234.

articulate with, and give effect to, the proposed essential package of care for children and adolescents.

34. The Office of Health Standards Compliance is responsible for ensuring that health care is safe and of high-quality, through inspections to measure progress to achieving national core standards. Critical and systemic challenges identified in the 2015/2016⁹¹ audit include budgetary constraints, vacant posts, shortages of medical supplies and equipment, poor leadership, governance and quality of care. In addition, it would be useful to disaggregate the data by age in the annual inspection reports to reflect standards for adults and standards for children and adolescents.
35. Stock-outs and shortages of ARV or TB treatment increased from 21% in 2013 to 36% in 2015, while vaccine stock outs decreased slightly from 15% to 11% over the same period,⁹² yet remain pervasive and can be life threatening: For example, only 48% of children in an Eastern Cape study were up to date with immunisations at 3 months with stock-outs accounting for 53% of incomplete immunisations.⁹³ Significant shortages of vaccines were also found in a better resourced district in Gauteng.⁹⁴ Many of these stock-outs lasted over a fortnight.

Recommendation

36. We therefore call on the State to fast track the development of an Essential Package of Care for children inclusive of norms and standards for physical infrastructure, equipment and consumables; staffing cadres, numbers and skills; together with clear targets to ensure that child health services are adequately resourced, and government held accountable.
37. Appropriate funding is essential and a ring-fenced budget for maternal and child health services needs to be considered. This essential package needs to be integrated with existing accountability and quality improvement mechanisms such as the National Core Standards and Office of Health Standards Compliance.

⁹¹ Office of Health Standards Compliance (2017) *2015/2016 Annual Inspection Report*. Pretoria: OHSC.

⁹² Stop Stock Outs Project (2015) *2015 Stockouts National Survey: The continuing crisis*. Pretoria: Doctors Without Borders, the Rural Doctors Association of Southern Africa, the Rural Health Advocacy Project, the Treatment Action Campaign, SECTION27 and the Southern African HIV Clinicians Society.

⁹³ Le Roux K, Akin-Olugbade O, Katzen LS, Laurenzi C, Mercer N, Tomlinson M, et al. Immunisation coverage in the rural Eastern Cape – are we getting the basics of primary care right? Results from a longitudinal prospective cohort study. *SAMJ*. 2016;107(1).

⁹⁴ Ngcobo NJ & Kamupira MG (2017) *South African Medical Journal*;107(6):535-538 <http://www.samj.org.za/index.php/samj/article/view/11914>

38. An active civil society and community participation in clinic committees and hospital boards are also needed to improve accountability at local level, while use of the courts and Chapter 9 institutions have also proven effective.

V INVESTING IN COMMUNITY HEALTH WORKERS AND BUILDING CAPACITY FOR MATERNAL AND CHILD HEALTH AT DISTRICT LEVEL

39. South Africa has made progress in improving children's access to health care, providing free primary health care, and free health care for pregnant women, children under 6 and social grant beneficiaries; however, in 2014 one in five children still travelled more than 30 minutes to reach a health facility⁹⁵ – and transport costs and safety concerns continue to cause life-threatening delays in accessing treatment.

40. Children with disabilities and pregnant teenagers continue to experience discrimination in accessing health care. Despite the National Health Act and Uniform Patient Fee Schedule confirming refugees and asylum seekers right to access basic health care services and anti-retroviral therapy, and a national circular confirming all children's rights to the Road to Health Book and associated services, providers frequently obstruct their access to health services.⁹⁶

41. Stark inequities persist between rural and urban areas as well as the private and public health care sectors - 52% of health care spending is focused on the richest 16% of the population who can afford private health care,⁹⁷ with the majority of South Africans dependent on the public health system where resources are thinly stretched. Only 32% of medical practitioners work in the public sector, and specialists remain concentrated in the wealthier and more urban provinces of the Western Cape and Gauteng.⁹⁸ While rural areas house 44% of South Africa's children,⁹⁹ rural provinces continue to experience significant shortages of nurses and medical practitioners¹⁰⁰ – which are likely to increase in the context of many public health sector posts being frozen due to austerity

⁹⁵ Child centred analysis of 2014 General Household Survey. Viewed on 22 April 2016 at: www.childrencount.uct.ac.za

⁹⁶ Dass, D. et al. 2014. Socio-Economic Rights of Refugees in South Africa, in Khan, F. and T Schreier. *Refugee Law in South Africa*. Cape Town: Juta.

