

South African **Child Gauge** 2021/2022

Child and Adolescent Mental Health

Mark Tomlinson, Sharon Kleintjes & Lori Lake



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Broad overview of the *South African Child Gauge 2021/2022*

The *South African Child Gauge*[®] is published annually by the Children's Institute, University of Cape Town, to monitor progress towards realising children's rights. This issue of the *South African Child Gauge* focuses attention on child and adolescent mental health and how early experiences of adversity ripple out across the life course and generations at great cost to individuals and society.

PART ONE: Children and Law Reform

Part one outlines recent legislative developments that affect the lives and rights of children. These include the National Health Insurance Bill, Draft Admission Policy for Ordinary Public Schools and Draft Firearms Control Amendment Bill, together with a ruling by the Constitutional Court that has declared Section 10 of the Births and Deaths Registration Act unconstitutional.

See pages 12 – 23.

PART TWO: Child and Adolescent Mental Health

Part two presents a set of 10 chapters that examine current challenges and identify critical points for intervention to promote children's mental health and well-being across the life course and across a range of settings. This includes a deeper examination of the social, economic and environmental determinants of child and adolescent mental health, and how positive and negative life events impact on children's development across the life course in ways that either enhance or undermine their mental health. We then consider how to create a more enabling and supportive environment by strengthening the role of families, educational facilities, health care services and digital platforms in promoting children's mental health, as well as the need for intersectoral collaboration to address complex challenges such as violence and disability. The final concluding chapter calls on the South African government and the whole of society to place children at the centre of all policies and to create an enabling environment that will protect children from harm, build their capacity to cope with stress and adversity, and provide them with opportunities to thrive.

See pages 24 – 159.

PART THREE: Children Count – The numbers

Part three updates a set of key indicators on children's socio-economic rights and provides commentary on the extent to which these rights have been realised. The indicators are a select subset taken from the website www.childrencount.uct.ac.za.

See pages 160 – 198.

Front cover photograph:

Children's mental health is shaped in powerful ways by their relationships with their caregivers, their families and the network of other children and communities around them. Warm, sensitive, playful and responsive caregiving helps children experience joy and hope, learn how to regulate their emotions, engage in healthy relationships, and meet life's challenges with confidence.

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Abbreviations

ACE	Adverse Childhood Experiences	IPV	Intimate Partner Violence
ADHD	Attention Deficit Hyperactivity Disorder	ISHP	Integrated School Health Programme
Bt30	Birth to Thirty cohort study	LMIC	Low- and Middle-Income Countries
CAMH	Child and Adolescent Mental Health	LTHC	Long-Term Health Condition
CAMHSS	Child and Adolescent Mental Health Services and Systems	MDT	Multi-Disciplinary Team
CBT	Cognitive Behavioural Therapy	NCDs	Non-Communicable Diseases
CDG	Care Dependency Grant	NCF	Nurturing Care Framework
CHC	Community Health Centre	NEETs	Not in Employment, Education or Training
CHWs	Community Health Workers	NGOs	Non-Governmental Organisations
CMD	Common Mental Disorders	NHI	National Health Insurance
CP	Cerebral Palsy	NIDS	National Income Dynamics Study
CSG	Child Support Grant	NSSF	National School Safety Framework
CSTL	Care and Support for Teaching Learning	PFA	Psychological First Aid
DBE	Department of Basic Education	PHC	Primary Health Care
DCSTs	District Clinical Specialist Teams	PLH	Parenting for Lifelong Health
DHA	Department of Home Affairs	PTSD	Post-Traumatic Stress Disorder
DHS	District Health System	SAPS	South African Police Service
DMHT	District Mental Health Team	SASSA	South African Social Security Agency
DoH	Department of Health	SDGs	Sustainable Development Goals
DSD	Department of Social Development	SRS	Stress Response System
ECD	Early Childhood Development	Stats SA	Statistics South Africa
ECE	Early Childhood Education	UHC	Universal Health Coverage
FCG	Foster Child Grant	UNCRC	United Nations Convention on the Rights of the Child
GHS	General Household Survey	UNCRPD	United Nations Convention of the Rights of Persons with Disability
HCD	Human-Centred Design	VAC	Violence Against Children
HIV	Human Immunodeficiency Virus	VAW	Violence Against Women
HPS	Health Promoting Schools	WHO	World Health Organization
ID	Intellectual Disability		

Foreword

Linda Richter

Emeritus Professor, DSI-NRF Centre of Excellence in Human Development, University of the Witwatersrand

This 2022 issue of the *South African Child Gauge* focuses attention on promoting child and adolescent mental health and well-being. It also addresses the unhappiness, isolation, shame, anger and fear which we all feel at some time in our lives along a continuum from mild to moderate and extreme forms of mental distress. It looks at how experiences, feelings and behaviours can worsen, persist, evolve and, amongst a minority of children and adolescents, find expression in longer-term and even life-long mental disorders.

The wide spectrum of mental distress makes it difficult to estimate how many children and adolescents may benefit from early intervention to reduce the potential for mental health problems; how many young people are already affected and may need additional care and support from families, schools and trained counsellors; and how many would benefit from specialised psychological treatment, medication or support to promote their recovery and participation in everyday living, learning, working or socialising across a significant period of their lives.

The prevalence rates we use frequently rely on diagnosable forms of mental disorder, but the vast majority of children and adolescents in the world do not make it to a specialist office or receive a diagnosis. Children and adolescents who suffer mental distress and those who love, live or work with them know only too well how stressful it is for everyone involved and how difficult it is to find support and treatment for the young people in our care.

Children and adolescents affected by mental ill health are themselves often not able to talk about their feelings and what help they need; for example, the trauma and confusion experienced by a baby who is neglected or abused, the angry biting and scratching of a toddler, the grief of a schoolchild teased and rejected by peers, the need for recognition

expressed in violence and aggression, the inconsolable loss of a loved family member or friend, or a teenager's desperate search for means to end a life which seems unbearable in the face of all that feels wrong.

What we do know is that disturbed and disturbing thoughts, feeling and behaviours can be experienced at all ages, starting in infancy, and that they are shaped by a variety of physical, social and psychological factors. The undernourished child living with a poor family may be withdrawn and clinging, just as a confused and anxious teenager may struggle to adjust between seemingly uncontrollable feelings and bewildering physical changes.

So how can we respond to children's distress appropriately and enable them to thrive in the face of adversity? The paediatrician Donald Winnicott asserted that powerful loving relationships are at the heart of the therapeutic journey. And, indeed, affectionate and supportive family members, teachers and friends can help children and adolescents to cope with both the adjustments which usual life-stage changes may present, and more serious mental health challenges, and prevent them from re-occurring. The Nurturing Care Framework describes how child-centred laws, policies and services can create an enabling environment in which families, school, and communities can protect children from harm, nurture them physically and emotionally, and ensure that they have opportunities to expand their mental health in creative ways and realise their own unique potential.

A key thing to remember is that most children and adolescents go through life well despite what at times may seem like very difficult challenges. Most children will have episodes of anxiety and worry at some point in their life. Babies cry, and some babies cry considerably more than others. There are very few toddlers that do not test the patience of their parents. Some adolescents seem rebellious



during their exploration of society, and a desire for privacy can feel like they are turning away from their family. Many of these behaviours are characteristic of life and developmental stages, and most children will move on through to new stages in their journey through life. The vast majority will regain their equilibrium, and only very few will develop a serious mental disorders or mental illness. That these experiences may seem transient, does not mean they should be ignored. Rather we need to remember that the first port of call for children and adolescents is their family and caregivers, and both children and parents need to feel supported, reassured when they worry, and offered assistance when they think an issue might be becoming a sign of something more serious.

The consequences of mental ill health, even in the short-term, are deeply injurious – to the individual child and adolescent, their families, and their society. Learning may stop and sometimes even regress, interrupting their cognitive, emotional and social functioning. For example, children

may disconnect from family relations and their behaviour and performance at school may start to deteriorate. If these losses are not remediated by early identification and efforts to address their causes, they can become heavy weights for a child to bear and may drag them down for the rest of their lives, with adverse consequences for them and our society.

In a country beset by poverty, inequality, social exclusion and violence, our most important responsibility is to our children and adolescents. We need to identify those who face difficulties early on and try to rectify or ameliorate these problems so that children can continue their life-long journey with strength and resources. It is therefore essential that our laws and policies, our services for children and families, our leaders and their decisions, and our everyday interactions with one another help to foster, create and maintain conditions that enable all children to be part of powerful loving relationships that comfort them in times of adversity, celebrate their strengths and encourage them to thrive.

Mental health for children and adolescents: A human rights imperative

Advocate Bongani Majola, Chairperson of the South African Human Rights Commission

Mental health is a fundamental human right for all children and adolescents. The mental health of children is an integral part of their overall health and well-being. Children's mental, emotional, and behavioural health are integral components of mental health. These aspects affect the way they feel, think, and behave. In addition, they influence how children handle stress, relate to other people, and make healthy decisions. For children to survive and thrive, they must grow in an enabling and supportive environment that caters to all their needs, including mental health and psychosocial support.

Due to historical neglect and underinvestment in mental health, generally, there are serious gaps in prevention and care for children and adolescents in South Africa. These gaps often lead to gross human rights violations that rob children and adolescents not only of their quality of life, but also life itself. This was the case in the Life Esidimeni tragedy.

The current COVID-19 pandemic has intensified pressures on children and adolescents and, as a result, a whole generation's mental health and well-being has been jeopardised by the pandemic. Children and adolescents feel afraid, angry and anxious because their routines, education, recreation and family finances have been disrupted.

Other notable factors that contribute to children's mental well-being in the South African context include, amongst others, high levels of racial inequality, gender inequality, poverty and malnutrition, disability, gender-based violence (GBV) at home and violence against children.¹ These factors are, amongst others, significant contributors to the deteriorating mental health in children and adolescents. In that regard, it becomes clear that in seeking to resolve the barriers to accessing mental health care for children and adolescents in particular, a holistic approach that takes into

consideration all the underlying causes of mental health should be adopted.

Human rights are interrelated in nature, thus the deprivation of one right can often lead to the infringement of one or several other rights. This has been noted to be the case with children's rights, especially for children on the

move. For example, in its monitoring work, the South African Human Rights Commission (Commission) documents that many children on the move do not have legal documentation due to a myriad factors, including the lack of birth registration, loss of documentation, death of parents and delayed applications at the Department of Home Affairs. Due to the lack of legal documents, children have been unable to access basic human rights such as education, welfare support, medical care and adequate nutrition.

The lack of access to such basic human rights deprives children, thereby putting them at a disadvantage in terms of cognitive, emotional and physical development. In contrast, children who enjoy these basic human rights to the fullest extent have a much better quality of life. Due to the various psychological traumas that children on the move have endured in their historical and present circumstances, many of them require individual, specialised, psychological support. However, such support has largely been inaccessible, especially in rural communities, where the health care system is overburdened, under-resourced and under-capacitated.

The extensive nature of socio-economic inequality in South Africa has also polarised access to adequate mental health care for children and adolescents in South Africa, in that while those having access to economic resources continue to receive the best psycho-social support, those who are economically marginalised do not have the same enjoyment



¹ <https://www.unicef.org/southafrica/stories/tracking-wellbeing-children-south-africa>.

of their right to adequate health care, which includes mental health care services.

This is one of the reasons why the Commission appreciates the fact that South Africa has adopted policies at the national level which have been delegated for implementation at the provincial level. Such policies include, amongst others, the recently lapsed National Mental Health Policy Framework and the 2003 National Policy Guidelines for child and adolescent mental health. The adoption of national policies which are delegated for implementation at the provincial level ensures that the extraordinary circumstances of the country's socio-economic and socio-cultural structure are considered.

However, this approach has its own shortcomings, which have been noted by the Commission. For instance, the Commission found that none of the provinces had a policy or implementation plan to support the national policy. This indicates that mental health and mental health for children and adolescents is not given priority on the policy agenda. Further, during its hearing on mental health, the Commission found that the lack of intersectoral collaboration on mental health has resulted in children falling through the cracks. As such, efforts must be made to strengthen the implementation of a multisectoral integrated response that addresses the needs of vulnerable children and adolescents. In addition, governmental programmes and systems intended to improve the well-being of children as mandated by the Children's Act 38 of 2005 as amended by Act 41 of 2007 must be strengthened.

Extensive infrastructural limitations at district and regional levels exist, which constitute significant obstacles to the

effective and humane assessment and management of adolescents requiring psychiatric admission or outpatient services. For instance, few health facilities have dedicated 72-hour assessment wards for adolescents, which results in adolescents being kept in adult wards and, in most cases, in medical wards. Consequently, 72-hour assessments are predominantly performed in unsafe, inappropriate structures often by inadequately trained staff who lack the appropriate skills and expertise. This is compounded by the fact that transfer hospitals are often full, a factor that forces these primary facilities to keep psychiatric patients for longer than the 72-hour limit, thereby contravening the Mental Health Act.

We should ensure that caregivers (including parents, teachers and guardians) and children are adequately equipped to identify mental health issues and seek appropriate help. This was highlighted in UNICEF South Africa's U-Report poll 2021,² which found that 65% of young people with mental health issues stated that they did not seek help for the mental health issues they had. There is thus a need to raise awareness among children across all races, gender and social-economic status. This must adequately consider each child's best interest and should adequately respect their dignity.

In the final analysis, mental health must be prioritised. Further, it is important to ensure that children and adolescents are not only afforded access to health care but that an environment that actively supports their mental health is established. Mental well-being should thus be linked with every other socio-economic right.

2 <https://www.unicef.org/southafrica/press-releases/65-cent-young-people-mental-health-related-issues-did-not-seek-help-unicef>



PART 1

Children and Law Reform

Part one summarises and comments on recent policy and legislative developments that affect children including the:

- National Health Insurance Bill
- Draft Admission Policy for Ordinary Public Schools
- Births and Deaths Registration Act
- Draft Firearms Control Amendment Bill

Reading stimulates the imagination and builds a strong foundation for lifelong learning and development. This resource centre provides a rich learning environment to stimulate a love of reading in young learners attending ECD programmes at the Bulungula Incubator Project in the Eastern Cape

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Legislative and policy developments affecting children

Paula Proudlock,ⁱ Mbonisi Nyathi,ⁱ Lori Lake,ⁱ Mila Hardingⁱⁱ and Zita Hansungule-Nefaleⁱⁱⁱ

In this chapter we provide detailed analysis of four developments affecting children:

- The **National Health Insurance Bill** aims to create equitable access to health care services.
- The **Draft Admission Policy for Ordinary Public Schools** aims to address discrimination and exclusion in the admission process.
- The Constitutional Court has confirmed that section 10 of the **Births and Deaths Registration Act** is unconstitutional, obliging the Department of Home Affairs (DHA) to enable unmarried fathers to register their children's births without the mother's presence.
- The draft **Firearms Control Amendment Bill** aims to strengthen the Act and its enforcement to prevent the proliferation of illegal firearms and reduce gun-related deaths and injuries.

We analyse how these legal and policy developments affect children and provide recommendations to strengthen their design and implementation.

National Health Insurance Bill

The National Health Insurance Bill¹ was tabled in Parliament in August 2019. Public hearings began in May 2021 and were still in session at the date of publication of this chapter, due to the high volume of submissions received. The Bill aims to provide universal health care (UHC) for all. It includes a strong focus on maternal and child health, yet several amendments are needed to ensure that National Health Insurance (NHI) adequately covers the specific needs and vulnerabilities of pregnant women, children and adolescents.

There is growing evidence that early intervention during sensitive phases of development such as during pregnancy, the first 1,000 days of life, and adolescence is not only essential, but also the most cost-effective strategy to promote children's optimal health and development, stem the tide of non-communicable diseases, and disrupt the intergenerational cycle of poverty.²⁻⁴

This includes efforts to enhance access to and quality of services, as one in five children still travels more than 30 minutes to reach a health facility,⁵ and a lack of 'positive and caring attitudes'⁶ continues to undermine uptake of both antenatal care⁷ and adolescent health services⁸. It is therefore vital that the specific health care needs of pregnant women, children and adolescents are prioritised. Particular attention needs to be paid to the most vulnerable children – including neonates, adolescents, children with disabilities and long-term health conditions (LTHCs), undocumented children, and those living in rural areas and informal settlements – to ensure that no child is left behind.

Registration of users

The Bill provides that patients must have proof of registration to access health services under NHI. Registration can only be done at accredited health establishments. To apply for registration at an accredited health establishment, a person will have to provide biometrics, fingerprints, proof of residence, identity card, original birth certificate, or refugee identity card.

Children born to health service users are regarded as having been registered automatically when their births are registered with DHA, but older children will need to be registered by their parents or can register themselves from age 12 onwards. An original identity card, birth certificate or refugee identity card will be required for registration.

The proposed registration process and requirements pose a number of barriers:

- Babies and other children whose births are not yet registered may be excluded. Statistics South Africa's 2020 report on recorded live births reveals that of babies born in 2020, only 80% had their births registered within 30 days of their birth.⁹ And there are many children in South Africa without birth certificates – at least 500,000, of which 80% are South African citizens and 20% are foreign nationals.¹⁰
- Many public facilities serving poor, under-resourced and rural communities may not meet the standards for

ⁱ Children's Institute, University of Cape Town

ⁱⁱ SECTION27

ⁱⁱⁱ Independent

accreditation and therefore may not be able to register users, which may further prejudice those children most in need.

- Accredited facilities with limited staff and internet access will struggle to register users efficiently. This is likely to negatively affect rural populations in particular.

If the National Department of Health is committed to promoting health equity and UHC, then the current accreditation and registration requirements should be revised to ensure that they do not deepen existing inequalities in access to health care.

Quality, accreditation and inequity

Some of the measures in the Bill have the potential to exacerbate inequity, including user registration and the accreditation of health care facilities. The most recent report of the Office of Health Standards Compliance found that that only five out of the 696 public health facilities surveyed met the norms and standards required for certification.¹¹

After more than two decades of public sector austerity, many public sector and specifically rural health care facilities are understaffed and under-equipped, and unlikely to qualify for NHI accreditation. Hospitals are more likely to be accredited than clinics and community health centres. Lack of accredited facilities at community level will discriminate against people most dependent on local facilities and is likely to increase the hospital centeredness of the health service.

Private facilities are not only more likely to get accreditation but are also overwhelmingly based in urban centres, so the accreditation process has the potential to further increase both urban-rural and private-public inequities. Furthermore, the fact that the Bill ignores the Certificate of Need contained in the National Health Act, which regulates where private service providers can open services, represents a key missed opportunity to improve equity. Considering all these factors, there is a strong possibility that the most vulnerable communities may not have access to NHI-funded health care at all.

Defining a package of basic health care services

Following concerns raised in response to the NHI White Paper,¹² the Bill includes a clause that specifically upholds the Constitutional right of all children to 'basic health care services'.¹³ But it is not yet clear how this right translates into a package of essential health care services for children and adolescents. It is therefore urgent to define 'basic health care services' and ensure that a comprehensive package of services is introduced that extends beyond a narrow focus on

survival and that also promotes children's optimal health and development. It is vital that the Benefits Advisory Committee includes and engages with experts in maternal, child and adolescent health to develop an essential package of care for pregnant women, children and adolescents. This must build on the work of the Committee on Mortality and Morbidity of Children under five years (COMMIC) who have developed a framework for an essential package of health care services for children that includes children with LTHCs and those requiring palliative care.¹⁴

The rights of foreign children

People eligible for NHI include South African citizens, permanent residents, refugees, inmates, and 'certain categories of individual foreigners determined by the Minister of Home Affairs, after consultation' with the Ministers of Health and Finance. Adult asylum seekers and illegal foreigners are entitled only to emergency medical services and services for notifiable conditions of public health concern, but the Bill upholds the constitutional right of all children, including children of asylum seekers or illegal migrants, to basic health care services. A challenge here is that many children of asylum seekers and illegal immigrants will not have the formal identity documents needed to register as users, so further detail is needed on how these children will access services.

It is not clear in the Bill whether the drafters of the Bill are interpreting children's constitutional right to basic health care services to include antenatal and obstetric care for their pregnant mothers. The Bill currently excludes pregnant adult asylum seekers from such services. Yet, these are key determinants of a newborn baby's health and survival, and both pre- and postnatal care are considered by the United Nations Committee on the Rights of the Child as an essential component of children's right to health.¹⁵ The Bill should therefore expressly provide that pregnant asylum seekers and illegal immigrants are entitled to antenatal and obstetric services.

Representation for child and adolescent health

The Bill requires the minister to appoint three advisory committees:

- The Benefits Advisory Committee will determine and review the health care service benefits and types of services that the fund will pay for, at each level of care from primary to tertiary hospitals.
- The Health Benefits Pricing Committee will recommend the prices of health service benefits.

- A Stakeholder Advisory Committee will comprise representatives from the statutory health professions councils, 'health public entities, organised labour, civil society organisations, associations of health professionals and providers as well as patient advocacy groups'.

None of these advisory committees are required to include representatives with expertise in maternal, child or adolescent health, raising concerns that children's specific needs may not be given sufficient attention. For example, the National Core Standards for Health Care Establishments pay little or no attention to children outside of neonatal and paediatric wards, despite, for example, the vulnerability of neonates and children in emergency department settings, and of adolescent patients when they move from paediatric to adult services. It is therefore vital that the specific health care needs of children and adolescents are justly and adequately represented on all NHI structures, to ensure a child-focused basket of care and formulary.^{iv}

The re-engineering of primary health care

The Bill commits to strengthening Primary Health Care (PHC) services and intends to make extensive use of community- and home-based services:

- PHC outreach teams will visit households regularly, provide health promotion and education, identify those in need of preventive or rehabilitative services, and refer them to the relevant PHC facility. The outreach teams will also facilitate community involvement and participation in identifying health problems and behaviours and implement interventions to address these problems at a community level.
- School health services will be provided to improve the physical and mental health and general well-being of school-going children, and
- Private providers will be included to increase capacity and access to care.

However, in the face of austerity budgeting, it will be hard to turn public services around after years of neglect, and promoting private sector provision will not necessarily address the critical needs in child health.

The original plans for PHC re-engineering also provided for the establishment of District Clinical Specialist Teams (DCSTs) to provide leadership and clinical governance for maternal and child health at district level. It is therefore of concern that there is no longer any reference to the DCSTs in the NHI Bill, as this investment in clinical governance is

essential to strengthen systems, improve coordination and ensure effective delivery of maternal, child and adolescent health services in response to the local burden of disease, and to drive intersectoral collaboration to address the social determinants of health.¹⁶

Similarly, the original plans to re-engineer rehabilitation services at district level should be revived to address the needs of large and growing numbers of children with LTHCs and disability, especially those in rural areas.¹⁴

It is also vital that the NHI invests in sufficient numbers of community health workers, as well as their education, supervision and support, so that they are able to play a broader role in supporting families with young children and enabling children to not only survive but thrive, as outlined in the National Integrated Early Childhood Development Policy,¹⁷ Nurturing Care Framework³ and National Adolescent and Youth Health Policy¹⁸. Yet, it is currently not clear that the work of the ward-based outreach teams will be funded under the NHI. There is a risk that efforts to promote efficiency and a one-size-fits-all approach might compromise the quality of outreach services and fail to make adequate provision for time spent travelling long distances and/or supporting families in difficult circumstances, which is much harder to quantify than a simple diagnosis and medication.

Conclusion

It is vital that the NHI prioritises maternal, child and adolescent health, as early and sustained investment – starting in pregnancy and continuing into adolescence – yields the greatest lifelong returns. This requires strong leadership for maternal, child and adolescent health at district, provincial and national level, and adequate representation on the Advisory Committees to ensure that the unique vulnerabilities and specific health care needs of pregnant women, children and adolescents are explicitly addressed in both the formulary and baskets of care.

A similar process of engagement is needed with the Office of Health Standards Compliance to ensure that the national norms and standards are aligned with children's rights and best interests. Greater efforts are needed to drive improvements in the quality of care at clinics and hospitals serving rural and vulnerable children in particular, to ensure they can be accredited as part of the NHI.

Draft Admission Policy for Public Schools

The Minister of Basic Education, on 10 February 2021, called for comments on amendments proposed to the Admission

iv List of approved medicines

Policy for Ordinary Public Schools ('the Draft Policy'). The Draft Policy provides all Provincial Departments of Education and the governing bodies of all ordinary public schools with a framework for developing admission policies for schools. The proposed amendments have the potential to strengthen the legal framework governing school admissions through, amongst other things, taking into account court judgments^v regarding discriminatory admission practices.¹⁹

This write-up does not address all the proposed amendments made to the Admission Policy but highlights those issues with glaring defects that need to be remedied.

Administration of admissions

The Draft Policy does not clearly articulate the responsibility of Members of the Executive Council (MECs), as set out in section 3(3) of the Schools Act,^{vi} to ensure that there are enough school places so that every child who lives in their province can attend school.²⁰ Lack of space in school is a consistent problem for school placements each year.²¹ The failure to include this obligation of MECs in the Draft Policy misses an important opportunity to reiterate the obligations of MECs, which may enhance the accountability and oversight of MECs over the admission of learners into public schools – and ultimately better protect children's rights to basic education.²¹

Submissions made by the Equal Education Law Centre (EELC) and Equal Education (EE) further highlight the failure to address various problems with the administration system for admissions, which ultimately result in delayed placement of learners. These include:

- An absence of effective coordination and communication channels between education districts and schools.²² Such instances include cases where district offices struggled to adequately assist parents to find placements for their children because they did not retain databases of unplaced learners; these records were kept by the schools that applications were made to and that did not have space.
- Online application systems that are not user friendly and a lack of support given to the parents or caregivers who need to use the systems.²³
- A lack of prescribed timelines for the processing of admission appeals, resulting in parents and learners having to wait unacceptably long periods of time to receive feedback.²⁴

As part of the administration of admissions in public schools, clause 9 of the Draft Policy includes a list of instances in which discrimination is prohibited. These include race, gender, sex, marital status, ethnicity or social origin, colour, sexual orientation, age, disability, HIV status, religion, conscience, belief, culture, language, birth, immigration status or nationality or any other arbitrary ground. While the list is non-exhaustive, pregnancy is a glaring omission from the list,^{25, 26} as well as gender identity, sex characteristics, and documentation status²⁷.

Documents required for the admission of learners

Clause 15 of the Draft Policy, in relation to documents required for the admission of learners, requires parents to present birth certificates that have identity numbers. If the birth certificates are not available, then a written affirmation or sworn statement is required.

The requirement that the certificate must include an identity number creates a potential barrier to education, as many birth certificates do not have identity numbers – for example, in cases where children are born to non-nationals and, in some instances, where children are born to one South African parent and one non-national.²⁸ EE and EELC's proposed remedy to this defect is the removal of the reference to 'identity number'.²⁹

On the other hand, the inclusion of the option of submitting a sworn statement or affirmation for children who do not have certificates is a welcome development. The inclusion is a result of the case of *Centre for Child Law vs MEC of Education*, in which the High Court declared that excluding children without birth certificates from admission to school was unconstitutional.³⁰

Admission of learners who are not South African

Clause 20 of the proposed amendments requires non-citizens to provide a birth certificate and asylum visa, refugee visa or study visa when applying to public schools. The requirement to produce a birth certificate is problematic as often asylum seekers and refugees do not have their birth certificates with them due to the circumstances in which they had to flee their home countries.³¹ Other groups of non-citizens face similar issues. The Legal Resources Centre and EELC thus recommend that it be made clearer that the applicant is allowed to produce whatever documents they have when it is not possible to produce a birth certificate,

v The judgments include but are not limited to: *MEC for Education in Gauteng Province and Other v Governing Body of Rivonia Primary School and Others* [2013] ZACC 34; *Centre for Child Law and Others v Minister of Basic Education and Others* [2019] ZAECGHC 126; and *Federation of Governing Bodies for South African Schools (FEDSAS) v Member of the Executive Council for Education, Gauteng and Another* [2016] ZACC 14.

vi Section 3(3) of the Schools Act states that 'every Member of the Executive Council must ensure that there are enough school places so that every child who lives in his or her province can attend school'.

as is further elaborated on below regarding learners who are undocumented.³¹

Admission of undocumented learners

While many provincial education departments released Circulars in 2020 or 2021 informing schools of their duties to admit undocumented learners,^{vii} the circulars did not impose a specific duty for School Governing Bodies (SGBs) to amend their admission policies to reflect this change and to supply a copy to Heads of Department (HODs) for approval. Many schools therefore still expressly exclude undocumented learners in their written admission policies.

Clause 23 of the Draft Policy attempts to ensure that undocumented children have access to education without barriers through providing that 'schools are advised to admit learners and serve their education requirements irrespective of whether the learner or parent of a learner does not produce documents listed ... [in] this policy'. However, it is concerning that the term 'advised' is used as it may be interpreted by schools as a discretion. If such an interpretation is adopted, it contradicts the High Court order that 'directed' that all undocumented learners be admitted into public schools,³² and the fact that basic education is an immediately realisable right available to 'everyone'.³³

It has also been recognised by the United Nations Committee on Economic Social and Cultural Rights (Committee) that South Africa has not made sufficient progress to ensure access to education for undocumented children since 2018.³⁴ While the Committee welcomed the measures taken by South Africa to remove legal barriers, the Committee noted that there were still obstacles faced by undocumented children in accessing basic education.³⁴ Specifically, the Committee acknowledged that schools were still excluding undocumented learners.³⁴ South Africa is now obliged to report to the Committee to provide further information on progress made on the recommendation in its next periodic report which is due in 2023.³⁴ This was an important finding in recognising the inadequacy of the steps taken by South Africa thus far. These International Convention on Economic, Social and Cultural Rights (ICESCR) reporting obligations will hopefully inspire the government to prioritise the finalisation of the National School Admissions Policy and take further steps to ensure schools are aware of their legal obligations not to exclude or intimidate undocumented learners.

A further concern is clause 24 of the Draft Policy, which states that the 'Head of Department must hold the parents of undocumented learners accountable for acquiring birth certificates for their children'.³⁵ It has been clearly noted in court papers that children's lack of documentation is often not the fault of the parents or caregivers, but is a result of barriers faced at the DHA and its restrictive policies and/or practices.³⁶ It is, at this stage, important to note that it is not the Department of Basic Education's (DBE) responsibility to hold parents accountable for obtaining children's birth certificates; this is the job of the DHA. The DBE must instead ensure that schools are safe learning havens for children. It is essential to ensure that parents are supported to obtain their children's documentation rather than threatened or prejudiced in any way.³⁷

Conclusion

Provincial laws and policies require individual schools to review their admission policies on a periodic basis and then submit them to the HOD for approval. The Gauteng Admissions Regulations (2019), for example, provide that SGBs are required to review and amend their admissions policies and submit a copy to the HOD for certification within three months of the publishing of the regulations and every three years thereafter.³⁸ SGBs in Gauteng will thus be reviewing and amending their admissions policies in 2022 in line with the regulated three-year cycle. The review period for these SGBs is imminent.

Therefore, to ensure that SGBs have access to important guidance for their school admissions policies to conform with the Constitution, case law and best practice, finalisation of the National School Admissions Policy should have been one of DBE's priorities in early 2022.

Births and Deaths Registration Act (s10) declared unconstitutional

Naki v DG of Home Affairs 2018 (Grahamstown High Court)

In the 2020 issue of the *Child Gauge*,³⁹ we reported on the developments in the *Naki* case⁴⁰ which resulted in the High Court declaring sections of the Regulations to the Births and Deaths Registration Act (BDRA)⁴¹ unconstitutional. The High Court found that these regulations prevented an unmarried father from registering the birth of his child in circumstances where the child's mother was undocumented, deceased or

vii See Eastern Cape Department of Education Circular 2 of 2020; Kwa-Zulu Natal Department of Education Circular 21 of 2021; Northern Cape Department of Education Circular 12 of 2021; Limpopo Department of Education Circular 63 of 2021; Western Cape Department of Education Circular 53 of 2021. The North West Department of Education released Circular 17 of 2021 which is in blatant contradiction with the Phakamisa judgment and the constitutional rights of undocumented learners. The Circular states that undocumented learners should be admitted for a maximum of 12 months pending them acquiring documentation.

otherwise not present. The Court, however, disagreed with the Centre for Child Law's (CCL) arguments that section 10 of the Act was also a barrier to unmarried fathers, and the CCL subsequently appealed this part of the judgment to the full bench of the High Court.

Centre for Child Law v DG of Home Affairs 2020 (Full bench of the Grahamstown High Court)

The appeal was successful and section 10 of the Act was declared unconstitutional,⁴² because by requiring the mother's signed consent to the child taking the father's surname, it implicitly bars an unmarried father from giving notice of his child's birth in the absence of the mother. It held that this was discriminatory not only against the father but also against the child.⁴² The court ordered a 'reading-in' (substitution) as the appropriate remedy to remove the barrier created by section 10 and gave Parliament 24 months to amend the Act.⁴²

CCL v DG of Home Affairs 2021 (Constitutional Court)

CCL then approached the Constitutional Court for confirmation of the High Court's order of invalidity.⁴³ The DHA, entering the case for the first time, agreed that section 10 was unconstitutional but submitted that this unconstitutionality was not because it prevented an unmarried father from registering his child, but because the section restricted the father and child to using the surname of the mother.⁴⁴ This in turn infringed the father's right to equality and the child's right to their father's surname from birth. DHA submitted that by removing section 10 in its entirety, as well as the words 'subject to the provisions of section 10' from section 9(2), it would enable any father, irrespective of their marital status, to give notice and register the birth of their child.⁴³

The court noted that the constraints of section 10 affect all unmarried fathers as a category, in that it results in disadvantages for them which are not experienced by married fathers.⁴⁵ The court adopted a gender-neutral and marital-neutral approach by confirming the High Court's order of constitutional invalidity on the basis that section 10 unfairly limited the ability of an unmarried father to register his child and to pass his surname on to his child.⁴⁶ Section 10 irrationally discriminated between categories of people and, in the absence of a legitimate government purpose put forward by DHA for this discrimination, it was found to amount to unfair discrimination. In addition, it perpetuated stereotypical gender roles and the assumption that childcare is inherently a mother's duty. The court emphasised that it is

both parents who bear the primary responsibility to care for their child, as is provided for in the Children's Act 38 of 2005.⁴⁷

The court also found that section 10 perpetuates the notion of 'illegitimacy' by differentiating between children born in and outside of a marriage.⁴⁸ The Court has previously emphasised that children must be regarded as autonomous, albeit vulnerable, rights-bearers who are not mere extensions of their parents. Therefore, the unfair discrimination of children based on parental marital status conflicts with the principle that the best interests of the child are of paramount importance.⁴⁹ The court recognised that 'South African society is not homogenous, and it must be accepted that the concept of 'marriage' no longer retains its stereotypical meanings'.⁵⁰

The court accordingly found section 10 to be manifestly inconsistent with the rights to equality, human dignity and the best interests of the child, and ordered that it be severed from the Act with immediate effect.^{viii} The court also severed the proviso in section 9(2), which stated that section 9(2) was 'subject to the provisions of section 10'.⁵¹

The practical effect of this judgment is that, from 22 September 2021, with regards to birth registration law, unmarried parents are in the same position as married parents – either of them can give the notice of birth in terms of section 9 of the Act. They can do so under either the father's surname or the mother's surname, or the surnames of both the father and the mother joined together as a double-barrelled surname.⁵¹

Non-compliance with the court orders

Since the judgments, public interest organisations have attempted to implement the three court judgments on behalf of unmarried fathers and their children.^{ix} Their experiences are that DHA local offices are not complying with the court orders and, in 2022, are still not allowing unmarried fathers to give notice of the birth of their children, or to do so under their surname.

As a result, numerous vulnerable children remain without a birth certificate. These public interest organisations have written to the Minister of Home Affairs outlining what they have experienced at office level:

- a. Many local officials are unaware of the judgments.
- b. Some officials are aware but are unwilling to implement the judgments in the absence of a directive from the Minister, or unable to implement it due to the current computer programme and application forms not yet having been adapted in response to the judgments.

viii As of 22 September 2021.

ix Lawyers for Human Rights, Children's Institute, Centre for Child Law, and the Legal Resources Centre.

- c. Many officials are willing to implement the judgments only if the father provides a paternity test, which will cost him a minimum of R2,000 and is only available at state laboratories in urban cities, requiring long distance travel at prohibitively high cost for fathers and children.
- d. Some officials are willing to register the child if the father has a court order that declares the children to be 'in need of care and protection' in terms of section 156 of the Children's Act, but then only under the mother's surname.

New directive and application forms needed

For the judgments to be implemented in practice, DHA needs to issue a directive to its local offices explaining the orders and their practical effect for applications by fathers. It should also amend its birth registration application forms, prescribed affidavits and computer programme, as they currently require the mother's signed consent. All managers and front-line officials would then need to be retrained and sensitised to the new approach.

The new system should follow the guidance provided by the Constitutional Court:

- The court commented on the concerns raised by DHA about the potential human trafficking if proper safeguards are not provided. The court was satisfied that section 9 1(A) provides sufficient protection against trafficking by providing that '[t]he Director-General may require that biometrics of the person whose notice of birth is given, and that of his or her parents, be taken in the prescribed manner'.
- The court stated that paternity tests may create insurmountable practical burdens for unmarried fathers and their children.
- The court noted that sections 7(1)(a) and (b) of the Act empower the Director-General to request further particulars where a suspicion is raised as to the validity of the parent's relationship to the child. However, the Court stressed that the contention that a married father can be trusted, whereas an unmarried father automatically raises suspicion, is ultimately a prejudicial approach because a married father can also falsify a marriage certificate and be a trafficker.⁵²
- Furthermore, the court stressed that it is important that any additional proof requested from an unmarried father must in reality be accessible to him for him to be able to meet this requirement. The implication of this part of the judgment is that DHA cannot insist on proof that an unmarried father cannot provide.

Conclusion

At the time of publication, a new Directive had not yet been issued by the national DHA to ensure that all its officials implement the court orders. As a result, thousands of children in the care of unmarried fathers remain without birth certificates

Draft Firearms Control Amendment Bill 2021

On 21 May 2021, the Civilian Secretariat for Police Service (CSPS) published the draft Firearms Control Amendment Bill 2021 for comment. The draft Bill proposes a number of amendments to the Firearms Control Act⁵³ that are aimed at strengthening the law and its enforcement.

The purpose of the amendments is to reduce the proliferation of firearms in society and, in turn, reduce gun-related criminal activity. Consequently, the draft Bill seeks to amend the purpose of the Act to 'restrict access to firearms by civilians and to comply with regional and international instruments of firearms regulations'.⁵³ The amendment which has sparked the most controversy is the proposal to remove 'self-defence' as one of the reasons why a person may apply for a licence to possess a firearm. This amendment is supported by Gun Free South Africa (GFSA), as research shows that the main source of illegal firearms in South Africa are legal firearms held by the state and civilians,⁵⁴ with civilians losing seven times more guns to criminals than the police.

The Children's Institute's (CI) relied on evidence on South Africa's high rates of child injuries and deaths when expressing its support for the Bill:⁵⁵

- The South African child murder rate of 5.5 per 100,000 children⁵⁶ is significantly more than double the estimated global rate of 1.6 per 100,000 children.⁵⁷
- The national homicide study found that just under 8% of all child murders were related to a firearm and that adolescents were most at risk,⁵⁸ while the Child Death Review project in the Western Cape revealed that firearms accounted for a much higher percentage of child murders (42%), with 88% of these firearm murders occurring in the 10 – 17 year age group.⁵⁹
- Among adolescents, females (24%) were more likely than males (21%) to be killed by a firearm and by a known person in the home.⁵⁸
- A third of firearm-related child deaths are linked to gang violence and mainly affect children 10 – 17 years of age. Younger children under the age of 10 years are mainly killed as innocent bystanders or caught in crossfire when killed by a firearm.

- Among adolescents, males are mainly killed in public spaces (61%) while females are more likely to be killed in the home by a family member or someone known to them (39%).⁵⁸ It was also shown that perpetrators were more likely to be younger males (under the age of 20 years).⁵⁸
- The dynamics in adolescent male homicides point to male perpetrators being young and often the victims are participants in the violence that results in their death, for instance engaging in fights that become lethal. While young women are mainly victims in their own home, with these murders driven by acts of gender-based violence.⁵⁸
- Children who are victims of gun violence or who witness gun violence experience negative psychological and physical harm and are likely to experience adverse outcomes later in life.⁵⁵

The CI therefore supported the amendments that are aimed at banning the ownership of guns for self-defence and making schools gun-free zones. The CI recommended that the age limit for obtaining a licence should be raised from 21 to 25 years and submitted that people with a history of violence should be more effectively prevented from holding a firearm licence.⁵⁵

The CI emphasised that the implementation of the new measures proposed by the Bill will help South Africa meet the Sustainable Development Goals related to the reduction of gender-based violence and the promotion of peaceful and inclusive societies, and, in particular, to significantly reduce all forms of violence against children.⁵⁵ In this regard, the CI supported the proposed amendment allowing the Registrar to temporarily suspend firearm licences of persons guilty of an offence under the Domestic Violence Act or the Protection of Harassment Act.

The publishing of the Bill resulted in 118,000 submissions, mainly from gun owners and pro-gun proponents opposing the Bill.⁶⁰ Much of this opposition stems from a lack of trust in the South African Police Service's (SAPS) ability to protect people from criminals, SAPS' history of not implementing the Act effectively, the many guns stolen from or lost by SAPS, and an un-proven belief that allowing civilians to possess guns for self-defence will enable civilians to protect themselves against criminals.

Gun Free South Africa's (GFSA) submission argues that while the right to self-defence is a universally recognised right, there is no universal right to own a gun for self-defence.⁶¹ GFSA also notes that there is no constitutional right to own a firearm in South Africa, and both the Supreme Court of Appeal⁶² and the Constitutional Court⁶³ recently

held that gun ownership is a privilege in our country which is regulated by law.⁶⁴ GFSA's position is supported by overwhelming evidence that shows that gun violence in South Africa has reached epidemic proportions and that guns have overtaken knives as the weapons used in most murders in the country.⁶¹ Sonke Gender Justice also raised similar concerns in its submission and revealed that the latest annual crime statistics from SAPS shows that every day, 23 people are shot and killed in South Africa.⁶⁵

Furthermore, Sonke Gender Justice supported all the clauses^x in the Bill that reduce the risk of legal guns being lost or stolen and falling into criminal hands by making provision for ballistic sampling of all privately-owned and state-owned firearms, strengthening the Central Firearms Registry and vetting of Designated Firearms Officers (DFOs).⁶⁵ This was also supported by GFSA, whose submission revealed that reducing access to firearms reduces gun violence, as global scientific research indicates that a gun in the home most endangers household members by increasing the risk of murder, suicide and death or injury from an unintentional shooting.⁶¹ GFSA also submitted that guns in the home are targeted by robbers and a comprehensive study in South Africa shows that civilian gun owners are the biggest source of lost and stolen guns.⁶¹ Sonke Gender Justice's submission refers to the decision in *South Africa Hunters and Game Conservation Association v Minister of Safety and Security*⁶⁶ where the court held that firearms are hazardous, that possession and ownership must be strictly controlled, and that failure by the licence holder to comply with the Act exposes the public to potential harm.⁶⁵

Following the volume of submissions received and the vocal opposition to the Bill expressed by gun owners and the pro-gun lobby, the Chief State Law Adviser has been requested to provide a legal opinion on the constitutionality of some of the proposed amendments, notably the removal of self-defence as a legal ground for obtaining a license and owning a firearm.⁶⁰ The Portfolio Committee on Police advised the CSPS to consult more widely on the Bill before it submits the Bill to Cabinet and then to Parliament.

Conclusion

The NHI Bill aims to enable equitable access to health care services and is desperately needed, but in its current form it is likely to fail some of the most vulnerable children: those in rural areas, those without birth certificates, and those born to undocumented non-nationals. Parliament will need to creatively re-design the Bill or refer it back to the Executive

x Clauses 21, 25, 58 and 64.

for re-design if it wants to ensure that the NHI can achieve equity in access to health care.

The Draft Admission Policy for Ordinary Public Schools should have been prioritised for finalisation in early 2022 to guide the re-drafting of provincial and school admission policies, and ensure that a range of court judgments are implemented at ground level. Further delays in its finalisation will result in continued non-compliance with court orders at school level.

While three court judgments oblige the DHA to allow unmarried fathers to register their children's births without the mother's presence, local DHA offices are not implementing

the judgments. A directive from national DHA and amended application forms are urgently needed to make the court orders a reality for thousands of unregistered children and their fathers.

The draft Firearms Control Amendment Bill aims to prevent the proliferation of illegal firearms and reduce gun-related deaths and injuries. Opposition by the numerically small but vocally strong pro-gun lobby threatens to delay this much needed reform. Increased public participation by the larger constituency that is negatively affected by gun-violence could balance the debate

References

1. B11-2019
2. Norris S, Lake L, Draper C. Child health matters: A life course perspective. In: Shung-King M, Lake L, Sanders D, Hendricks M, editors. *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town; 2019.
3. World Health Organization, UNICEF, World Bank Group. *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential*. Geneva: WHO. 2018.
4. World Health Organization. *Health for the world's adolescents: A second chance in the second decade. Summary*. Geneva: WHO. 2014.
5. Hall K. *Child health - Children living far from health care facility*. Children Count website. Cape Town: Children's Institute, University of Cape Town; 2019. Accessed: 5 May 2022. Available from: <http://childrencount.uct.ac.za/indicator.php?domain=5&indicator=49>.
6. Visser R, Bhana R, Monticelli F. *National Health Care Facilities Baseline Audit: National summary report*. Durban: Health Systems Trust. 2012.
7. Amnesty International. *Struggle for Maternal Health: Barriers to antenatal care in South Africa. Executive Summary*. London: Amnesty International. 2014.
8. Jana M, Mafa I, Limwame K, Shabalala A, editors. *Challenges to youths accessing sexual and reproductive health information and services in Southern Africa: A review of qualitative research in seven countries*. 5th Africa Conference on Sexual Health and Rights, Windhoek, Namibia, September; 2012.
9. Statistics South Africa. *Statistical release P0305. Recorded live births 2020*. Pretoria: Stats SA. 2021. [<http://www.statssa.gov.za/publications/P0305/P03052020.pdf>]
10. Centre for Child Law and Others v Minister of Basic Education and Others 2020 (3) SA 141 (ECG) (12 December 2019).
11. Office of Health Standards Compliance. *Annual Inspection Report 2016/17*. Pretoria: OHSC. 2018.
12. Department of Paediatrics and Child Health. *National Health Insurance White Paper and Child Health: Comment from the Department of Child Health and Paediatrics, University of Cape Town*. Cape Town: DPCH, UCT. 2016.
13. Constitution of the Republic of South Africa Act 108 of 1996. Section 28 1(c).
14. Department of Health. *1st Triennial Report. Ministerial Committee on Mortality and Morbidity in Children under 5 Years of Age in South Africa*. Pretoria: DoH. 2011.
15. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly resolution 44/25*. Geneva: United Nations. 1989.
16. McKerrow N, Doherty T, Coetzee M, North N, Bezuidenhout M, Rispel L. Building a workforce for a child- and family-centred health service. In: Shung-King M, Lake L, Sanders D, Hendricks H, editors. *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town; 2019.
17. Republic of South Africa. *National Integrated Early Childhood Development Policy*. Pretoria: Government Printers. 2015.
18. Department of Health. *National Adolescent and Youth Health Policy 2017*. Pretoria: DoH. 2017.
19. Centre for Child Law. *Centre for Child Law's Comments on the Department of Basic Education's Admission Policy for Ordinary Public Schools*. 2021.
20. Equal Education, Equal Education Law Centre. *Equal Education and Equal Education Law Centre's Joint Comment on the Department of Basic Education's Amended National Admission Policy for Ordinary Public Schools*. 2021. [<https://equaleducation.org.za/wp-content/uploads/2021/05/12.03.2021-eelc-ee-joint-comment-on-amended-admissions-policy-for-ordinary-public-school.pdf>]
21. Above EE and EELC, at p3.
22. Above EE and EELC, at p7.
23. Above EE and EELC, at p9.
24. Above EE and EELC, p10.
25. Above CCL submission, at p5.
26. Legal Resources Centre. *Submission to the Department of Basic Education on the Admission Policy for Ordinary Public Schools*. 2021. [<https://lrc.org.za/wp-content/uploads/submissions/2021%2003%2012%20LRC%20Submission%20on%20Admission%20Policy.pdf>]
27. Above LRC, at p3.
28. Above EE and EELC, at p24 and LRC, at p6.
29. Above EE and EELC, at p23-24.
30. Centre for Child Law and Others v Minister of Basic Education and Others 2020 (3) SA 141 (ECG) para 131.
31. Above LRC, at p7.
32. Centre for Child Law and Others v Minister of Basic Education and Others 2020 (3) SA 141 (ECG).
33. Section 29 of the Constitution and Centre for Child Law and Others v Minister of Basic Education and Others 2020 (3) SA 141 (ECG) para 94.
34. *Committee on Economic, Social and Cultural Rights (2021-104/CESCR/FU) (10 November 2021)*. [https://www.dailymaverick.co.za/article/2021-12-16-reflections-on-the-lack-of-progress-on-socio-economic-rights-25-years-after-the-enactment-of-the-constitution/?utm_term=Autofeed&utm_medium=Social&utm_source=Twitter#:~:text=committee%20released%20its-,observations,-Echoing%20many%20of]
35. Draft Admissions Policy clause 25.
36. Above LRC, at p26.
37. Above LRC, at p27.
38. Gauteng Schools Education Act, 1995 (6/1995): Amendments to Regulations Relating to the Admission of Learners to Public Schools, 2019 Regulation 3(3).
39. Proudlock P, Nyathi M, Jamieson L. Legislative Developments in 2019/2020. In: May J, Witten C, Lake L, editors. *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town; 2020.
40. Naki and Others v Director General: Department of Home Affairs and Another [2018] 3 All SA 802 (ECG).
41. Act 51 of 1992. The Grahamstown High Court declared aspects of regulations 3, 4, 5 & 12 unconstitutional.
42. Centre for Child Law v Director-General: Department of Home Affairs and Others 2020 (6) SA 199 (ECG).
43. Centre for Child Law v Director-General: Department of Home Affairs and Others [2021] JOL 51232 (CC).
44. Above CCL v DHA 2021 (CC) paras 22 – 24.
45. Above CCL v DHA 2021 (CC) para 39.
46. Above CCL v DHA 2021 (CC) paras 38 –46.
47. Above CCL v DHA 2021 (CC) para 46 and 79.
48. Above CCL v DHA 2021 (CC) paras 52 –74.
49. Above CCL v DHA 2021 (CC) para 76.
50. Above CCL v DHA 2021 (CC) paras 79 –81.
51. Above CCL v DHA 2021 (CC) paras 86 – 89.
52. Above CCL v DHA 2021 (CC) Paras 82 – 85.
53. No. 60 of 2000.
54. Gun Free South Africa. *The illegal firearms trade in South Africa. Firearms Control Briefing 3, 15 November. (Online)*. 2021. Accessed: 26 April 2022. Available from: <https://gfsa.org.za/2021/11/14/briefing-3-of-2021-the-illegal-firearms-trade-in-south-africa/>.
55. Jamieson L, Mathews S. *Children's Institute submission on the Draft Firearms Control Amendment Bill 2021*. 2021.
56. Mathews S, Abrahams N, Jewkes R, Martin LJ, Lombard C. The epidemiology of child homicides in South Africa. *Bulletin of the World Health Organization*. 2013;91:562-568.
57. United Nations Office on Drugs and Crime. *Global Study on Homicide 2019*. Vienna: UNODC. 2019.
58. Mathews S, Abrahams N, Martin LJ, Lombard C, Jewkes R. Homicide pattern among adolescents: A national epidemiological study of child homicide in South Africa. *Plos One*. 2019;14(8):e0221415.
59. Child Death Review 2019 Data. Children's Institute University of Cape Town.
60. Portfolio Committee on Police. *Minutes of the Portfolio Committee of Police 24 November 2021*. 2021. [www.pmg.org.za]
61. *GfSA Media statement (26 May 2021)*. [Available at <https://gfsa.org.za/2021/05/26/statement-welcome-draft-firearms-control-amendment-bill/>]
62. National Commissioner of Police and Another v Gun Owners of South Africa (561/2019) [2020] ZASCA 88 (23 July 2020).
63. Minister of Safety and Security v South African Hunters and Game Conservation Association [2018/ ZACC 14.
64. Norton Rose Fulbright letter to Civilian Secretariat for Police sent of behalf of GFSA dated 2 August 2021. See also GFSA media statement above.
65. Sonke Gender Justice submission on the draft Firearms Control Amendment Bill, 2021.
66. 2017 (2) SACR 288 (GP).





PART 2

Child and adolescent mental health: Building the foundations

Part 2 presents 10 chapters that outline the challenges facing South Africa's children and opportunities for intervention, including:

- Shifting our understanding of child and adolescent mental health
- Addressing the social determinants of health
- Adopting a life-course perspective
- Strengthening family foundations
- Using schools as nodes of care and support
- Investing in child and adolescent mental health services
- Exploring the potential of digital platforms
- Mobilising the whole of society to prevent violence and trauma
- Addressing discrimination and enhancing participation
- Putting children at the centre of policy and programmes

Nurturing healthy relationships, the National Association of Child Care Workers' Isibindi Programme provides essential support to children and families in their homes using everyday tasks and ordinary human interaction as a means to transcend basic care and meet young people's emotional needs.

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Shifting perspectives: Towards a holistic understanding of child and adolescent mental health

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“There can be no keener revelation of a society’s soul than the way in which it treats its children.”

Nelson Mandela, 8 May 1995

Mandela’s words speak deeply to our love and care of children, and our intuitive recognition of the benefits of investing in the well-being and development of the next generation. When Mandela spoke those words of hope at the dawn of our democracy, he also challenged us all to get it right for children. So, to what extent have we fulfilled our constitutional promise to ‘heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights; and to improve the quality of life and free the potential of all citizens’?

Children and adolescents’ mental health is deeply rooted in the environments in which they live, and their health, well-being and hope for the future are steadily – and at times brutally – being eroded by poverty, violence, discrimination, and a climate crisis driven by the exploitation of human and natural resources. This matters not only for children today, but for the future of our society, as children’s exposure to multiple risks and insults accumulates over time, causing long-term harm that ripples out across generations. This issue of the *South African Child Gauge* also challenges the reader to consider what is needed to promote mental health, well-being and resilience, and enable South Africa’s children to thrive.

In this chapter we explore how children may move along a continuum of mental health in response to their changing life circumstances. We describe how young people in South Africa continue to experience a significant burden of mental disorders, and how children’s mental health is shaped in powerful ways by their psychosocial, political, economic and physical environments. Finally, we consider how children’s rights can be used as a tool to enhance the provision of

mental health services, address the social and environmental determinants of health and create an environment that supports children’s optimal health and development.

What is the mental health continuum?

When we think of mental health problems or mental disorders, we tend to think in binary terms, as if there is some imagined point at which a person moves from being well to unwell. Having a line is important for diagnosis to enable treatment, but mental health is more complex than this and thinking in binary terms is not useful, especially given the fear and stigma associated with mental disorders that often prevents people from speaking out, seeking care or offering help. For many, mental health is understood as a subjective feeling of well-being and happiness. Yet, this is only part of the story, as mental health is crucially about our ability to cope with life’s challenges and respond in appropriate ways to stressors and negative events. Another source of confusion is the way in which concepts such as mental health, mental well-being, mental illness or mental disorders are used interchangeably. This often leads to a narrow focus on treatment of mental disorders, with little effort to promote mental health and well-being. It is therefore helpful to conceptualise mental health and well-being as falling on a continuum,² as illustrated in Figure 1.

On the one end of the continuum, children are thriving. They feel good about themselves, are in optimal relationships and perhaps feel a contentment about their place in the world. They are able to cope and respond appropriately to everyday stressors. In this formulation, mental health relates to children’s overall capacity to live their lives with agency

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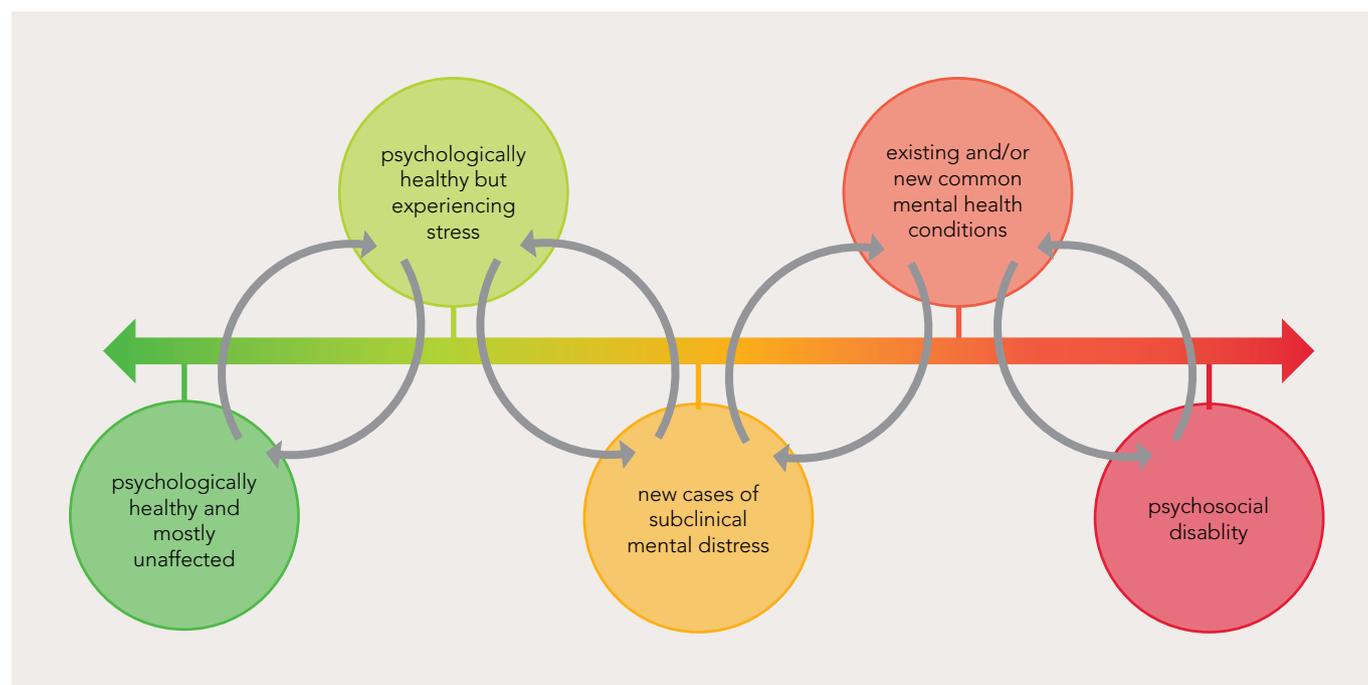
in the world, engaging their developmental potential for thought, emotions and behaviours in ways that enable them to cope with the everyday stresses of life. It is about their capacity to have meaningful relationships with others with whom they can be fully themselves, to be productive in study or work and to contribute to their community.¹ Children and adolescents who are ‘thriving’ experience contentment and happiness, and possess the ability to self-regulate, manage adversity and engage with life tasks with enthusiasm and to full potential. Young people who are ‘surviving’ still cope with their everyday routines, but may be worried, anxious, and distressed about one or more life areas. Children who are ‘struggling’ experience regular feelings of anxiety or low mood, worry excessively, have difficulty coping with their schooling or work, and may have poorer quality relationships. This does not constitute a mental disorder, but children may find the tasks of daily life more difficult, may start to exhibit signs of subclinical mental distress, and may take up maladaptive, self-soothing behaviours such as substance use. In these situations, children may need additional support, and intervening early helps to prevent them moving further along the continuum. Without intervention, a young person may move to a mental state of feeling severely anxious or depressed, not coping with their daily tasks, avoiding social interaction or engaging in more risky behaviour while experiencing significant emotional pain and suffering, and may even consider taking

their own lives. Early recognition to mobilise supports to enable children to address these life challenges is therefore essential and can build resilience and promote recovery and a return to thriving (see Case 2).²

Within this mental health framework, children’s capacity for engagement is shaped by their experience of mental health problems and their state of mental well-being: where mental well-being refers to children’s subjective experience of psychological, emotional and social well-being, and their sense of satisfaction with themselves as people and of the quality of life they are leading.¹⁻⁴

Mental illness can also be described on a continuum, ranging from a mild, time-limited illness to a longstanding, severely disabling condition. For example, a young person might experience a once-off episode of disabling clinical depression following a complicated bereavement and then fully recover, another might experience episodic disabling anxiety with major life transitions, while a third might experience a longstanding, persistent mental disorder which may give rise to a psychosocial disability that requires significant psychiatric, community and family support to assist the child or adolescent to cope at school or university, to enjoy creative and meaningful pursuits, to find and keep a job and to have satisfying relationships with others across the lifespan. So, children with mental disorders can – with support – experience well-being, thrive and lead a satisfying life.

Figure 1: The mental health continuum



Adapted from: Sherr, L., Cluver, L., Tomlinson, M., Idele, P., Banati, P., Anthony, D., Roberts, K., Haag, K., & Hunt, X. *Mind Matters: Lessons from past crises for child and adolescent mental health during COVID-19*, UNICEF Office of Research – Innocenti, Florence, 2021.

Box 1: Commonly used mental health-related terms

Mental well-being: A subjective sense of psychological coherence, emotional stability and social connectedness in environments that are experienced as supportive, promoting the flexibility and resilience to adapt in situations of stress and adversity (adapted from Keyes, 2002).²

Mental health: Ability to act with agency in environments that support best efforts to reach potential, capacity for meaningful relationships with other people, the skills to adapt and cope with adversity and common stresses of life and to contribute to one's community.³

Mental health problems: A disturbance in mental health and well-being that results in emotional and interpersonal distress and some difficulty coping with everyday stressors, but not severe enough to warrant a clinical diagnosis of a mental disorder (adapted from Lancet Commission, 2018).¹

Mental disorders: Disturbances of thought, emotion, behaviour, and relationships with others that lead to substantial suffering and functional impairment in one or more major life activities, as identified in the major classification systems such as the WHO International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders.¹

Psychosocial disability: Refers to young people's experience of enduring mental and emotional distress 'in interaction with various barriers... (which) hinder their full and effective participation in society on an equal basis with others'.⁵

Recovery: A process of change through which individuals experiencing enduring mental health problems improve their health and wellness, live a self-directed life, and strive to reach their full potential.⁶

Why is this important?

Acknowledging that all of us exist somewhere on this continuum, and that across our lives all of us can experience any aspect of this continuum in response to life experiences, is a fundamental way of de-stigmatising mental health problems. For example, the vagaries of mood, of everyday sadness and anger, are not the same as having a mental disorder. Anxiety, even for a few days, is not the same as panic disorder. Mood fluctuations are a perfectly normal part of child and adolescent development. While most children will recover on their own, it is important to recognise where a child is located on the continuum and when they need additional supports, and at what point they need to be referred to a mental health professional.

Children require a broad spectrum of support, with the first line being provided by caregivers, extended family and peers. When a child begins to feel some stress, they do not require professional intervention or a diagnosis. Far from it, what they most need is to feel safe with and supported by caregivers. Even in the immediate aftermath of a trauma,

the best thing to do is to help the child feel safe and warm and contained. Some children might require counselling if symptoms of difficulty emerge. If symptoms persist, and the functioning of a child at school or in their peer group appears to be threatened, then this is the time for more professional support or treatment. Understanding mental health as a continuum also highlights how there are always risk and protective factors at play – where protective factors promote children's mental health, well-being and resilience, and risk factors intensify mental distress and increase the chances of children developing a mental disorder. In other words, mental health is not simply located in the mind, it is shaped in powerful ways by children's relationships, life events and living conditions.

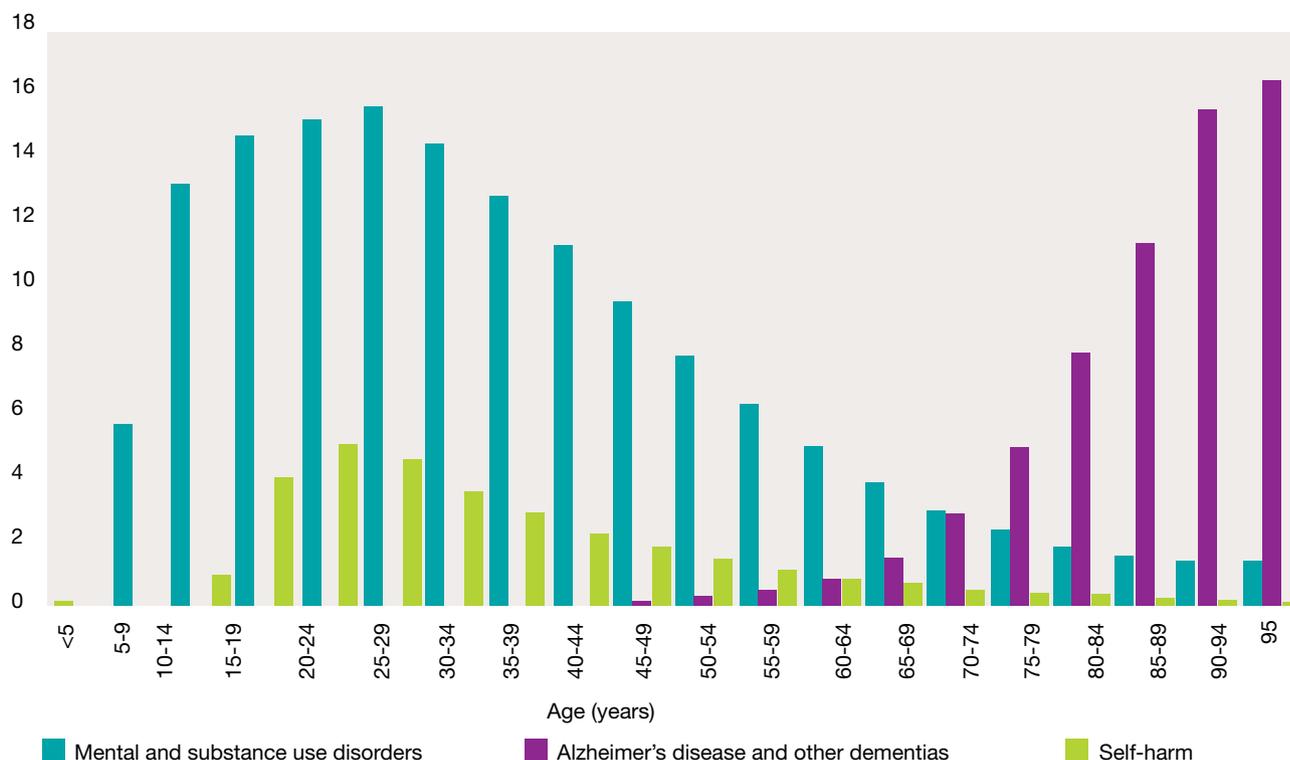
What are the current burden and long-term costs of child and adolescent mental disorders?

It is estimated that mental disorders account for 13% of the global burden of ill-health among 10 – 19-year-olds.⁷ Depression, anxiety and behavioural disorders are particularly prevalent amongst adolescents. Approximately 20% of young adults have a disabling mental disorder,⁸ and a systematic review of adolescent mental health problems in sub-Saharan Africa found a higher prevalence of mental disorders than in other low-to-middle-income countries.⁹

In the absence of a national prevalence study, data on the burden of child and adolescent mental disorders in South Africa are limited.¹⁰ The 2009 South African Stress and Health study¹¹ did not include children and adolescents, and a somewhat dated expert consensus study estimated an overall annual prevalence rate of 17% for mental disorders occurring in childhood and adolescence in the Western Cape.¹² Yet, even without reliable prevalence data, it is clear that many children in South Africa are failing to thrive due to widespread violence, discrimination and poverty¹³ and that our failure to prevent, promote and treat mental disorders will become increasingly costly.

Children and adolescents are vulnerable to a range of mental disorders. One of the leading causes of illness and disability during adolescence is depression^{7, 14} and rates increase rapidly between early- and middle-adolescence, particularly in contexts of family depression¹⁵. Depression contributes directly to suicide, which is the fourth leading cause of death amongst 15 – 19-year-olds.⁷ Anxiety disorders often co-occur with other disorders like depression and are associated with increased rates of anxiety and depression and adverse outcomes in adulthood.¹⁶ Other disorders requiring attention include psychotic disorders, autism spectrum disorders, attention deficit hyperactivity disorder (ADHD),

Figure 2: The global burden of mental health conditions across the life course



Source: Global burden of disease health data (2016) Reproduced with permission from: Patel V, Saverna S, Lund C, et al. The Lancet Commission on Global Mental Health and Sustainable Development. *The Lancet*, 2018;392: 1553-1598.

post-traumatic stress disorder (PTSD), learning disorders and conduct disorder, among others. In addition, there is a high burden of substance abuse disorders in South Africa, where 20% – 49% of those admitted to drug treatment centres in the first six months of 2020 were 10 – 19-year-olds.¹⁷

Alcohol exposure can have devastating effects on children’s development and mental health, with South Africa having the highest rate of Foetal Alcohol Spectrum Disorders in the world.¹⁸ A South African Medical Research Council study found that a large percentage of adolescents in the Western Cape reported alcohol (60%) and cannabis (23%) use, with over half of the large sample being at medium to high risk for mental health problems.¹⁹ A study of 1,034 young people in Cape Town found that those exposed to violence had much higher odds of having PTSD, with the likelihood increasing as the degree of exposure to violence increased.¹³

Early intervention matters

Half of all adult mental health problems have their origins prior to age 14, and 75% by age 24,²⁰ making early prevention and promotion essential. Figure 2 provides a stark portrayal of how the burden of mental disorders shifts with age and how most mental disorders have their origins in childhood and adolescence. Across the life course, mental and

substance use disorders peak in late adolescence and young adulthood, as does self-harm.

As Desmond and colleagues have pointed out, when we fail an individual child, the lifetime and generational impact is felt at a societal level.²¹ The costs of not intervening, of not strengthening families and support systems for vulnerable children and families, and of not improving platforms (such as schools and health facilities) to better support children and families, are huge.²¹ Investing early is a moral imperative but investing early is also perhaps the best investment that can be made in the generational health of our society, in that it offers an opportunity to break the cycle of poverty, violence and mental ill health.

What are the key drivers of poor mental health?

The United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health argues that: ‘Mental health and well-being cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential’.²²

Case 1: Putting children's perspectives at the centre of our analysis

Shazly Shavalⁱ, Sabirah Adamsⁱⁱ and Elizabeth Benningerⁱⁱⁱ

Child well-being is often reported on using pre-determined objective indicators (statistics on social and living conditions, excluding self-perceptions and independent of personal evaluations) of children's living conditions, which are distilled from population-based surveys and administrative data (data collected from government institutions to facilitate the delivery of services and programmes). For example, over the past 28 years, the South African government has made significant progress in developing strategies to measure the extent of child poverty and children's access to education, health care, housing, water, and sanitation.

However, using objective indicators as the exclusive means of determining child well-being is limited. In recent years, a strong argument has been made for the inclusion of children's subjective perceptions, which are measured by asking children to evaluate their own lives and living conditions. While this subjective, or self-reported, stance on well-being is well-known in the adult literature, there has been less investment in empirical research with children and adolescents. Yet, there is sound scientific evidence that subjective and objective indicators of well-being are strongly associated and it is now well-established within the scientific literature that both objective and subjective indicators are important considerations in the assessment of the overall well-being of children.⁹⁶

Asking children their opinions also highlights the importance of children's active and authentic participation in the decisions, processes, programmes, and policies that affect their lives. In South Africa, child participation is deeply enshrined in a range of legal and policy frameworks, including the Children's Act. As a general principle, it should guide the design and implementation of policies and programmes to ensure they give effect to children's 'best interests'. Similarly, child-centred approaches to research position children's subjective understandings or 'standpoints' at the centre of enquiry.⁹⁷

What do we mean by subjective and psychological well-being?

The concept of well-being has its origins in the Greek philosophical concepts of 'hedonia' and 'eudaimonia', collectively referred to as self-reported well-being in research with children and adults. Figure 3 provides a

visual representation. Hedonic well-being focuses on life satisfaction, happiness, and subjective well-being (SWB), denoted as 'feeling well', representing the good life, and concretised as experiencing happiness.⁹⁸⁻⁹⁹ SWB is a multifaceted expansive concept that comprises cognitive and affective components, including individuals' perceptions, experiences, reflections, and appraisals of their lives.^{100,101} The cognitive component refers to global and domain-based life satisfaction, while the affective component refers to positive and negative affect.¹⁰² When we ask children about their SWB, we are asking them to which extent they are satisfied with their lives in general and with certain aspects of their lives (such as family life, friends, or school), and how they feel about their lives, both in terms of positive and negative emotions.¹⁰³

By contrast, eudaimonic well-being focuses on the extent to which an individual is fully functioning in society. This includes having a sense of purpose and meaning in life, autonomy, life goals, opportunities for self-actualisation, and is often described as 'psychological well-being' (PWB).¹⁰⁴⁻¹⁰⁷ The eudaimonic orientation of PWB reflects an historical shift of the conceptualisation of health advanced by the World Health Organisation in 1946, from a focus on risk and illness to an emphasis on well-being and factors that support human health.¹⁰⁸ This paradigm shift aligns with a growing interest in positive psychology, and positive social science more generally. In the field of child research, the construct of children's PWB has not received much attention, largely as a result of a widely held belief that children lack the cognitive capacity to reflect meaningfully on their PWB. Recent studies provide contrary evidence, and have distilled valuable data on children's PWB.¹⁰⁹

What do we know about child well-being in South Africa?

Savahl and Adams¹¹⁰ used a population-based sample of 10 – 12-year-old children to examine children's SWB and PWB, as part of the Children's Worlds: International Survey of Children's Well-Being. Unique to this study was the inclusion of children's perspectives in the development of the questionnaire. Scores on children's SWB and PWB are usually presented on a 100-point-scale, with scores typically ranging from 70 – 90 with a mean of 80. The results of the national survey showed a SWB mean score of

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86.10 and a PWB mean score of 85.90. This suggests that children across South Africa are presenting with scores above the expected mean. These scores place South Africa in the midpoint of the distribution in comparison with other countries participating in the global survey.

However, in relation to specific aspects of children's well-being there were varying results in comparison with other countries. South Africa scored higher than other countries in relation to children's 'satisfaction with their life as a student' and the 'things that they learned at school'. These findings point to the important role that school plays in children's lives and their experiences of well-being. Interestingly, South Africa's children also scored relatively well on 'body image' in comparison with the other countries. However, a comparative analysis of the scores across a range of other aspects of children's lives presented concerning results. For example, considering children's safety across contexts (home, school, and the neighbourhood), South African children presented with the lowest scores for feeling safe in comparison to other countries. More than 10% of children indicated feeling unsafe at home, more than 13% at school, and more than 30% in their neighbourhood and community.

Further, it was found that bullying, victimisation and school violence were among the highest in comparison to the other countries, across all forms of bullying. Children from South Africa also indicated feeling 'least safe' 'traveling to and from school'. South African children also ranked relatively low on satisfaction with their family; the home where they live; relationships with classmates; and their perceptions about their future. The study further

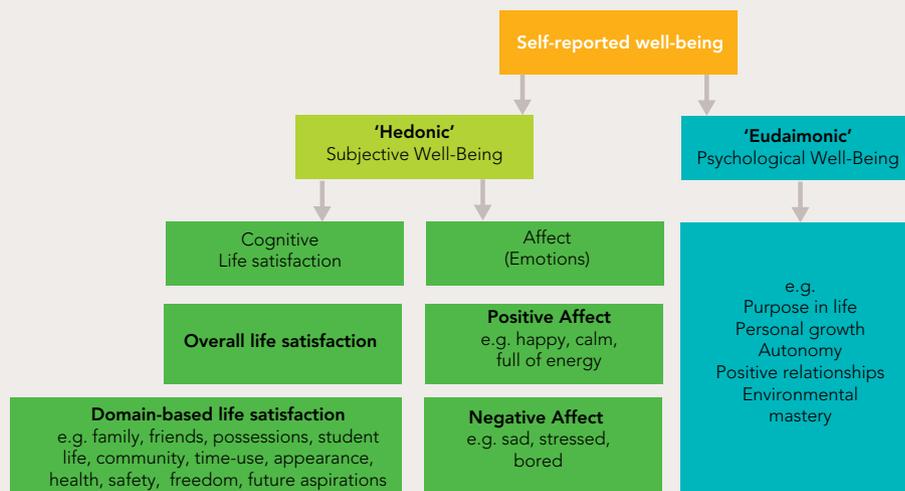
found that positive social relationships, access to safe spaces, spending time with family and friends, and lower levels of material deprivation were all associated with higher levels of well-being.

How can we enhance children's well-being?

Further research is needed to establish which factors contribute to higher or lower levels of SWB and PWB. A starting point for addressing this would be to consider UNICEF's multi-level framework of child well-being,¹¹¹ which illustrates how children's well-being and development is influenced by their interactions with their environment. This includes the immediate 'world of the child', the 'world around the child', and the 'world at large'.

The end-goal should be to develop child-friendly societies where the well-being of children is embedded in both the physical spaces and the social dynamics that shape social and community life. While national policies are critical in addressing the structural factors influencing families and communities, we suggest that a bottom-up approach, focusing on local policies and regulatory frameworks, would likely yield more impactful results. In both cases, these efforts need to start by (re)conceptualising children's position in society – from passive beings to active citizens and rights holders. This requires an acknowledgement of children's agency, not only as social actors engaging in different contexts, but also social agents affecting and shaping their social and physical environments, so that their views and experiences inform the design and delivery of services and support.⁹⁶

Figure 3: Self-reported well-being



Adapted from: Rees, G., Goswami, H., Pople, L., Bradshaw, J., Keung, A., & Main, G. (2013). The Good Childhood Report. London: The Children's Society

The social ecological model

The social ecological model is perhaps the most widely used and well-known model in medicine and social science. Figure 4 shows how children are nested first and foremost within the family, and certainly for the infant and young child, the influence of the family is huge. But the social ecological model also highlights how even the most insular, and seemingly ‘untouched’ family, is embedded within communities (that may have high levels of violence and pollution), which in turn are embedded within broader political systems (where the rights of the child and their caregivers may not be protected). In addition, we are increasingly understanding the key role played by the commercial determinants of child and adolescent nutrition and mental health. Children and adolescents are bombarded from an especially young age by social media and advertising for junk food, alcohol, tobacco,

gambling and an endless array of products that exploit their vulnerabilities and need for affirmation and belonging.²³

Embodiment: Krieger uses the term ‘embodiment’ to illustrate how children’s physical and mental health and well-being are shaped by—and embedded in—their environments.²⁴ In other words, our bodies (and our humanity) cannot be divorced from the social and material conditions of our existence. The socio-economic, political and environmental conditions in which we live become embodied in our bodies and psyches, giving rise to our experiences of health and/or disease at the individual, family, community, national and global levels – where societal patterns of disease reflect the biological consequences of how power and resources are distributed in society. These environmental impacts on our bodies and minds also shape individual power and agency, and the extent to which we are in a position to recognise the

Figure 4: The social ecological model



stories our bodies may tell, and if we are able to, allowed to, or choose to tell those stories.^{24,25} Embodiment therefore also speaks to the relative power of children and adolescents, their families and their communities to be physically and mentally well, and to act with agency to improve their circumstances.

Inflammation: Another way of thinking about embodiment is by way of understanding inflammation. When the body detects a threat, experiences an environmental injury or is stressed and damaged, it mounts what is known as an inflammatory response.²⁶ Marya and Patel refer to this inflammatory response as our bodies' ancient mechanism of self-healing.²⁷ The response involves multiple cells and molecular messengers, whose aim is to restore balance. The way our body works is that when the injury is healed or the threat disappears, the inflammatory response is switched off.²⁷ This is how it is supposed to work. However, when the threat or trauma is chronic, when violence is repeated, the inflammatory system does not get 'switched off', resulting in a hyperinflammatory response.²⁶ Marya and Patel describe this as a 'smouldering fire'²⁷ that creates ongoing damage such as triggering diseases, most notably a number of psychiatric disorders.²⁶ There is increasing evidence of how trauma and PTSD are associated with inflammatory diseases,²⁸ which leave 'deep wounds, and the immune system keeps those stories alive in the body' (p69).²⁷ It is not only experiences of violence and environmental insult that result in increased inflammation. Racism and other forms of discrimination are associated with chronic inflammation in adulthood and these are mediated through stress.²⁹

Violence: Children in South Africa are exposed to extremely high levels of violence, including all forms of abuse and exposure to intimate partner violence.³⁰ High levels of exposure to violence (85%) were found to increase the likelihood of experiencing depression, anxiety and PTSD,¹³ while South African adolescents who reported sexual violence were two to three times more likely to report PTSD, anxiety or depression than those who had not.³¹ Sexual violence, with a prevalence of 35% amongst adolescents in South Africa,²⁷ has a strong association with unintended pregnancy in girls and adolescents,³² which can have detrimental mental health, physical health and socio-economic impacts for girls and the children they bear.

Economic hardship: The strain of living in poverty is a form of 'slow violence'³³ which steadily erodes the mental health and well-being of children, families and communities, and is often accompanied by problems such as food insecurity, violence, crime, illicit alcohol and drugs, crumbling infrastructure and poor access to basic services. Exposure to

adverse economic events (such as a global recession or losing a job) can intensify stress within the family and precipitate an increase in mental health problems.³⁰ At the same time, economic hardship reduces families' ability to travel to and pay for mental health services, helping fuel a cycle of poverty and poor mental health (see Figure 9 on p45).

Treatment gap: An estimated 90% of children with mental disorders in South Africa are unable to access mental health care.³¹ The unmet need for mental health care is associated with poorer performance at school, and risk-taking behaviours such as substance abuse and criminal activity, which then impacts on skills development, readiness for adult life roles, social and economic independence and ability to contribute to family economic security.³⁴ This is one of the strongest motivations for intersectoral collaboration to strengthen support systems and to address both the root causes of poor mental health, as well as to ensure better health promotion and prevention using different platforms (see the schools chapter).