⁹⁷ McIntyre D, Doherty J & Ataguba J (2014) *Universal Health Coverage Assessment: South Africa*. Global Network for Health Equity.

⁹⁸ Gray A, Vawda Y. Health Policy and Legislation. In: Padarath A, King J, Mackie E, Casciola J, editors. *South African Health Review 2016*. Durban: Health Systems Trust; 2016.

⁹⁹ Hall K & Sambu W. 2015. Housing and Services—Urban-rural Distribution. Child centred analysis of GHS 2014 data. *Children Count* website, Children's Institute, UCT. Accessed on 23 April 2017.

¹⁰⁰ RUDASA 2015. Rural Health Fact Sheet 2015.

measures.¹⁰¹ However, living in an urban area does not equate to improved health as Apartheid-era urban planning gave rise to dense informal settlements on fringes of South African cities where poverty, violence and a lack of basic services, including health services, continue to compromise children's health and safety in the context of increasing urbanisation.

42. As described above in relation to the NHI, the re-engineering of Primary Health Care (PHC-R) which involves Ward-Based Outreach Teams (WBOTs), Integrated School Health Programme and District Clinical Specialist Teams have the potential to improve the reach and quality of maternal and child health services provided they are adequately staffed and implemented with fidelity.
43. The community health worker (CHW) programme, through the WBOTs, remains uncoordinated and underfunded, and this is a major impediment that limits children's access to preventative and primary health care. A recently completed investment case¹⁰² on CHWs undertaken for the NDoH found that increasing the number of CHWs to 96 000 (from the current 60 000) and paying a stipend of R2500/month including costs for training, equipment and supervision would amount to 15% of the current public sector primary health care expenditure and over 10 years would lead to cost savings due to deaths averted.¹⁰³
44. The District Clinical Specialist Teams (DCSTs) have the potential to strengthen leadership for child health at district level and are intended to improve clinical governance, enhance quality of care, and drive intersectoral collaboration in response to the local burden of disease. While there are examples of promising practice, most teams are understaffed and struggling to establish an identity, too often undertaking administrative tasks (such as clinic audits), or addressing gaps in the district management team, rather than improving quality of care. For example, in September 2016, only 40% of DCSTs had appointed a paediatrician.¹⁰⁴
45. The emphasis on school health services since 2012 is a welcome move by the NDoH. However, implementation remains a challenge, with national coverage (for a limited range of services) cited as no more than 23% for quintile 1 and 2 schools in the 2014/15 NDoH

¹⁰¹ Gonzalez LL (2016) The Big Chill: Health post freeze threatens services. *Health-e news*, February 1, 2016. Accessed: 22 April 2017: <http://www.rhap.org.za/health-e-raises-alarm-on-frozen-posts-following-rhap-investigation/>

¹⁰² <http://www.mrc.ac.za/sites/default/files/files/2017-10-30/SavingLivesSavingCosts.pdf>

¹⁰³ Sazawal S & Black RE (2003) Effect of pneumonia case management on mortality in neonates, infants, and preschool children: a meta-analysis of community-based trials. *Lancet Infect Dis* 3(9):547-56.

¹⁰⁴ Personal communication. Neil McKerrow

Annual report.¹⁰⁵ A shortage of school nurses, social workers and allied health professionals' compromises screening and referrals and limits the range of services delivered on the ground. As yet no packages of care or onward referral pathways exist – in particular for child and adolescent mental health, and as such, the huge potential of the Integrated School Health Policy (ISHP) remains untapped. A focus on the concept of school health teams, where the nurse leads a team of less skilled individuals who can competently undertake screening and health promotion tasks may make it possible to deliver at scale.