Discrimination and exclusion: Discrimination along the lines of race, ethnicity, gender and disability, for example, interface with income, education and geographical location to shape health inequalities. Discriminatory pathways include economic and social deprivation, excess exposure to toxins and hazardous conditions, social trauma, inadequate medical care and ecosystem degradation and alienation from land.²⁵ In the South African context, historical systems of slavery and the dispossession of indigenous people during the early colonisation of South Africa, coupled with systemic structural segregation during apartheid, and the failure to address the racial and ethnic polarisation still prevalent in the country^{36,37} has left the majority of young South Africans struggling with endemic post-apartheid poverty. This locks young people and their families within an intergenerational cycle of poverty and deepening income and health inequalities.³⁸

Racism: Recent global events, such as the Black Lives Matter Movement, have also brought attention to the widespread negative impact of historical, institutional and socio-cultural patterns of race-based discrimination on the mental health and trauma of black, indigenous and other people of colour. Black, indigenous and other young people of colour are more likely to experience, for example, implicit and explicit exclusion and devaluation, differential access to societal resources, lack of safety, and increased risk of entering a correctional facility rather than be referred to mental health services.³⁵ Within mental health settings, language barriers and the impact of cultural factors on symptom expression may also impact on practitioner intervention choice for black, indigenous and other young people of colour.

Gender: Gender is a key determinant of mental health across the life course. Sex differences in the prevalence of mental disorders in children and adolescents are common with males having significantly higher prevalence rates of ADHD, autism spectrum disorder, oppositional defiant disorder (ODD) and conduct disorder.⁴⁰ Towards the end of adolescence, adolescent females are more likely to be diagnosed with anxiety and mood disorders.³⁶ In adulthood, depression is diagnosed twice as often in women than in men. Increasingly, there is also the recognition of how diversity in gender identity is associated with poor mental health in children and young people.⁴⁰

Disability: Children with neurodevelopmental disorders, such as intellectual disability, autism spectrum disorder, ADHD and specific learning disorders experience a higher prevalence of mental health problems than the general population, yet services and expertise to address their mental health problems are underdeveloped in the South African context. For young people with co-occurring mental disorders and intellectual disability, for example, accurate understanding and diagnosis of stress or mental health problems are challenging as these conditions may present atypically, with behaviour such as aggression or self-injury, as well as developmental regression and loss of communication skills.⁴¹ In a context where clinical skills training in working with people with intellectual disability is lacking, and patients struggle to communicate their experiences, mental health

problems or disorders may go undetected and untreated in people with intellectual and developmental disability.^{42, 43}

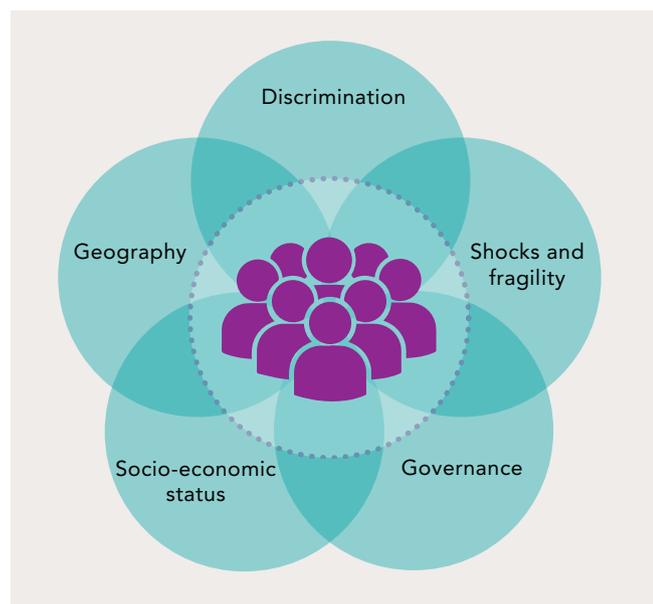
Intersectionality: Over the past 30 years there has been a growing recognition that experiences of discrimination along the lines of age, race, class, gender, ability and other individual characteristics are not isolated and distinct, but rather 'intersect' with one another in complex, cumulative and often mutually reinforcing ways that serve to marginalise, silence or exclude certain individuals or groups, and to perpetuate the play of power and privilege in society. For example, whilst adolescent girls may share much in common due to their age and gender, their experiences also diverge and are shaped in different ways by their 'race', 'age', 'class' and 'sexuality'. Adopting an intersectional lens can help mental health professionals, policy makers and programmers become more attuned to how social norms and the play of power in society shape the unique lived experiences of individuals and communities, and encourage them to partner more intentionally with individuals, groups, communities and children to challenge discrimination and develop strategies that promote mental health, well-being and inclusion across a range of settings including families, schools and health facilities.

Figure 5 captures the ways in which certain groups of children are subject to multiple and compounding experiences of deprivation and exclusion, including: children living below the poverty line, children living in rural areas or informal settlements who have poorer access to services and economic opportunities, and children who experience discrimination, including children with disabilities, adolescent mothers and children of immigrants, refugees and asylum seekers. It also draws attention to how these patterns of disadvantage may be intensified by shocks such as economic recession and climate change, and/or poor governance, where corrupt or unaccountable or unresponsive officials fail to deliver services.

It is children at the intersection of these five circles who are most likely to be silenced, rendered invisible and left behind in our pursuit of the Sustainable Development Goals, and who need to be actively included and prioritised if we are to move beyond the rhetoric and realise the vision of the Constitution and the National Development Plan.

COVID-19: Humanitarian crises and shocks such as conflict, climate change and pandemics tend to intensify inequalities and highlight the fragility of our support systems in ways that leave children particularly vulnerable. For example, the COVID-19 pandemic and associated lockdown measures severely stretched the capacity of families to maintain

Figure 5: What does it mean to leave no-one behind?



Source: United Nations Development Programme. *What does it mean to leave no one behind? A UNDP discussion paper and framework for implementation.* New York: UNDP. 2018.

their sense of well-being and mental health, and disrupted access to social and environmental supports, including food, income and other essentials. It has reduced opportunities to attend school and to work, threatening the security of homes and reducing the mental health and capacity of parents and other supporters to maintain a stable, emotionally regulated and secure environment. The human need for relationships, contact with family, friends and neighbourhood support was disrupted, and many families are still grappling with the loss of both loved ones and livelihoods.^{44, 45}

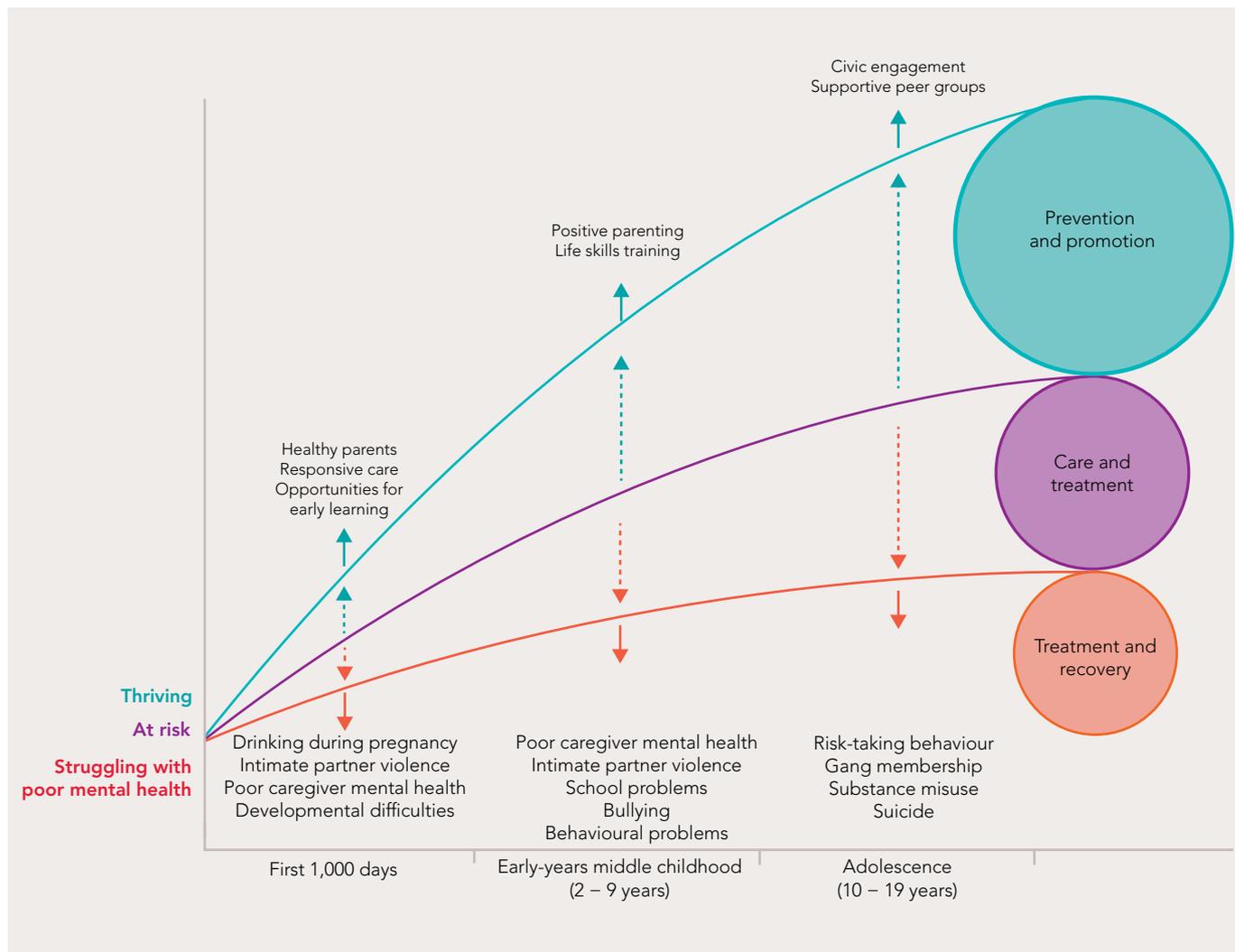
Climate breakdown: Rising temperatures and extreme weather events such as floods, fire and droughts, are threatening food and water security, destabilising communities and increasing stress and the propensity for aggression.^{46, 47} It is therefore not surprising that climate breakdown is impacting on child and adolescent mental

health and giving rise to anxiety, depressed mood and trauma from exposure to natural disasters and resultant displacement, as well as young people’s growing awareness of the existential threat to their future (see Case 34 on p153). In addition, the environmental, social and health impacts of climate change are likely to intensify existing inequalities, with the effects concentrated more intensely on already marginalised communities⁴⁸ and children whose developing bodies and brains are particularly sensitive to environmental exposures⁴⁹.

Enabling environments

All of these social and environmental determinants have a profound impact on children’s mental health and well-being. Yet, their impacts are also mediated in significant ways by the immediate world of children’s families, friends and communities. Secure attachment, self-regulation, self-

Figure 6: Protective factors and risk factors in the early life course



Adapted from: Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, Chisholm D, Collins PY, Cooper JL, Eaton J, Herrman H. The Lancet Commission on global mental health and sustainable development. *The Lancet*. 2018 Oct 27;392(10157):1553-98.

Case 2: Resilience – A multisystemic, contextually responsive process

Linda Theron

Across the world, child and adolescent health and well-being are threatened by significant shocks and stressors, many of which appear to be relentless, such as armed conflict and other forms of violence, the threats of climate change, and multidimensional poverty. Given this harsh and apparently intractable reality, multiple researchers are committed to understanding – and mobilising – the factors and processes that support young people's resilience or capacity to function adaptively (i.e., to be/do okay), despite significant risks to their health and well-being.⁸⁴ Positive outcomes associated with child and adolescent resilience in South Africa include minimal symptoms of psychological distress, continued school engagement, and young people's positive contributions to their household, family, and/or community.⁸⁵

Resilience is misrepresented when positive outcomes are solely or mostly attributed to young people's personal strengths. While earlier studies did attribute positive outcomes to young people's personal strengths, current resilience science emphasises how human resilience is facilitated by promotive and protective factors and processes across multiple systems, both within the individual person and outside of them.^{86, 87} Put differently, resilience draws on biological, psychological, social, institutional and environmental resources that work together to produce positive outcomes. These resources can promote positive outcomes when exposure to risk is low and/or protect children and facilitate positive outcomes when exposure to risk is high. For example, a systematic review of 61 South African studies of child and adolescent resilience showed that young people's positive outcomes were shaped by a combination of resources from multiple systems.⁸⁵ These included:

- physical health,
- psychological strength (e.g., being goal-directed or making hopeful meaning),
- social support (from family members, peers, community members, teachers, and/or service providers),
- financial resources (e.g., prospects for employment),
- quality schooling,
- facilities in the immediate built environment (e.g., recreational centre, library, or safe spaces to play), and/or
- opportunities to engage in enabling religious or cultural activities.

Although some resources (e.g., warm caregivers) recur across studies of resilience,⁸⁴ there is increasing interest in how some resources have greater impact on positive outcomes than others, with some sense that social and ecological resources may matter more than personal ones in places where there is higher risk and adversity.⁸⁸ The usefulness of resources – and even what form they take – could relate to young people's stage of development,⁸⁹ the severity of the risks they are exposed to,⁸⁸ and/or their socio-cultural context.⁹⁰ For example, a study with a sample of Australian Aboriginal adolescents found that high self-esteem supported positive mental health outcomes for adolescents in families with low or high levels of adversity, whereas peer support only enabled resilience for adolescents exposed to high levels of family adversity.⁹¹ However, a South African study showed that peer support did not enable the mental health resilience of adolescents with experiences of domestic and other forms of violence.⁹² Similarly, supportive peers did not facilitate school engagement over time for a sample of South African adolescents living in a stressed community. Instead, warm parents predicted the school engagement of adolescents younger than 16, and warm parents and competent teachers predicted the school engagement of adolescents older than 16.⁹³ African resilience studies have shown that warm parents are not necessarily biological parents; they can be relatives (e.g., grandmothers or siblings) or non-relatives who take on a parent role (e.g., caring teachers; supportive social workers); and this more flexible understanding fits with the traditional African valuing of interdependence that is not limited to biological kin.⁹⁴

These variations mean policymakers and practitioners should take care not to make assumptions about what is needed to best support the resilience of children and adolescents. Optimally supporting young people to be/do okay when their health and well-being is threatened, needs to be rooted in understanding 'which promotive and protective factors or processes are best for which people in which contexts at what level of risk exposure and for which outcomes'.⁹⁵ This understanding then needs to be translated into developmentally and contextually responsive interventions that facilitate and sustain these resources across multiple systems to build resilience and champion young people's health and well-being.

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esteem, self-efficacy, problem-solving skills, attributions, engagements and connections with others are all protective factors that promote resilience and positive development.⁵⁰ We also know that caregivers and families are foundational to ensuring optimal child development and to creating enabling environments that build resilience in children and adolescents.

A developmental life-course approach

Understanding child and adolescent development as a life-course enterprise allows us to examine the onset of health problems and understand how health disparities develop, are amplified, mitigated or reproduced across generations, to enable more effective interventions.⁵¹ Specifically, this perspective helps us understand how social risks and opportunities create vulnerability or resilience at each life stage, and how they accumulate, or are reduced across lives and generations.⁵¹ A life-course perspective shifts our understanding from simple, linear, and mechanistic explanations to a perspective that acknowledges that mental health is complex, interactive, holistic and adaptive.⁵² Perhaps most importantly, it gives us a way of showing how both ordinary and extraordinary experiences may 'get under the skin'.⁵³

Poverty, violence and substance use, coupled with limited access to sexual and reproductive health services, increase the risk of unwanted pregnancies and are associated with an increased likelihood of a woman drinking during pregnancy. This may compromise the health and nutrition of mother and her developing child and result in foetal alcohol syndrome. Food insecurity and domestic violence are also associated with maternal depression, which further compromises the mother's capacity to provide responsive and nurturing care in ways that may give rise to stunting and developmental delays. These children are then more likely to struggle at school and to exhibit behavioural problems that in adolescence make them more susceptible to risk-taking behaviours that may lead to truancy, school dropout, substance use, violence and adolescent pregnancy, which may in turn compromise the health and education outcomes of the next generation of children.

On the other hand, outcomes may be different where a mother is in a supportive relationship and can rely on a group of friends and a network of familial support. Where the household is food secure, and she is able to receive six months of paid maternity leave, she is able to be present for her infant and to exclusively breastfeed for six months. The presence of a supportive and responsive caregiver

helps infants and children calm down and cope with adverse experiences when they occur.⁵⁴ It is important to state that in both scenarios, nothing is cast in stone (see Figure 6). Even in the worst-case scenario, there are numerous points on the poor mental health pathway for early intervention, referral and support. Optimal early life experiences may help children cope with turmoil later in life, but they are not an inoculation.

How can a human rights approach enhance child and adolescent mental health?

In November 2021, during the COVID-19 pandemic, the United Nations Human Rights Council hosted a consultation to strengthen a human rights-based approach to mental health laws, policies and practices. This includes a global effort to promote and protect the rights of persons with mental health problems or psychosocial disabilities within mental health systems, and to address the broader social, economic and environmental determinants of mental health.

The United Nations Convention on the Rights to the Child (UNCRC),⁵⁵ United Nations Convention of the Rights of Persons with Disability (UNCRPD),⁵⁶ African Charter on the Rights and Welfare of the Child (African Charter)⁵² and the Bill of Rights in the South African Constitution together outline the State's obligations to promote children's optimal health and development by providing access to resources to meet their physical, psychological and social needs, protecting them from harm, and supporting their active participation in society.

Provision: Access to resources to meet basic needs

The UNCRC and African Charter recognise the right of children to the highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health,^{53, 54} as does the UNCRPD for those with disabilities⁵⁹. This includes 'timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services',⁶⁰ which should be available, accessible to all without discrimination, acceptable and of good quality.⁶¹ But children's right to health extends beyond the provision of health care services and includes the 'right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health'.⁶⁰ While parents and families have the primary obligation to care for children and provide the conditions needed to support their health, well-being and development, states have an obligation to assist in case of need⁶² and to provide for the socio-economic rights of children, including their rights to basic education, health care services, social services, social security, housing and shelter.

Case 3: Promoting participation - Child monitors as advisors

Steps have been taken in realising children's right to participation. For example, the Western Cape appointed a Child Commissioner in 2020, tasked with independently protecting and promoting the rights, needs and interests of children in the areas of education, health, social development, cultural affairs and sport. The Office of the Child Commissioner actively engages children in governance, programme development and ad hoc project implementation. Children recommended by organisations working with children have been selected as Child Government Monitors who provide advice and recommendations to the Commissioner in fulfilling her monitoring and research duties.

In discussions held by Child Monitors at schools in August 2021, for example, children noted their concern about underfunding of mental health in schools, their need for equal access to counselling and support in public schools, the importance of education and awareness about mental health and the need to break down stigma associated with mental health concerns at schools.^{82, 83}

While the state is obliged to progressively realise everyone's right to have access to health care services, sufficient food and water, and social security within its available resources, Section 28 of the Constitution guarantees children a direct and unqualified right to basic health services, basic nutrition, shelter and social services, which should be prioritised in the allocation of state resources. In addition, the United Nations Committee on the Rights of the Child has stated that even in an economic crisis, governments may only introduce regressive measures as a last resort, after considering all other options and ensuring that children are the last to be affected.⁶³

Protection: Ensuring that children and adolescents are safe from harm

Children also have the right to be protected from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation,⁶⁰⁻⁶² economic exploitation⁶⁷⁻⁶⁹ and harmful traditional, social and cultural practices^{57, 70}. This includes the right of child victims of neglect, exploitation, abuse and any form of inhumane treatment to psychological recovery and social

reintegration,^{71, 72} and the right of children who are placed in care to have periodic treatment reviews.⁷³ The Children's Act specifies that the Department of Social Development should assist children in need of care and protection, including those with disabilities. This includes children who have been abandoned or orphaned without any support, live and work on the streets, are addicted to substances and without support to access treatment, live in or are exposed to circumstances that are harmful to their well-being, or are neglected, maltreated, abused or degraded by a parent or caregiver. The Act provides for prevention and early intervention programmes, including parenting programmes, counselling and mediation, to help children and families resolve conflicts and improve caregiving practices. It mandates social services and the courts to ensure that children in need of care and protection can access therapeutic services and alternative care and describes the role of social workers and psychologists in custody, adoption and parenting plans.

Children also have the right to play, rest, leisure and recreation, and the right to education that develops children's personality, talents and mental and physical abilities to their fullest potential and instils a respect for human rights and the natural environment.⁷³ Finally, children have a right to an environment that is not harmful to their health, and sustainable development that protects the environment for the benefit of present and future generations.⁷⁴

Figure 7: Children's rights to mental health are interdependent and indivisible



Participation: Involving children and adolescents

Article 12 of the UNCRC asserts the right of all children to express their views in all matters that affect them (including judicial and administrative proceedings) and for their views to be given due weight in accordance with their age and maturity. The UNCRPD raises the need for assistance to realise this right for children with disabilities,⁷⁵ and obliges states to consult with and involve children with disabilities when developing legislation and policies⁷⁶. Section 10 of the Children's Act⁷⁷ affirms children's right to participate in matters concerning them in the South African setting and provides clear guidance on children's consent to medical treatment, while the Mental Health Care Act⁷⁸ regulates consent to treatment by children with mental disorders.

In addition, children have the right to parental guidance consistent with their evolving capacities;⁷⁹ information which promotes their social, spiritual and moral well-being, and physical and mental health;⁸⁰ and health information that enables them to make informed decisions and take responsibility for their own health in ways that are age-appropriate and accessible to children (see Case 3).⁸¹

Non-discrimination and equality

These rights and freedoms are universal and apply to all children and states must put in place measures to protect children from discrimination. The South African Constitution is founded on the values of human dignity, equality and freedom, and Article 9 expressly prohibits discrimination on the grounds of 'race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth'. This extends beyond equal opportunity and includes measures such as affirmative action and reasonable accommodations to level the playing field and ensure substantive equality – or equal outcomes.

Finally, Section 28 of the Constitution asserts that child's best interests are of paramount importance in every matter affecting a child or group of children. This best interest standard should guide all decisions, actions and proceedings regarding the health, care, protection and well-being of the child – from custody disputes to the design and delivery of health care services.

Children's rights place a legal obligation on the state to put in place laws, policies, programmes and services – and the necessary human and financial resources – to give effect to these rights. Yet, despite developing a suite of ambitious laws, policies and programmes that aim to promote

children's optimal health, development and well-being, poor implementation continues to compromise children's mental health, and violate their human rights. It is therefore essential to recognise that children's rights are also a powerful advocacy tool for transformation that can be used by health workers, teachers, social workers, policy makers, families and children themselves to challenge these limitations, hold government accountable, and actively champion children's best interests from their homes, schools and communities to the corridors of power.

Conclusion

Children and adolescents in South Africa are facing an uncertain future, so it is vital that we find ways to promote children's mental health and resilience, and ensure they are equipped to cope with life's challenges. These solutions need to extend beyond medical treatment and the health care system to address social and environmental drivers of ill health, and to create supportive environments that enable children to thrive. In our search for solutions, we need to radically re-orient our way of thinking about how we include children and adolescents in decisions about their future. This must include a strong focus on equity, and approaches that ensure the inclusion of all children – and particularly the most vulnerable such as children with disabilities who live in poverty – to ensure that no-one is left behind.

In this 16th edition of the *South African Child Gauge*, we have compiled a set of 10 chapters that examine current challenges and identify critical points of intervention to promote children's mental health and well-being across the life course, and across a range of settings. This includes a deeper examination of the social, economic and environmental determinants of child and adolescent mental health, and how positive and negative life events impact on children's development across the life course in ways that either enhance or undermine their mental health. We then consider how to create a more enabling and supportive environment by strengthening the role of families, educational facilities, health care services and digital platforms in promoting children's mental health, as well as the need for intersectoral collaboration to address complex challenges such as violence and disability. The final concluding chapter calls for a whole-of-society, life-course approach that places children – and child mental health and well-being – at the centre of all policies to create an enabling environment in which our children and the planet can thrive.

References

- Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, Eaton J. The Lancet Commission on global mental health and sustainable development. *The Lancet*. 2018;392(10157):1553-1598.
- Keyes CL. The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior*. 2002;207-222.
- World Health Organization. *Promoting mental health: Concepts, emerging evidence, practice. A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne*. Report No.: 9791157467679. 2005.
- Cunningham W. *Mental Health First Aid training: Effects on participant knowledge, confidence and subjective well-being*. Masters thesis report 2014/15: Faculty of Applied Sciences Department of Psychology, University of Sunderland, Australia; 2016.
- United Nations. *Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*. Office of the United Nations High Commission for Human Rights. 2006. [<http://www.un.org/esa/socdev/enable/rights/convtexte.htm>]
- Substance Abuse and Mental Health Services Administration. *Recovery. National and Regional Resources*. 2014. [<https://www.samhsa.gov/sites/default/files/samhsa-recovery-5-6-14.pdf>]
- World Health Organisation. *Adolescent Mental Health*: 2021. Accessed: 5 October 2021. Available from: <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>.
- Belfer ML. Child and adolescent mental disorders: The magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry*. 2008;49(3):226-236.
- Jörns-Presentati A, Napp A-K, Dessauvagie AS, Stein DJ, Jonker D, Breet E, Suliman S. The prevalence of mental health problems in sub-Saharan adolescents: A systematic review. *PLoS One*. 2021;16(5):e0251689.
- Mokitimi S, Jonas K, Schneider M, De Vries PJ. Child and Adolescent Mental Health Services in South Africa—Senior Stakeholder Perceptions of Strengths, Weaknesses, Opportunities, and Threats in the Western Cape Province. *Frontiers in Psychiatry*. 2019;10:841.
- Herrman AA, Stein DJ, Seedat S, Heeringa SG, Moomal H, Williams DR. The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal*. 2009;99(5).
- Kleintjes S, Flisher A, Fick M, Railoun A, Lund C, Molteno C, Robertson B. The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *South African Psychiatry Review*. 2006;9(3):157-160.
- Stansfeld SA, Rethon C, Das-Munshi J, Mathews C, Adams A, Clark C, Lund C. Exposure to violence and mental health of adolescents: South African Health and Well-being Study. *BJPsych Open*. 2017;3(5):257-264.
- James SL, Abate D, Abate KH, Abay SM, Abbafati C, Abbasi N, Abdelalim A. Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*. 2018;392(10159):1789-1858.
- Kuo C, LoVette A, Stein DJ, Cluver LD, Brown LK, Atujuna M, Beardslee W. Building resilient families: Developing family interventions for preventing adolescent depression and HIV in low resource settings. *Transcultural Psychiatry*. 2019;56(1):187-212.
- Creswell C, Waite P, Cooper PJ. Assessment and management of anxiety disorders in children and adolescents. *Archives of Disease in Childhood*. 2014;99(7):674-678.
- Dada S, Harker Burnhams N, Erasmus J, Lucas W, Parry C, Bhana A, Weimann R. Monitoring alcohol, tobacco and other drug abuse treatment admissions in South Africa. January - June 2020. Phase 48. *SACENDU (South African Community Epidemiology Network on Drug Use) 2021*:1-72.
- Adebiyi BO, Mukumbang FC, Beytall A-M. To what extent is Fetal Alcohol Spectrum Disorder considered in policy-related documents in South Africa? A document review. *Health Research Policy and Systems*. 2019;17(1):1-12.
- Morojele N, Myers B, Townsend L, Lombard C, Plüddemann A, Carney T, Nkosi S. *Survey on substance use, risk behaviour and mental health among Grade 8-10 learners in Western Cape provincial schools*, 2011. Cape Town: South African Medical Research Council. 2013.
- Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 2005;62(6):593-602.
- Desmond C, Watt K, Tomlinson M, Williamson J, Sherr L, Sullivan M, Cluver L. Other people's children and the critical role of the social service workforce. *Vulnerable Children and Youth Studies*. 2022:1-13.
- United Nations. *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. New York: United Nations. 2019.
- Clark H, Coll-Seck AM, Banerjee A, Peterson S, Dalglish SL, Ameratunga S, Costello A. A future for the world's children? A WHO-UNICEF-Lancet Commission. *Lancet*. 2020;395(10224):605-658.
- Krieger N. Proximal, distal, and the politics of causation: What's level got to do with it? *American Journal of Public Health*. 2008;98(2):221-230.
- Krieger N. Methods for the scientific study of discrimination and health: An ecosocial approach. *American Journal of Public Health*. 2012;102:936-945.
- Yuan N, Chen Y, Xia Y, Dai J, Liu C. Inflammation-related biomarkers in major psychiatric disorders: a cross-disorder assessment of reproducibility and specificity in 43 meta-analyses. *Translational Psychiatry*. 2019;9(1):233.
- Marya R, Patel R. *Inflamed: Deep Medicine and the Anatomy of Injustice*. London: Allen Lane; 2021.
- Lin JE, Neylan TC, Epel E, O'Donovan A. Associations of childhood adversity and adulthood trauma with C-reactive protein: A cross-sectional population-based study. *Brain, Behavior, and Immunity*. 2016;53:105-112.
- Simons RL, Lei MK, Beach SRH, Barr AB, Simons LG, Gibbons FX, Philibert RA. Discrimination, segregation, and chronic inflammation: Testing the weathering explanation for the poor health of Black Americans. *Developmental Psychology*. 2018;54(10):1993-2006.
- Naicker SN, Norris SA, Mabaso M, Richter LM. An analysis of retrospective and repeat prospective reports of adverse childhood experiences from the South African Birth to Twenty Plus cohort. *PLoS One*. 2017;12(7):e0181522.
- Ward CL, Artz L, Leoschut L, Kassanjee R, Burton P. Sexual violence against children in South Africa: A nationally representative cross-sectional study of prevalence and correlates. *The Lancet Global Health*. 2018;6(4):e460-e468.
- Ajayi AI, Ezegbe HC. Association between sexual violence and unintended pregnancy among adolescent girls and young women in South Africa. *BMC Public Health*. 2020;20(1):1-10.
- Nixon R. *Slow Violence and the Environmentalism of the Poor*. Boston: Harvard University Press; 2011.
- Golberstein E, Gonzales G, Meara E. How do economic downturns affect the mental health of children? Evidence from the National Health Interview Survey. *Health Economics*. 2019;28(8):955-970.
- Docrat S, Besada D, Cleary S, Daviaud E, Lund C. Mental health system costs, resources and constraints in South Africa: A national survey. *Health Policy and Planning*. 2019;34(9):706-719.
- Gelb S. *Inequality in South Africa: Nature, causes and responses*. Edge Institute Johannesburg. 2003.
- Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*. 2009;374(9692):817-834.
- Obuaku-Igwe CC. Health inequality in South Africa: A systematic review. *African Sociological Review*. 2015;19(2):96-131.
- Mental Health America. *Racism and Mental Health*: Undated. Accessed: 13 May 2022. Available from: <https://www.mhanational.org/racism-and-mental-health>.
- Martin J, Hadwin JA. The roles of sex and gender in child and adolescent mental health. *JCCP Advances*. 2022:e12059.
- Kildahl AN, Bakken TL, Iversen TE, Hølvorsen SB. Identification of post-traumatic stress disorder in individuals with autism spectrum disorder and intellectual disability: A systematic review. *Journal of Mental Health Research in Intellectual Disabilities*. 2019;12(1-2):1-25.
- Daveney J, Hassiotis A, Katona C, Matcham F, Sen P. Ascertainment and prevalence of post-traumatic stress disorder (PTSD) in people with intellectual disabilities. *Journal of Mental Health Research in Intellectual Disabilities*. 2019;12(3-4):211-233.
- Kleintjes S, McKenzie J, Abrahams T, Adnams C. Improving the health of children and adults with intellectual disability in South Africa: legislative, policy and service. *South African Health Review*. 2020;2020(1):19-34.
- Bryson H, Mensah F, Price A, Gold L, Mudiyansele SB, Kenny B, Kemp L. Clinical, financial and social impacts of COVID-19 and their associations with mental health for mothers and children experiencing adversity in Australia. *PLoS One*. 2021;16(9):e0257357.
- Gademann AC, Thomson KC, Richardson CG, Gagné M, McAuliffe C, Hirani S, Jenkins E. Examining the impacts of the COVID-19 pandemic on family mental health in Canada: Findings from a national cross-sectional study. *BMJ Open*. 2021;11(1):e042871.
- Cianconi P, Betto S, Janiri L. The impact of climate change on mental health: A systematic descriptive review. *Frontiers in Psychiatry*. 2020:74.
- Hayes K, Blashki G, Wiseman J, Burke S, Reifels L. Climate change and mental health: Risks, impacts and priority actions. *International Journal of Mental Health Systems*. 2018;12(1):1-12.
- van Nieuwenhuizen A, Hudson K, Chen X, Hwang AR. The effects of climate change on child and adolescent mental health: Clinical considerations. *Current Psychiatry Reports*. 2021;23(12):1-9.
- Rother A, Wijesekera S, Ward F. The impact on the environment on South Africa's child and adolescent health: An overlooked health risk. In: Shung-King M, Lake L, Sanders D, Hendricks H, editors. *South African Child Gauge 2019*. Cape Town: Children's Institute, University of Cape Town 2019.
- Annalakshmi N. Resilience and academic achievement among rural adolescents at-risk: Role of self-regulation and attachment style. *Indian Journal of Positive Psychology*. 2019;10(4):260-266.

51. Braveman P. What is health equity and how does a life-course approach take us further toward it? *Maternal and Child Health Journal*. 2014;18(2):366-372.
52. Halfon N, Larson K, Lu M, Tullis E, Russ S. Lifecourse health development: past, present and future. *Maternal and Child Health Journal*. 2014;18(2):344-365.
53. Schmidt KL, Merrill SM, Gill R, Miller GE, Gadermann AM, Kobor MS. Society to cell: How child poverty gets "Under the Skin" to influence child development and lifelong health. *Developmental Review*. 2021;61:100983.
54. Hertzman C, Boyce T. How experience gets under the skin to create gradients in developmental health. *Annual Review of Public Health*. 2010;31:329-347.
55. United Nations. *United Nations Convention on the Rights of the Child*. 1990. [Accessed 7 October 2021].
56. African Union. *African Charter on the Rights and Welfare of the Child*. 1990.
57. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 24. Geneva: United Nations. 1989.
58. Secretary General of the Organisation of the African Union. *African Charter on the Rights and Welfare of the Child, OAU Resolution 21.8/49*. Article 14. Addis Ababa: OAU. 1990.
59. United Nations General Assembly. *Convention on the Rights of Persons with Disabilities, 13 December 2006, A/RES/61/106, Annex I*. Article 25. 2006.
60. United Nations Committee on the Rights of the Child. General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15. 2013.
61. United Nations Committee on Economic Social and Cultural Rights. *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4. 2000.
62. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 27. Geneva: United Nations. 1989.
63. Gerber P, Kyriakakis J, O'Byrne K. General comment 16 on state obligations regarding the impact of the Business sector on children's rights: What is its standing, meaning and effect. *Melbourne Journal of International Law*. 2013;14:93.
64. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 19. Geneva: United Nations. 1989.
65. Secretary General of the Organisation of the African Union. *African Charter on the Rights and Welfare of the Child, OAU Resolution 21.8/49*. Article 16. Addis Ababa: OAU. 1990.
66. Constitution of the Republic of South Africa, Act 108 of 1996. Section 28 1 (d).
67. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 32. Geneva: United Nations. 1989.
68. Secretary General of the Organisation of the African Union. *African Charter on the Rights and Welfare of the Child, OAU Resolution 21.8/49*. Article 5 and 15. Addis Ababa: OAU. 1990.
69. Constitution of the Republic of South Africa, Act 108 of 1996. Section 28 1 (e).
70. Secretary General of the Organisation of the African Union. *African Charter on the Rights and Welfare of the Child, OAU Resolution 21.8/49*. Article 14. Addis Ababa: OAU. 1990.
71. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 39. Geneva: United Nations. 1989.
72. United Nations General Assembly. *Convention on the Rights of Persons with Disabilities, 13 December 2006, A/RES/61/106, Annex I*, Article 16. 2006.
73. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 25. Geneva: United Nations. 1989.
74. Constitution of the Republic of South Africa, Act 108 of 1996. Section 24.
75. United Nations General Assembly. *Convention on the Rights of Persons with Disabilities, 13 December 2006, A/RES/61/106, Annex I*, Article 7. 2006.
76. United Nations General Assembly. *Convention on the Rights of Persons with Disabilities, 13 December 2006, A/RES/61/106, Annex I*, Article 4. 2006.
77. Children's Act 38, 2005.
78. Mental Health Care Act 17 of 2002.
79. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 5. Geneva: United Nations. 1989.
80. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Article 17. Geneva: United Nations. 1989.
81. Children's Act 32 of 2005. Section 13.
82. Office of the Western Cape Children's Commissioner. *Mental Health in Schools*: 2021. Accessed: 13 May 2022. Available from: <https://www.westerncape.gov.za/childrens-commissioner/files/thumbnails/image/western%20health.jpg>.
83. Commissioner for Children. *Child Government Monitors: Reflections on 2020 engagements and achievements*. Cape Town: Office of the Western Cape Commissioner for Children. 2021.
84. Masten AS. *Ordinary magic: Resilience in development*. New York: The Guilford Press; 2015.
85. van Breda AD, Theron LC. A critical review of South African child and youth resilience studies, 2009–2017. *Children and Youth Services Review*. 2018;91:237-247.
86. Masten AS, Lucke CM, Nelson KM, Stallworthy IC. Resilience in development and psychopathology: Multisystem perspectives. *Annual Review of Clinical Psychology*. 2021;17:521-549.
87. Ungar M, Theron L. Resilience and mental health: How multisystemic processes contribute to positive outcomes. *The Lancet Psychiatry*. 2020;7(5):441-448.
88. Ungar M. Which counts more: Differential impact of the environment or differential susceptibility of the individual? *British Journal of Social Work*. 2017;47(5):1279-1289.
89. Yoon S, Howell K, Dillard R, Shockley McCarthy K, Rae Napier T, Pei F. Resilience following child maltreatment: Definitional considerations and developmental variations. *Trauma, Violence, & Abuse*. 2021;22(3):541-559.
90. Theron L, Liebenberg L, Ungar M. *Youth resilience and culture*. Springer. 2015.
91. Hopkins KD, Taylor CL, Zubrick SR. Psychosocial resilience and vulnerability in Western Australian Aboriginal youth. *Child Abuse & Neglect*. 2018;78:85-95.
92. du Plessis B, Kaminer D, Hardy A, Benjamin A. The contribution of different forms of violence exposure to internalizing and externalizing symptoms among young South African adolescents. *Child Abuse & Neglect*. 2015;45:80-89.
93. Theron L, Ungar M, Höltge J. Pathways of resilience: Predicting school engagement trajectories for South African adolescents living in a stressed environment. *Contemporary Educational Psychology*. 2022;69:102062.
94. Theron L, van Breda A. Multisystemic enablers of sub-Saharan child and youth resilience to maltreatment. *Child Abuse & Neglect*. 2021;119:105083.
95. Ungar M. Designing resilience research: Using multiple methods to investigate risk exposure, promotive and protective processes, and contextually relevant outcomes for children and youth. *Child Abuse & Neglect*. 2019;96:104098.
96. Savahl, S., Adams, S., Benninger, E., Florence, M., Manuel, D., Mpilo, M., Bawa, U., & Isobell, D. (2019). Researching Children's Subjective Well-Being in South Africa: Considerations for Method, Theory and Social Policy (pp. 407-430). In I. Elof (Ed), *Quality-of-life in African societies*. Springer.
97. Fattore, T., Mason, J., & Watson, E. (2016). *Children's understandings of well-being. Towards a Child Stand Point*. Springer.
98. Adler, A. & Seligman, M. E. P. (2016). Using wellbeing for public policy: Theory, measurement, and recommendations. *International Journal of Wellbeing*, 6(1), 1-35. <http://doi:10.5502/ijw.v6i1.1>
99. Huta, V., & Ryan, R. M. (2010). Pursuing pleasure or virtue: The differential and overlapping well-being benefits of hedonic and eudaimonic motives. *Journal of Happiness Studies*, 11(6), 735-762. <http://dx.doi.org/10.1007/s10902-009-9171-4>
100. Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95, 542-575. <http://doi:10.1037/0033-2909.95.3.542>
101. Diener, E. (2001). Psychology of well-being (subjective). In N. J. Smelser & P. B. Baltes (Eds.), *International Encyclopedia of the Social & Behavioral Sciences* (pp. 16451-16454). Pergamon.
102. Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125(2), 276-302. <https://doi.org/10.1037/0033-2909.125.2.276>
103. Savahl, S., Malcolm, C., Slembrouch, S., Adams, S., Willenberg, I.A. & September, R. (2015). Discourses on Well-Being, *Child Indicators Research*, <https://doi.10.1007/s12187-014-9272-4>
104. Casas, F. (2011). Subjective social indicators and child and adolescent well-being. *Child Indicators Research*, 4, 555-575.
105. Nahkur, O. & Casas, F. (2021). Fit and Cross-Country Comparability of Children's Worlds Psychological Well-Being Scale Using 12-Year-Olds Samples. *Child Indicators Research*, 14(6), 2211-2247.
106. Rees, G., Savahl, S., Lee, B., & Casas, F. (2020). *Children's views on their lives and well-being in 35 countries: A report on the Children's Worlds project, 2016–19*. Children's Worlds Project (ISCWeB).
107. Ryff, C.D., Singer, B.H. Know Thyself and Become What You Are: A Eudaimonic Approach to Psychological Well-Being. *Journal of Happiness Studies*, 9, 13–39. <https://doi.org/10.1007/s10902-006-9019-0>
108. Wells, N. M. (2014). The role of nature in children's resilience: Cognitive and social processes. In K.G. Tidball, & M.E. Krasny, *Greening in the red zone: Disaster, resilience and community greening* (pp. 95-110). Springer.
109. Nahkur, O., & Casas, F. (2021). Fit and Cross-Country Comparability of Children's Worlds Psychological Well-Being Scale Using 12-Year-Olds Samples. *Child Indicators Research*, 1-37.
110. Savahl, S. & Adams, S. (2020). *Children's Worlds National Report 2020 (Wave 3): South Africa*. University of the Western Cape/University of Cape Town.
111. Gromada, A., Richardson, D., Rees, G. (2020). Childcare in a Global Crisis: The Impact of COVID-19 on work and family life, *Innocenti Research Briefs* no. 2020-18.