Recommendations

46. We therefore call on the State to:

- i. Expand both the numbers of CHWs and their scope of practice and improve their remuneration and conditions of service to ensure meaningful gains for child health;
- ii. Amend the Medicines Control Council and Pharmacy Council regulations to enable CHWs to commence treatment for pneumonia;
- iii. Ensure that all DCSTs have a full pediatric complement, and appoint provincial lead clinicians to improve provincial co-ordination, define clearer clinical governance roles for DCSTs, and imbue the teams with sufficient authority to be able to demand accountability for clinical activities; and
- iv. Identify a workable model for school health teams and develop packages of care and referral pathways to realise the potential of school health services and take them to scale.

VI PRIORITISING CHILDREN IN HIV AND TB PREVENTION AND TREATMENT

47. HIV and TB have exacted a particularly heavy toll on children in South Africa, who are affected by HIV and TB either directly through infection, or indirectly through the illness or death of family members and caregivers.¹⁰⁶ Although various interventions have been implemented to prevent transmission of HIV to children and to protect child health in general, there are still multiple challenges in the delivery of health care services and these

¹⁰⁵ Department of Health (2015) *Annual Report 2014/15*. Pretoria: NDoH.

¹⁰⁶ Slemming W and H Saloojee. 2013. Beyond survival: the role of health care in promoting ECD. In: Berry L, L Biersteker, A Dawes, L Lake and C Smith (eds) *South African Child Gauge 2013*. Cape Town: Children's Institute, UCT

lead to negative health outcomes in children. These include: the continued transmission of HIV from mother to child especially in adolescent mothers;¹⁰⁷ the lack of decisive policy action on the distribution of condoms at schools and on sexual violence at schools; medicines stock-outs that lead to treatment default, potential resistance, and increased morbidity and mortality; the lack of effective and tolerable treatment regimens for TB patients; poor information systems, which may contribute to late initiation of children on treatment; and insufficient support for community-level workers.

48. In South Africa the high burden of TB in children is often overlooked as it is difficult to diagnose.¹⁰⁸ Childhood TB is still not addressed in the 2017 – 2022 National TB Plan.¹⁰⁹ TB is thought to be a major contributor to under-five mortality in South Africa, however, children dying from TB are often incorrectly classified as pneumonia, meningitis, HIV or malnutrition deaths.¹¹⁰ Poor integration of the TB and MCWH programme contributes to this problem.¹¹¹ Although active case-finding and contact tracing is essential, these services have seldom functioned optimally and presently are being cut-back, and are currently not included in community caregivers' scope of practice. As the drug-resistant TB burden in the country increases, there are increasing numbers of children with drug-resistant TB (DR-TB). These children are treated with adult drugs not tested in children, as children-friendly formulations have not been developed.¹¹² Furthermore, they are often hospitalized for many months.¹¹³ TB prevalence is also reportedly increasing in adolescence.
49. The absence of appropriate pediatric TB formulations for treating DR-TB means that children are not able to exercise their Rights to Enjoy the Benefits of Scientific Progress, a right contained in article 27 of the ICESCR.
50. Children have benefited enormously from the rollout of ARVs and prevention of mother-to-child transmission (PMTCT). The most recent evaluation of the PMTCT programme

¹⁰⁷ Ramrai T, Jackson D et al. (2018) Adolescent Access to Care and Risk of Early Mother-to-Child HIV Transmission. *Journal of Adolescent Health*: 62(4):434-443.

¹⁰⁸ Beyers N, Gie R, Schaaf H, Van Zyl S, Nel E, Talent J, et al. Delay in the diagnosis, notification and initiation of treatment and compliance in children with tuberculosis. *Tubercle and Lung Disease* 1994,75:260–265.

¹⁰⁹ TB Think Tank. South Africa National Department of Health National Tuberculosis Programme Strategic Plan: 2017-2021. In: Unpublished, draft; 2017.

¹¹⁰ Graham S, Sismanidis C, Menzies HJ, et al. Importance of tuberculosis to address child survival. *Lancet* 2014,383:1605–1607

¹¹¹ Marais B. Improving access to tuberculosis preventive therapy and treatment for children. *Int J Infect Dis* 2017,56:122-125. doi: 110.1016/j.ijid.2016.1012.1015. PMID: 27993688.

¹¹² Seddon JA, Furin JJ, Gale M, Del Castillo Barrientos H, Hurtado RM, Amanullah F, et al. Caring for Children with Drug-Resistant Tuberculosis. *American Journal of Respiratory and Critical Care Medicine* 2012,186:953-964.

¹¹³ Loveday M, Sunkari B, Master I, Daftary A, Mehlohlakulu V, Hlangu S, et al. Household context and social impact of childhood MDR-TB in KwaZulu-Natal, South Africa. *In print* 2017

shows that transmission rates have declined to less than 1.3%,¹¹⁴ yet less than 50% of young HIV-positive individuals are on treatment.¹¹⁵ To date, evaluations of HIV care programmes report sub-optimal levels of treatment acceptance, poor ART adherence and low retention in HIV care among HIV-positive children and adolescents, including high levels of co-morbidities (HIV and tuberculosis (TB)), premature disability and mortality.¹¹⁶

51. HIV prevalence among women 15 to 19 years attending antenatal clinics remains high, with no appreciable declines (2009: 13.7%, 2013: 12.7%)¹¹⁷ and estimates based on the 2012 national survey indicate that young women aged 15 - 24 years are at highest risk of incident HIV infection - higher than men and higher than women in any other age group.¹¹⁸
52. South Africa has an excellent National Strategic Plan for HIV, STIs and TB 2017-2022, but it fails to provide clear guidelines or specify the funds, human resources and indicators needed to ensure effective implementation and track progress, raising concerns about implementation and capacity to hold provincial and district health departments accountable.

Recommendations

53. We therefore call on the State to prioritise children within HIV and TB prevention and treatment. This includes greater effort to ensure the provision of preventive TB therapy to all young children exposed to an infectious source, increased training, awareness and improve diagnosis of childhood TB, child-friendly TB formulations and access to MDR-TB prevention and treatment when appropriate.

Children and adolescents also need to be prioritised in HIV budgetary allocations. The most effective combinations of biomedical, behavioural and structural HIV prevention interventions need to be identified and scaled-up. Effective and cost-effective models and HIV treatment and care targeting key economic (distance, transport) and health system

¹¹⁴ Chirinda W, Ngandu NK, Ngoma K, Bhardwaj S, Feucht U, Davies N, Ntloana M, Mhlongo O, Silere-Maqetseba T, Moyo F, Sherman G. Closing the gaps to eliminate mother-to-child transmission of HIV (MTCT) in South Africa: Understanding MTCT case rates, factors that hinder the monitoring and attainment of targets, and potential game changers. *South African Medical Journal*, [S.l.], p. s17-s24, mar. 2018. ISSN 2078-5135. Available at: <<http://www.samj.org.za/index.php/samj/article/view/12242>>. Date accessed: 09 Aug. 2018. doi:10.7196/SAMJ.2017.v108i3b.12817..

¹¹⁵ World Health Organization. *Global HIV/AIDS Response* Geneva, Switzerland: WHO; 2011 [cited 2014 15 September]. Available from: http://www.who.int/hiv/pub/progress_report2011/en/.

¹¹⁶ Nglazi MD, Kranzer K, Holele P, Kaplan R, Mark D, Jaspan H, et al. Treatment outcomes in HIV-infected adolescents attending a community-based antiretroviral therapy clinic in South Africa. *BMC Infect Dis*. 2012;12:21.

¹¹⁷ The South African National Department of Health. 2015. *The 2013 National Antenatal Sentinel HIV Prevalence Survey South Africa*.

¹¹⁸ Human Sciences Research Council 2014. *South African National HIV Prevalence, Incidence and Behaviour Survey* Cape Town, South Africa: HSRC Press.

(drug stock outs, lack of human resources, clinic waiting times) barriers must be identified and scaled-up to improve HIV treatment outcomes.