Environment matters: The social determinants of child and adolescent mental health

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The circumstances in which children and adolescents live have a profound impact on their mental health, both in the present and across the life course. In recent years there has been growing awareness of these social determinants of child and adolescent mental health, including from low and middle-income countries (LMICs).¹ If we are to prevent mental health problems and promote child and adolescent mental health, it is vital that we understand more about the social causes of mental health problems and develop interventions to address these social determinants. Needless to say, this is not a straightforward task.

This chapter will begin by presenting key concepts and a framework for the social determinants of child and adolescent mental health, with relevant evidence across five domains. This will be followed by a consideration of the evidence for interventions, together with implications for policy, research, teaching and advocacy. The focus is on South Africa, with consideration of relevant evidence from other LMICs. While the situation in South Africa is similar to many other LMICs, our particularly brutal history of colonialism and apartheid have created a context where a number of social adversities and injustices collide to shape the mental health of children and adolescents.

What are the social determinants of mental health?

Social determinants of child and adolescent mental health refer to the social and economic conditions that have a direct influence on the prevalence and severity of mental health conditions across the life course.¹ Social determinants include a wide array of factors such as poverty, food insecurity, inequality, discrimination, violence, orphanhood, climate change, forced migration and other humanitarian emergencies. These social determinants include both the structural, social and economic arrangements of a society, which lead to disparities in living conditions and access to opportunities and services, as well as young people's exposure to adverse life events.

Importantly, social determinants frequently co-occur, leading to cumulative risks among vulnerable children who face multiple adversities. For example, children and adolescents who live in poverty not only face scarcity of material resources, but are also at increased risk of other adversities, including violence and maltreatment. Cumulatively this increases their risk for a range of mental health difficulties, often in an interaction with other health conditions. In the context of cumulative risk, the concept of intersectionality is particularly important in highlighting the ways in which social categories such as race, class, gender and ability give rise to intersecting patterns of privilege and discrimination that then influence the mental health and well-being of children and adolescents. In recent years, syndemic approaches have highlighted the cumulative effects of co-occurring social determinants and co-morbid health conditions.²

How do these social determinants impact on child and adolescent mental health?

There is a growing body of evidence from South Africa and other LMICs on the way in which social determinants influence the mental health of children and adolescents.^{1,3} Here we present a framework for the social determinants of mental health (see Figure 8) which highlights the influence of demographic, economic, neighbourhood, environmental events and social/cultural domains. In each of these five domains, young people's mental health is shaped both by their immediate environment (proximal factors) as well as broader socio-economic, political and environmental forces (distal factors). For example, the effect of an economic recession during a pandemic (distal factor) on mental health is experienced through reduced household income, increased debt, erosion of assets and financial strain.⁴ These in turn may result in a child having less access to educational opportunities and being exposed to increased conflict in the home as a result of adults' responses to stress (proximal factors). It should be conceded that the evidence for proximal determinants is more robust than that for more distal

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Figure 8: The social determinants of child and adolescent mental health and the Sustainable Development Goals



Adapted from: Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, et al. Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *Lancet Psychiatry*. 2018;5(4):357-69.

determinants of child and adolescent mental health – mainly due to the nascence of the field and the methodological challenges involved in demonstrating the effects of distal determinants. It is also possible that different mechanisms come into play in the case of children and adolescents.

The role of the family or household is particularly important in mitigating or exacerbating the impact of distal factors, such as economic recession or violence in communities. The household context may increase risk or resilience in young people and influence the way in which these factors get

'under the skin' or, more specifically, into the neural pathways of the developing child or adolescent's brain. For example, children growing up in violent communities may experience a number of difficulties regarding mental health and day-to-day functioning (e.g., difficulty making or keeping friends, or difficulty concentrating in the classroom).⁵⁻⁷ Young people who feel supported and accepted by their families and who have loving relationships with adult caregivers are less likely to experience significant mental health problems due to social determinants such as community violence.^{8,9}

These social determinants interact with genetic and biological risk factors across the life course – meaning that early exposure to adversity or deprivation in childhood has a significant impact on subsequent lifelong mental health.¹ The United Nations' Sustainable Development Goals (SDGs) have developed specific targets for many of these social determinants, and for this reason, the SDGs that are most relevant to each domain are included in the framework. Further research is required to identify the mechanisms by which specific SDGs might yield improvements in child and adolescent mental health.

In the section that follows, we unpack the evidence, according to each of these five domains.

Demographic determinants

Childhood and adolescence constitute a vulnerable time during which social determinants can have particularly adverse effects on cognitive and emotional development. For this reason, mental disorders and self-harm often manifest during adolescence, with long-term impact later in adulthood.¹⁰ Even then, sex differences are evident: adolescent girls tend to suffer from depression,^{11,12} anxiety¹³ and eating disorders¹⁴ more than boys, while adolescent boys are more likely to develop behavioural disorders, such as conduct disorder and attention deficit/hyperactivity disorder, and early onset schizophrenia,^{15,16} and are more likely to commit suicide^{17,18}. Further, sexual minority youth and young people who identify as gender-nonconforming, also known as lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) youth are at higher risk of mental health difficulties than heterosexual, cisgender young people.¹⁹ SDG 5 (gender equality) is particularly relevant for the demographic domain.

Age and sex differences are also apparent in how other proximal and distal socio-demographic determinants affect young people's mental health. For example, young girls' socio-emotional development is more susceptible than boys' development to racism and discrimination,²⁰ and there are stronger associations between discrimination

and depression, anxiety, behavioural problems, lower self-esteem and poorer resilience in adolescents, than in younger children²¹. However, the literature suggests that even children as young as five years old are at increased risk of depression if they are among minority ethnic groups within their communities, who are at higher risk of experiencing racism and discrimination.²² These findings are pertinent in South Africa, where racism and discrimination are still rife 25 years after the end of apartheid.

Economic determinants

There is extensive evidence that certain dimensions of poverty, such as food insecurity and household unemployment, are associated with poorer mental health among children and adolescents.²³ Children of families of lower socio-economic status are at increased risk of mental, emotional and behavioural health problems, independent of other factors associated with poverty, such as parental education or race.⁵ Studies which have investigated perceived rather than absolute socio-economic status have shown that adolescents with higher subjective socio-economic status were more likely to report improved psychological well-being and self-esteem, and were less likely to be depressed.³ In fact, relative poverty, rather than absolute poverty, is often reported as a risk factor for poor mental health among children.²⁴

In South Africa, this means that young people's mental health and well-being continue to be impacted by high levels of income inequality brought about by our history of colonialism and apartheid. The COVID-19 pandemic and policy measures to reduce transmission are also likely to have exacerbated income inequality in the country, by depriving children of nutrition and protection, and by increasing risk of education delay or school dropout.²⁵ In turn, young people who disengage with education or who do not complete secondary school are more likely to use alcohol and other drugs and to report poor mental health,²⁶ and are less likely to be economically active in adulthood,²⁷ thus perpetuating the cycle of poverty and poor mental health.

The cycle of poverty and mental ill-health (see Figure 9) is characterised by a *social causation* pathway, by which circumstances of poverty increase risk for mental ill-health through social exclusion, high stress, reduced access to a social safety net, malnutrition, violence, obstetric risks, trauma, poor parenting and family fragmentation. Conversely, living with a mental disorder increases the risk of drifting into or remaining in poverty. This *social drift* pathway is characterised by stigma, poor educational attainment, school dropout and unemployment. SDG 1 (no poverty),

Figure 9: Cycle of poverty and mental illness in children and adolescents



Adapted from: Flisher, A.J., Lund, C., Funk, M., Banda, M., Bhana, A., Doku, V., Drew, N., Kigozi, F., Knapp, M., Omar, M., Petersen, I., & Green A. (2007). Mental health policy development and implementation in four African countries. *Journal of Health Psychology* 12: 505-516.

SDG 2 (zero hunger), SDG8 (decent work and economic growth), SDG9 (industry, innovation and infrastructure) and SDG10 (reduced inequalities) are particularly relevant for the economic domain.

Neighbourhood determinants

Neighbourhoods beyond the family setting should provide an environment in which children and adolescents can develop safely and thrive. The neighbourhood domain refers to the social and environmental characteristics of the neighbourhood or area in which a child or adolescent lives, which confer risk or resilience over and above the individual

characteristics of the people who live in that neighbourhood. Although most available evidence has focused on physical health or adult populations,^{28, 29} various characteristics of neighbourhoods have been shown to impact mental health in young people.

Diverse measures of neighbourhood deprivation have been associated with psychosocial difficulties, including increased externalising behaviour problems such as delinquency and aggressive behaviour.^{30, 31} Additionally, features of neighbourhoods such as access to nature and public open spaces, often associated with wealthier communities, are generally protective against mental health

problems in children and adolescents.^{32, 33} At the household level, overcrowding, poor quality housing and poor air quality have also been associated with poor mental health,^{34, 35} such as increased depressive symptoms,³⁶ although data are scarce for children and adolescents.

Exposure to violence in communities has a well-documented association with mental health problems, whereby witnessing violence and violence victimization are consistently linked to adverse mental health outcomes, such as depression, anxiety, post-traumatic stress symptoms and externalising behaviours.³⁷⁻³⁹ Further, reactions to community violence from parents and young people may result in decreased opportunities for young people to engage in physical activity (including transport such as cycling or walking and play),⁴⁰ which may negatively impact their mental health.⁴¹ SDG6 (clean water and sanitation), SDG7 (affordable and clean energy), SDG11 (sustainable cities and communities) and SDG12 (responsible consumption and production) are particularly relevant for the neighbourhood domain. SDGs that are linked to violence prevention, including SDG5 and SDG16, are also relevant for the neighbourhood domain.

Environmental events

Environmental events are defined as significant disruptions in community functioning that surpass the available community resources to cope. As seen in Figure 8, environmental events can include: natural disasters, industrial disasters, war or conflict, climate change and forced migration. SDG 13 (climate change action) and SDG 16 (peace, justice, and strong institutions) are particularly relevant for this domain.

Several meta-analyses and systematic reviews reveal that children exposed to environmental events report significantly higher levels of post-traumatic stress disorder (PTSD), depression, and anxiety compared to the general population. These outcomes have been documented after exposure to nuclear disasters,^{42, 43} war, terrorism and conflict⁴⁴ and the displacement of refugees and asylum seekers.⁴⁵ More recently, studies have investigated the impact of climate change on child and adolescent mental health, as outlined in Case 34 on p135.⁴⁶ The frequency and severity of extreme weather events, such as droughts,⁴⁷ seem to be increasing in Africa, which may be further impact on the mental health of children and adolescents⁴⁸.

Social and cultural determinants

The social and cultural factors that impact child and adolescent mental health include low levels of education, poor social cohesion, and detrimental peer and family relationships.¹ In

South Africa, educational success is particularly challenging for Black adolescents, as they are more likely to attend under-resourced schools in communities with high levels of violence and poverty.⁴⁹ This is rooted in structural racism and a deeply inequitable education system. Studies suggest that mental health problems are associated with poor grades and school adjustment, resulting in poor academic achievement in young adulthood. Young people who drop out of school and students struggling to perform academically are at greater risk of depression^{50, 51} and suicidal ideation⁵². Further, children with behaviour problems are more likely to struggle academically, and experience lower graduation rates.⁵³ SDG4 (quality education) is particularly relevant for the social and cultural domain.

Being part of a social group is especially important to adolescents as they strive for emotional autonomy from their parents and search for their unique identity.⁵⁴ While their reliance on peer relationships may provide them with the opportunity to develop strong social connections and give and receive support, it also makes them susceptible to peer pressure and bullying. Poor social cohesion is associated with low self-esteem and can result in depression, anxiety and behavioural problems in children and adolescents.^{55, 56} Conversely, highly cohesive neighbourhoods protect young people who are experiencing stressful life events from depression and anxiety.⁵⁷

What does the evidence mean for interventions?

From the above evidence regarding key social determinants and the mechanisms by which they influence the mental health of young people, several potential targets for interventions can be identified. However, a number of challenges arise when developing interventions to tackle these social determinants of mental health. First, social determinants are often quite distal to the mental health outcome. Second, some social determinants may be more amenable to change than others (for example, it is extremely difficult to address structural challenges such as income inequality or global economic recessions). Third, the mechanisms by which social determinants influence child and adolescent mental health are poorly understood. For example, we know very little about exactly how experiences of poverty shape the neural pathways of the developing adolescent brain and lead to specific mental health problems, such as depression, anxiety or conduct disorder. Fourth, the complex nature of these challenges requires an interdisciplinary approach and collaboration of researchers from social sciences, mental health, economics and epidemiology. And finally, given these

Case 4: Culture and mental health – ways of seeing

Leslie Swartzⁱ and Siyabulela Mkhaleⁱⁱ

What does it mean to be ‘culturally sensitive’ in mental health practice and research? There are differing assumptions about what the relationship is between culture and mental health.

Although things are more complex, it is useful to distinguish between those who believe that mental disorder is universal but expressed differently in different contexts. Relativists, by contrast, would argue that we need to attend very carefully to a person’s context to understand mental disorder, and that making comparisons across different contexts is always problematic. If we take, for example, the phenomenon of *kufungisisa* in Zimbabwe (translated approximately as ‘thinking too much’), a universalist may say that *kufungisisa* in Zimbabwe is anxiety expressed in a particular local way, but a relativist would want to understand what ‘thinking too much’ means locally, what the symptoms imply for family and social relationships.

A further layer of understanding culture and mental health relates to problematic ideas about the relative qualities of different groups of people. In the history of psychiatry, Social Darwinism contributed to a situation in which people linked certain disorders to qualities valued in dominant western culture. In what is sometimes termed an evolutionist view, it was once thought that African people were not as developed cognitively as Europeans (clearly a racist view), and for this reason, they did not have the finer feelings which would enable them to experience depression. Depression was seen as a disorder or a state of being which required a level of introspection which only ‘sophisticated’ people could have. This view is clearly absurd, and in fact, in multiple epidemiological studies in Africa, we find very high rates of depression.

Partly in response to the clear political problems associated with evolutionism, researchers in the culture and mental health field have become interested in exploring ways in which practices labelled as cultural may be affected by social and economic conditions. Studies on the relationship between different emotional styles in families and the course and outcomes of mental disorders now try to look not just at different family emotional styles, but also at how these styles may relate to the economic demands of a particular context. For example, there is some evidence that harsh parenting styles may be

associated with the development of anxiety in children. Parenting styles are culturally patterned, but a contextual view would also look at issues such as access to resources, which may contribute to different patterns of parenting. For instance, where people have the money to buy disposable nappies, and have reliable washing machines at home, they may be more relaxed about toilet training than where resources are scarce, and people do not have running water. It is always important to look at the ways in which the material context interacts with, and may even to an extent determine, styles within families which are seen as cultural. Where people live in violent contexts, to use another example, they may be much more restrictive about the movements of people with mental disorders or others whom they view as vulnerable.

More fundamentally, cultural issues need to be considered in global and historical context. For example, our country has an ongoing history of extractive and dangerous labour practices, where families have been broken up by internal migration and men have lived in single-sex hostels and done dangerous work on the mines. These factors profoundly affect how families interact, what happens to migrant workers who develop mental health problems or physical disabilities, and what then becomes a cultural norm around care.

There are no neat distinctions between cultural groups, and culture changes over time and context. Nobody, especially in the complex context we live in, is a ‘member’ of a single culture. What is more important is in all cases to inquire as to how people, in different contexts, understand and deal with relationships, mental health and ill health, and the challenges of life. A useful starting point is to begin with what the psychiatrist-anthropologist Arthur Kleinman called ‘explanatory models’.⁷⁹ We all have different understandings of what causes a disorder, what it is, what will make it better, and whether anything can be done about it and by whom, for example. And each individual may have different sets of understandings for what is happening to them and their family members, colleagues and friends and acquaintances at different times. All these beliefs shape the experience of mental health and illness, and all are useful to consider in developing appropriate interventions. Simply put, we need to consider the world .

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Case 5: Reducing child abuse through a parenting and economic strengthening programme in Tanzania

Child abuse is highly prevalent in LMICs, and most commonly perpetrated by parents and older relatives.⁷³ Victims of child abuse may experience physical and mental health problems, and difficulty at school and in relationships. The effects are intergenerational, with victims of abuse being more likely to abuse their own children and engage in intimate partner violence.⁷⁴ Parenting programmes may reduce child abuse by strengthening the relationship between parents and children by helping caregivers better manage child behaviour problems.⁷⁵ As poverty is a major risk factor for child abuse, economic strengthening programmes may reduce child abuse, especially in low resource settings.

The Skilful Parenting and Agribusiness Child Abuse Prevention Study⁷⁶ investigated the effect of an economic strengthening and parenting programme on child abuse outcomes using a cluster randomised control trial in rural Tanzania. The economic strengthening component consisted of farmers getting access to drought-resistant

seeds, credit for farm inputs, advice for improve farming techniques and market connections. The parenting component consisted of group-based sessions on parenting skills, child protection and family budgeting. Eight villages were randomised to three treatment arms (only the parenting component, only the economic component, and a combination of the two) and a control arm. Both parents and children who received the combined intervention reported a significant reduction in child abuse. Parents in the groups that only received one of the interventions also reported a reduction in child abuse, though the levels were not significant in the child reports. In all arms, parents reported significant reductions in child behaviour problems, and borderline reductions in adult depression. Results suggest that while a combination of parenting and economic strengthening is most effective at reducing child maltreatment outcomes, parenting programmes delivered alone may also be effective.

complexities, interventions may require collaboration across different sectors and government departments.

What works?

Table 1 provides a series of illustrative examples of interventions targeting social determinants of child and adolescent mental health that have been shown to yield improved mental health outcomes, particularly from LMICs. There is some evidence of interventions that have been shown to be effective in addressing social determinants of child and adolescent mental health. In Tanzania, Lachman and colleagues have shown how a agribusiness and skillful parenting programme led to a reduction in child abuse (see Case 5), while in South Africa Sherr and colleagues have shown how a combination of parental praise, parental supervision, food security, safe communities and support from community-based organisations can accelerate improvements mental health outcomes (see Case 7).

Few interventions implemented at the neighbourhood level have been specifically evaluated for their effect on child and adolescent mental health. However, we can hypothesise that interventions such as urban upgrading or community violence prevention projects, which have shown some promise amongst adult populations⁵⁸ in improving psychosocial or health outcomes,^{59, 60} may have a positive

impact on young people, either directly or indirectly through their caregivers' improved well-being. Evidence is available regarding the positive mental health effects of recreational programmes, including sport,⁶¹ and after-school programmes. Yet, evidence is scarce globally regarding mental health outcomes and upgrading of urban areas for improved safety, including for walking or cycling, or for increased recreation or nature exposure opportunities.⁶²

What are the policy implications?

Although the South African National Mental Health Policy Framework and Strategic Plan (2013-2020)⁶⁸ included specific mention of the social determinants of mental health and the need for intersectoral action to address them, this policy has now lapsed, and at the time of writing, the Department of Health was yet to renew it. A very useful review of national and provincial child and adolescent mental health policy in South Africa, published by Mokitimi et al. in 2018, found no specific reference to social determinants of child and adolescent mental health in the content of current policy.⁶⁹

If policies are going to have a substantial impact on the powerful social and economic drivers of child and adolescent mental health, then governments need to adopt a 'whole of society', integrated approach that links mental health and social interventions. For example, policies related to child

Table 1: Examples of interventions that target key social determinants of mental health, per domain

Domain	Intervention	Mental health outcomes	Gaps
Demographic	School-based mental health promotion interventions ⁶³	Improved social and emotional competence and resilience	All evidence from high-income countries; limited evidence of long-term impact
Economic	Conditional/unconditional cash transfer programmes ⁶⁴	Reduced depressive and anxiety symptoms; improved behavioural and emotional development	Few studies among children or younger adolescents. Evidence from Africa mainly for unconditional cash transfers. Limited evidence on long-term impact.
Neighbourhood	After-school programmes, ^{60, 65} Recreational activity programmes, including sport ^{61, 66}	Increased self-esteem/self-confidence; improved prosocial behaviours, decreased problem behaviours	Few LMIC studies and few studies evaluating mental health outcomes
Environmental events	Focused psychosocial support interventions for children exposed to traumatic events in humanitarian settings in LMIC ⁶⁷	Reduced symptoms of PTSD and functional impairment; increased hope, coping and social support	Results indicate these interventions are not as effective in children under 15 and for displaced children, possibly due to most interventions employing cognitive behavioural techniques, not accessible to younger children
Social and cultural	Higher educational attainment ⁵¹	Reduced depression in adolescence	Most evidence from high-income countries

protection, social protection (such as the Child Support Grant (CSG)), food security and housing need to ensure that they are coordinated to maximise mental health benefits for children – in keeping with the approach of the SDGs. More specifically, policies need to be informed by the evidence, particularly on the mechanisms by which social determinants interventions yield specific mental health improvements. For example, there is some evidence that poverty affects child and adolescent mental health both directly and through its influence on self-regulation.⁷⁰ Self-regulation refers to the ability to develop and sustain goal-directed behaviour, despite emotionally salient and challenging environments. Therefore, poverty reduction policies, such as the CSG should ideally be accompanied by evidence-based mental health promotion and mental illness prevention interventions (delivered either through community-based organisations, schools or after-school programmes) to help vulnerable children, adolescents and their caregivers strengthen self-regulation skills to better cope with adversity. Strategies taught could include emotional regulation, problem-solving skills and planning for the future. Developing a sense of agency and activism are vital on the pathway to transformation, inclusion and healing. Key vulnerable populations, as identified in the above framework on social determinants, should be prioritised in South Africa to promote more equitable and inclusive development and ensure no-one is left behind. This is particularly important for children and adolescents exposed to intersectional and

cumulative risks, such as those related to poverty, violence and discrimination on the basis of race, gender or ability.

An interesting example of the need to coordinate policy across different sectors is that of alcohol use in adolescence. The prevalence of alcohol use climbs significantly during adolescence, with a number of adverse outcomes related to mental health, sexual risk taking, and injuries. In responding, policies need to not only support interventions that address individual adolescents' drinking behaviour, but also address the commercial determinants of alcohol consumption. For example, aggressive marketing of alcohol by the industry requires urgent regulation and change.⁷¹ The Western Cape Alcohol-Related Harms Reduction White Paper⁷² is an example of a multi-pronged policy, including a range of interventions to reduce alcohol related harms (see Case 6).

It is important to distinguish longer-term and shorter-term political processes that are required to address social determinants, recognising some social determinants may be more difficult to address than others. For example, broader structural arrangements which support the enormous racial and income inequalities in South Africa will take longer to address. But short-term gains for child and adolescent mental health can be obtained through addressing pressing social challenges, such as child hunger and maltreatment. Adversities precipitated by COVID-19 are particularly pressing,²⁵ as they require a rapid response to mitigate immediate and long-term harm.

Case 6: Structural interventions to address adolescent alcohol use in South Africa

Charles Parry and Jason Bantjesⁱⁱ

Alcohol use was identified as the leading risk factor for death and disability in sub-Saharan Africa, and globally for adolescents aged 15 – 19 years.⁸⁰ In South Africa, a 2011 national survey of learners in Grades 8 – 11 found that 37% of males and 28% of females reported drinking in the past 30 days, with an alarming 30% of male and 20% of female learners reporting binge drinking during the same period.⁸¹

Direct and indirect consequences of drinking among children and adolescents in South Africa include rape, interpersonal violence, absenteeism, school failure, unwanted pregnancies, sexually transmitted infections, HIV, and foetal alcohol spectrum disorders (FASD).⁸²

Drinking during pregnancy at any age can damage the unborn child, and rates of FASD in South Africa are among the highest in the world, with a recent study reporting population prevalence rates of 14% – 21% in certain, mainly rural, communities of the Western Cape.⁸³ FASD causes intellectual and behavioural problems, which create considerable obstacles to children's social development and educational outcomes in addition to developmental delays, hyperactivity, attention deficits, learning disabilities, intellectual deficits, and sometimes seizures.^{84, 85}

Adolescents with alcohol use problems often also experience mental health problems, including mood disorders, anxiety disorders, conduct disorders, and suicidal behaviour.^{86, 87} These mental health problems can be both a precipitant and consequence of alcohol use.

Impulsivity and risk taking are both hallmarks of

adolescence.⁸⁸ Alcohol use exacerbates impulsivity and impairs judgement, thus increasing risk-taking behaviour during adolescence and increasing the likelihood of adverse outcomes, including injury and death.⁸⁹

Young people are prolific consumers of media, and they are frequently exposed to alcohol advertising and marketing.^{90, 91} Furthermore, adolescents are vulnerable to the harmful influence of alcohol advertising,⁹² and may be disproportionately exposed to marketing by alcohol producers.⁹⁰ Voluntary advertising industry guidelines are not adequate to protect young people,⁹⁰ highlighting the importance of – and urgent need for – more government oversight in this area.

The South African government 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. While government has taken concrete action in a few areas, progress has been slow. There is a lot more the government could and should be doing: equipping parents to be good role models and to set appropriate boundaries for their children, banning packaging that appeals to young people, increasing excise taxes on products that appeal to young people such as fruit flavoured alcoholic drinks, dealing firmly with venues that sell alcohol to underage drinkers, accrediting school-based prevention programmes to improve the quality of such programmes, and ensuring that there are appropriate and high-quality treatment programmes available for young persons who need such an intervention.

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What are the priorities for research, teaching and advocacy?

South Africa already has relatively high coverage of the CSG, providing a platform for developing cash + care or cash + parenting programmes to address social determinants of child and adolescent mental health. There is also promising preliminary evidence of the potential benefits of 'cash-plus' programmes for child health outcomes, although the evidence of mental health benefits is currently limited.⁷⁷ Such interventions need to make use of existing infrastructure

through schools, early child development programmes, after-school programmes and parenting support, and there are encouraging local examples, such as the Western Cape government's Enriched after-school programme⁷⁸ and the suite of combined approaches developed by Sherr and colleagues (Case 7). For many, basic infrastructure support for clean and safe communities, including basic sanitation, housing, transport and access to good quality education, are important priorities. Active participation of children,

Case 7: Combinations of interventions to boost child well-being

Lorraine Sherrⁱ

Child mental health and well-being is the key to many pathways of happiness, achievement, productive relationships and agency. Feelings and emotions are core to everyone's existence. However, extreme emotions or burdensome experiences can cause misery and it is important that interventions are available to support children, prevent burdensome experiences in the first place, promote positive emotional experiences and provide care pathways for those in distress.

In the past, help for different aspects of a child's life was often compartmentalised. This narrow approach was not helpful to overall well-being. Today we use a more holistic approach and understand that there is no health without good mental health⁹³ – an idea that is true for children of all ages and adults alike.

There is good evidence that a number of interventions can have a beneficial effect. Cash transfers, or forms of monetary support, have been shown to have a significant effect on reducing mental health burden in adolescents in a recent systematic review.⁹⁴ This comprehensive review cautioned that cash support alone could be insufficient in extreme risk settings and that the practice of linking such cash transfers to eligibility conditions may be counterproductive. This clearly opens the door to looking at combination interventions. An exciting current development sets out good evidence that combinations of these interventions can boost or accelerate beneficial effects. This sounds fairly straightforward, perhaps even obvious, when looked at simply. But it is important to understand which interventions are most useful, which combinations give the best results, and whether these interventions and combinations can affect mental health outcomes.

Social protection and financial support measures in the form of social grants such as child support grants or old age pensions into the household have been shown to be effective for many child and adolescent outcomes.⁹⁵ A set of South African studies have provided good evidence on how cash plus care can be of benefit.⁹⁶ Early studies showed that cash together with good parenting had a number of positive impacts on adolescents – such as reducing their risk behaviour, increasing their adaptive

behaviour such as treatment adherence for those with HIV, clinic attendance for those with chronic conditions, and sexual risk behaviours. So, the next step was to find out whether these findings applied to younger children as well. One way to go about this is to understand what childhood measures predict later risk. The next step is to examine interventions that were effective in helping improve these predictors. With this understanding we can then test whether such provision in real life settings actually impacts a host of outcomes for young children.

The Community Care study in South Africa provided such an opportunity.⁹⁷ This study examined the effects of cash plus various forms of care on a set of mental health and cognitive outcomes for young children. The study gathered children supported by community-based organisations (CBOs)ⁱⁱ and monitored mental and cognitive measures for these children. It also used a group of children not attending community-based organisations as a comparison group. Cash included any type of cash grant to the family and care included good parenting, adequate food or access to support from a CBO. It is important to note that these children resided in environments typified by poverty, high HIV rates and social challenge. The study showed that children attending CBOs had lower rates of suicidal ideation, fewer depressive symptoms, less perceived stigma, fewer peer problems, fewer conduct problems, and lower odds of experiencing weekly domestic conflict, domestic violence or abuse at 18-month follow-up compared to children without CBO contact.

A series of analyses showed the specific advantages of cash grants plus good parenting, and cash grants plus food security⁹⁸ on children's cognitive functioning. We found that cash transfers are associated with improved cognitive outcomes, and that cash plus good parenting enhances the effects. This holds true for memory, overall cognition, learning and recall. A detailed look at the findings also suggested that fragile groups may need multiple support avenues. This provides a clear motivation for parenting programmes to be made available in conjunction with cash transfers to enhance the effects and improve cognitive development outcomes for young children – especially in high HIV affected areas.

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ii Community-based organisations included any grassroots organisation providing child support services to children and/or their caregivers or both, with a specific remit for HIV – such as ECD programmes, randomly selected from a full list of all organisations supported by a selection of 11 international funders (n=580; 28 selected).

This opened the idea of studying various combinations to see if they had beneficial outcomes. All children lived in poverty-stricken households and were eligible for – or in need of – cash grants and multiple supports. Three groups were created: The first group (20%) received neither a cash grant nor food support. The second group (32.4%) received one of these measures (either cash or food) and the third group (47.9%) received both cash grants and food support. Receiving either form of support was linked to the child being in the correct class for age, higher scores of non-verbal cognition and higher working memory scores. Receiving both reduced educational risk and improved odds of being in the correct class for age, attending school regularly, missing less than a week of school in the previous two weeks, scoring higher on aspects of cognition and working memory, and learning new things more easily. Benefits are enhanced when social protection is received in combination.

Finally, this accelerator idea was tested out over time – at baseline and 18-month follow-up – to examine associations between access to five accelerating services and 12 child outcomes.⁹⁹ The five were food security, cash grants, positive parenting, safe communities and community support, all derived from detailed measures from well tested measurement inventories. This showed that food security is associated with positive child education

and cognitive development outcomes. Cash grants were positively associated with nutrition and cognitive development outcomes, and living in a safe community was positively associated with all mental health outcomes. Experiencing a combination of two of these protective factors was associated with a higher probability of positive child outcomes. However, experiencing all three was associated with better child outcomes, compared with any of the individual factors by themselves, with substantial improvements noted in child education outcomes.

A second accelerator analysis provided specific insight into the role of accelerated provision and mental health outcomes.¹⁰⁰ Significant additive effects of combining interventions were present for five out of the six mental health outcomes investigated (no depression, no suicidality, overall mental health, no peer problems, and no substance misuse). The only exception was post-traumatic stress disorder. This suggests that applying a combination approach represents a sound investment for reducing the mental health burden in children and adolescents.

The figure below shows how combinations of interventions affect a range of mental health outcomes. Such findings support the notion of synergistic social protection responses for children and suggest that careful choice and combinations can maximise the benefits for children.

Figure 10: Impact of combined interventions on mental health outcomes



Source: Haag K, Du Toit S, Rudgard WE, Skeen S, Meinck F, Gordon SL, Mebrahtu H, Roberts KJ, Cluver L, Tomlinson M, & Sherr L. Accelerators for achieving the sustainable development goals in sub-Saharan-African children and young adolescents - a longitudinal study. *World Development*. 2021; 151 [105739]. Note: No MDD refers to No Depression above the cut-off point of the measure.

adolescents and caregivers as agents of change is vital in this process as their agency is integrally linked to their mental health and a vital mechanism for addressing the social determinants.

Within this overall approach, a number of key priorities can be identified:

- In relation to *research priorities*, first, we need to know more about how social determinants impact on the mental health of children and adolescents. The current evidence base would be strengthened by a nationally representative epidemiological study of child and adolescent mental health, including risk and protective factors; and by large, longitudinal studies, exploring the intergenerational transmission of poverty, responses to adverse life circumstances (such as inequality, discrimination, violence or trauma in communities) and mental health conditions. We also need to explore what works, for whom and under what circumstances. This requires the design and testing of interventions, including analysis of the mechanisms by which social interventions might yield improvements in child and adolescent mental health. In all research, we must hear child and adolescent perspectives on and priorities for their needs and well-being, and this requires active participation by children and adolescents in research programmes.

- The emerging evidence base needs to inform *priorities for teaching*. This means teaching mental health professionals (psychologists, psychiatrists) about public mental health approaches, and the benefits of delivering social interventions alongside clinical interventions. Currently the education of psychologists and psychiatrists focusses narrowly on clinical care, with limited focus on interventions to address social determinants. It is therefore essential to broaden the curriculum to include a greater focus on public mental health, in order to raise awareness of the social determinants of mental health. This is vital to equip mental health professionals with the knowledge and skills to link children and families with a range of support services and to advocate on behalf of children in their care. This also requires teaching child policy makers about the potential to improve child and adolescent mental health by addressing its social determinants.
- Finally, in relation to *advocacy priorities*, we need to link a variety of stakeholders around a common agenda of improving child and adolescent mental health by addressing its social determinants. This requires advocating to sectors of government aligned to health (housing, transport, community safety, education, social development) about the importance of addressing social drivers of child and adolescent mental health.

References

1. Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, Saxena S. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry*. 2018;5(4):357-369.
2. Mendenhall E, Kohrt BA, Norris SA, Ndeti D, Prabhakaran D. Non-communicable disease syndemics: Poverty, depression, and diabetes among low-income populations. *Lancet*. 2017;389(10072):951-963.
3. Patel V, Burns JK, Dhingra M, Tarver L, Kohrt BA, Lund C. Income inequality and depression: A systematic review and meta-analysis of the association and a scoping review of mechanisms. *World Psychiatry*. 2018;17(1):76-89.
4. COVID-19 Mental Disorders Collaborators. Global prevalence and burden of depression and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *Lancet*. 2021;398:1700-1712.
5. Fowler PJ, Tompsett CJ, Braciszewski JM, Jacques-Tiura AJ, Baltes BB. Community violence: A meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. *Development and Psychopathology*. 2009;21(1):227-259.
6. Kuposov R, Isaksson J, Vermeiren R, Schwab-Stone M, Stickley A, Ruchkin V. Community violence exposure and school functioning in youth: Cross-country and gender perspectives. *Front Public Health*. 2021;9:692402.
7. Schneider S. Associations between childhood exposure to community violence, child maltreatment and school outcomes. *Child Abuse & Neglect*. 2020;104:104473.
8. Foster H, Brooks-Gunn J. Children's exposure to community and war violence and mental health in four African countries. *Social Science & Medicine*. 2015;146:292-299.
9. Yule K, Houston J, Grych J. Resilience in children exposed to violence: A meta-analysis of protective factors across ecological contexts. *Clinical Child & Family Psychology Review*. 2019;22(3):406-431.
10. Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, Johns N. Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. *The Lancet*. 2013;382(9904):1575-1586.
11. Petermann F. Common risk factors of depressive and anxiety symptoms in childhood and adolescence: A systematic review from transdiagnostic perspectives. *Fortschritte der Neurologie-psychiatrie*. 2015;83(6):321-333.
12. Luppá M, Sikorski C, Luck T, Ehreke L, Konnopka A, Wiese B, Riedel-Heller SG. Age- and gender-specific prevalence of depression in latest-life-systematic review and meta-analysis. *Journal of Affective Disorders*. 2012;136(3):212-221.
13. Baxter AJ, Scott KM, Vos T, Whiteford HA. Global prevalence of anxiety disorders: A systematic review and meta-regression. *Psychological Medicine*. 2013;43(5):897-910.
14. Qian J, Hu Q, Wan Y, Li T, Wu M, Ren Z, Yu D. Prevalence of eating disorders in the general population: A systematic review. *Shanghai Archives of Psychiatry*. 2013;25(4):212.
15. Bale TL, Epperson CN. Sex differences and stress across the lifespan. *Nature Neuroscience*. 2015;18(10):1413-1420.
16. Merikangas KR, Nakamura EF, Kessler RC. Epidemiology of mental disorders in children and adolescents. *Dialogues in Clinical Neuroscience*. 2009;11(1):7.
17. Hor K, Taylor M. Suicide and schizophrenia: A systematic review of rates and risk factors. *Journal of Psychopharmacology*. 2010;24(4 suppl):81-90.
18. Hawton K, Comabella CC, Haw C, Saunders K. Risk factors for suicide in individuals with depression: A systematic review. *Journal of Affective Disorders*. 2013;147(1-3):17-28.
19. Russell ST, Fish JN. Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annual Review of Clinical Psychology*. 2016;12:465-487.
20. Berry OO, Tobón AL, Njoroge WF. Social determinants of health: The impact of racism on early childhood mental health. *Current Psychiatry Reports*. 2021;23(5):1-10.
21. Priest N, Paradies Y, Trenerry B, Truong M, Karlsen S, Kelly Y. A systematic