VII INVESTING IN ADOLESCENT HEALTH

54. 'What we fail to measure, we fail to act on', therefore the WHO recommends incorporating a focus on adolescents into all health policies, strategies and programmes.¹¹⁹ Yet the word 'adolescent' appears only once in the 2015/6 Annual Inspection Report of the OHSC. Adolescents are at high risk of HIV and other adverse sexual and reproductive health outcomes and are more likely than adults to have difficulties accessing sexual and reproductive health services. It is particularly important to track adolescents' experience of positive and caring attitudes from health workers, waiting times and availability of medicines and supplies. We therefore welcome the inclusion of adolescent and youth friendly services in the 2017 definition of an Ideal Clinic.
55. We welcome the renewed focus on adolescent health and the development accreditation standards for Adolescent and Youth Friendly Services, and the recent endorsement of the National Adolescent and Youth Health Policy in 2017 which provides for both pre- and in-service training on Adolescent and Youth Friendly Services (including psychosocial and communications skills); and it is hoped that these commitments will address adolescents' dissatisfaction with public health services, quality of care, and long waiting times.¹²⁰
56. Despite provisions in the Integrated School Health Policy, the government has yet to provide a package of school-based sexual and reproductive health services. This should ideally include evidence-based behavioural interventions, HIV testing, TB and STI screening, pregnancy tests, condoms and other contraceptives provision, and referrals for HIV/TB services. Given that condoms are one of the most effective biomedical HIV prevention technologies, and that school-based distribution programmes work¹²¹ we acknowledge the Department of Basic Education's 2017 National Policy on HIV, STIs and TB which has finally made provision for learners to have 'discreet' access to condoms.

¹¹⁹ Dick B & Ferguson BJ (2015) Health for the World's Adolescents: A second chance in the second decade. *Journal of Adolescent Health* 56: 3-5.

¹²⁰ Schriver, B., Meagley, K., Norris, S., Geary, R., & Stein, A. D. Young people's perceptions of youth-oriented health services in urban Soweto, South Africa: A qualitative investigation. *BMC Health Services Research* 2014, 14, 625–630; Mokomane Z Mokhele T, Mathews C, Makoea M. Availability and accessibility of public health services for adolescents and young people in South Africa. *Children and Youth Services Review* 2017, 74: 125-132.

¹²¹ Wang T, Lurie M, Govindasamy D, Mathews C. (2018) The Effects of School-Based Condom Availability Programs (CAPs) on Condom Acquisition, Use and Sexual Behavior: A Systematic Review. *AIDS Behaviour* (1):308-320.

However, the policy suggests that these will be provided by 'suitably (sic) persons in a supportive and friendly manner ... based on age of consent, inquiry or need', raising concerns around how this will be implemented – and to what extent learners would feel comfortable approaching a 'friendly' intermediary particularly in conservative settings – and implementation will need to be carefully monitored.

Recommendations

57. We therefore call on the State to:

- a) To identify a workable model for school health teams with standardized packages of care and referral pathways;
- b) ensure the delivery of school-based sexual and reproductive health services; and
- c) ensure that core standards for adolescent health care are monitored by the OHSC in both clinic and hospital services, in order to realise the potential of school and facility based adolescent health services and take them to scale.

VIII ALCOHOL ABUSE

58. Drinking during pregnancy can damage the unborn child, and rates of foetal alcohol spectrum disorder have been found to be among the highest in the world (at 14% and 21% for grade 1 learners in certain rural communities of the Western Cape).¹²² Drinking amongst high school learners remains prevalent with 37% of males and 28% of females report drinking in the past 30 days, and an alarming 30% of male and 20% of female learners reporting binge drinking during the same period.¹²³ Drinking amongst children and adolescents is associated with sexual and interpersonal violence, absenteeism, school failure, unwanted pregnancies, sexually transmitted infections, HIV, and FASD.¹²⁴

¹²² May, P.A., Blankenhip, J., Marais, A-S., Gossage, J.P., Kalberg, W.O., Barnard, R., de Vries, M., Robinson, L.K., Adnams, C.M., Buckley, D., Manning, M., Jones, K.L., Parry, C., Hoyme, H.E., & Seedat, S. (2013). Approaching the prevalence of the full spectrum of fetal alcohol spectrum disorders in a South African population-based study. *Alcoholism: Clinical & Experimental Research*, 37, 818-830.

¹²³ Reddy SP, James S, Sewpaul R, Sifunda S, Ellahebokus A, Kambaran NS, Omardien RG. *Umfhente Uhlaba Usamila – The 3rd South African National Youth Risk Behaviour Survey 2011*. Cape Town: South African Medical Research Council, 2013.

¹²⁴ Morojele, N., Parry, C., Brook, J., & Kekwaletswe, C. (2012). Alcohol and drug use. In A. van Niekerk, S. Suffla & M. Seedat (Eds.), *Crime, violence and injury in South Africa: 21st century solutions for child safety* (pp.195-213). Tygerberg: MRC-University of South Africa Safety & Peace Promotion Research Unit.

59. The State has attempted to address these problems by proposing to ban the advertising of alcohol, raise the legal drinking age, limit hours for alcohol sales, and lower the legal alcohol limit for drivers. Progress has been slow in instituting any of these changes, ostensibly because of disputes within government departments about the consequences of these actions. While government has taken concrete action in a few areas, there is a lot more the government could and should be doing.

Recommendations

60. Key recommendations include:

- i. banning alcohol packaging that appeals to young people and banning all advertising of alcohol product; at the very least, releasing its Control of Alcohol Marketing Bill for public comment;
- ii. increasing taxes on alcohol products that appeal to young people such as fruit flavoured alcoholic drinks;
- iii. dealing firmly with venues that sell alcohol to underage drinkers;
- iv. instituting a graduated driving license policy so that novice drivers who test positive when driving under the influence of alcohol are deprived of a license for a number of years;
- v. accrediting school-based prevention programmes to improve their quality; equipping parents to be good role models and to set appropriate boundaries for their children;
- vi. and ensuring that there are appropriate and quality alcohol misuse treatment programmes available for young persons who need such an intervention.¹²⁵

IX ENDING VIOLENCE AGAINST CHILDREN

61. The State has invested in a strong legal framework to give effect to children's right to be protected from maltreatment, abuse, and neglect, but the need outweighs the capacity of

¹²⁵ Morojele NK, Parry CDH, Brook JS. (2009). *Substance Abuse and the Young: Taking Action*_(Research Brief). Pretoria: MRC.

the child protection and criminal justice system compromising children's access to protection, justice, and therapeutic services.

62. Violence is pervasive, with 824 cases of child murder reported in 2016,¹²⁶ and a child homicide rate of 5.5/100 000, more than double the global rate of 2.4/100 000 with child homicides peaking amongst adolescent boys, yet nearly half of child homicides occur in the context of child abuse and neglect; with these cases concentrated in young children aged 0-4.¹²⁷ One in three children are victims of sexual violence and physical abuse, 12% of children report neglect and 16% report emotional abuse.¹²⁸ In other words, many children experience and/or witness multiple forms of violence in the home, family, community and school, often at the hands of someone they know, resulting in complex and continuous trauma.

63. The intergenerational cycle of violence has its roots in early childhood, where exposure to domestic violence, neglect, abuse, substance abuse and mental illness may result in toxic stress - causing long-lasting neurological and psychological damage in children.¹²⁹ This early exposure to violence places girls at increased risk of sexual assault and intimate partner violence, with boys more likely to become perpetrators.¹³⁰ It is therefore essential to intervene early before patterns of violence become entrenched.

Recommendations

64. We therefore call on the NDoH to play a more proactive role in preventing violence against children by looking out for - and responding to - signs of maternal depression, substance abuse and domestic violence; promoting warm and responsive caregiving and ensuring that mothers and caregivers of young children have adequate material and social support. The provision of adolescent-friendly services – including school and community-based

¹²⁶ South African Police Services Crime data 2016. Viewed at: <http://childrencount.uct.ac.za/indicator.php?domain=10&indicator=64>

¹²⁷ Abrahams N, Mathews S, Martin LJ, Lombard C, Nannan N & Jewkes R. 2016. Gender differences in homicide of neonates, infants and under-five year olds in South Africa: Results from the 2009 national child homicide study. *PloSmed*. 13(4): 1-15. e1002003. doi:10.1371/journal.pmed.1002003.