- review of studies examining the relationship between reported racism and health and wellbeing for children and young people. *Social Science & Medicine*. 2013;95:115-127.
22. Stirling K, Toumbourou JW, Rowland B. Community factors influencing child and adolescent depression: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry*. 2015;49(10):869-886.
 23. Grantham-McGregor S, Cheung YB, Cueto S, Glewwe P, Richter L, Strupp B, Group ICDS. Developmental potential in the first 5 years for children in developing countries. *Lancet*. 2007;369(9555):60-70.
 24. Bouffard L, Dubé M. Mental income inequality: A "virus" which affects health and happiness. *Sante Mentale au Quebec*. 2013;38(2):215-233.
 25. Kola L, Kohrt BA, Hanlon C, Naslund JA, Sikander S, Balaji M, Patel V. COVID-19 mental health impact and responses in low-income and middle-income countries: Reimagining global mental health. *Lancet Psychiatry*. 2021;8(6):535-550.
 26. Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, Kieling C. Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *The Lancet Psychiatry*. 2018;5(4):357-369.
 27. Branson N, De Lannoy A, Kahn A. *Exploring the transitions and well-being of young people who leave school before completing secondary education in South Africa*. Report No.: 192851605X. NIDS Discussion Paper 2019/11. Cape Town: National Income Dynamics Study. 2019.
 28. Salgado M, Madureira J, Mendes AS, Torres A, Teixeira JP, Oliveira MD. Environmental determinants of population health in urban settings: A systematic review. *BMC Public Health*. 2020;20(1):853.
 29. Gascon M, Triguero-Mas M, Martínez D, Dadvand P, Fornis J, Plasencia A, Nieuwenhuijsen MJ. Mental health benefits of long-term exposure to residential green and blue spaces: A systematic review. *International Journal of Environmental Research and Public Health*. 2015;12(4):4354-4379.
 30. Brumley LD, Jaffee SR. Defining and distinguishing promotive and protective effects for childhood externalizing psychopathology: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*. 2016;51(6):803-815.
 31. Visser K, Bolt G, Finkenauer C, Jonker M, Weinberg D, Stevens GWJM. Neighbourhood deprivation effects on young people's mental health and well-being: A systematic review of the literature. *Social Science & Medicine*. 2021;270:113542.
 32. Alderton A, Villanueva K, O'Connor M, Boulangé C, Badland H. Reducing inequities in early childhood mental health: How might the neighborhood built environment help close the gap? A systematic search and critical review. *International Journal of Environmental Research and Public Health*. 2019;16(9).
 33. Fleckney P, Bentley R. The urban public realm and adolescent mental health and wellbeing: A systematic review. *Social Science & Medicine*. 2021;284:114242.
 34. Sharpe RA, Taylor T, Fleming LE, Morrissey K, Morris G, Wigglesworth R. Making the case for "whole system" approaches: Integrating public health and housing. *International Journal of Environmental Research and Public Health*. 2018;15(11):2345.
 35. Weimann A, Oni T. A systematised review of the health impact of urban informal settlements and implications for upgrading interventions in South Africa, a rapidly urbanising middle-income country. *International Journal of Environmental Research and Public Health*. 2019;16(19).
 36. Rautio N, Filatova S, Lehtiniemi H, Miettunen J. Living environment and its relationship to depressive mood: A systematic review. *International Journal of Social Psychiatry*. 2018;64(1):92-103.
 37. Ali-Saleh Darawshy N, Gewirtz A, Marsalis S. Psychological intervention and prevention programs for child and adolescent exposure to community violence: A systematic review. *Clinical Child & Family Psychology Review*. 2020;23(3):365-378.
 38. Shields N, Nadasen K, Pierce L. The effects of community violence on children in Cape Town, South Africa. *Child Abuse & Neglect*. 2008;32(5):589-601.
 39. Wiafe S, Mihan A, Davison CM. Neighborhood-level influences and adolescent health risk behaviors in rural and urban Sub-Saharan Africa: A systematic review. *International Journal of Environmental Research and Public Health*. 2021;18(14).
 40. Zougheibe R, Jepson B, Norman R, Gudes O, Dewan A. Is there a correlation between children's outdoor active mobility behaviour and neighbourhood safety? A systematic review of the evidence. *BMJ Open*. 2021;11(7):e047062.
 41. Hosokawa R, Katsura T. The relationship between neighborhood environment and child mental health in Japanese elementary school students. *International Journal of Environmental Research and Public Health*. 2020;17(15).
 42. Bromet EJ, Goldgaber D, Carlson G, Panina N, Golovakha E, Gluzman SF, Schwartz JE. Children's wellbeing 11 years after the Chernobyl catastrophe. *Archives of General Psychiatry*. 2000;57(6):563-571.
 43. Latif F, Yeatermeyer J, Horne ZD, Beriwai S. Psychological Impact of Nuclear Disasters in Children and Adolescents. *Child and Adolescent Psychiatric Clinics of North America*. 2015;24(4):811-822.
 44. Slone M, Mann S. Effects of war, terrorism and armed conflict on young children: A systematic review. *Child Psychiatry & Human Development*. 2016;47(6):950-965.
 45. Blackmore R, Gray KM, Boyle JA, Fazel M, Ranasinha S, Fitzgerald G, Gibson-Helm M. Systematic review and meta-analysis: The prevalence of mental illness in child and adolescent refugees and asylum seekers. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2020;59(6):705-714.
 46. Cianconi P, Betrò S, Janiri L. The impact of climate change on mental health: A systematic descriptive review. *Front Psychiatry*. 2020;11:74.
 47. Baudoin M-A, Vogel C, Nortje K, Naik M. Living with drought in South Africa: Lessons learnt from the recent El Niño drought period. *International Journal of Disaster Risk Reduction*. 2017;23:128-137.
 48. Vins H, Bell J, Saha S, Hess JJ. The mental health outcomes of drought: A systematic review and causal process diagram. *International Journal of Environmental Research and Public Health*. 2015;12(10):13251-13275.
 49. Rose T, Lindsey MA, Xiao Y, Finigan-Carr NM, Joe S. Mental health and educational experiences among black youth: A latent class analysis. *Journal of Youth and Adolescence*. 2017;46(11):2321-2340.
 50. Gautam P, Dahal M, Ghimire H, Chapagain S, Baral K, Acharya R, Neupane A. Depression among adolescents of rural Nepal: A community-based study. *Depression Research and Treatment*. 2021;2021:7495141.
 51. Esch P, Bocquet V, Pull C, Couffignal S, Lehnert T, Graas M, Anseau M. The downward spiral of mental disorders and educational attainment: A systematic review on early school leaving. *BMC Psychiatry*. 2014;14.
 52. Castellvi P, Miranda-Mendizabal A, Alayo I, Pares-Badell O, Almeria J, Alonso I. Assessing the relationship between school failure and suicidal behavior in adolescents and young adults: A systematic review and meta-analysis of longitudinal studies. *School Mental Health*. 2020.
 53. Rose T, Lindsey MA, Xiao Y, Finigan-Carr NM, Joe S. Mental Health and Educational Experiences Among Black Youth: A Latent Class Analysis. *J Youth Adolesc*. 2017;46(11):2321-2340.
 54. Mitchell JJ. *Adolescent struggle for selfhood and identity*. Bellingham, WA: Temeron Books, Inc; 1992.
 55. Kingsbury M, Kirkbride JB, McMartin SE, Wickham ME, Weeks M, Colman I. Trajectories of childhood neighbourhood cohesion and adolescent mental health: Evidence from a national Canadian cohort. *Psychological Medicine*. 2015;45(15):3239-3248.
 56. Donnelly L, McLanahan S, Brooks-Gunn J, Garfinkel I, Wagner BG, Jacobsen WC, Gaydos L. Cohesive neighborhoods where social expectations are shared may have positive impact on adolescent mental health. *Health Affairs (Millwood)*. 2016;35(11):2083-2091.
 57. Kingsbury M, Clayborne Z, Colman I, Kirkbride JB. The protective effect of neighbourhood social cohesion on adolescent mental health following stressful life events. *Psychological Medicine*. 2020;50(8):1292-1299.
 58. Henson RM, Ortigoza A, Martinez-Folgar K, Baeza F, Caiaffa W, Vives Vergara A, Lovasi G. Evaluating the health effects of place-based slum upgrading physical environment interventions: A systematic review (2012-2018). *Social Science & Medicine*. 2020;261:113102.
 59. Kondo MC, Andreyeva E, South EC, MacDonald JM, Branas CC. Neighborhood interventions to reduce violence. *Annual Review of Public Health*. 2018;39(1):253-271.
 60. D'Agostino EM, Frazier SL, Hansen E, Patel HH, Ahmed Z, Okeke D, Messiah SE. Two-year changes in neighborhood juvenile arrests after implementation of a park-based after-school mental health promotion program in Miami-Dade County, Florida, 2015-2017. *American Journal of Public Health*. 2019;109(S3):S214-s220.
 61. Elsborg P, Nielsen G, Klinker CD, Melby PS, Christensen JH, Bentsen P. Sports-based recreation as a means to address social inequity in health: Why, when, where, who, what, and how. *BMC Public Health*. 2019;19(1):1084.
 62. Audrey S, Batista-Ferrer H. Healthy urban environments for children and young people: A systematic review of intervention studies. *Health Place*. 2015;36:97-117.
 63. O'Reilly M, Svirydzenka N, Adams S, Dogra N. Review of mental health promotion interventions in schools. *Social Psychiatry and Psychiatric Epidemiology*. 2018;53(7):647-662.
 64. Zimmerman A, Garman E, Avendano Pabon M, Araya Baltra R, Evans-Lacko S, McDaid D, Lund C. The impact of cash transfers on mental health in children and young people in low- and middle-income countries: A systematic review and meta-analysis. *BMJ Global Health*. 2021;6(4):e004661.
 65. Durlak JA, Weissberg RP, Pachan M. A meta-analysis of after-school programs that seek to promote personal and social skills in children and adolescents. *American Journal of Community Psychology*. 2010;45(3):294-309.
 66. Eime RM, Young JA, Harvey JT, Charity MJ, Payne WR. A systematic review of the psychological and social benefits of participation in sport for children and adolescents: Informing development of a conceptual model of health through sport. *International Journal of Behavioral Nutrition and Physical Activity*. 2013;10:98.
 67. Purgato M, Gross AL, Betancourt T, Bolton P, Bonetto C, Gastaldon C,

- Barbui C. Focused psychosocial interventions for children in low-resource humanitarian settings: A systematic review and individual participant data meta-analysis. *Lancet Global Health*. 2018;6(4):e390-e400.
68. Department of Health. *National Mental Health Policy Framework and Strategic Plan, 2013-2020*. Pretoria: Department of Health; 2013.
 69. Mokitimi S, Schneider M, De Vries P. Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis. *International Journal of Mental Health Systems*. 2018;12(1):36.
 70. Palacios-Barrios EE, Hanson JL. Poverty and self-regulation: Connecting psychosocial processes, neurobiology, and the risk for psychopathology. *Comprehensive Psychiatry*. 2019;90:52-64.
 71. Siegfried N, Parry C. Do alcohol control policies work? An umbrella review and quality assessment of systematic reviews of alcohol control interventions (2006 - 2017). *PLoS One*. 2019;14(4):e0214865.
 72. Department of the Premier. *Western Cape Alcohol-related Harms Reduction Policy White Paper*. Western Cape Government. 2017. [https://www.westerncape.gov.za/text/2017/September/white_paper_alcohol-related_harms_reduction.pdf]
 73. Stoltenborgh M, Bakermans-Kranenburg MJ, van Ijzendoorn MH, Alink LR. Cultural-geographical differences in the occurrence of child physical abuse? A meta-analysis of global prevalence. *International Journal of Psychology*. 2013;48(2):81-94.
 74. Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Med*. 2012;9(11):e1001349.
 75. Chen M, Chan KL. Effects of parenting programs on child maltreatment prevention: A meta-analysis. *Trauma Violence Abuse*. 2016;17(1):88-104.
 76. Lachman J, Wamoyi J, Spreckelsen T, Wight D, Maganga J, Gardner F. Combining parenting and economic strengthening programmes to reduce violence against children: A cluster randomised controlled trial with predominantly male caregivers in rural Tanzania. *BMJ Global Health*. 2020;5(7).
 77. Little MT, Roelen K, Lange BCL, Steinert JI, Yakubovich AR, Cluver L, Humphreys DK. Effectiveness of cash-plus programmes on early childhood outcomes compared to cash transfers alone: A systematic review and meta-analysis in low- and middle-income countries. *PLoS Med*. 2021;18(9):e1003698.
 78. See <https://www.enriched.co.za/>.
 79. Kleinman A. *Patients and healers in the context of culture*. Berkeley: University of California press; 1980.
 80. Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H, Andrews KG. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010. *The Lancet*. 2012;380(9859):2224-2260.
 81. Reddy S, James S, Sewpaul R, Sifunda S, Ellahebokus A, Kambaran NS, Omardien RG. *Umthente uhlaba usamila: The 3rd South African national youth risk behaviour survey 2011*. 2013. [<https://repository.hsric.ac.za/handle/20.500.11910/2487>]
 82. Manu E, Maluleke XT, Douglas M. Knowledge of high school learners regarding substance use within high school premises in the Buffalo Flats of East London, Eastern Cape Province, South Africa. *Journal of Child & Adolescent Substance Abuse*. 2017;26(1):1-10.
 83. May PA, Blankenship J, Marais AS, Gossage JP, Kalberg WO, Barnard R, Buckley D. Approaching the prevalence of the full spectrum of Fetal Alcohol Spectrum Disorders in a South African population-based study. *Alcoholism: Clinical and experimental research*. 2013;37(5):818-830.
 84. Streissguth AP, Bookstein FL, Barr HM, Sampson PD, O'Malley K, Young JK. Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. *Journal of Developmental & Behavioral Pediatrics*. 2004;25(4):228-238.
 85. Lubbe M, Van Walbeek C, Vellios N. The prevalence of fetal alcohol syndrome and its impact on a child's classroom performance: A case study of a rural South African school. *International Journal of Environmental Research and Public Health*. 2017;14(8):896.
 86. Meque I, Dachev BA, Maravilla JC, Salom C, Alati R. Externalizing and internalizing symptoms in childhood and adolescence and the risk of alcohol use disorders in young adulthood: A meta-analysis of longitudinal studies. *Australian & New Zealand Journal of Psychiatry*. 2019;53(10):965-975.
 87. Clark DB, Bukstein OG. Psychopathology in adolescent alcohol abuse and dependence. *Alcohol Health and Research World*. 1998;22(2):117.
 88. Crone EA, van Duijvenvoorde AC. Multiple pathways of risk taking in adolescence. *Developmental Review*. 2021;62:100996.
 89. Bonomo Y, Coffey C, Wolfe R, Lynskey M, Bowes G, Patton G. Adverse outcomes of alcohol use in adolescents. *Addiction*. 2001;96(10):1485-1496.
 90. King C, Siegel M, Ross CS, Jernigan DH. Alcohol advertising in magazines and underage readership: Are underage youth disproportionately exposed? *Alcoholism: Clinical and experimental research*. 2017;41(10):1775-1782.
 91. Finan LJ, Lipperman-Kreda S, Grube JW, Balassone A, Kaner E. Alcohol marketing and adolescent and young adult alcohol use behaviors: A systematic review of cross-sectional studies. *Journal of Studies on Alcohol and Drugs, Supplement*. 2020(s19):42-56.
 92. Bonnie RJ. Reducing underage drinking: A collective responsibility. *Developments in Mental Health Law*. 2004;23:1.
 93. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, Rahman A. No health without mental health. *The Lancet*. 2007;370(9590):859-877.
 94. Zaneva M, Guzman-Holst C, Reeves A, Bowes L. The impact of monetary poverty alleviation programs on children's and adolescents' mental health: A systematic review and meta-analysis across low-, middle-, and high-income countries. *Journal of Adolescent Health*. 2022.
 95. Cluver LD, Orkin FM, Boyes ME, Sherr L. Cash plus care: Social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa. *AIDS*. 2014;28:S389-S397.
 96. Sherr L, Macedo A, Tomlinson M, Skeen S, Cluver LD. Could cash and good parenting affect child cognitive development? A cross-sectional study in South Africa and Malawi. *BMC Pediatrics*. 2017;17(1):1-11.
 97. Sherr L, Yakubovich AR, Skeen S, Cluver LD, Hensels IS, Macedo A, Tomlinson M. How effective is help on the doorstep? A longitudinal evaluation of community-based organisation support. *PLoS One*. 2016;11(3):e0151305.
 98. Sherr L, Roberts KJ, Tomlinson M, Skeen S, Mebrahtu H, Gordon S, Cluver LD. Food should not be forgotten: Impacts of combined cash transfer receipt and food security on child education and cognition in South Africa and Malawi. *AIDS and Behavior*. 2021;25(9):2886-2897.
 99. Mebrahtu H, Skeen S, Rudgard WE, Du Toit S, Haag K, Roberts KJ, Tomlinson M. Can a combination of interventions accelerate outcomes to deliver on the Sustainable Development Goals for young children? Evidence from a longitudinal study in South Africa and Malawi. *Child: Care, Health and Development*. 2021.
 100. Haag K, Du Toit S, Rudgard WE, Skeen S, Meinck F, Gordon SL, Tomlinson M. Accelerators for achieving the sustainable development goals in Sub-Saharan-African children and young adolescents – a longitudinal study. *World Development*. 2022;151(C).

A life-course perspective on the biological, psychological and social development of child mental health

Tamsen Rochat and Stephanie Redinger

Public interest in child and adolescent development is often driven by societal concerns around citizenship and focused on supporting children to become healthy, productive and moral citizens who are able to contribute meaningfully to society. Yet, the majority of South Africa's children are confronted with high levels of adversity and risk that substantially undermine their ability to achieve happiness, self-fulfilment and mental health.¹ The limits placed on their developmental potential as citizens will play out over their lifetime, with implications for them as individuals, for the next generation of children, and for broader South African society. Understanding the broader developmental context of childhood, and in particular the theories by which mental health may develop or be hindered, helps to contextualise policies and interventions that could facilitate sustainable improvements for all South Africans.

In this chapter we explore how exposures, including positive and negative life events, can impact on normal and necessary developmental processes – which in turn impact on mental health. We explore this from a life-course and developmental perspective, introducing key concepts and processes and unpacking the importance of the timing of exposures and their interaction with normal developmental processes, with a focus on the stress response system, emotional regulation and cognitive control. We illustrate this with a case study that describes how behavioural difficulties or conduct problems can develop and lead to high rates of violence and aggression in educational and social settings; and conclude by outlining important considerations for intervention and policy.

Table 2: Key concepts in life-course perspectives

Term	Broad description
Developmental origins	Health and disease are determined through both hereditary processes (genetics) and environmental exposures starting before conception and extending across the life course (epigenetics). Although we are born with a genetic 'blueprint' of health and disease risk, our genes can be turned on or off in response to environmental exposures.
Biological embedding	Biological embedding is the process by which early life experiences and environmental exposures affect the developing body and brain. Biological systems can be changed by our exposures (for example, maternal nutritional status impacts on their child's linear growth and later disease risk).
Life-course development	Human development involves processes that take place over time in a cumulative way, unfolding sequentially, in specific stages, linked to each other and to chronological age, and should not be treated separately.
Contextual influence	The way in which children's relationships and the contexts in which they live influence their health and development (for example, the positive influence of a nurturing caregiver may help mitigate the harmful effects of poverty).
Human agency	Individuals construct their lives through the choices and actions they take, within social structures that either provide opportunities and/or impose constraints on their human agency.
Historical context	The lives of individuals are embedded in, and shaped by, both historical time and geographical place (north vs south populations) and where they live relative to current events (for example, climate change or war-induced migration or displacement).
Cultural embedding	Social and cultural experiences become embedded in a worldview and the way in which children make sense of the world (including attitudes towards mental health, cultural beliefs about the origin of mental illness).
Linked lives	People's lives can only be lived interdependently and that most development is contextualised within relationships or a culture of relationship (with families, partners, friends, siblings).

How does a life-course approach enhance our understanding of children's development and mental health?

By definition, a life-course approach explores the long-term effects of physical and social exposures during pregnancy, childhood and adolescence on health and disease risk in later life.² It acknowledges that there are sensitive periods of development and describes different pathways by which health and disease develop across the life course, and intergenerationally. Life-course approaches are important because they prompt us to consider how multiple biological, psychological, social, environmental influences contribute to risk or resilience, as well as *when* and *why* things might go wrong.

Most disciplines – including biology, public health, psychiatry, psychology, sociology, anthropology, history and philosophy – subscribe to some kind of life-course approach in thinking about how health and mental health emerges over the lifespan, across generations and through the course of history.

Key concepts

Each discipline tends to adopt a different lens when theorising about the importance of different life-course influences. For example, biology may have a very specific focus on the role

of genetics, while sociology might take a broader view with an emphasis on socio-political environments. Over time, a number of key concepts have emerged across a range of disciplines to describe the complex influences on the development of health and disease,³ as outlined in Table 2.

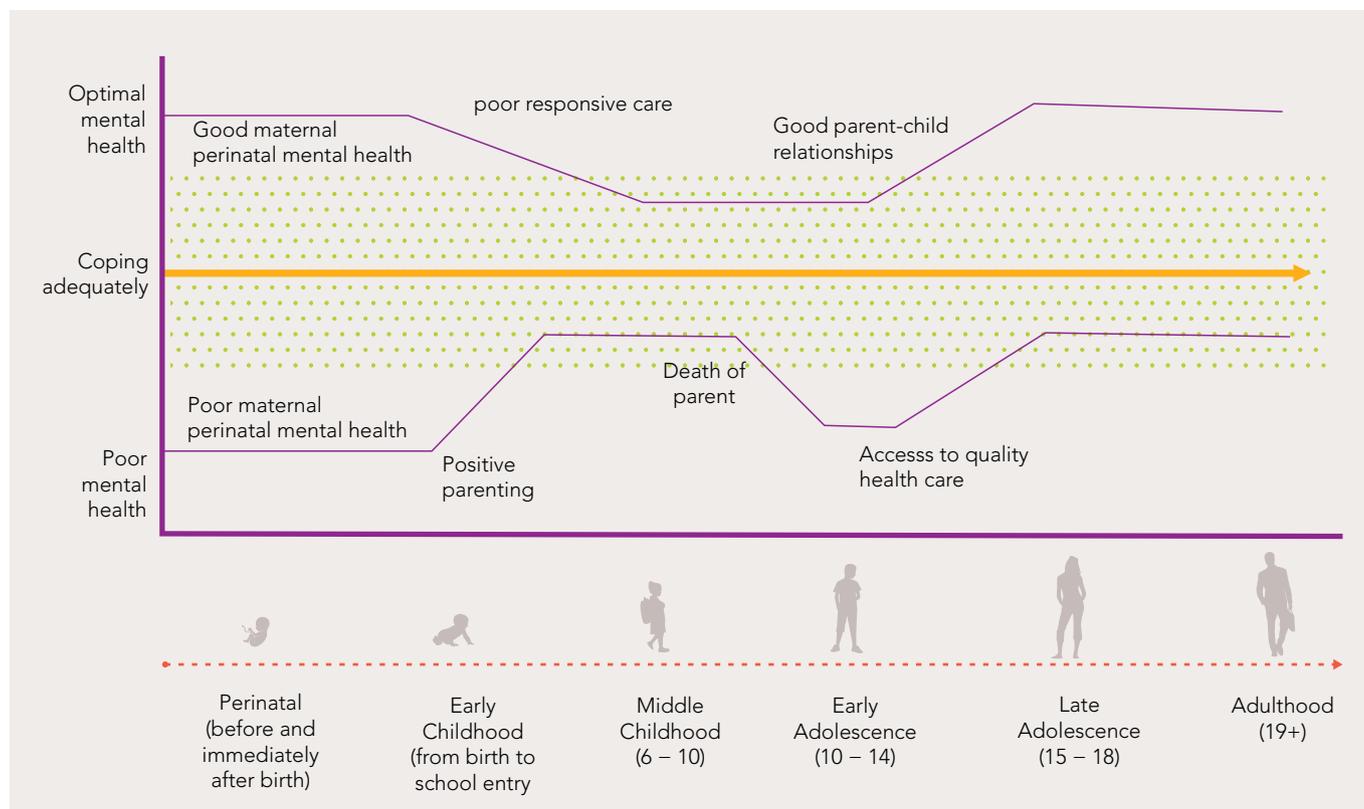
How do life-course effects impact on children's mental health?

Figure 11 provides a simple illustration of how stressors, vulnerabilities and other life-course effects can influence mental health during childhood.

The top line represents someone who is born with a low vulnerability for mental health problems, and whose mother had good perinatal mental health. In early childhood, their environment changes and the care they receive is not adequate to their needs, resulting in a downward turn in their mental health during early and middle childhood, although they still cope adequately. In early adolescence, their parenting environment changes once again, and they experience good parent-child relationships. This sets them back on an upward trajectory towards better mental health in adulthood.

The bottom trajectory represents someone with a high vulnerability to mental health problems – a family history of mental illness and an exposure to their mother's poor mental

Figure 11: Influences on mental health across the life course



health in the womb and during the first few months of their life. In early childhood, their mother receives a mental health intervention and both parents are able to provide a warm, nurturing and responsive environment and this sets their mental health on a positive trajectory. Unfortunately, during middle childhood, the father dies and this leads the mother to develop depression which negatively impacts on the child's mental health. By late adolescence, both mother and child are coping adequately again thanks to quality health care and a targeted intervention to address their bereavement. However, the child still enters adulthood with a mental health vulnerability.

Case 9 presents findings from the South African Birth to Thirty cohort (Bt30) which has contributed enormously to our understanding of development and mental health over the course of childhood in South Africa.

Types of life-course effects

Life-course effects describe how a complex interplay of risk and protective factors affects children's mental health and development over time.

- **Latent effects** occur when a long period of time elapses between an environmental exposure and when its effects become visible. Some exposures may occur in early childhood and remain dormant until triggered by an internal or an external cue later on in life – like how early childhood toxic stress can impact health or non-communicable disease (NCD) outcomes in adulthood.⁴
- **Pathway effects** are the result of experiences or exposures that change a child's developmental trajectory in a positive or a negative way. Unlike the latent effect which may only show itself later in life, pathway effects are immediate adjustments that then determine how things move forward. Even a single experience of trauma or adversity (such as being exposed to war) can significantly alter not only the child's mental health at a point in time, but also their mental health trajectory going forward.⁵
- **Cumulative effects** are things that add up over time. Depending on whether these are positive or negative exposures, they can enhance mental health or lead to mental health problems. Where you end up depends on where you start, but it also depends on what happens (or does not happen) along the way.⁶
- **Bi-directional effects** relate to the influence that children and their environments (family, social, physical, cultural) have on each other across the life course.⁷ This allows for an understanding of how parental involvement operates across the life course, how it affects the child's behaviour,

and how the child's behaviour in turn can impact on the parent-child relationship and the parent's actions.

How does stress impact children's development and mental health?

Sustained exposure to poverty, inequality and stress, often referred to as toxic stress or developmental trauma, can impact negatively on children's development and their mental health trajectories.⁶ The human body deals with stress using what is called the Stress Response System (SRS), which is a biological process by which the body is able to respond to stress or threat using either a flight or fight response (moving away from or toward the threat).¹⁴

When the body perceives that it is under threat, it steps into action by sending a message from the hypothalamus in the brain to the pituitary gland using the Hypothalamic Pituitary Axis (HPA) to trigger the sympathetic nervous system. This leads to a series of physiological responses (increased heart rate, secretion of adrenalin) and the production of the hormone cortisol in the adrenal system.¹⁵ Cortisol is a stress hormone that stimulates glucose production so that we have the energy we need to respond to a threat. Once the threat is resolved, the parasympathetic nervous systems helps the body get back to normal. While cortisol is needed to help our body survive, too much cortisol can be bad for our health.

When stress is experienced during sensitive and critical developmental periods, or when the stress is ongoing and chronic, it can increase the risk of NCDs such as cardiovascular disease, obesity and poor mental health later in life.^{16, 17} Table 3 illustrates how the SRS system develops over childhood and adolescence, and how toxic or chronic stress can influence children's healthy development and mental health during these key developmental stages and later in life.

All children will experience some stress as part of their daily lives and learning to manage stress is an important part of the child's developmental journey. But what we do understand because of life-course science is that how children respond to stress, and how much stress they can cope with, is a delicate balancing act, a bit like a seesaw where protective factors can help balance or limit the impact of stress and adverse events.

For example, children experiencing bullying at school might have feelings of self-doubt, sadness or depression as a result of being bullied. This may lead to withdrawn behaviour and eventually isolation from their friends and teachers who normally support and encourage them. This

Table 3: Evolution of the stress response system and impact of stress across the life course

Developmental period	Prenatal	Childhood	Adolescence
Development of the stress response system	SRS system is very sensitive while developing in the foetus. Prenatal stress can lead to programming effects, which change the way the brain develops and can 'train the brain' to be over-sensitive to stress or lead to the body being less able to recover from stress	Period of stress hypo-responsiveness emerges over infancy and lasts for most of childhood. Child's SRS is less responsive to stress to protect the brain and body from the negative effects of stress hormones on their development. However, chronic stress impacts on physiological development	Puberty triggers changes in the brain, particularly in the frontal lobe which controls risk-taking and sensation-seeking behaviours. During adolescence, onset of puberty and sex hormones make the SRS more sensitive to stress and these effects can differ by gender
Impact of high or chronic stress	Maternal stress, depression and anxiety in pregnancy can lead to: <ul style="list-style-type: none"> • Lower birthweight • Heightened HPA response at 6 months, 5 and 10 years • Increased attention and behavioural difficulties • Sleep disorders 	Chronic stress and adverse childhood events can lead to: <ul style="list-style-type: none"> • Learning and behavioural difficulties childhood and post-traumatic stress disorder (PTSD) in adulthood • Smaller brain volume and lower self-control in adolescence and adulthood • Childhood stress becomes evident and manifests in abnormal development in adolescence 	Adolescent stress can lead to: <ul style="list-style-type: none"> • Abnormal frontal lobe and HPA functioning and • Stress-related mental disorders like depression, anxiety and increased risk taking • Earlier stress is linked to poor health outcomes like early onset obesity and sleep problems in adolescence

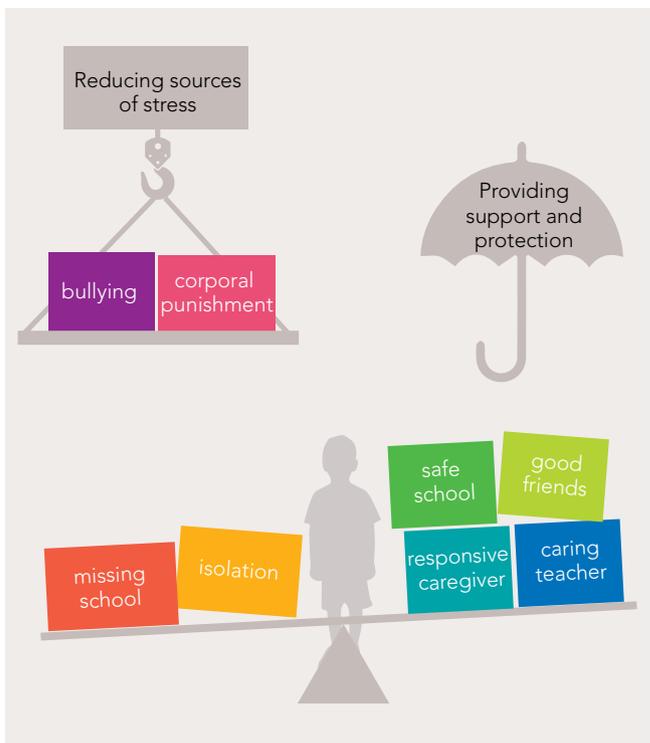
then impacts on their ability to pay attention in school, resulting in academic failure and more feelings of self-doubt and shame. These compounding stressors tip the seesaw and increase their risk of developing a mental health problem like depression.

Once children have a problem, it is hard for them to just 'bounce back'. Instead, we need to find ways to reduce the sources of stress, and/or provide support and protection to help children achieve a healthier balance and recover their mental health, as illustrated in Figure 12.

It is also important to recognise that stressors are experienced differently by different individuals. For example, a negative life event such as a divorce may be experienced as a relief for a child whose was witness to their parents' conflictual or abusive relationship, whereas it can be highly distressing for a child who was unaware of their parents' marital problems.

If we think about mental health in this way, then the differences amongst children's mental health outcomes can be seen as the sum of their individual characteristics – including their hereditary, genetic and biological attributes; their cognitive and psychological capacities; and their exposures and interactions with the world in which they are growing up.

Figure 12: Mental health - a delicate balance between sources of stress and protection



Adapted from: Center on the Developing Child. How to Help Families and Staff Build Resilience During the COVID-19 Outbreak: Harvard University; 2022 [Available from: <https://developingchild.harvard.edu/resources/how-to-help-families-and-staff-build-resilience-during-the-covid-19-outbreak/>.]

Case 8: Life-course influences on the development of conduct disorder

Conduct disorders are an important mental health priority for four reasons: they are on the rise in South Africa and globally; they predict, with high specificity, adulthood anti-social disorders and violent or criminal behaviours; they predict (non-specifically) a broad range of other psychological disorders (depression, anxiety, substance abuse) in adulthood; and they have substantial immediate and longer-term costs for both children and society.

Conduct problems are highly prevalent in South Africa, occurring in both child and adolescent populations, and are equally common amongst rural and urban populations.^{8, 10} While most children and adolescents will experience some behavioural difficulties as a normal part of growing up, behaviours linked to conduct disorders are distinctive in that they result in either violation of the rights of others (aggression, destruction of property, theft) or bring them into significant conflict with societal norms and authority figures. If conduct problems emerge early in childhood, they can start as young as age three, with rates rising substantially by seven to nine years old.¹¹ Outcomes for children who have conduct problems before age 10 tend to be worse than for those who start to have conduct problems in adolescence.¹²

Conduct disorders can be treated but this is challenging and expensive. For the vast majority of children and adolescents with conduct problems, these will resolve before they reach adulthood, in many cases even without psychological or psychiatric intervention. But because conduct disorder is defined by difficult and socially unacceptable behaviours, children with more severe conduct problems are often highly stigmatised.

Public perceptions of conduct disordered children often blame the child for their behaviour – and their parents for failing to control their child. This can lead to isolation and social exclusion at a time when both the child or adolescent and their parents are extremely vulnerable and need support.

Multiple risks that children with conduct problems need to navigate

Contrary to public perceptions that conduct problems are simply about children behaving badly, conduct disorders offer a good illustration of how a range of biological, social and environmental factors may increase the risk of

children developing conduct disorders. This is important because how we look at something and understand it often determines how, if at all, we will respond to it.

The child is navigating the risks within their bodies

Biological risk factors include a complex combination of hereditary (personality traits or temperament, lower prosocial traits) and other genetic factors. Yet, conduct disorder is more likely to be shaped by shared environments (family and parenting relationships) than by genetics alone. Although these are not specific indicators of the disorder, children with conduct disorders have also consistently been shown to have a lower resting heartrate, a biomarker not associated with other mental disorders. Other common associations include reduced autonomic fear conditioning, particularly low skin conductance.

The child is navigating the risks within their brains

Neurobiological and structural differences and deficits in the brain itself and in the connections between the different parts of the brain are also common in conduct disorders. These particularly involve the frontal lobe – or control centre of the brain – which is strongly involved in executive function and impulse control. Deficits in executive functions such as poor attentional control, lower cognitive flexibility, high impulsivity, low frustration tolerance, misreading of emotional cues – specifically seeing neutral cues as aggressive – have been found in children and adolescents with conduct problems.

The child is navigating the risks within their emotions

For the conduct disordered child, there is an important developmental link between emotional dysregulation (outbursts, aggression), their cognitive deficits and their behaviour problems. These deficits lead to obvious problems such as poor impulse or self-control, but also include problems in areas of cognitive flexibility which limit the child's ability to find alternative strategies in heightened or emotive situations. Positive social exposures including role modelling and co-regulation can mitigate these effects. Emotional dysregulation puts the child at high risk of experiencing severe depression or anxiety which, when combined with social isolation, can lead to self-harm and substance abuse.

The child is navigating the risks within their families

Psychosocial risk factors are often present in both parent and child, and within the parenting environment. Familial influences include psychiatric history, stress, harsh parenting and a family history of violence. This can degrade the quality of parenting over generations. While the parent-child relationship is critical to the development of emotional regulation, it is often strained by the child's difficult behaviour.¹³ Parents may become frustrated and resort to harsh parenting – which in turn escalates behavioural difficulties in particular amongst families of lower socio-economic status. While stricter parenting in childhood may lower behavioural problems in the immediate term, it also substantially increases the risk of adolescent affective disorders (such as depression) in the longer term.

The child is navigating the risks within their community

Social influences that heighten risk for conduct problems can include ongoing adversity across the life course (e.g., poverty or lack of access to support services) and 'snares' in childhood and adolescence (e.g., aggression, school expulsion or substance use) which may trap the child or adolescent into persistent problems. As a result of social isolation, the child's exposure to positive influences become more limited. Frustrated educators will often brush children aside as hopeless cases. This heightened negative attention on the child can lead to escalating punishment and truancy or may lead to harsher outcomes like suspension or expulsions, further isolating children from positive peer networks. Adolescents in particular then become vulnerable to being drawn into

further delinquent behaviours through negative peer networks such as neighbourhood gangs who encourage and endorse negative behaviours. Children may also be mislabelled as having conduct disorders where children are growing up in environments where disruptive or aggressive behaviours are considered the norm – for example, when living in highly threatening, violent and criminal communities. This is an important consideration given the epidemic of bullying and violence in home, school and community settings in South Africa.

Implications for interventions for conduct disorders

Parenting and behavioural interventions are the more common response to conduct problems; however, in communities where prevalence is high, school and community-wide interventions should be considered. Parenting and behavioural programmes can be stigmatising and uptake and participation by children and adolescents is often poor. Executive functions and emotional regulation have important intervention potential. This is because interventions (such as cognitive training, non-computerised games, aerobics, martial arts and yoga, and school-based interventions including mindfulness) are relatively cost-effective and feasible to scale up, and have benefits for the broader population of children who are not affected by conduct problems. While interventions focused on executive functions should not replace behavioural interventions in severe cases, they may certainly augment them, and may reduce the stigma associated with the latter.²³⁻²⁶

Why is it important for children to learn how to control their thoughts and emotions?

Most common mental health problems involve some difficulty with emotions, self-regulation and cognition. There is a bi-directional effect as our cognitive capacities (or the way we think, process information and problem solve) interact with our emotional capacities (or the extent to which we can or cannot control our emotions and feelings). Together these two capacities (commonly referred to emotional regulation and cognitive or self-control) help drive our behaviour (the things we do).

Depression, for example, involves the emotional experience of sadness, loss of interest or feelings of shame or guilt; being unable to control or regulate one's emotions

(uncontrolled crying or angry outbursts); and difficulties in thinking (including problems concentrating or experiencing repetitive intrusive thoughts). Children and adolescents who have higher capacities for emotional regulation and cognitive control are often more resilient to mental health difficulties, like depression. For this reason, the healthy development of emotional regulation and cognitive control are central to achieving mental health and regulating our behaviour.

These central capacities are emergent, meaning that they change and develop throughout childhood in response to social exposure and physiological and neurological developments, as we become increasingly sophisticated in our psychological capacity for self-control (both emotional and cognitive control). Children need to learn and develop

these skills over the course of childhood through physical development, relationships, stimulation and healthy socio-emotional experiences. While the development of emotional regulation and cognitive control is dependent on a child's individual characteristics, they are also heavily influenced by the quality of parenting, familial and social exposures. When disrupted or not fully developed, deficits in emotional regulation and cognitive control can lead to children being less able to navigate complex and threatening environments, making them more vulnerable to mental health difficulties

How do disruptions in core capacities undermine mental health?

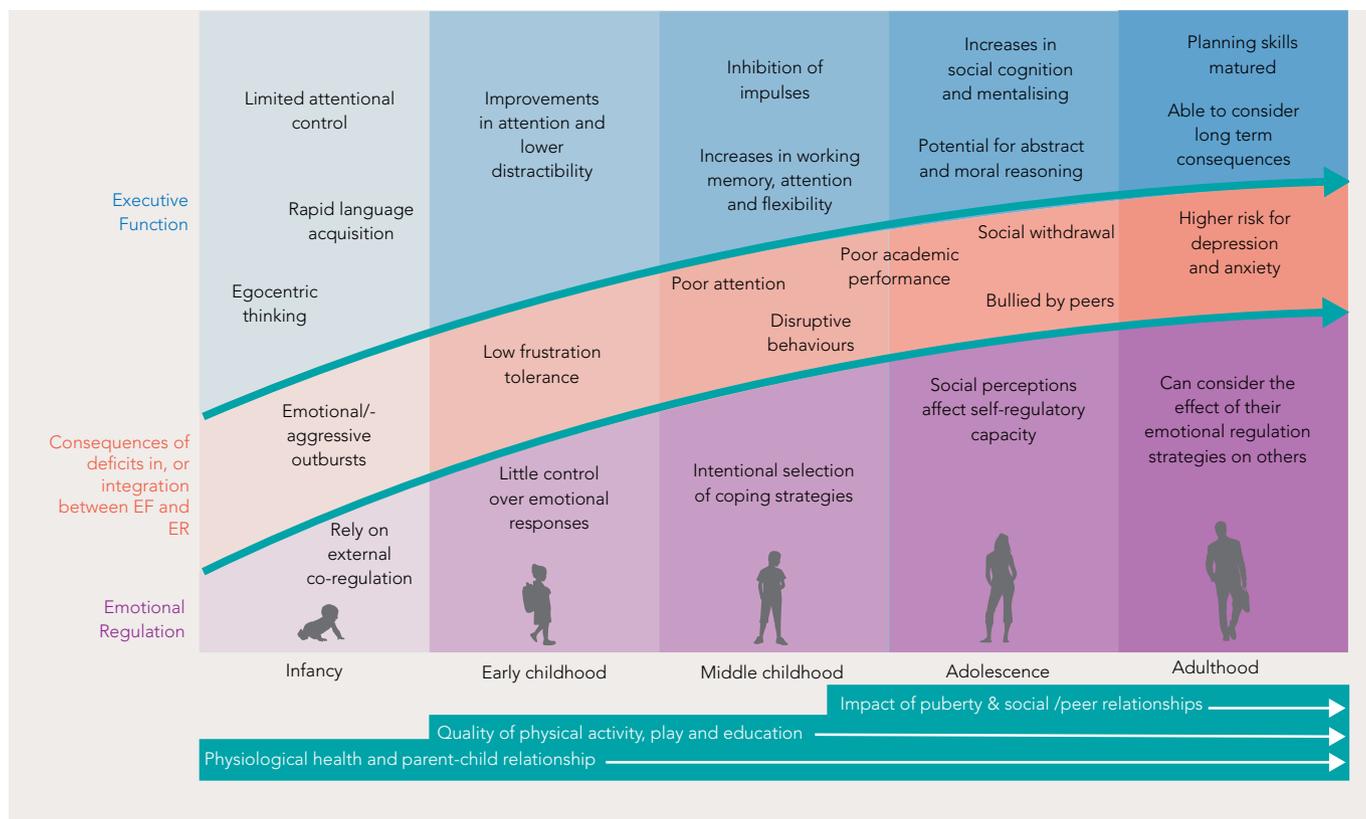
As the child moves from one developmental stage to another biological, cognitive, psychological and social systems become more regulated, integrated and in tune with one another, to drive healthy human behaviour.¹⁸⁻²⁰ Mental health problems can emerge when normal development is disrupted by biological changes or triggers²¹ like genetic vulnerabilities or illnesses, or by negative socio-emotional experiences, or environmental traumas.²² These vulnerabilities can also change children's behaviours, and these new behaviours can make children more resilient or put them at risk. And the child's behaviours and actions then influence the responses of those around them.

This process of development is illustrated in Figure 13, alongside potential consequences when normal development becomes disrupted. This does not mean that the child's development is locked into a negative path because most – if not all such – vulnerabilities can be mitigated by positive relationships or positive environmental exposures.

When we think about emotional regulation and cognitive function as important features of mental health, we begin to understand that deficits in these areas may operate in different ways. Firstly, they may predispose children and adolescents to mental health problems (for example, aggression and behaviour problems). Secondly, they may be affected by the mental health problem itself (for example, depression can lead to repetitive negative intrusive thoughts). Lastly, they may maintain the mental health problem or extend its course (for example, your mood may improve but your way of thinking remains negative which then affects your mood, which may make you more vulnerable to relapses).