¹²⁸ Artz L, Burton P, Ward CL, Leoschut L., Phyfer J, Kassanje R, & Le Mottee C. (2016). *Optimus Study South Africa: Technical Report. Sexual victimisation of children in South Africa. Final report of the Optimus Foundation Study: South Africa.* (Zurich: UBS Optimus Foundation), pg. 31.

¹²⁹ Center on the Developing Child. *The Impact of Early Adversity on Child Development (InBrief)* (2007). Viewed 14 October 2016: www.developingchild.harvard.edu.

¹³⁰ Dunkle K, Jewkes R, Brown HC, Yoshihama M, Gray GE, McIntyre JA, & Harlow Social Development. Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology* 2004, 160(3): 230-239; Mathews S, Jewkes R & Abrahams N. 'I had a hard life': Exploring childhood adversity in the shaping of masculinities among men who killed an intimate partner in South Africa. *British Journal of Criminology* 2011; 51(6): 960-977.

programmes to promote healthy non-violent relationships, self-esteem, mental health, and gender equality is also essential.

65. In cases where abuse has occurred, further training is needed to ensure health professionals uphold their reporting obligations under the Children's Act and Sexual Offences Amendment Act. In addition to completing a J88 to trigger a criminal justice investigation, it is essential they submit a Form 22 to the Department of Social Development or designated child protection organisation to trigger an investigation to ensure children's safety and access to therapeutic and mental health services. In addition, we need to build the capacity of health and social service practitioners to identify and respond appropriately to continuous, complex and intergenerational trauma.

X Mental health

66. Globally, the greatest burden of disease amongst children and adolescents between the ages of 10-20 years is attributable to mental health disorders: 80% of all mental health problems start in the first 18 years of life, and an estimated 17% of young South African's will have a diagnosable and treatable mental health disorder.¹³¹ Early identification and early evidence-based treatments are effective and cost-effective and can prevent many of the secondary deficits associated with mental health problems including burden on families, school drop-out, poor academic and occupational achievement, crime and substance abuse. However, in spite of these obvious needs, there are fewer than 50 child & adolescent psychiatrists in South Africa, of those only 15 are in state-funded posts, and only four are funded training posts. Most provinces do not have child and adolescent psychiatrists or in-patient paediatric facilities, or training capacity in child & adolescent psychiatry. There is grave concern that child & adolescent mental health is rapidly becoming a forgotten service, despite the high burden of disease.

67. There is an urgent need to develop an evidence-base that focuses attention on mental health problems affecting children and to identify what works in local (often adverse) contexts and to consider adopting a public mental health approach that provides for community-based services.¹³² While the promotion of adolescent mental health and

¹³¹ Kleintjes S., Flisher A. J., Fick M., Railoun A., Lund C., Molteno C. *et al.* (2009) The prevalence of mental disorders among children, adolescents and adults in the western Cape, South Africa. *South African Psychiatry Review* 9, 157–60.

¹³² Petersen I, Bhana A, Flisher AJ, Swartz L, Richter L. Promoting mental health in scarce-resource contexts. Emerging evidence and practice. Cape Town: HSRC Press; 2010.

wellbeing is a key priority in the Department of Health's Adolescent and Youth Health Policy, there is no mention of treatment services,¹³³ and school- and community-based prevention and promotion programmes and technologies will need to be developed and tested at scale.

Recommendations

68. Given high levels of poverty, violence, substance abuse and trauma, we call on the State to prioritise child and adolescent mental health by scaling up treatment services and designing effective school- and community-based prevention and promotion programmes.

¹³³ Department of Health. Policy guidelines for youth and adolescence health. In: Health Do, editor. Pretoria: Government Printers; 2001.