Case 8 on the previous page illustrates how it is important to understand the complex interplay of a range of biological, social and environmental factors increase the risk of children developing conduct disorders which are highly prevalent amongst children in South Africa.

Figure 13: The interconnectedness of emotional regulation and executive function



How can we protect children from threats to their mental health?

Importantly, life-course effects do not mean that a child's trajectories are predetermined or that the outcome is necessarily going to be negative if they experience a high stress load. This is because we also understand that most, if not all, vulnerabilities can be mitigated by positive relationships or environmental exposures. It does, however, mean that children who are born of parents with a heavy load of lifetime risk exposures are likely to be more vulnerable to future negative risk exposures than children who are not. It is therefore important to understand how the negative effects of environmental factors (which are shared and often difficult to change) can be mitigated by potentially protective factors. Protective factors which are modifiable become productive pathways for targeted interventions in adverse settings.⁹

Life-course research and evidence suggests that family is an important ingredient in limiting the impact of high stress load on children's mental health. Functional family environments play a critical role in mitigating the effects of genetic vulnerabilities, stressful life events and adverse environments. Several gene-environment studies, for example, have shown that genetic variations can lead to increased risk of behavioural problems, but only when combined with exposure to a dysfunctional family environment. Likewise, there is evidence to suggest that the most 'toxic' effects of stress on children occur when that stressor is experienced within the absence of a stable and supportive familial or caregiving environment. Similarly, family level interventions for children and adolescents 'at risk' of mental health problems have shown consistent benefits. These can include improving parental mental health, increasing capacity for parental supervision and monitoring, or increasing parental sensitivity to child and adolescent mental health needs. Family-wide interventions for alcohol and substance use, for example, tend to have better outcomes than individual treatment programmes.

The burden of protecting children's mental health should not, however, rest with families alone. Many adversities such as chronic exposure to violence and crime, poverty and inadequate health care are the responsibility of society and are critical to change because of the pervasive negative effect they have on mental health. This is important because exposure to childhood adversities is one of the strongest predictors of poor mental health outcomes for children, regardless of where they start in life or what their socioeconomic status is. A worldwide survey by the World Health Organization (WHO) in 2010 (including over 50,000 participants from 21 countries)

suggested that elimination of childhood adversities – especially those associated with maladaptive family functioning (parental mental illness, child abuse, neglect) – could lead to a 30% reduction of mental disorders across the lifetime.

What are the implications for policy and practice?

The key contribution of life-course approaches are that they promote an understanding of the importance of early care, universal and selective prevention, and health promotion.²⁷ This is because we understand that targeting children and their families with universal services that can help mitigate or protect them from the adversities they might face can help prevent problems both at the time the stressor is present, and also later in their lives. If we wait until a child or adolescent reaches the extreme end of the continuum (a mental disorder) before offering access to mental health support or services, the services needed will likely be more intensive, specialised and expensive, while having a lesser chance of success than if we prevented the problem in the first place.

The acknowledgement of how critical the early years of life are, not only for lifelong health but also the realisation of sustainable societies, has started to permeate policy and programme design globally. A key framework in directing efforts for improving child survival and optimal development is the Nurturing Care Framework (NCF), which was launched in 2018 at the World Health Assembly. Nurturing care is multi-faceted, comprising five components - good health, adequate nutrition, protection from threat, opportunities for learning and responsive caregiving – which are needed to ensure children not only survive, but thrive.²⁸ No one component is sufficient on its own, and all are interdependent. Although the NCF focuses on the early years (0 – 3 years), emphasising how crucial they are as the foundation for lifelong health, it has been proposed that the framework be extended from preconception through to early adulthood.²⁹

It is critical that the lessons inherent in a life-course approach begin to permeate service delivery and practice, and in particular that these service provisions are child and adolescent sensitive.³⁰ This includes implementing universal or selective prevention, promotion and or early intervention programmes to ensure we eliminate or minimise the effects of adversity on child and adolescent mental health. The focus and locus of these preventative and intervention efforts shifts from one developmental stage to the other, therefore child and adolescent mental health service plans should be sensitive to developmental pathways, as illustrated by some examples of both universal care and selective prevention or early intervention in Table 4.

Table 4: A developmentally sensitive approach to prevention, promotion and early intervention

Stage	Pregnancy	Early childhood	Middle childhood	Early adolescence	Late adolescence
Key Risks	Inadequate health and nutrition and high stress and adversity exposures can lead to immediate (low birth weight, poor growth) and longer term (mental health and NCD) negative outcomes for children	Inadequate health, nutrition, stress and poor quality of parental care can lead to stunting, restricted brain growth, limited cognitive capacity, genetic vulnerability and the impact of stress on the SRS can be intensified in the context of dysfunctional familial environments. Early signs and symptoms of behavioural disorders can be present.	Capacities for emotional regulation and cognitive control can be severely disrupted by adverse childhood events and negative social exposures, high vulnerability to ACEs both in the home, community, school environment and online. First rise in mental illnesses.	Poor education and social exposures can limit the development of self-control, problem solving and increase risk of violence (perpetration and victimisation). Pubertal changes trigger increased risk taking and unhealthy behaviours (alcohol use, smoking, sedentary behaviours) and emergence of body image concerns (with disordered eating).	High risk of school dropout or incompletion, early pregnancy, injuries. Increased risk for non-communicable and infectious diseases, (including HIV). Peak of onset of mental disorders, suicidal ideation and behaviours.
Universal services and support	Access to high quality health services Social support systems to limit food insecurity, provide sources of regular income and secure housing Nutritional and iron supplementation and access to safe delivery	Support for good infant feeding practices, regulatory controls of commercial food industry, maternity leave benefits, workplace policies to promote breastfeeding. Access to home visiting to support responsive caregiving and access to local ECD services and preschools. Environmental programs to ensure safe households, neighbourhoods and to limit children's exposure to toxins.	Strong social welfare system to limit children's exposure to physical and sexual abuse in the home. Safety in schools and monitoring of internet usage, prevention of bullying. Good quality schooling, feeding programmes and regulation of the sugar industry. Community wide initiatives to prevent child abuse and exploitation	Access to high quality health and mental health preventative services (including suicide prevention) through adolescent friendly school services. Psycho-educational services to support positive parenting in adolescence. Social interventions for 'at risk' adolescents, in particular in juvenile justice settings. Strengthen community responsiveness to limit negative social exposures (e.g., under-age access to alcohol)	Adolescent friendly reproductive health services, Early intervention for victims of IPV and community violence. Nutritional supplementation and structured economic support to ensure health during preconception period. Public works and entrepreneurial programmes to foster employment and educational opportunities.
Key intervention targets	Caregivers Health systems and services	Caregivers Early childhood development (ECD) services	Caregiver-child relationship School environment Community	Parental monitoring. Peer interventions School health services Community	Adolescent self-efficacy and access to services Higher education and employment
Prevention, promotion and intervention	Selective prevention through provision of facility and home-based mental health services for 'at risk pregnant women', including those at high risk of mental health problems, HIV, intimate partner violence, food insecurity.	Selective prevention in home-visiting services and well-baby clinics that deliver integrated care (including caregiver mental health support, support for early learning opportunities and responsive caregiving) aligned to the nurturing care framework. Access to additional resources to reduce harsh parenting.	Promotion of anti-bullying and anti-corporal punishment campaigns to raise community awareness. Selective prevention including low-cost, school-wide interventions to encourage physical activity, limit screen time, and encourage emotional regulation and cognitive control.	Selective prevention that limits exposure to social determinants of poor health. Monitoring of expulsion and punitive processes in education that systemically disadvantage children with mental health problems. Early interventions for mental health linked to parental monitoring and supervision. Interventions that promote parent-led sex education.	Access to early intervention for high prevalence mental health problems (depression, anxiety, conduct, substance use, psychosis). Continuity in care systems to ensure prevention of relapse.

Conclusion

While South Africa still has a way to go to advance clear and specific child and adolescent mental health services policies and services, life-course perspectives on mental health offers some important guiding principles for policy makers and service providers.

These include:

1. The early years of life are critical in determining adolescent and adult mental health outcomes, suggesting that universal and population-wide early years interventions could reap significant preventative rewards.
2. Interventions would benefit from being delivered through age-appropriate settings, for example, interventions in early childhood may be best delivered through the home, health facilities or early childhood development programmes, while interventions for adolescents may be better placed in schools or communities.
3. Mental health services cannot be delivered in isolation of other services and should not target individual problems but rather should be delivered alongside efforts to ensure stable and responsive relationships and safe, supportive environments with access to quality services.
4. Specific age groups have specific vulnerabilities which, if not eliminated, could have very negative consequences for society. Responding to this should involve universal approaches for all children. This in turn can be complemented with specific and selective prevention and early intervention efforts for 'at risk' groups.
5. Interventions which start early have cumulative positive effects, but if interventions are not maintained or exclude older age groups, then the benefits of early intervention can be lost or degraded. It is therefore critical to ensure that efforts to support children through developmental transitions are sustained throughout childhood and carried forward into early adulthood.

Case 9: Mental health over the life course – findings from the Birth to Thirty Cohort Study

Sara Naicker, Shane Norris & Linda Richter

The longitudinal Birth to Thirty (Bt30) Cohort Study embodies a life-course approach and highlights critical opportunities to prevent and mitigate mental health problems at key stages of life – from preconception, pregnancy, infancy, and childhood, through to adolescence and adulthood.

This uniquely South African cohort began in 1990 and is the largest and longest running prospective birth cohort in Africa, studying the health and well-being of children born in the Greater Johannesburg area. Numerous high-quality, robust and age-appropriate mental health measures were used in the study to assess behavioural, cognitive and socio-emotional problems in childhood and adolescence, including depression, anxiety, somatization and social dysfunction in later life, and maternal depression.

This case highlights the key findings from Bt30 on the antecedents and consequences of mental ill health, organised by life stage from the study's inception to date.

The early years: preconception to age five

With three generations included in the cohort, Bt30 has the unique capacity to investigate the intergenerational patterning of mental health. Exposure to prenatal stress during the third trimester of pregnancy more than doubled the risk of two-year-old children developing

behavioural problems.³¹ These effects continued into late adolescence, where adolescents aged 17 – 18 years born to young mothers with high levels of prenatal stress had a greater likelihood of experiencing psychological distress.³²

We also considered the mental health of mothers and links to mental ill health in their children. At age two, child behaviour problems were significantly associated with maternal postnatal depression in the first six months of a child's life, strongly mediated by the child's nutritional status.³³ Concurrent undernutrition was also independently associated with child behaviour problems, demonstrating the interplay between a child's mental and physical health. At age 10, postnatal maternal depression was again associated with poor child mental health. Children of mothers reporting postnatal depression were more than twice as likely to have substantial psychological difficulties than 10-year-olds born to mothers without postnatal depression, even when taking into account concurrent maternal depression.³⁴ Postnatal maternal depression was also associated with risk for increased and persistent internalising symptoms, such as depression and anxiety, from adolescence to adulthood in the cohort.³⁵ Taken together, the findings illustrate a consistent link between prenatal stress and maternal postnatal depression and the psychological maladjustment of their children over the first

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three decades of life. This supports the hypothesis that mental health problems operate intergenerationally and that early maternal mental health difficulties are linked to the development of mental health problems among their children later in life.³⁶

These findings may be explained through a number, and possibly a combination, of mechanisms. Through genetic pathways, vulnerability to mental ill health can be passed from parent to child,³⁷ or epigenetic triggers may work in tandem with the early environment to produce dysregulation in physiological systems that increase the risk for mental health difficulties.³⁷ For example, high levels of exposure to the stress hormone cortisol early in life can alter how the body functions, where an individual then develops a sensitivity for cortisol at low levels and responds with anxiety and depressive symptoms. The experience of postnatal depression may also influence maternal responsiveness and other caregiving behaviours, leading to poorer psychological outcomes for children.^{38, 39} Mothers who develop postnatal depression generally have more sources of stress and less support³⁷ which work together to produce negative developmental outcomes for children.⁴⁰ Predictors of postnatal maternal depression in the Bt30 cohort were found to be family and societal stress and difficulties with a partner during pregnancy.^{31, 41} Interventions should therefore identify women with these risk factors, provide adequate support during and after pregnancy and should, where possible, include partners. A home-based intervention in a South African peri-urban setting showed positive impacts on the mother-infant relationship, infant attachment and on maternal depressive symptoms.⁴²

Primary school years

Broader contextual factors have also been shown to influence behaviour problems in childhood. An assessment of the effects of socio-economic status and levels of community violence found that higher levels of exposure to interpersonal violence were linked to anxiety, depression, aggression and poor emotional adjustment among six-year-olds.^{43, 44} Context was also associated with the prevalence and patterning of problematic behaviours. Compared to African American children in similar age groups, South African children in their early school years displayed more externalising problems such as disruptive behaviour – bullying, rule breaking and attention seeking, while African American children showed internalising

problems such as anxiety, sadness and an over-dependence on adults.^{45, 46} Individual child resilience and supportive family environments were found to mitigate the impacts of direct and indirect violence on children's psychological adjustment.⁴⁴

The impacts of exposure to violence on children include physical ill health, psychological maladjustment and a broad range of social problems that reduce an individual's potential and well-being.⁴⁷ Using longitudinal data on a range of violence indicators across the Bt30 cohort, one study was able to demonstrate that South African children were exposed to widespread, continuous and excessive violence across all settings, including in their homes, schools and communities, among their peers and in their intimate relationships, and were also perpetrating similarly high levels of violence.⁴⁸

Adolescence

Adolescence, loosely considered the second decade of life, is a phase of profound physical, cognitive, hormonal and socio-emotional change.⁴⁹ The age of onset of puberty – or pubertal timing – and the rate at which it progresses – or tempo – influences adolescent physical and mental health⁵⁰ through complex interactions between biological, social, cognitive and emotional factors. Using measures of pubertal development, data from Bt30 showed that early pubertal onset and increased tempo were associated with an increased risk for psychological distress as well as increased likelihood of risky behaviour.⁵¹ One proposed pathway is the tension between advanced physical development and slower cognitive and emotional development which may place adolescents in situations where they do not have the capacity to make good decisions.⁵² Early maturing adolescents are likely to benefit from interventions during their pubertal transition at the level of the individual, family and peers.⁵¹ Interventions such as the Parenting for Lifelong Health (Sinovuyo) Caring Families Programme for Parents and Teens, PREPARE, and SKILLZ Street show promise for reducing risky behaviour and improving well-being for adolescents.⁵³

Environmental influences on the psychological adjustment of the cohort were also examined. Lead exposure continues to be a threat to health worldwide with the highest burden in low-middle income countries.⁵⁴ Children in South Africa, particularly those from poorer communities,⁵⁵ are exposed to lead through lead-based paint in toys, playground equipment, and other

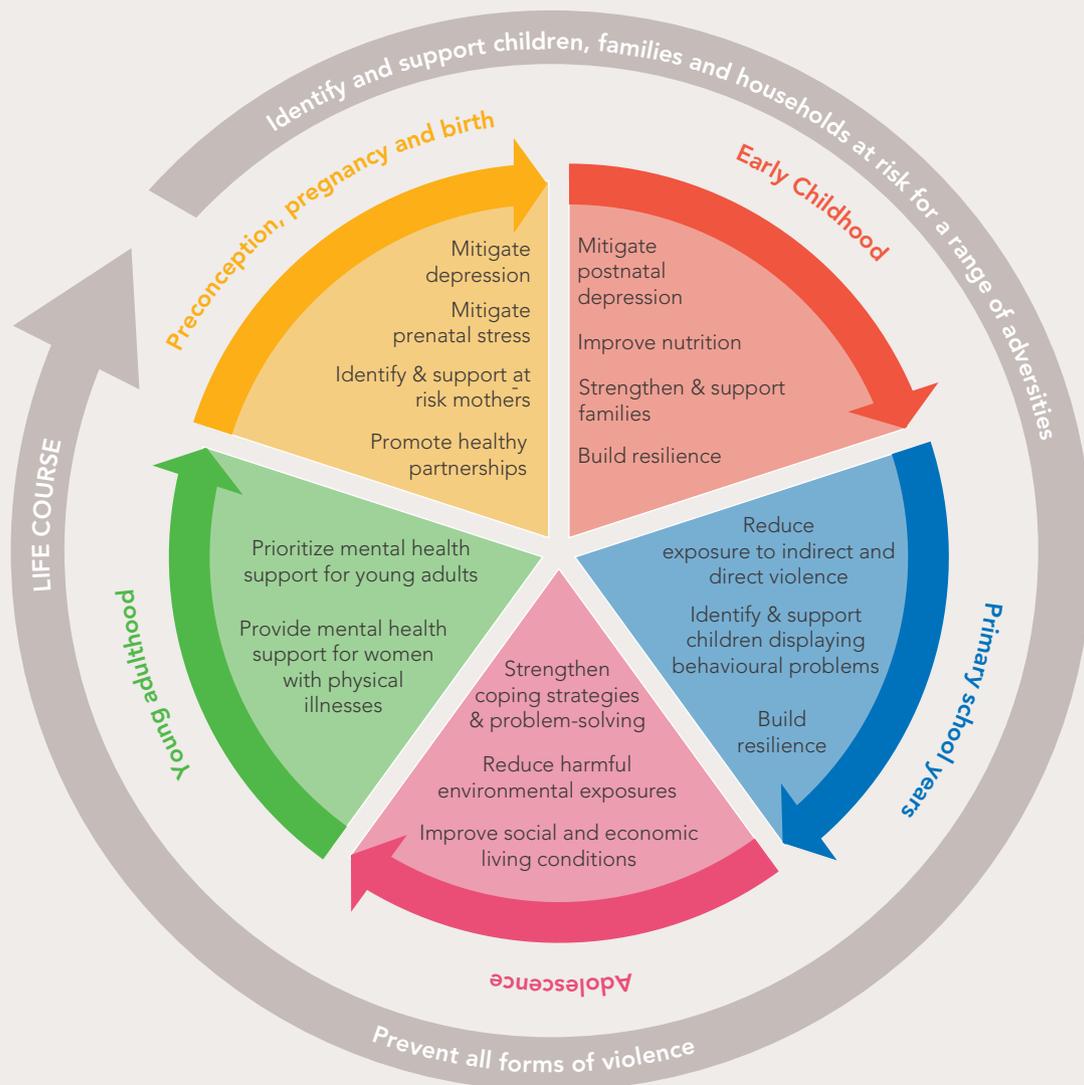
sources⁵⁶⁻⁵⁹ Two studies in the cohort show high blood lead levels and link these to increased antisocial and destructive behaviour among boys in early adolescence,⁶⁰ direct aggression among boys in mid-adolescence,⁶¹ and increased risk for indirect aggression among girls in mid-adolescence.⁶¹ South Africa gazetted a complete ban on lead in paint in October 2021, due to come into effect October 2022. This alignment with the WHO and United Nations Environment Programme has been welcomed but advocates emphasise the harmful legacy of old lead paint in houses, schools and playgrounds across South Africa and call for elimination of additional sources of lead.⁶²

Young adulthood

In addition to demonstrating the effects of direct and indirect violence on mental ill health in early childhood,^{43,44} the impact of interpersonal violence on young women in

the cohort was examined. Young women were twice as likely to display psychological distress if they reported high levels of exposure to interpersonal violence, compared to those with low levels of exposure.⁶³ The same measure of psychological distress (the GHQ-28) was used to assess co-morbidity with physical illness among mothers of the cohort. The presence of one physical illness was significantly associated with a risk for psychological distress, and the presence of additional physical illnesses increased this risk substantially.⁶⁴ These results point to the possible bi-directionality of physical and mental comorbidities where specific illnesses may precede psychological symptoms, and chronic untreated psychological disorders over the life course may increase the risk for physical illness.⁶⁵ These findings may underestimate the link between physical and psychological health given the exclusion of HIV from the assessment of physical illnesses and the well-

Figure 14: Findings from Bt30 on mental health throughout the life course



established association between HIV infection and mental ill health.⁶⁶ Apart from recognising that lifelong mental ill health contributes to the burden of disease and efforts to reduce the latter should address the former, these findings emphasise the need for increased mental health support in the treatment of physical illness.

Other individual risk factors for mental ill health have been investigated in the cohort, for example, child sexual abuse measured prospectively among boys aged 11 – 18 years and mental health in young adulthood (age 22). Young men who reported sexual abuse as children were more likely to express overall psychological distress, as well as anxiety and depression, compared to men who did not report sexual abuse.⁶⁷ These findings were not significant when adjusted for social and personal vulnerabilities – such as height, pubertal timing, maternal education, father presence, and socio-economic status – which suggests that these factors may also play a role in mental ill health in adulthood.

The breadth of the Bt30 study made it possible to track indices of risk factors over the life course. One specific index is a measure of adverse childhood experiences (ACEs), which tracks the cumulative impact of the range of adversity children are exposed to, including direct and indirect violence, abuse, neglect and various forms of household dysfunction. ACEs were found to be highly prevalent in the cohort, whether measured prospectively or retrospectively.^{68, 69} An analysis of ACEs and mental health in the cohort showed that the risk for psychological distress in young adulthood increased with the number of ACEs in childhood, and that young women were twice as likely to experience psychological distress even though they reported fewer ACEs.⁷⁰ Children living with single mothers, absent fathers and in poorer households were likely to experience higher numbers of ACEs.⁶⁹ Therefore, single parent families, families in poor communities and dysfunctional households may need additional support to mitigate the co-occurrence of ACEs that may act in combination to lead to mental health difficulties later in life.

Implications for policy and practice

The evidence from Bt30 has collectively demonstrated that mental health problems have their origins in early life, perhaps even before conception, and that they can be passed from parents to children intergenerationally through the interplay of social and biological factors. This can lead to persistent mental health difficulties, identifiable

in childhood through to young adulthood. A number of important learnings can be drawn for policy and practice.

- Timely investment in mental health – to address the causes rather than the consequences of ill-health – leads to high, long-term benefits for both public health and economies.
- A life-course approach highlights multiple entry points for intervention:
 - Pregnancy and birth should be a healthy and positive experience for parents to provide the best possible start for their child. Support should be provided for mothers with high levels of family and social stress and little social support. Efforts should be made to include partners in any intervention, and the risk factors for postnatal depression should be assessed and addressed early.
 - A healthy and supportive environment in the early years fosters healthy adjustment and is particularly important for mitigating adversity. Recognizing the interplay between a young child's physical and mental health through holistic responses is critical to ensuring optimal development. The Nurturing Care Framework is an evidence-based framework that promotes children's health, nutrition, protection, learning, and socio-emotional development through guidelines for intervention at the micro- and macro-levels, including in the home, at ECD centres, schools, and beyond.
 - Well-adjusted adolescents are able to make choices that could delay the onset of negative health behaviours. Intervening at vulnerable transition periods, such as the onset of puberty, can provide them with the resources to cope, recover and thrive, particularly in contexts of hardship and adversity.
 - Mental ill health is prevalent in young South African adults, is exacerbated by current stress, and often co-occurs with physical illness. More effort should be made to support young adults with mental ill health, not least to prevent the intergenerational transmission of psychological difficulties.
 - The pervasiveness of violence in children's lives and its link to poorer mental health outcomes warrant intensive violence prevention efforts in all settings.
 - Interventions to mitigate the impact of adverse childhood experiences should be directed at individual and household level, as well as the broader community.

References

1. Statistics South Africa. *Mid-Year Population Estimates—P0302*. Pretoria: Stats SA. 2019.
2. Jacob CM, Baird J, Barker M, Cooper C, Hanson M. *The Importance of a Life Course Approach to Health: Chronic disease risk from preconception through adolescence and adulthood*. Geneva: World Health Organization. 2017.
3. Alwin DF. Commentary: It takes more than one to tango - life course epidemiology and related approaches. *International Journal of Epidemiology*. 2016;45(4):988-993.
4. Shonkoff JP, Garner AS, Siegel BS, Dobbins MI, Earls MF, McGuinn L, Care D. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e232-e246.
5. Betancourt TS, Khan KT. The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry*. 2008;20(3):317-328.
6. Sameroff A. A unified theory of development: A dialectic integration of nature and nurture. *Child Development*. 2010;81(1):6-22.
7. Bornstein MH. Toward a model of culture – parent – child transactions. In: Sameroff A, editor. *The transactional model of development: How children and contexts shape each other*. American Psychological Association; 2009. p. 139–161.
8. Verkuil NE, Richter L, Norris SA, Stein A, Avan B, Ramchandani PG. Postnatal depressive symptoms and child psychological development at 10 years: A prospective study of longitudinal data from the South African Birth to Twenty cohort. *The Lancet Psychiatry*. 2014;1(6):454-460.
9. Hsiao C, Richter LM. Early mental development as a predictor of preschool cognitive and behavioral development in South Africa: The moderating role of maternal education in the Birth to Twenty cohort. *Infants & Young Children*. 2014;27(1):74-87.
10. Rochat TJ, Houle B, Stein A, Pearson RM, Newell ML, Bland RM. Cohort profile: The Siyakhula cohort, rural South Africa. *International Journal of Epidemiology*. 2017;46(6):1755-1756n.
11. Rochat TJ, Houle B, Stein A, Pearson RM, Bland RM. Prevalence and risk factors for child mental disorders in a population-based cohort of HIV-exposed and unexposed African children aged 7–11 years. *European Child & Adolescent Psychiatry*. 2018.
12. Rochat TJ, Houle B, Stein A, Coovadia H, Coutsooudis A, Desmond C, Bland RM. Exclusive breastfeeding and cognition, executive function, and behavioural disorders in primary school-aged children in rural South Africa: A cohort analysis. *PLoS Medicine*. 2016;13(6):e1002044.
13. Rochat TJ, Houle B, Stein A, Pearson RM, Newell ML, Bland RM. Psychological morbidity and parenting stress in mothers of primary school children by timing of acquisition of HIV infection: A longitudinal cohort study in rural South Africa. *Journal of Developmental Origins of Health and Disease*. 2018;9(1):41-57.
14. Cohen JL. Stress and mental health: A biobehavioral perspective. *Issues in Mental Health Nursing*. 2000;21(2):185-202.
15. Lupien SJ, McEwen BS, Gunnar MR, Heim C. Effects of stress throughout the lifespan on the brain, behaviour and cognition. *Nature Reviews Neuroscience*. 2009;10(6):434-445.
16. Barouki R, Gluckman PD, Grandjean P, Hanson M, Heindel JJ. Developmental origins of non-communicable disease: Implications for research and public health. *Environmental Health*. 2012;11(1):1-9.
17. Roberts AG, Lopez-Duran NL. Developmental influences on stress response systems: Implications for psychopathology vulnerability in adolescence. *Comprehensive Psychiatry*. 2019;88:9-21.
18. Blakemore S-J. The social brain in adolescence. *Nature Reviews Neuroscience*. 2008;9(4):267.
19. Patton GC, Neufeld LM, Dogra S, Frongillo EA, Hargreaves D, He S, Norris SA. Nourishing our future: The Lancet Series on adolescent nutrition. *Lancet*. 2022;399(10320):123-125.
20. Davidson LL, Grigorenko EL, Boivin MJ, Rapa E, Stein A. A focus on adolescence to reduce neurological, mental health and substance-use disability. *Nature*. 2015;527(7578):S161-S166.
21. Norris SA, Frongillo EA, Black MM, Dong Y, Fall C, Lampl M, Patton GC. Nutrition in adolescent growth and development. *Lancet*. 2022;399(10320):172-184.
22. Lester BM, Conradt E, Marsit CJ. Epigenetic basis for the development of depression in children. *Clinical Obstetrics and Gynecology*. 2013;56(3):556.
23. Moffitt TE, Arseneault L, Jaffee SR, Kim-Cohen J, Koenen KC, Odgers CL, Viding E. Research Review: DSM-V conduct disorder: research needs for an evidence base. *Journal of Child Psychology and Psychiatry*. 2008;49(1):3-33.
24. Lahey BB. Why are children who exhibit psychopathology at high risk for psychopathology and dysfunction in adulthood? *JAMA Psychiatry*. 2015;72(9):865-866.
25. Diamond A. Executive functions. *Annual Review of Psychology*. 2013;64:135-168.
26. Diamond A, Lee K. Interventions shown to aid executive function development in children 4 to 12 years old. *Science*. 2011;333(6045):959-964.
27. Colizzi M, Lasalvia A, Ruggeri M. Prevention and early intervention in youth mental health: Is it time for a multidisciplinary and trans-diagnostic model for care? *International Journal of Mental Health Systems*. 2020;14(1):1-14.
28. Black MM, Walker SP, Fernald LC, Andersen CT, DiGirolamo AM, Lu C, Shiffman J. Early childhood development coming of age: Science through the life course. *The Lancet*. 2017;389(10064):77-90.
29. Black MM, Behrman JR, Daelmans B, Prado EL, Richter L, Tomlinson M, Yoshikawa H. The principles of nurturing care promote human capital and mitigate adversities from preconception through adolescence. *BMJ Global Health*. 2021;6(4):e004436.
30. Mokitimi S, Schneider M, de Vries PJ. Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis. *International Journal of Mental Health Systems*. 2018;12(1):1-15.
31. Ramchandani PG, Richter LM, Norris SA, Stein A. Maternal prenatal stress and later child behavioral problems in an urban South African setting. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2010;49(3):239-247.
32. Kim AW, Mohamed RS, Norris SA, Richter LM, Kuzawa CW. Psychological legacies of intergenerational trauma under South African Apartheid: Prenatal stress predicts increased psychiatric morbidity during late adolescence and early adulthood in Soweto, South Africa. *medRxiv*. 2021:2021.2001.2011.21249579.
33. Avan B, Richter LM, Ramchandani PG, Norris SA, Stein A. Maternal postnatal depression and children's growth and behaviour during the early years of life: Exploring the interaction between physical and mental health. *Archives of Disease in Childhood*. 2010;95(9):690.
34. Verkuil NE, Richter L, Norris SA, Stein A, Avan B, Ramchandani PG. Postnatal depressive symptoms and child psychological development at 10 years: A prospective study of longitudinal data from the South African Birth to Twenty cohort. *The Lancet Psychiatry*. 2014;1(6):454-460.
35. Orri M, Besharati S, Ahun MN, Richter LM. Analysis of maternal postnatal depression, socioeconomic factors, and offspring internalising symptoms in a longitudinal cohort in South Africa. *JAMA Network Open*. 2021;4(8):e2121667.
36. Hofstra MB, Van Der Ende JAN, Verhulst FC. Child and adolescent problems predict DSM-IV disorders in adulthood: A 14-year follow-up of a Dutch epidemiological sample. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2002;41(2):182-189.
37. Sawyer KM, Zunszain PA, Dazzan P, Pariante CM. Intergenerational transmission of depression: Clinical observations and molecular mechanisms. *Molecular Psychiatry*. 2019;24(8):1157-1177.
38. Ahun MN, Consoli A, Pingault J-B, Falissard B, Battaglia M, Boivin M, Côté SM. Maternal depression symptoms and internalising problems in the offspring: The role of maternal and family factors. *European Child & Adolescent Psychiatry*. 2018;27(7):921-932.
39. Goodman SH, Simon HFM, Shamblaw AL, Kim CY. Parenting as a mediator of associations between depression in mothers' and children's functioning: A systematic review and meta-analysis. *Clinical Child and Family Psychology Review*. 2020;23(4):427-460.
40. Glover V. Maternal depression, anxiety and stress during pregnancy and child outcome: What needs to be done. *Best Practice & Research Clinical Obstetrics & Gynaecology*. 2014;28(1):25-35.
41. Ramchandani PG, Richter LM, Stein A, Norris SA. Predictors of postnatal depression in an urban South African cohort. *Journal of Affective Disorders*. 2009;113(3):279-284.
42. Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, Murray L. Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: Randomised controlled trial. *BMJ*. 2009;338:b974.
43. Barbarin OA, Richter L. Economic status, community danger and psychological problems among South African children. *Childhood (Copenhagen, Denmark)*. 2001;8(1):115-133.
44. Barbarin OA, Richter L, deWet T. Exposure to violence, coping resources, and psychological adjustment of South African children. *The American Journal of Orthopsychiatry*. 2001;71(1):16-25.
45. Barbarin OA, Richter LM. *Mandela's children: Growing up in post-Apartheid South Africa*. New York: Routledge; 2001.
46. Barbarin OA. Social risks and psychological adjustment: A comparison of African American and South African children. *Child Development*. 1999;70(6):1348-1359.
47. Gilbert R, Widom CS, Browne K, Fergusson D, Webb E, Janson S. Burden and consequences of child maltreatment in high-income countries. *The Lancet*. 2009;373(9657):68-81.
48. Richter LM, Mathews S, Kagura J, Nonterah E. A longitudinal perspective

- on violence in the lives of South African children from the Birth to Twenty Plus cohort study in Johannesburg-Soweto. *South African Medical Journal*. 2018;108(3).
49. Blakemore S-J, Burnett S, Dahl RE. The role of puberty in the developing adolescent brain. *Human brain mapping*. 2010;31(6):926-933.
 50. Susman EJ, Rogol A. Puberty and psychological development. In: Lerner RM, Steinberg L, editors. *Handbook of Adolescent Psychology*. Hoboken, NJ: John Wiley and Sons; 2014.
 51. Kowalski AJ, Addo OY, Kramer MR, Martorell R, Norris SA, Waford RN, Stein AD. Longitudinal associations of pubertal timing and tempo with adolescent mental health and risk behaviour initiation in urban South Africa. *Journal of Adolescent Health*. 2021;69(1):64-73.
 52. Brooks-Gunn J, Petersen AC, Eichorn D. The study of maturational timing effects in adolescence. *Journal of Youth and Adolescence*. 1985;14(3):149-161.
 53. Amisi M, Naicker SN. *Preventing violence against women and children: An evidence review*. Pretoria: Institute for Security Studies. 2021.
 54. Institute for Health Metrics and Evaluation. *GBD Compare*. Seattle, WA: IHME, University of Washington. 2019.
 55. Naicker N, Norris SA, Mathee A, von Schirnding YE, Richter L. Prenatal and adolescent blood lead levels in South Africa: Child, maternal and household risk factors in the Birth to Twenty cohort. *Environmental Research*. 2010;110(4):355-362.
 56. Mathee A, Singh E, Mogotsi M, Timothy G, Maduka B, Olivier J, Ing D. Lead-based paint on playground equipment in public children's parks in Johannesburg, Tshwane and Ekurhuleni. *South African Medical Journal*. 2009;99:819-821.
 57. Mathee A, Röllin H, Levin J, Naik I. Lead in paint: Three decades later and still a hazard for African children? *Environmental health perspectives*. 2007;115(3):321-322.
 58. Mathee A, Naicker N, Kootbodien T, Mahuma T, Nkomo P, Naik I, de Wet T. A cross-sectional analytical study of geophagia practices and blood metal concentrations in pregnant women in Johannesburg, South Africa. *South African Medical Journal*. 2014;104(8):568-573.
 59. Mathee A. Towards the prevention of lead exposure in South Africa: Contemporary and emerging challenges. *NeuroToxicology*. 2014;45:220-223.
 60. Naicker N, Richter L, Mathee A, Becker P, Norris SA. Environmental lead exposure and socio-behavioural adjustment in the early teens: The birth to twenty cohort. *Science of The Total Environment*. 2012;414:120-125.
 61. Nkomo P, Naicker N, Mathee A, Galpin J, Richter LM, Norris SA. The association between environmental lead exposure with aggressive behavior, and dimensionality of direct and indirect aggression during mid-adolescence: Birth to Twenty Plus cohort. *Science of The Total Environment*. 2018;612:472-479.
 62. South African Medical Research Council. *Action to curb lead paint hazards in South Africa: 2021*. Accessed: 14 December 2021. Available from: <https://www.samrc.ac.za/media-release/action-curb-lead-paint-hazards-south-africa>.
 63. Manyema M, Norris SA, Said-Mohamed R, Tollman ST, Twine R, Kahn K, Richter LM. The associations between interpersonal violence and psychological distress among rural and urban young women in South Africa. *Health & Place*. 2018;51:97-106.
 64. Mendenhall E, Richter LM, Stein A, Norris SA. Psychological and physical co-morbidity among urban South African women. *PLOS ONE*. 2013;8(10):e78803.
 65. Mezuk B, Eaton WW, Albrecht S, Golden SH. Depression and type 2 Diabetes over the lifespan. *Diabetes Care*. 2008;31(12):2383.
 66. Myer L, Smit J, Roux LL, Parker S, Stein DJ, Seedat S. Common mental disorders among HIV-infected individuals in South Africa: Prevalence, predictors, and validation of brief psychiatric rating scales. *AIDS Patient Care and STDs*. 2008;22(2):147-158.
 67. Richter LM, Mathews S, Nonterah E, Masilela L. A longitudinal perspective on boys as victims of childhood sexual abuse in South Africa: Consequences for adult mental health. *Child Abuse & Neglect*. 2018;84:1-10.
 68. Naicker SN, Norris SA, Mabaso M, Richter LM. An analysis of retrospective and repeat prospective reports of adverse childhood experiences from the South African Birth to Twenty Plus cohort. *PLOS ONE*. 2017;12(7):e0181522.
 69. Manyema M, Richter LM. Adverse childhood experiences: Prevalence and associated factors among South African young adults. *Heliyon*. 2019;5(12).
 70. Naicker SN, Norris SA, Richter LM. Secondary analysis of retrospective and prospective reports of adverse childhood experiences and mental health in young adulthood: Filtered through recent stressors. *EClinicalMedicine*. 2021.

Families: Foundations for child and adolescent mental health and well-being

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“Children learn about the nature of the world from their family. They learn about power and about justice, about peace and about compassion within the family. Whether we oppress or liberate our children in our relationships with them will determine whether they grow up to oppress and be oppressed or to liberate and be liberated.”

— Desmond Tutu

Families exist everywhere in the world to bear and rear children, to care for and protect vulnerable members during old age, illness, and misfortune, and to meet our relational needs. They are the bedrock of cultural traditions, norms and values, and behaviour patterns transmitted from one generation to the next. Our whole lives are spent in close interaction with family members and, as such, families play a critical role in our mental and physical well-being at all ages, but especially in the formative development period of childhood and adolescence. We begin here by describing the various forms that families can take, the central role families play in children’s health and well-being, the ways in which dysfunction in the family can have long-lasting effects on mental health and well-being, and what is necessary to support families to best provide nurturing care.

While families are universal, they are not uniform with respect to size, gender, age groups or even whether they are based on biological or social connections. Together, these characteristics define family form – the shape, composition and structure of a family unit. For the purposes of this chapter, we consider a family to be a single individual or group of individuals related to each other either socially or biologically, with at least one child in the family unit.

Globally, families are becoming smaller with fewer children, generally leading to more investment in the health and education of each individual child, a long-standing trend beginning in the late 1800s described in Viviana’s Zelizer’s book, *Pricing the Priceless Child: The Social Values of Children*. When child mortality is high and there is little space

for upward mobility, families have many children to assist with labour and to assure care of dependent members, including in old age. As social and economic conditions improve and upward mobility is possible through health and education, families have fewer children and invest more in their human capital.

Families are also becoming more diverse, with increasing non-marital fertility and cohabitation, as well as parents living in different households. Children living with one or neither parent is a common arrangement in low- and middle-

Box 2: Children’s household types

Household type

A household is a living arrangement in a housing unit; one-person households comprise one individual who makes provision for themselves. Multi-person households include two or more people living together and sharing resources. These households might contain more than one family unit as well as members outside of these family units.

Childed couple: spouse/partner couple with their own children and no other members

Lone parent: single parent with own children and no other members

Extended: not childed couple or lone parent, and all members are related

Composite: not childed couple or lone parent, and some members are not related

Source: Hall K, Richter L. Introduction: Children, families and the state In: Hall K, Richter L, Mokomane Z, Lake L, editors. *South African Child Gauge 2018: Children, Families and the State - Collaboration and Contestation*. Cape Town: University of Cape Town; 2018.

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income countries (LMICs), as is living with extended family members. It is predicted that by 2030, lone parent families will make up 40% of all families in many countries.¹ South Africa has overshot this with 46% of children living with only their mother or father, and 20% living with neither biological parent,² although these trends are more marked amongst families at the lower end of the socio-economic spectrum.

Recent data from the 2019 General Household Survey shows that the more children there are in a household, the greater the chances that they are cared for by extended family members.³ It is important to note that these variations in living arrangements, where parents and children are not co-residents, do not necessarily equate to emotional estrangement, non-involvement, or divorce.

What are the factors driving diversity in families?

Global economic development has affected family form and stability worldwide. Closer to home, there are a number of factors that affect family form in South Africa. Migrant labour systems reminiscent of the apartheid era still characterise much of South Africa's rural landscape. While the patterns of inter- and intra-provincial job-seeking migration, driven by poverty and unemployment, have changed considerably, they still influence family form.⁴ Similarly, although the social impacts of HIV/AIDS are declining, mortality and orphaning continue to have lasting impacts on families. Within this context of poverty and high unemployment, the transition to a cash-based *lobola* system has also made marriage unaffordable for many men.⁵ Shifts in social norms are also influencing trends in family decision-making. Marriage decisions are increasingly made by a couple instead of an agreement between two families, the birth of children outside marriage is more acceptable, and the occurrence of same-sex couples with children is more common.

In South Africa, and elsewhere, family is not the same as household. Members of close-knit extended families may move between different households, both in rural and urban areas, as they seek opportunities for better work, accommodation or care, and this is one of the most commonly used strategies to deal with poverty and family crises. For example, when a household cannot feed all members, one or more may be sent to live, temporarily or for an extended period, with better-off relatives; when work opportunities open up in an area, job seekers look to live with family in nearby locations; when a family member becomes sick or disabled, they may be sent to live in a household where care can be provided, or a caregiver in the family may be sent to live with them. While these strategies may not always lead

to desired outcomes, they are dearly valued within families, even at considerable 'cost'; for example, in the form of 'Black tax', whereby better-off members of extended families are obliged to support members in need in the knowledge that help is reciprocated within the family network.⁶

There are a myriad of factors that work together to determine what a family looks like, and with this, increasing recognition that the shape of the family does not necessarily indicate stability, strength or vulnerability.⁷ Questions continue to be raised about the influence of family form on child and adolescent mental health. For example, are two parents better than one for children's mental health; do heterosexual couples make it easier for children and adolescents to enjoy mental health than same-sex parents; are small families better than big extended families, and so on. Nevertheless, what all functional families have in common is a long-term commitment to support one another and, where children are present, to care for and protect them. And despite the diversity of families, there is little evidence that family form significantly influences child and adolescent health bar through indirect influences such as the likelihood of more or less economic and emotional resources and disruptions or continuity in family life.

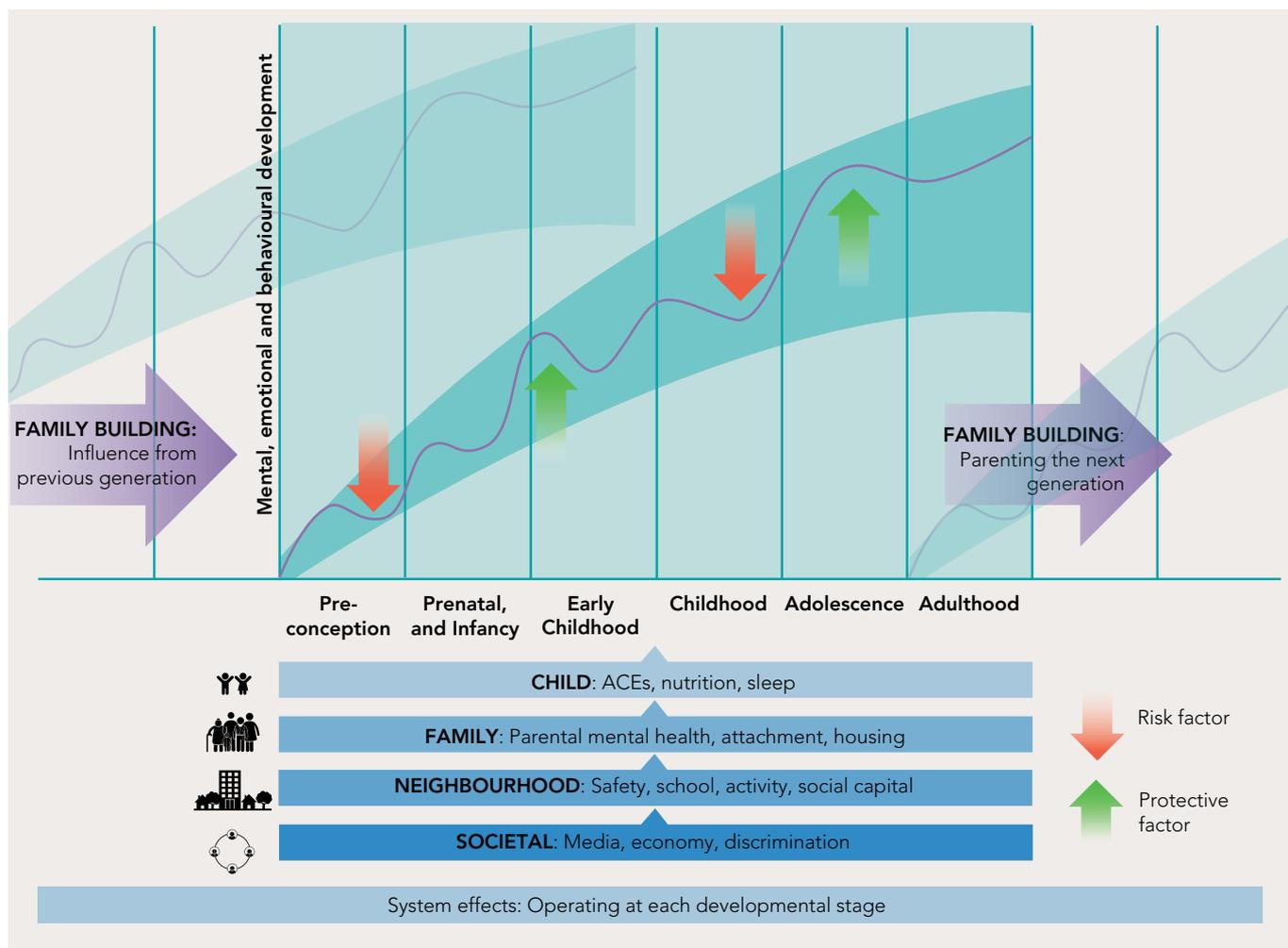
Why do families matter?

Regardless of their form, families have a profound impact on children's health and well-being, and they play an active role in creating the social environment in which children develop. This environment must be conducive for children to thrive. The home environment should be stimulating, promote children and adolescents' participation and inclusion in family life, and include responsive, nurturing and consistent caregivers who are attentive to children's holistic needs at all stages of development.

How do families influence children's mental health across the life course?

Early childhood is a pivotal stage of life, where the foundations for health, education, relational skills, employability and other measures of well-being are established within the family environment. Infants and young children are greatly dependent on their caregivers and family members for nurturing care, support and protection. Maintaining daily routines, modelling appropriate behaviour and interactions, and responding to cues from non-verbal young children in particular, are all important activities that family members perform to develop safe and supportive family environments. As children mature, healthy families will adapt to children's

Figure 15: Multiple influences on mental, emotional and behavioural development across the life course



Source: National Academies of Sciences, Engineering, Medicine. *Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda*. Washington, DC: The National Academies Press; 2019.

changing needs. During early adolescence, with the onset of puberty and a remodelling of the brain’s reward system, adolescents have low levels of risk perception, low resistance to peer influences and poor self-regulation. The brain continues to develop at a rapid pace in late adolescence, and the influence of the family takes on a different but still important form as does the educational setting. Family and school environments remain critical social contexts during this time, cultivating safe and supportive environments for adolescents to learn, build connections and develop greater autonomy.

Figure 15 shows the many ways in which the family influences the mental, emotional, and behavioural development of children across the life course, and how the child and family are nested within and influenced by their neighbourhood and wider society. Families living under conditions of overwhelming stress and hardship or

experiencing shocks are more vulnerable to poor outcomes for both adults and children, i.e., the risk factors outweigh the protective factors. For example, COVID-19 represents an extreme shock to family well-being, with significant effects on families that were already vulnerable.

These many layers of relationships and environments interact with each other – ultimately influencing how children develop and become resilient. Importantly, intra-familial processes have long-term effects on children and can result in patterns and behaviours that are transmitted from one generation to another.⁸ These processes are not distinct but interdependent, convoluting their effects on child health and well-being. For example, a genetic predisposition to parental mental ill health can create an environment that is unstable and filled with tension, and influences parent behaviour and interactions with their child (see Case 18 on p100).

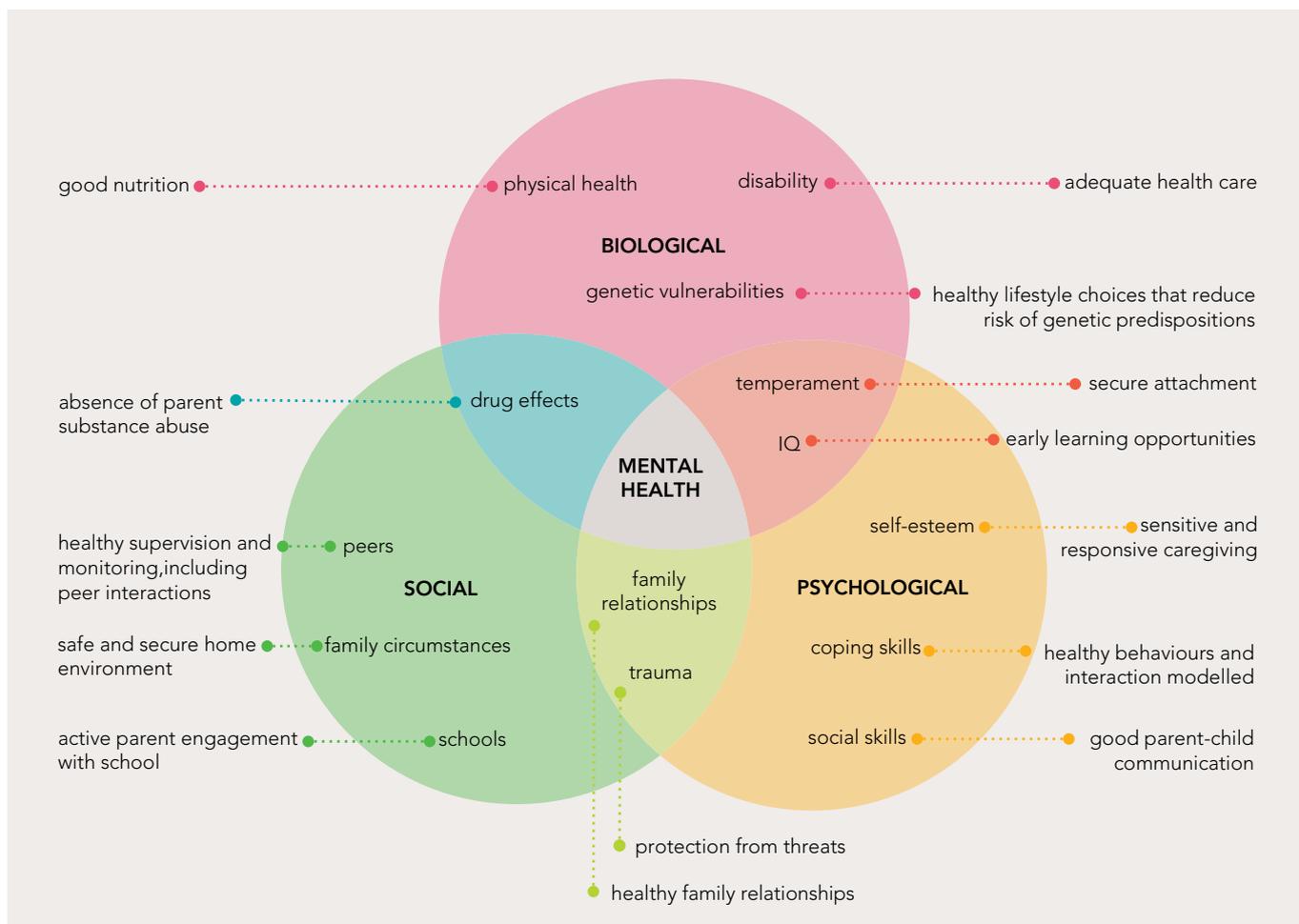
How do families influence child mental health problems?

Looking at the biological, social, and psychological origins of child mental health, we can map the ways in which the interaction of biology, environment and behaviour influences child development (see Figure 16). For example, the social domain – including risk factors such as violence and substance abuse in the family, peer group or school environment – can contribute to mental ill health in childhood; but families also play a key role in mitigating the effects of risk factors at a community level by establishing a healthy home environment, interacting with a child’s school, and monitoring or managing engagements with peers. Similarly, a child’s self-esteem, coping skills and social skills that help mitigate mental health problems can be attributed to healthy parent-child communication, the modelling of good social and coping skills, and responsive caregiving that promotes secure attachment within family relationships.

Family characteristics and dynamics work to either mitigate

or aggravate the negative consequences of adversity and can promote both adaptive and maladaptive strategies that contribute to health and well-being outcomes. For example, children experiencing or witnessing violence in the home are likely to perceive violence as the norm and enact it in their own behaviours, including once they themselves become adults. Children’s positive experiences in the family tend to have additive but not compensatory effects.⁹ A stable, stimulating, and loving home can cumulatively build resilience and promote mental health, but negative relationships with parents cannot be compensated with positive peer relationships. In essence, how families influence mental health and well-being depends on their functionality, particularly under conditions of strain. Families can become temporarily dysfunctional, for example, as a result of acute stresses such as the death of a close family member, but families may also become dysfunctional into the longer term as a consequence of parental conflict, substance abuse and parental mental or physical ill-health.

Figure 16: Family influences on the origins of child mental health problems



Adapted from: Engel GL. The clinical application of the biopsychosocial model. *American Journal of Psychiatry*. 1980;137(5):535-544.

The family stress model

The family stress model¹⁰ illustrates how chronic and acute stressors put children and caregivers at risk of psychological and relationship problems. Economic hardships and pressures exacerbate child maladjustment through caregivers' psychological distress, caregiver/parental relationship problems and disrupted parenting. The model's predictions hold true for diverse family forms. In turn, relational and mental health problems in the home may impact on the ability to work, creating a cycle that ultimately affects the physical environment and relationships in the family. There are two different ways in which families influence child and adolescent mental health: through family dynamics or relationships within a family, and through external stressors such as poverty and adversity that impact on family functioning.

Family dynamics

Family relationships can substantially affect mental health, behaviour, and even physical health. Numerous studies have shown that these relationships can have both long- and short-term effects on a child's mental health, and depending on the nature of these relationships, mental health can be enhanced or impacted negatively.¹¹

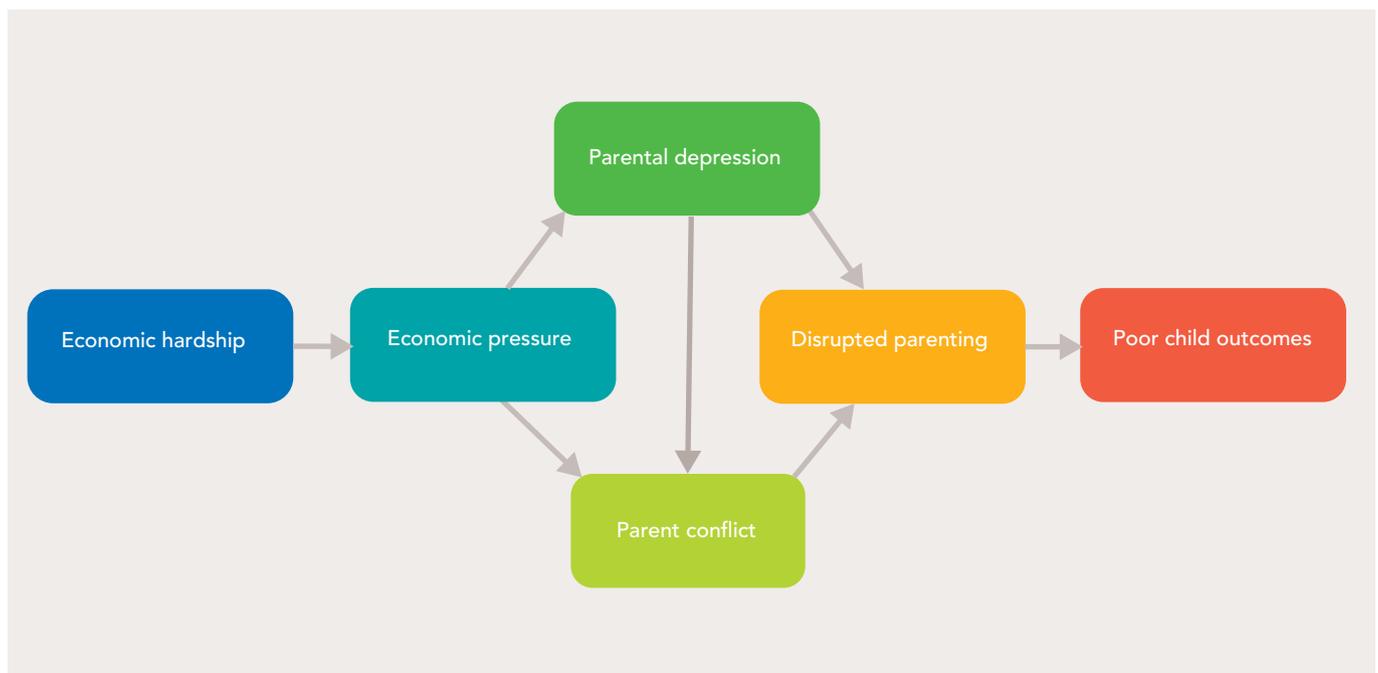
The biological connections that underlie the intergenerational transmission of mental health problems are well researched. Studies have also been able to tease out differences in mental health outcomes based on genetics,

those based on the unique environment (the relationship between a single child and their caregiver), and those based on the shared environment (the family or home environment).¹² Less understood are the ways in which the presence of a family member with a mental illness impacts on the mental health and well-being of other family members, particularly children. When someone in a family experiences mental health problems, it can have a substantial impact on the well-being of the family as a whole, financially and psychosocially. Children may be too young to fully grasp the concept of mental health problems, leading to self-blame, feelings of isolation and loneliness, strained relationships, and perhaps their own psychological, behavioural, and social problems. Overall, parental mental illness is an important risk factor for family functioning – leading to more conflict in the home, less cohesion, disorganized living, and other challenges.^{13, 14}

Family dysfunction

Family dysfunction can be characterised by neglect, violence, abandonment, shame, inconsistency, poor communication, substance abuse, fear, and more. A healthy family environment may present with one or more of these traits some of the time, but dysfunctional families are those families that fail to provide for many of their children's physical and emotional needs.¹⁵ The frequency and severity of dysfunction are also important indicators of how likely family dysfunction is to negatively impact a child's mental health.

Figure 17: The family stress model



Adapted from: Hurwich-Reiss, E. (2017). Family processes among Early Head Start families: Testing the role of parental self-efficacy in the Family Stress Model.

Family resilience

Family resilience, or their capacity to overcome significant challenges, has emerged as a key concept that enables families to function and recover in the context of adversity. Family resilience is determined by many factors – family structure, resources, diverse cultures and socio-economic and developmental influences in the outside environment and the extent to which there are positive and supportive relationships in the family. Individual resilience, although linked to family resilience, is also important for protecting mental health and well-being, and generally works through the strong emotional bonds between family members.¹⁶ Family relationships that are stable and supportive have a protective effect on the mental health of family members, especially children, even under conditions of strain.

Harsh, cold, and inconsistent parenting

The most important relationship in a child's life is shared with their primary caregivers – a mother or father figure, referred to hereafter as 'parents'. Poor parenting – characterised by a lack of warmth and responsiveness, inconsistent behaviour, and harshness – is a key risk factor in the development of child mental health problems. Harsh, cold, and inconsistent parenting increases the risk that children will develop both externalising disorders (behavioural problems such as aggression) and internalising disorders (anxiety and depression). A study of a Soweto-Johannesburg birth cohort found that harsh punishment was associated with children's behavioural difficulties.¹⁷ A study in the Western Cape also found that direct violence to children in the form of spanking and slapping was significantly associated with

Box 3: The mental health of fathers and implications for family functioning and child health and well-being

Expectant and new fathers, like pregnant women and new mothers, experience biological and ecological stressors, including changes to hormone concentrations and brain circuits, that can increase their risk of depressive symptoms. Although paternal mental health does not expose children's pre-birth development to the same physiological risks as maternal depression during pregnancy, paternal genetic and psychological factors may act on the child directly during conception and after birth, and indirectly through maternal well-being and family functioning.

In general, parents who have their own mental health problems may have difficulty in caring for their own children and in supporting their partners. Poor paternal mental health has been linked to adverse effects on maternal and child health and development, including a variety of negative socio-emotional, cognitive, physical, and behavioural outcomes in children.²¹ Fathers who are mentally healthy are more likely to be more involved with their children and supportive to their partners than fathers who are depressed and anxious.²² Apart from their own mental health, paternal caregiving practices are also associated with children's well-being and development. Fathers who are sensitive and supportive are more likely to have children who develop better social skills and language.²³ Involved fathers are considered better able to promote the mental health and well-being of their children when they actively engage with their children and families, and are accessible to – and assume responsibility for – their children.²⁴

When fathers act as a source of maternal emotional support, the quality of the mother-child relationship is enhanced, which in turn leads to children's positive adjustment. In the same vein, when fathers are unsupportive, the mental health of children suffers.^{25, 26} A father's active involvement in caregiving after birth can also ease the burden of care placed on the mother, buffering the child's exposure to stress during that period and acting as a source of compensatory support to the child in the event that the mother needs to recover from mental health problems.²⁷

Despite this knowledge, the importance of promoting fathers' mental health is not widely or fully acknowledged and is seldom researched in South Africa. A clearer understanding of how fathers' mental health shapes the mental, physical, behavioural, and emotional development of their children may lead to new opportunities for paternal mental health interventions which promote equity in the health care system. Barriers such as poverty, inequality, and unemployment play important roles in undermining men's health practices – including their promotion of maternal and child health. Fathers therefore need gender-specific health care and workplace support, such as paternal leave,²⁸ to prevent or mitigate the effects of mental health problems working their way from the father to the mother and the child.

For more information on how fathers can play an active role in supporting children and families, see the 2nd State of South Africa's Fathers report: <https://genderjustice.org.za/publication/state-of-south-africas-fathers-2021/#>

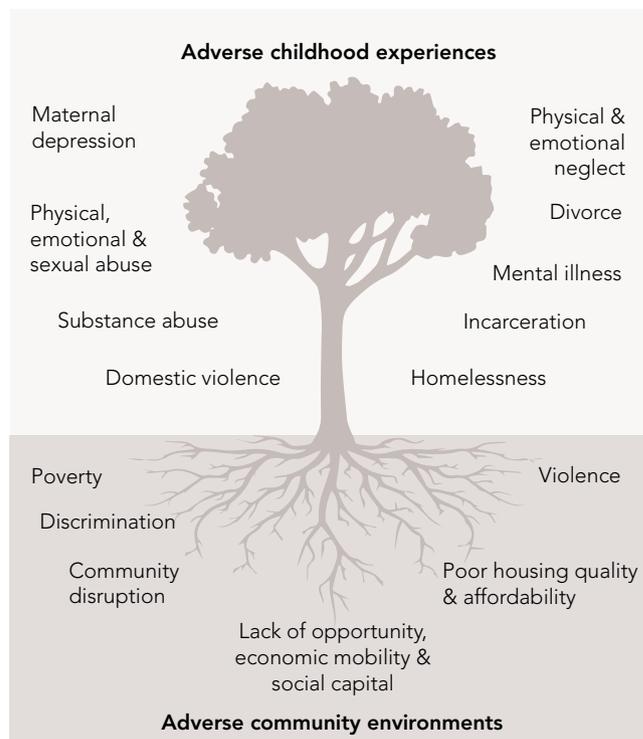
children's poor mental health. Furthermore, indirect violence in the form of exposure to intimate partner violence in the home and generational transferences of violent behaviour, either as perpetrators or victims, were also associated with externalising symptoms.¹⁸ Although parenting practices differ culturally, there are key elements that enable a child to thrive, and these can be promoted. Low levels of sensitive parenting and greater use of harsh discipline are crucial areas for intervention. Enhancing parenting early in life, when the child's brain and biological systems that underlie mental health are rapidly taking shape, is most ideal.

It is also important to remember that parents struggling with their own mental health problems may have more difficulty in providing sensitive, responsive care, particularly when they lack support and resources, exacerbating their own and their child's mental health difficulties. Mothers with mental health problems can engage in maladaptive interactions with their children, characterized by insensitive and hostile parenting.¹⁹

The role of fathers

From conception, fathers can play important roles in providing practical and emotional support, promoting positive health behaviours, supporting maternal well-being, moderating stress levels, and creating a safe and secure environment for both mother and child. The relationship between fathers, mothers, and children – or the father-mother-child relationship – has implications for both maternal and child health and well-being. In fact, increased father involvement also has a positive impact on the lives of men, increasing their sense of personal responsibility and self-reflection, prompting the avoidance of risky behaviours like substance abuse, and initiating positive behaviour changes that have an overall protective effect on their own health and well-being.²⁰ However, there are a number of individual and structural factors that affect father involvement. In the South African context, where financial provision is deeply entrenched in masculine identity and fatherhood, fathers who are able to support their families economically are more likely to be involved and nurturing in their interactions with children.²¹ Another South African study demonstrated how father involvement during and after pregnancy had a protective effect on post-natal maternal mental health, emphasising the need to promote father involvement from conception throughout childhood.²² Box 3 illustrates the ways in which the mental health and well-being of fathers has implications for both mothers and children in the family.

Figure 18: Adverse childhood experiences



Source: Ellis WR, Dietz WH. A new framework for addressing adverse childhood and community experiences: The building community resilience model. *Academic Pediatrics*. 2017. 17(7):S86-93.

Stress, poverty and adversity

Poverty and material hardship create stressful environments that can negatively impact on a family's capacity to provide adequate care.²⁹ Yet a nurturing environment can mitigate the negative effects of cumulative adversity, such as ongoing exposure to violence, on cognitive functioning and mental health.³⁰ While individual resilience in the child can do the same, there are other characteristics of the family or caregiving environment that play a direct role. Competent parenting that is emotionally responsive, and caregivers with resources such as education, positive mental health, peer support, and healthy attachment are all linked to resilience in children.³¹ Specific behaviours that characterise the interactions between parents and their children have been linked to positive mental health for children, including healthy communication between parents and children, and parental engagement in their child's school life.³² In fact, in some cases, child mental health was more strongly linked to the quality of parent-child communication than to family form or socio-economic status.³³ A trial of a parenting programme to reduce violence against children in South Africa found that improving parenting skills independently of household-level economic welfare led to benefits for child well-being, but combining parenting and economic strengthening boosted the effectiveness of the

programme.³⁴ Overall, a family's socio-economic context remains a significant factor in child mental health.³²

Aside from poverty and economic hardship, children can experience other types of adversities, and in low-resource settings, these are likely to be multiple or continuous adversities, such as ongoing child abuse, chronic neglect, or long-term substance abuse by family members (see Figure 18). The accumulative effects of such adversities, if left unchecked, is likely to lead to chronic stress, which can impact on children's present and future mental and physical health. Findings from the South African Birth to thirty cohort demonstrate how cumulative adversity and family dysfunction leads to psychological distress in young adulthood (see Case 9 on p65).

What support is needed to enable families to provide nurturing care?

One of the primary roles of families is to protect children from potential adversities. However, families require resources and support to provide nurturing, protective environments in a sustainable manner. Policy frameworks for supporting families and the role they play in the health and well-being of children have evolved over time. Post-1994, the South African government introduced a series of legislative and policy reforms aimed at promoting stronger, more cohesive families. The revised White Paper on Families in South Africa 2021 prioritises the promotion of family well-being and family relationship strengthening with an increased focus on promotive and preventive interventions as outlined in Table 5.

Table 5: Priorities and strategies from the White Paper for Families 2021

Core aspects of the White Paper for Families 2021
<p>Promote family well-being: Recognition of the importance of economic empowerment for families, the basic resources they need to access to function well and fulfil their roles and responsibilities in society. Achieved through:</p> <ul style="list-style-type: none"> • Ensuring access to safe and secure housing; basic services; food security; functioning and accessible health services; equitable and accessible education; safe, secure and sustainable environments; necessary legal documentation; basic income support; social welfare services; and psychological and spiritual support. • Promoting access to economic opportunities for families through cross-departmental strategies and empowering families to develop sustainable livelihood strategies. • Ensuring families can balance caregiving and economic empowerment through mechanisms and policies, including paternal and maternal leave, to facilitate the balancing of work and family responsibilities and more equitable distribution of caregiving between caregivers, and promoting gender equity in families. • Empowering families with knowledge of their rights and ensuring a culture of dignified treatment for families. • Ensuring no unfair discrimination in all policies and legislation against families based on any characteristics including marital status, sexual orientation, and family composition.
<p>Family relationship strengthening: Recognition of the need to strengthen families through provision of opportunities, relationship skills, and networks of support and protection. Achieved through:</p> <ul style="list-style-type: none"> • Collaboration with civil society and local government to ensure that all families can access programmes and services and support appropriate to them, particularly during key moments of family transition, such as marriage, parenting and caring for the elderly. • Offer and widen access to parenting support programmes, including antenatally and with emphasis on <i>mental health support</i>, while recognising the role both men and women play in child-rearing. • Enhance families' and caregivers' capacity to protect children. • Offer and widen access to family strengthening programmes to promote strong intra-familial relations, including those that are intergenerational and those between couples; and to support the dissolution of relationships in healthy ways. • Promote family resilience to care for vulnerable members and deal with stressful situations and acute stress.
<p>Treatment and support for vulnerable families: Provision of prevention, early detection and intervention, treatment, and reunification and aftercare services. Achieved through:</p> <ul style="list-style-type: none"> • Strengthening awareness and education on domestic violence, abuse, substance abuse; and supporting interventions that challenge norms and systems that discourage help-seeking by family members. • Empowering service providers with knowledge to identify and respond to at-risk families. • Offering programmes for families who require it, including therapeutic services. • Initiating communities of care that offer holistic support for the family. • Ensuring treatment services are accessible, have an individual-within-family focus, and acknowledge behavioural effects on family. • Facilitating family access to support and services, especially during key transition times and conflict. • Encouraging family-centred extended kin fostering as most appropriate and cost-effective placement for children, strengthen existing adoption and foster care systems. • Where appropriate, implementing reintegration and reunification of family members who have been separated for extended periods.

The national policy also recognizes the key role that family functioning plays in child mental health – from the effects of family stress and parental mental health status to instability and violence in the family. This comprehensive framework should encourage resilient, well-functioning families that are able to nurture, support and care for the members of the family; however, the capacity for its implementation has been called into question, particularly since there is limited evidence of impact of the inaugural 2013 White Paper.³⁵

Globally, the Nurturing Care Framework (NCF) recognises the central role of the family in enabling children to thrive, and identifies the critical factors needed to support healthy development from pregnancy and early childhood through to adolescence. At the core of nurturing care is a stable environment and behaviours that ensure good health and nutrition, protection from threats, opportunities for learning, and relationships that are supportive and responsive.³⁶ In the early years, young children are overwhelmingly at the receiving end of nurturing care inputs. With growing agency and autonomy, adolescents begin to shape their own relationships and environments.³⁷ The NCF can be used as a guideline for implementation of multi-sectoral policies, services and programmes from preconception to adolescence that promote the health and well-being of children, as outlined in Figure 19.

These frameworks clearly identify provision of support to families across the life course as multi-dimensional, requiring the delivery of a broad spectrum of services and the involvement of multiple government departments and civil society actors. These include the provision of:

- health services through maternal and child health care services, including maternal mental health screening;
- social services such as prevention and early intervention services, and responsive and support services when traumatic events, such as violence, occur;
- crime prevention and policing services in communities to protect children and families; and
- the education system as an important setting for reaching older children as outlined in the next chapter on schools.

The range of services and support to families is too extensive to adequately address here. We have opted to focus on two key areas with significant potential to impact on family well-being – social protection and parenting programmes.

Social protection

National social protection measures, such as cash transfer programmes, have been shown to improve mental health

– with one study in Kenya reporting a 38% reduction in depressive symptoms.³⁸ Similarly, a study of the effects of the South African Child Support Grant (CSG) on adult mental health found strong positive effects.³⁹ Estimates also show that the CSG can have a large impact on the intergenerational transmission of mental health problems, reducing transmission from parent to adolescent by 40%.⁴⁰ Cash transfers could also increase the material support children need to attend school or participate in leisure activities, increasing their social connection and confidence.

When the pathways from unconditional cash transfers, in this case the CSG, to improvements in mental health are assessed, a number of important policy and practice takeaways can be made.⁴¹ First, the link between the CSG and mental health was independent of any additional intervention – no behaviour change, awareness-raising or educational supplements were necessary. Second, the additional income was invested in lifestyle changes that improved physical health and well-being, which was translated into better mental health, which in turn positively impacted on working and income-generating capacity. In some cases, the regularity and stability over time of cash transfers targeted the social determinants of mental health problems, for example, improved food security, reduced stress, a psychological safety net, and increased feelings of independence and control over resources and their future. Beneficiaries of the CSG in South Africa felt that the strongest impact on their mental health was the perception that they were able to provide better care in the household with the grant.⁴²

While social protection measures often incentivise investments that support children's health and well-being and mitigate against economic hardship underlying family stress, these cash transfers are limited. Increases to the CSG have been unable to adequately keep up with inflation⁴³ and barriers to accessing grants continue to exclude those arguably most in need.⁴⁴ Pregnant women in low-resource settings are particularly vulnerable to risks such as food insecurity which, apart from nutritional outcomes for children, is strongly associated with domestic violence and poor maternal mental health.⁴⁵ Investment in cash transfer programmes should begin as early as conception for those in need, where they are likely to render long-term health and mental well-being outcomes.

Combining economic strengthening with additional parenting or family strengthening components tends to boost the benefits for both family and child health and well-being.⁴⁶ An evaluation of a family strengthening programme

Figure 19: Key inputs to support nurturing care from preconception to adolescence

	Preconception/ prenatal	Newborn	Infancy	Preschool	Middle childhood	Adolescence
Enabling environments	Universal health care, ban on environmental toxins (eg, lead); free preschooling, primary and secondary schooling, child protection; safe water and sanitation; inclusive policies and services for people with disabilities					
Health	Inclusive preventive and promotive quality health care for children and adolescents					
	Prenatal services, smoking, drug use cessation	Baby-friendly hospital initiative	Immunisation	Well-child evaluations	Promotion of physical activity	Access to sexual and reproductive services
Nutrition	Equitable access to safe, nutritious and affordable foods					
	Healthy diet, micronutrients, food assistance	Exclusive breastfeeding	Exclusive breastfeeding, complementary feeding, micronutrients	Food assistance, healthy school meals	Food assistance, healthy school meals	Food assistance, healthy school meals
Security and safety	Protection for children and adolescents					
	Violence prevention	Clean water, air, and sanitation	Clean water, air, and sanitation	Injury prevention	Bullying prevention	Prevention of child marriage
Learning	Free and inclusive education					
	Prenatal care	Pregnancy and birth preparation	Parental education and quality care	Quality care, education and parental support	Quality instruction and parental engagement	Vocational and life skills training
Responsive relationships	Care for children and adolescents					
	Prevent gender-based violence	Promote skin-to-skin contact	Parent-infant attachment support	Prevent harsh punishment	Promote prosocial peer relations	Partnership and leadership opportunities

Source: Black, M.M., et al., The principles of Nurturing Care promote human capital and mitigate adversities from preconception through adolescence. *BMJ Global Health*, 2021. 6(4): p. e004436.

paired with the CSG increased positive parenting, reduced caregiver depressive symptoms, and improved family and caregiver-child relationships.⁴⁷

Parenting programmes

Targeted family-centred interventions have also shown promise. Interventions involving psychoeducation, parent- and family-skills training, and behavioural, psychosocial and trauma-focused therapy have had positive effects on child mental well-being, as well as parenting behaviours and family functioning.⁴⁸ In resource-poor settings, supporting caregivers with strategies for positive parenting is especially important given the interactions between stressful environments, parental mental health and child well-being.³⁴ Interventions in South Africa aimed at promoting positive parenting have reached these desired outcomes. Case 10 summarises evidence from the Parenting for Lifelong Health

suite of parenting interventions that can improve parent-child relationships, promote secure child attachment, positively influence parenting, reduce maltreatment, and improve child cognitive and socio-emotional development.

The Department of Health leads the Side-by-Side initiative, a national campaign to promote secure and loving relationships to help child under five thrive. Based on the NCF and centred on the mother and child, the campaign uses print, audio and social media resources to promote young children's access to the full range of nurturing care services at both the health facility and household levels. The campaign has provided a structure for mobilizing health workers at health care facilities and in communities to promote and support more comprehensive approaches to child health and well-being. Further work needs to be done to expand and strengthen the package of services available to young children and their families through the health system.⁴⁹

Case 10: Parenting for Lifelong Health – a summary of evidence

Jamie Lachmanⁱ

The Parenting for Lifelong Health (PLH) initiativeⁱⁱ was founded in 2012 to develop, evaluate, and disseminate a suite of evidence-based, low-cost, and freely available playful parenting programmes to reduce violence against children and improve child well-being in the Global South.⁵³ The PLH programme suite targets caregivers and children from conception to age 17 years. Each programme was tested rigorously through randomised controlled trials (RCTs) in South Africa.⁵⁴⁻⁶⁰ Subsequently, additional trials have been conducted in El Salvador, Lesotho, Moldova, North Macedonia, Philippines, Romania, and Thailand.⁶¹⁻⁶⁴ The PLH programmes have since been disseminated in over 30 countries to approximately 250,000 families across the world.⁶⁵

PLH for Infants

PLH for Infants, known as the Thula Sana Mother-Infant Programme in South Africa, is a home-visiting programme delivered by trained community health workers and combines lay counselling and strategies to support infant care and positive parent-infant relationships from late pregnancy until the baby is 6 months old. An RCT in Khayelitsha found significant improvements in maternal sensitivityⁱⁱⁱ and reductions in intrusiveness after birth.⁵⁷ Significantly, there was improved secure infant attachment at 18 months. A follow-up study with 333 mothers and their children at age 13 years to examine the long-term effects of the programme⁶⁰ showed important effects on maternal mental health, although there was no effect on child cognitive development.⁶⁶

PLH for Toddlers

PLH for Toddlers, also known as Shared Reading, is a parenting programme that aims to improve toddlers' cognitive, emotional, and social development with versions for children ages 12 – 30 months and 30 – 60 months. Delivered by trained facilitators over 8 weekly sessions, this group-based programme includes a combination of videos, group discussions and opportunities for parents to

practice how to engage with their children through picture books. The programme has been tested in two separate trials in Khayelitsha which showed positive effects on maternal sensitivity and mother-child reciprocity^{iv} as well as large effects on child development outcomes, including language and attention. The programme was further tested in Lesotho as part of an integrated community intervention that combined Shared Reading with HIV-testing and treatment, and nutrition education for caregivers of children ages 1 – 5 years.⁶¹ Initial findings showed significant improvements in child receptive and expressive language, as well as increased rates of child HIV testing.⁶⁷

PLH for Young Children

PLH for Young Children, known as the Sinovuyo Caring Families Programme in South Africa, is a group-based parenting programme for caregivers of children ages 2 – 9 years. Integrating the core components of evidence-based parenting programmes within the local cultural context of South Africa,⁶⁸ PLH for Young Children uses group discussion, illustrated stories and role-plays to help parents learn positive parenting skills, stress management and non-violent forms of discipline. Initial testing demonstrated that the programme was acceptable to community-based facilitators and parents and had positive effects on observed parent-child interaction.^{69, 70} The programme was then evaluated in Khayelitsha and Nyanga, Western Cape, with low-income mothers whose children indicated elevated levels of behaviour problems.^v Results showed significant improvements in positive parenting and reductions in harsh parenting and child conduct problems. There were also increases in self-reported use of non-violent discipline strategies and observations of positive parenting behaviour, although no differences in negative child behaviour.⁵⁶ PLH for Young Children has subsequently been evaluated in the Philippines with moderate intervention effects for reduced overall maltreatment, dysfunctional parenting, child

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ii Parenting for Lifelong Health collaborators include members from UNICEF, WHO, Clowns Without Borders South Africa, Mikhululu Trust, Children's Early Intervention Trust, and the Universities of Cape Town, Stellenbosch, Bangor, and Oxford. For more information, please visit <https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health>.

iii Maternal sensitivity refers to the way mothers perceive and respond to their infant's behaviors and cues in a timely manner, whereas intrusiveness refers to the ways in which mothers may interfere, disrupt or restrict their infant's behaviour.

iv Mother-child reciprocity is a process of communication through which a mother and child read and respond to one another's facial and vocal expressions

v Elevated levels of child behavior problems were based on parent-report of difficult behaviors from the Eyberg Child Behavior Checklist-Problem Inventory (e.g., refusing to do chores, not obeying rules, having temper tantrums, etc.).

behaviour problems, and intimate partner violence, as well as increased parental efficacy and positive parenting.⁶⁴ More recently, an eight-session version of PLH for Young Children was tested in Thailand within the public health sector, also with positive results.⁶³

PLH for Teens

PLH for Teens, known as Sinovuyo Teens in South Africa, is a 14-session group-based parenting programme delivered to parents and their adolescents aged 10 – 17 years.⁷¹ Developed and tested in rural and peri-urban communities in the Eastern Cape, the programme uses a participatory-learning approach and includes adolescents in the group sessions. In addition to content on positive communication and relationship building, the programme includes modules on sexual behaviour risk reduction, stress reduction and emotional self-regulation, and family budgeting. Findings from a pragmatic cluster RCT of the programme showed 45% less abuse and corporal punishment reported by caregivers in the intervention. Caregivers and adolescents also reported improved positive parenting and parental involvement, and reductions in substance use and poor supervision. There were also significant reductions in parenting stress, mental health problems and the endorsement of corporal punishment, and children and adolescents reported improvements in social support, economic welfare, financial management, and plans to avoid violence. PLH for Teens has subsequently been disseminated throughout sub-Saharan Africa as part of community-wide HIV-prevention programmes.^{65, 72}

Moving to digital

During COVID-19 when in-person programmes were restricted, Parenting for Lifelong Health began developing digital adaptations of the programmes to increase their reach and enable the programme to continue. These include:

- Sharing Stories – an adaptation of PLH for Toddlers for delivery via WhatsApp with caregivers of children aged 9 to 32 months in Zambia and Tanzania. Initial results indicate moderate to large improvements in responsive caregiving and parent-child interaction, as well as lower rates of parental depression and anxiety.
- ParentChat – an adaptation of PLH for Young Children

and PLH for Teens for delivery via facilitated online chat groups. A multi-country pre-post evaluation of the ParentChat programme for parents of children ages 2 – 17 years in South Africa, Malaysia, Moldova, Montenegro, North Macedonia, and the Philippines found reduction in physical and emotional abuse, parenting stress, intimate partner violence, and improvement in positive parenting and respectful partner behaviour⁷³

- ParentApp – an offline-first app of PLH for Teens developed with families in South Africa and currently being tested in Tanzania, and
- ParentText – an interactive chatbot of the entire PLH suite for parents of children ages 0 – 17 years, currently being piloted in South Africa, Jamaica, Malaysia, Philippines, and Sri Lanka.

In conclusion

Parenting for Lifelong Health aims to provide freely available, evidence-based playful parenting support to parents and caregivers in the Global South, so that they are equipped with the knowledge and tools to help their children realise their learning potential and to prevent child sexual abuse, exploitation and family violence. Evidence from 14 randomised trials has demonstrated promising effects for vulnerable children and families in low-resource settings across a range of parenting and child mental health and well-being outcomes. The programmes have also shown to work across different cultural contexts and to retain their efficacy when embedded in government and NGO services. Additional research is needed to further optimise the delivery of the in-person programmes⁷⁴ and establish how programme implementation and effectiveness can be sustained at scale.⁷⁵ Lastly, the digital versions of PLH have the potential to vastly expand the reach of parenting programmes. Additional research is needed to 1) establish the effectiveness and cost-effectiveness of remote, digital, media, and blended delivery of parenting programmes across different settings; 2) investigate the mechanisms of change that lead to improved outcomes; 3) understand how to maintain safeguarding in the digital sphere and provide access to resources across the digital divide; and 4) determine how best to integrate PLH with government and community-based systems in order to deliver parenting programmes at scale.

Improving parent mental health has further protective effects on child well-being. When parents are healthy, well-equipped and capable, they are better able to provide environments that protect and promote children's mental health and well-being.³⁴ Parenting programmes are equally important as children reach adolescence, which often brings with it shifts in the parent-child relationship and increases in conflict. While these changes in how parents and adolescents interact are normal, a parent's ability to manage these changes and their capacity to maintain healthy parental involvement predicts adolescent health and well-being.⁵⁰ Reviews have consistently shown that family-focused interventions using non-specialist providers to improve parenting strategies are effective but require good training, supervision, and cultural adaptation.^{48, 51} These programmes are shown to be most effective if they reach parents when they are most receptive to change.⁵²

Conclusion

Families play a central role throughout childhood in the provision of nurturing care and promoting environments conducive to child and adolescent mental health. It is important to adopt a strengths-based approach when

working with families and to ask: What are the internal resources available to families? Are there extended family members who can offer support in times of vulnerability? Are there existing networks of care available through community-based structures or organisations?

At a macro level, the state plays a critical role in providing and maintaining comprehensive, multi-sectoral systems of services, policies, and strategies that promote nurturing care – and adopting a family-centred approach can help address the gaps that often exist between adult and children's services. Yet, it is clear that the foundations for positive mental health and well-being are laid and cemented in the home, and both influence and are influenced by interactions with other systems. As these systems evolve and families change alongside them, it is also clear that family functioning is more important than family form. It does not matter what families look like, it is how they function as a unit, relate to each other as a group, and are treated as individuals that determines to a large extent children's mental health and well-being. Therefore, family-based interventions that improve the relationships between family members offer a powerful avenue for enhancing child and adolescent mental health.

References

1. Organisation for Economic Co-operation and Development. *The Future of Families to 2030: A synthesis report*. Paris: Organisation for Economic Co-operation and Development. 2011.
2. StatsSA. *General Household Survey 2020*. Pretoria: Statistics South Africa. 2021.
3. StatsSA. *General Household Survey 2019*. Pretoria: Statistics South Africa. 2020.
4. Collinson M, Wolff B, Tollman S, Kahn K. Trends in internal labour migration from the rural Limpopo Province, male risk behaviour, and implications for spread of HIV/AIDS in rural South Africa. *Journal of Ethnic and Migration Studies*. 2006;32(4):633-648.
5. Mhongo C, Budlender D. Declining rates of marriage in South Africa: What do the numbers and analysts say? In: Claesens A, Smythe D, editors. *Marriage, Land and Custom: Essays on law and social change in South Africa*. Cape Town: Juta Law Publishing; 2013.
6. Mangoma A, Wilson-Prangley A. Black Tax: Understanding the financial transfers of the emerging black middle class. *Development Southern Africa*. 2019;36(4):443-460.
7. Hall K, Richter L. Introduction: Children, families and the state In: Hall K, Richter L, Mokomane Z, Lake L, editors. *South African Child Gauge 2018: Children, Families and the State - Collaboration and Contestation*. Cape Town: Children's Institute, University of Cape Town; 2018.
8. National Academies of Sciences, Engineering, Medicine. *Fostering healthy mental, emotional, and behavioral development in children and youth: A national agenda*. Washington, DC: The National Academies Press; 2019.
9. Moore GF, Cox R, Evans RE, Hallingberg B, Hawkins J, Littlecott HJ, Murphy S. School, peer and family relationships and adolescent substance use, subjective wellbeing and mental health symptoms in Wales: a cross-sectional Study. *Child Indicators Research*. 2018;11(6):1951-1965.
10. Masarik AS, Conger RD. Stress and child development: A review of the Family Stress Model. *Current Opinion in Psychology*. 2017;13:85-90.
11. Behere AP, Basnet P, Campbell P. Effects of family structure on mental health of children: A preliminary study. *Indian Journal of Psychological Medicine*. 2017;39(4):457-463.
12. Polderman TJC, Benyamin B, de Leeuw CA, Sullivan PF, van Bochoven A, Visscher PM, Posthuma D. Meta-analysis of the heritability of human traits based on fifty years of twin studies. *Nature Genetics*. 2015;47(7):702-709.
13. Wiegand-Grefe S, Sell M, Filter B, Plass-Christl A. Family functioning and psychological health of children with mentally ill parents. *International Journal of Environmental Research and Public Health*. 2019;16(7):1278.
14. Friedmann MS, McDermut WH, Solomon DA, Ryan CE, Keitner GI, Miller IW. Family functioning and mental illness: A comparison of psychiatric and nonclinical families. *Family Process*. 1997;36(4):357-367.
15. Ubaidi BAA. Cost of growing up in dysfunctional family. *Journal of Family Medicine and Disease Prevention*. 2017;3(3):1-6.
16. Yee NY, Sulaiman WSW. Resilience as mediator in the relationship between family functioning and depression among adolescents from single parent families. *Akademika*. 2017;87(1):111-122.
17. Barbarin OA, Richter LM. *Mandela's Children: Growing up in post-Apartheid South Africa*. New York: Routledge; 2013.
18. Ward CL, Gould C, Kelly J, Mauff K. Spare the rod and save the child: Assessing the impact of parenting on child behaviour and mental health. *South Africa Crime Quarterly*. 2015;51.
19. Eyden J, Winsper C, Wolke D, Broome MR, MacCallum F. A systematic review of the parenting and outcomes experienced by offspring of mothers with borderline personality pathology: Potential mechanisms and clinical implications. *Clinical Psychological Science*. 2016;47:85-105.
20. Philpott LF, Corcoran P. Paternal postnatal depression in Ireland: Prevalence and associated factors. *Midwifery*. 2018;56:121-127.
21. Makusha T, Richter L. Fatherhood in the first 1000 days. In: Van den Berg W, Makusha T, editors. *State of South Africa's Fathers 2018*. Cape Town: Sonke Gender Justice & Human Sciences Research Council; 2018. p. 49-63.
22. Drysdale RE, Slemming W, Makusha T, Richter LM. Father involvement, maternal depression and child nutritional outcomes in Soweto, South Africa. *Maternal & Child Nutrition*. 2021;17(S1):e13177.
23. Cabrera NJ, Volling BL, Barr R. Fathers are parents, too! Widening the lens on parenting for children's development. *Child Development Perspectives*. 2018;12(3):152-157.
24. Lamb ME, Pleck JH, Charnov EL, Levine JA. A biosocial perspective on paternal behavior and involvement. In: Lancaster JB, Altmann J, Rossi AS, Sherrod LR, editors. *Parenting across the life span: Biosocial dimensions*. London: Aldine Publishing Co; 1987. p. 111-142.
25. Cummings EM, Goetze-Morey MC, Raymond J. Effects of marital quality and marital conflict. In: Lamb ME, editor. *The Role of the Father in Child Development* 4th ed. Hoboken, NJ: John Wiley & Sons Inc; 2004. p. 49-65.
26. Cummings EM, Watson O'Reilly A. Effects of marital quality on child adjustment. In: Lamb ME, editor. *The Role of the Father in Child Development*. 3rd ed. Hoboken, NJ: John Wiley & Sons Inc; 1997. p. 49-65.
27. Gere MK, Hagen KA, Villabø MA, Arnberg K, Neumer S-P, Torgersen S. Fathers' mental health as a protective factor in the relationship between maternal and child depressive symptoms. *Depression and Anxiety*. 2013;30(1):31-38.
28. Makusha T, Ratele K. Mental health of fathers. In: Van den Berg W, Makusha T, Ratele K, editors. *State of South Africa's Fathers 2021*. Cape Town/Stellenbosch: Sonke Gender Justice, Human Sciences Research Council & Stellenbosch University; 2021. p. 144-159.
29. Gershoff ET, Aber JL, Raver CC, Lennon MC. Income is not enough: Incorporating material hardship into models of income associations with parenting and child development. *Child Development*. 2007;78(1):70-95.
30. Trude ACB, Richter LM, Behrman JR, Stein AD, Menezes AMB, Black MM. Effects of responsive caregiving and learning opportunities during pre-school ages on the association of early adversities and adolescent human capital: An analysis of birth cohorts in two middle-income countries. *The Lancet Child & Adolescent Health*. 2021;5(1):37-46.
31. Wyman PA, Cowen EL, Work WC, Hoyt-Meyers L, Magnus KB, Fagen DB. Caregiving and developmental factors differentiating young at-risk urban children showing resilient versus stress-affected outcomes: A replication and extension. *Child Development*. 1999;70(3):645-659.
32. Currie C, Morgan A. A bio-ecological framing of evidence on the determinants of adolescent mental health - A scoping review of the international Health Behaviour in School-Aged Children (HBSC) study 1983-2020. *SSM - Population Health*. 2020;12:100697.
33. Levin K, Inchley J, Currie D, Currie C. Subjective health and mental well-being of adolescents and the health promoting school. *Health Education*. 2012;112(2):170-184.
34. Cluver L, Shenderovich Y, Meinck F, Berezin MN, Doubt J, Ward CL, Steinert JI. Parenting, mental health and economic pathways to prevention of violence against children in South Africa. *Social Science & Medicine*. 2020;262:113194.
35. Hochfeld T, Patel L. *Weighing up South Africa's family policy: What does and doesn't work*. The Conversation, 27 November 2018. [https://theconversation.com/weighing-up-south-africas-family-policy-what-does-and-doesnt-work-107296]
36. WHO, UNICEF. *Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential*. 2018. [https://apps.who.int/iris/handle/10665/272603]
37. Black MM, Behrman JR, Daelmans B, Prado EL, Richter L, Tomlinson M, Yoshikawa H. The principles of Nurturing Care promote human capital and mitigate adversities from preconception through adolescence. *BMJ Global Health*. 2021;6(4):e004436.
38. Kilburn K, Thirumurthy H, Halpern CT, Pettifor A, Handa S. Effects of a large-scale unconditional cash transfer program on mental health outcomes of young people in Kenya. *Journal of Adolescent Health*. 2016;58(2):223-229.
39. Ohnberger J, Fichera E, Sutton M, Anselmi L. The effect of cash transfers on mental health - new evidence from South Africa. *BMC Public Health*. 2020;20(1):436.
40. Eyal K, Burns J. *Up or Down? Intergenerational Mental Health Transmission and Cash Transfers in South Africa*. Southern Africa Labour and Development Research Unit, University of Cape Town. 2016. [https://econpapers.repec.org/RePEc:ldr:wpaper:165]
41. Ohnberger J, Anselmi L, Fichera E, Sutton M. The effect of cash transfers on mental health: Opening the black box - A study from South Africa. *Social Science & Medicine*. 2020;260:113181.
42. Plagerson S, Patel V, Harpham T, Kielmann K, Mathee A. Does money matter for mental health? Evidence from the Child Support Grants in Johannesburg, South Africa. *Global Public Health*. 2011;6(7):760-776.
43. Hall K. *COVID-19 holds lessons for the future of social protection*. The Conversation, 24 February 2021. [https://theconversation.com/covid-19-holds-lessons-for-the-future-of-social-protection-155787]
44. Winchester MS, King B, Rishworth A. "It's not enough:" Local experiences of social grants, economic precarity, and health inequity in Mpumalanga, South Africa. *Wellbeing, Space and Society*. 2021;2:100044.
45. Laurenzi C, Field S, Honikman S. Food insecurity, maternal mental health, and domestic violence: A call for a syndemic approach to research and interventions. *Maternal & Child Nutrition*. 2020;24(4):401-404.
46. Amisi M, Naicker SN. *Preventing violence against women and children: An evidence review*. Pretoria: Institute for Security Studies. 2021.
47. Ross E, Patel L, Sitshange M, Matidza K. *Connecting cash with care for better child well-being*. Johannesburg: The Centre for Social Development in Africa (CSDA), University of Johannesburg. 2020.
48. Pedersen GA, Smallegange E, Coetzee A, Hartog K, Turner J, Jordans MJD, Brown FL. A systematic review of the evidence for family and parenting interventions in low- and middle-income countries: Child and youth mental health outcomes. *Journal of Child and Family Studies*. 2019;28(8):2036-2055.

49. Bamford L, Martin P, Slemming W, Richter L. Improving the early development of children through quality health care. *South African Health Review* 2019. Durban: Health Systems Trust; 2019.
50. Schwartz OS, Byrne ML, Simmons JG, Whittle S, Dudgeon P, Yap MBH, Allen NB. Parenting during early adolescence and adolescent-onset major depression: A 6-year prospective longitudinal study. *Clinical Psychological Science*. 2013;2(3):272-286.
51. Healy EA, Kaiser BN, Puffer ES. Family-based youth mental health interventions delivered by nonspecialist providers in low- and middle-income countries: A systematic review. *Families, Systems & Health*. 2018;36(2):182-197.
52. Nation M, Crusto C, Wandersman A, Kumpfer KL, Seybolt D, Morrissey-Kane E, Davino K. What works in prevention. Principles of effective prevention programs. *American Psychologist*. 2003;58(6-7):449-456.
53. Ward CL, Mikton C, Cluver L, Cooper P, Gardner F, Hutchings J, Wessels IM. Parenting for Lifelong Health: From South Africa to other low-and middle-income countries. *Early Childhood Matters: Responsive Parenting: A Strategy to Prevent Violence*. 2014;49.
54. Lachman JM, Cluver L, Ward CL, Hutchings J, Wessels I, Mlotshwa S, Gardner F. Randomized controlled trial of a parenting program to reduce the risk of child maltreatment in South Africa. *Child Abuse & Neglect*. 2017;72:338-351.
55. Cluver L, Meinck F, Steinert JI, Shenderovich Y, Doubt J, Lachman JM, Nocuza M. Parenting for Lifelong Health: A pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. *BMJ Global Health*. 2018;3(1):e000539.
56. Ward CL, Wessels IM, Lachman JM, Hutchings J, Cluver LD, Kassanjee R, Gardner F. Parenting for Lifelong Health for young children: A randomized controlled trial of a parenting program in South Africa to prevent harsh parenting and child conduct problems. *Journal of Child Psychology and Psychiatry*. 2019.
57. Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, Murray L. Improving quality of mother-infant relationship and infant attachment in a socioeconomically deprived community in South Africa: Randomised controlled trial. *BMJ*. 2009;338:b974-b974.
58. Vally Z, Murray L, Tomlinson M, Cooper PJ. The impact of dialogic book-sharing training on infant language and attention: A randomized controlled trial in a deprived South African community. *Journal of Child Psychology and Psychiatry*. 2015;56(8):865-873.
59. Murray L, De Pascalis L, Tomlinson M, Vally Z, Dadomo H, MacLachlan B, Cooper PJ. Randomized controlled trial of a book-sharing intervention in a deprived South African community: Effects on carer-infant interactions, and their relation to infant cognitive and socioemotional outcome. *Journal of Child Psychology and Psychiatry*. 2016.
60. Tomlinson M, Skeen S, Melendez-Torres G, Hunt X, Desmond C, Morgan B, Marlow M. First 1,000 days: Enough for mothers but not for children? Long-term outcomes of an early intervention on maternal depressed mood and child cognitive development: Follow-up of a randomised controlled trial. *Journal of Child Psychology and Psychiatry*. 2021.
61. Tomlinson M, Skeen S, Marlow M, Cluver L, Cooper P, Murray L, Esterhuizen T. Improving early childhood care and development, HIV-testing, treatment and support, and nutrition in Mokhotlong, Lesotho: Study protocol for a cluster randomized controlled trial. *Trials*. 2016;17(1):538.
62. Täut D, Băban A, Frantz I, Dănilă I, Lachman JM, Heinrichs N, Hutchings J. Prevention of child mental health problems through parenting interventions in Southeastern Europe (RISE): Study protocol for a multi-site randomised controlled trial. *Trials*. 2021;22(1):1-18.
63. Gardner F, McCoy A, Lachman JM, Melendez-Torres GJ, Ward CL, Cheah P, Topanya S. Randomized trial of a parenting intervention embedded within the public health system to reduce violence against children in Thailand. forthcoming.
64. Lachman JM, Alampay LP, Jocson R, Alinea MCD, Madrid B, Ward CL, Gardner F. Effectiveness of a parenting programme to reduce violence in a cash transfer system in the Philippines: RCT with follow-up. *The Lancet Regional Health - Western Pacific*. 2021;17:100279.
65. Shenderovich Y, Ward CL, Lachman JM, Wessels I, Sacolo-Gwebu H, Okop K, Cluver L. Evaluating the dissemination and scale-up of two evidence-based parenting interventions to reduce violence against children: Study protocol. *Implementation Science Communications*. 2020.
66. Fearon RP, Tomlinson M, Kumsta R, Skeen S, Murray L, Cooper PJ, Morgan B. Poverty, early care, and stress reactivity in adolescence: Findings from a prospective, longitudinal study in South Africa. *Development and Psychopathology*. 2017;29(2):449-464.
67. Tomlinson M, Marlow M, Stewart J, Lombard C, Mofokeng S, Makhetha M, Skeen S. The Early Morning Star HIV+ parenting programme to improve child health and development in rural Lesotho: Results of a cluster-randomised controlled trial. In submission.
68. Lachman JM, Sherr LT, Cluver L, Ward CL, Hutchings J, Gardner F. Integrating evidence and context to develop a parenting program for low-income families in South Africa. *Journal of Child and Family Studies*. 2016;25(7):2337-2352.
69. Lachman JM, Cluver L, Kelly J, Ward CL, Hutchings J, Gardner F. Process evaluation of a parenting program for low-income families in South Africa. *Research on Social Work Practice*. 2016.
70. Lachman J, Cluver L, Ward CL, Hutchings J, Mlotshwa S, Wessels I, Gardner F. Randomized controlled trial of a parenting program to reduce the risk of child maltreatment in South Africa. *Child Abuse & Neglect*. 2017;72:338-351.
71. Cluver L, Lachman JM, Ward C, Gardner F, Petersen T, Meinck F, Boyes M. Development of a parenting support program to prevent abuse of adolescents in South Africa: Findings from a pilot pre-post study. *Research on Social Work Practice*. 2016;27(7):758-766.
72. Martin M, Lachman JM, Wamoyi J, Shenderovich Y, Wambura M, Mgunga S, Manjengenja N. A mixed methods evaluation of the large-scale implementation of a school- and community-based parenting program to reduce violence against children in Tanzania: A study protocol. *Implementation Science Communications*. 2021.
73. Lachman JM, Han Q, Alampay LP, Jocson R, Reyes J, Okop K, Ward CL. COVID-19 e-Parenting for Lifelong Health (ePLH) Pilot study: Promoting positive parenting and preventing violence through online parent support groups - ParentChat. forthcoming.
74. Lachman JM, Heinrichs N, Jansen E, Brühl A, Taut D, Fang X, Foran HM. Preventing child mental health problems through parenting interventions in Southeastern Europe (RISE): Protocol for a multi-country cluster randomized factorial study. *Contemporary Clinical Trials*. 2019.
75. Shenderovich Y, Lachman JM, Ward CL, Wessels I, Gardner F, Tomlinson M, Cluver L. The science of scale for violence prevention: A new agenda for family strengthening in low- and middle-income countries. *Frontiers in Public Health*. 2021.

The role of educational institutions in promoting and protecting mental health across childhood, adolescence and youth

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In the face of deep inequality, growing unemployment, high rates of crime and violence, and the social and economic fallout from the COVID-19 pandemic, mental health trajectories for young South Africans look bleak. But what if our educational institutions were a powerful protective factor for child, adolescent and youth mental health? How are they currently promoting and protecting the mental health of South African children and adolescents? And how could mental health support and services at different developmental stages be strengthened or better linked to broader structures?

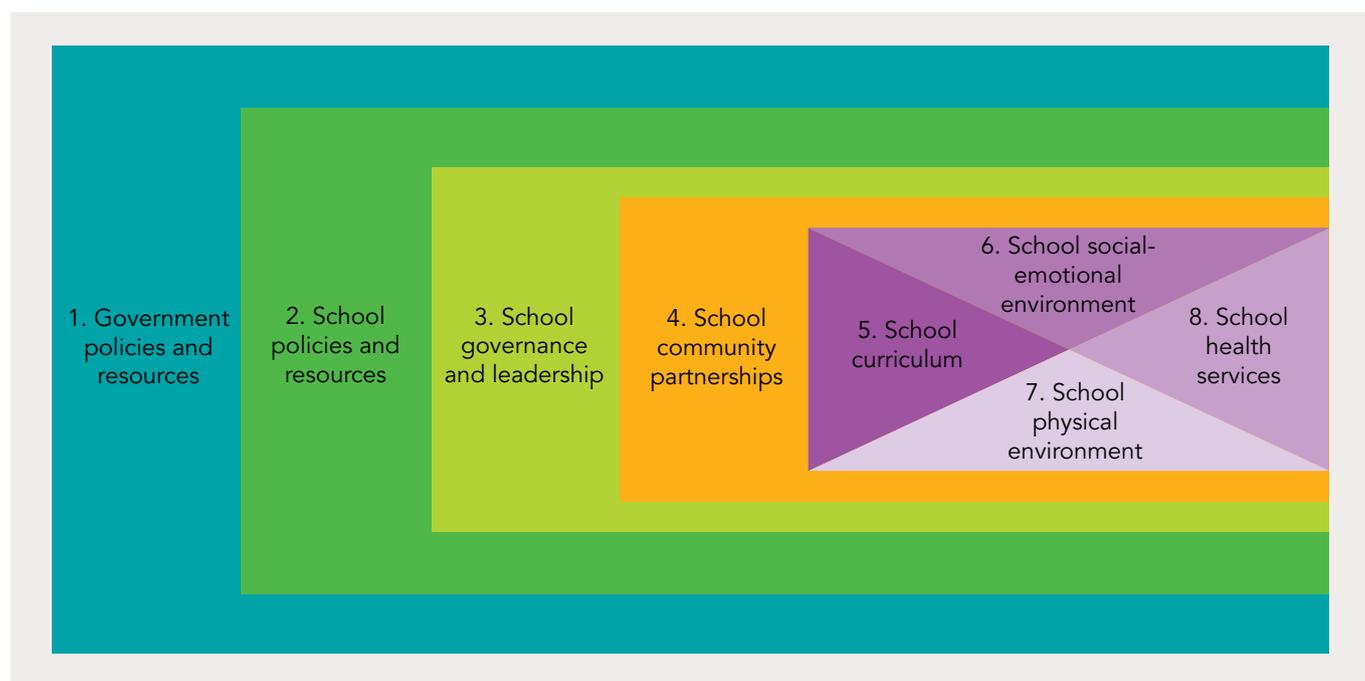
In this chapter we describe the current and potential role of educational institutions in promoting and protecting mental health in the South African context through four key stages: early childhood education (ECE), primary school,

secondary school, and tertiary education. Within each stage, we consider the current policies, provisions and subsequent challenges that exist. Using case studies as exemplars, we highlight potential opportunities for intervention at different levels within the education system to address gaps in psychosocial provision and support. We close the chapter by discussing several key cross-cutting issues that influence implementation and intervention responses.¹

Why use educational institutions to support young people's mental health?

Educational institutions are precious resources for mental health. In addition to the growing numbers of children attending early childhood development (ECD) centres, there is a near universal reach in primary and secondary schools, and increasing enrolment in tertiary education programmes.^{2,3}

Figure 20: Relations among global standards for health promoting schools (WHO)

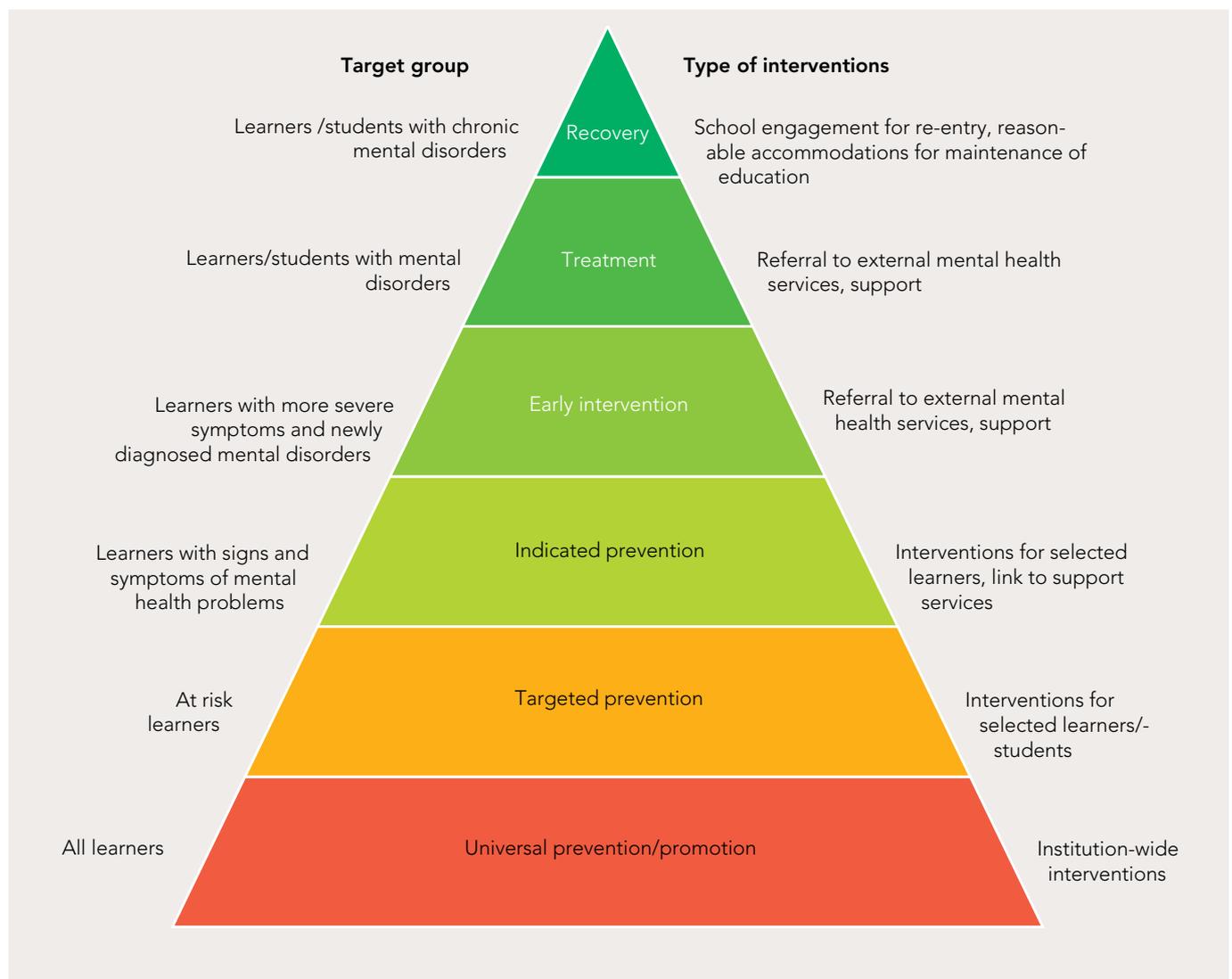


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These institutions have existing infrastructure, are networked locally and provincially, and offer opportunities for staff to be further trained in aspects of child and adolescent learning and development.^{4, 5} They are generally well connected to communities and facilitate contact between teachers, learners, parents and caregivers, and other community organisations and services. They are more accessible, and less stigmatised, than specialised mental health services. School connectedness – or the extent to which learners feel accepted, valued, respected, and included in the school – has been found to promote a sense of belonging, positive self-esteem, internal regulation of emotions, positive attitudes toward school, and motivation to achieve.⁶ Schools can provide support to learners living in fragile families, and supportive child-teacher relationships can be protective for mental health.⁷⁻⁹ School-based interventions can be delivered effectively by mental health professionals, teachers, paraprofessionals, lay counsellors and/or peers.¹⁰

However, intervening through schools and other educational institutions can be challenging, as these environments exist within complex systems involving multiple stakeholders, and with a different primary purpose. Structural issues such as poverty, violence, and social and gender inequality greatly influence how educational institutions operate, which in turn affects child and adolescent mental health.¹¹ In some cases, schools can be environments where children and adolescents are exposed to negative influences, including abuse and violence from peers and teachers.¹² Education systems are often overburdened and have limited capacity to provide comprehensive mental health responses, such as integrating mental health programming into school routines, coordinating with health and social services, communicating with parents and caregivers, and managing ethical issues such as informed consent and confidentiality.^{1,13} More recently, due to the COVID-19 pandemic, there has been an unprecedented loss of in-person learning time

Figure 21: Optimal mix of services in educational institutions



due to school closures. This led to the swift adoption of an educational model that relied heavily on remote learning, despite most learners having limited access to online platforms.

Why is it important to provide a continuum of care?

Mental health support in schools should respond to children's context, age, and developmental stage, and be provided along a continuum of care that covers promotion of positive mental health, prevention of mental health conditions, and access to treatment and recovery services.

Health promoting schools

Mental health service delivery benefits all learners and should be positioned within a Health Promoting Schools (HPS) framework.^{14, 15} An HPS is an educational institution that strives to improve the health of learners, staff, families, and other community members through the creation of a healthy living, learning and working environment. The World Health Organization's (WHO) HPS approach describes how improving health in an educational environment relies on strengthening the curriculum, the physical and psychological environment of the school, and school health services.¹⁶ These activities are supported by broader actions such as effective partnerships between schools and communities, sound school governance, policies and resources, and strong government policies and resources (see Figure 20).

Promotion, prevention, early intervention, treatment and recovery

To be effective, promotive and preventive efforts need to be introduced across the full population before mental health conditions emerge. Early interventions, required by a subset of children or adolescents, need to take place when symptoms of a condition first become apparent, and can have positive, lifelong impact on a child's health and well-being.¹⁷ Treatment and recovery services need to be available for an even smaller group: those living with mental health conditions. In Figure 21, types of preventive and treatment-related services, the target group for each level, and the role of educational institutions is further described.

What are the challenges and opportunities for intervention at different stages of education?

This section briefly outlines the mental health profile of learners as they pass through the education system and describes current and potential interventions to promote and protect child and adolescent mental health in South Africa, including both prevention and treatment. This is presented

for each educational stage, bearing in mind that there is much overlap in the risks to mental health that learners face at each stage and the types of responses that are appropriate.

Early childhood education

In South Africa, ECE forms part of a broader package of ECD programmes which aim to promote the cognitive, emotional, social and physical development of children from birth to nine years old. ECE, until April 2022, was the responsibility of two departments: the Department of Basic Education (DBE, managing Grades 1 – 3) and the Department of Social Development (DSD, managing preschool to Grade R). Preschool programming, including Grade R, has subsequently moved from being managed by DSD to DBE.

What are the mental health concerns and risk and protective factors?

Early signs and symptoms of depression, anxiety, attention deficit/hyperactivity disorder, and behaviour and affect dysregulation can begin to emerge at a young age.^{18, 19} Risk factors include exposure to early adversities such as violence, maltreatment, household stress or trauma, poverty, and poor nutrition.^{18, 20} Protective factors such as early identification of mental health problems and access to mental health support can have a positive, lifelong impact on a child's health and well-being.¹⁷

Case 11: Developing emotionally supportive classrooms

The Irie Classroom Toolbox is a teacher-training programme that aims to reduce corporal punishment and class-wide child aggression in preschools. The programme focuses on creating an emotionally supportive classroom environment, preventing and managing child behaviour problems, teaching social and emotional skills, and individual and class-wide behaviour planning. The programme is delivered to teachers of children aged 3 – 6 years by facilitators over a five-day period and eight in-class support sessions. The programme was assessed using a cluster-randomised control trial in Jamaica that found that the Irie Classroom Toolbox was effective in reducing the use of violence against children by teachers, improving child behaviour and inhibitory control, and teacher well-being in the longer term compared to controls.²⁸

Case 12: How play can promote self-regulation in children

Nicholas Dowdall and Jill Poppⁱ

Imagine that you are observing young children on a playground. Some children are climbing and swinging from bars on a jungle gym, two other children are trying to figure out how to make a house out of materials around them, and a few children are playing ‘three toti’ (three tins) where they aim to knock down a stack of empty pilchard tins. This may seem frivolous, but it’s quite the opposite. Children learn important skills during play, skills that support their academic *and* non-academic learning. For example, a child’s ability to self-regulate is a crucial determinant of how they navigate the social world, cope with stressful situations, manage their emotions and mentally course-correct where necessary. This all has significant bearing on their long-term mental well-being and ability to thrive.^{88, 89} We know from the literature that play is one of the best ways that young children practice and develop self-regulation skills.

*A child’s greatest self-control
occurs in play – Vygotsky, 1978*

Much of our framing of the central role of play in children’s development comes from Vygotsky’s⁹⁰ notion that children naturally set themselves appropriate challenges and thereby establish their own ‘zone of proximal development’ during play, in which their learning is optimised. Vygotsky also suggested that play makes a critical contribution to the development of symbolic representation and language skills which underpin self-regulation. Play is really the first medium through which children explore the use of symbols and spoken language. Specifically, very young children begin to represent ideas as they talking to themselves while they play. This type of self-talk promotes language development and gives children a greater repertoire of ways to express their behaviour and emotions.

Types of play that promote self-regulation

Play offers children an ideal context in which to activate, practice and master many of these skills and processes. It is through the activation of these pathways or mechanisms that play can facilitate the development of self-regulation in young children. Let’s take a look at how this works,

drawing on two of the most popular forms of play in childhood – pretend play and games with rules.

Pretend play

Make-believe, imaginative or fantasy play is often seen as a natural and joyful experience, but it can be a particularly powerful medium for the development of self-regulation. Pretend play allows the expression of both positive and negative feelings, and the modulation of affect through role-taking.⁹¹

When children take on roles in pretend play, they must navigate and negotiate differences and align their desires with others which forces them to flex their inhibitory control.⁹² Perhaps the most powerful aspect of role-taking is how it nudges children into taking on the perspectives of the character they are playing. In doing so, they are required to represent the mental states of another person or character which can help them become aware that to understand other people’s perspective, they need to see the world through the eyes of that other person (a concept called ‘theory of mind’). Children also need to follow social rules when playing a role, even if these rules are implicit. For example, their behaviour will follow the norms and rules of being a doctor caring for a sick patient, or a policeman making an arrest, all of which involve the use of internal mental representations, inhibitory control, and perspective-taking in order to keep the pretence going.⁹³

Collaborative pretend play can be particularly beneficial to language development as it involves rich conversational exchanges between players, both in the creation of the game and in acting it out.^{94, 95} This includes internal conversations known as private speech,^{96, 97} which also help strengthen children’s ability to self-regulate.⁹⁸

Games with rules

In pretend play most rules are implicit, while games with rules contain a set of clear and explicit rules that must be followed by players and are usually established at the start of the game. Children tend to progress from more pretend play between ages 3 – 6 towards more games with rules from age 7 – 12.⁹⁰ These games with rules tend to activate several core self-regulatory processes and executive functions, including working memory, executive attention and inhibitory control.⁹⁹

As an example, a game like 'Simon Says' taxes children's executive functions, particularly inhibitory control and attention, as they need to control an impulse or emotion to follow instructions that are not preceded by the code words 'Simon Says'. 'Freeze' games are similar, where the listener is required to exercise inhibitory control and stop dancing as soon as the music stops. In both these examples, working memory is also required for the child to hold the rule in their heads. The activation and taxation of working memory can also be increased in other word memory games, such as the indigenous Setswana game 'Tsamaya oreka Omo' (Go and buy Omo), where children begin with the statement, "I went to the shop and I bought Omo (washing powder)." Each player must then recall all the previous items before adding an item of their own to the shopping list, while simultaneously clapping and slapping their thighs.

Implications for parents and practitioners

Self-regulation enhances children's ability to cope with various stressors. Therefore, providing them with opportunities via play to exercise these skills is critical. Parents and early childhood development practitioners can help by providing structured and unstructured time for pretend play and games with rules and by providing multifunctional props or toys (these can be made from recycled materials) that can prompt children to create imaginary scenarios. It is important to let the child lead, and adults can help by asking questions, describing their perspective, or asking children how they feel. At times it might be helpful to suggest a new rule, element, or scenario to add complexity to the game, but child autonomy and ownership of the process should be maintained.

How can ECE centres promote and protect mental health?

ECE centres can support mental health in early childhood by:

- Promoting child functioning and well-being through curricula, pedagogical approach and school environment.
- Acting as hubs to screen for developmental or behavioural disorders.
- Linking children at risk of mental health problems (for example, those with early signs of behavioural problems) to local DSD or Department of Health (DoH) practitioners for additional support.
- Providing caregivers with information and linking them to services and support networks as required.

What is the current policy response in South Africa?

The National Integrated ECD Policy 2015 provides an overarching framework to strengthen ECD services at each level of government, including a description of programme components, roles and responsibilities, and the establishment of a coordinating structure.²¹ Part of this framework focuses on emotional well-being; however, it is predominantly geared towards screening for families at risk and supporting caregivers to promote healthy and safe home environments, and not on the role of ECE centres settings. The Integrated School Health Programme (ISHP) includes provisions for health screening, services, and education of Grade R learners. At this stage, mental health is intended to be included in health screening; however, no clear referral pathways are described, apart from provision of information around sexual, physical, and emotional abuse.²²

One of the key challenges in implementing current policy is that many ECE centres in South Africa operate in informal settings and are therefore unregulated and unsubsidised, which may introduce risks to child well-being and safety, in addition to providing care and education of inconsistent quality. Another key challenge is that very few ECE institutions are linked to child mental health services, despite the overarching intersectoral ISHP.

What are the promising opportunities for future service development?

Some promising early education-based models from low-resource settings include developing teachers' skills in fostering the socio-emotional development of young children and early identification of behavioural problems.^{23, 24} Other potential approaches include provision of individualised child assessment and therapy, and family assessment and support.²⁵

The ECE setting could be used as a platform to promote nurturing care and positive parenting and discipline techniques.²⁶ Psychosocial treatment for parental depression and specific mental health programmes focusing on parent-infant interaction have been found to help prevent impaired cognitive development and behavioural and emotional problems in disadvantaged children.²⁷

Primary schools

Primary school education is the responsibility of the DBE. It starts in Grade 1, when the learner turns 7, and continues until the end of Grade 7. Primary schools have the highest rates of enrolment and most learners attend no-fee public schools.

What are the mental health concerns and risk and protective factors?

The most commonly reported mental health concerns during the primary school years are anxiety, depression, post-traumatic stress disorder, aggression, substance abuse, and conduct and attention deficit/hyperactivity disorders.^{29, 30} High rates of bullying are also common,³¹ particularly for boys.³² Additionally, many learners are still exposed to corporal punishment,³³ despite it being outlawed in South Africa in 1997.³⁴ Corporal punishment has been linked to increased rates of anxiety, depression, aggression, and suicidal ideation.^{33, 35, 36}

Primary schools can be a safe and supportive space for learners, which can encourage school attendance and improve feelings of belonging.^{29, 37} However, the transition to primary school can be stressful and learners can struggle with associated changes such as new teachers, peers, rules and routines.³⁸

How can primary schools promote and protect mental health?

Primary schools can support the mental health of learners by:

- Building a positive school climate, improving relationships within schools, creating an environment that promotes respect and values diversity, and reducing exposure to risk factors through modifications to the physical and psychological environment.
- Incorporating emotional well-being and building skills such as emotional regulation into the curriculum.
- Involving parents/caregivers in initiatives that promote mental health and well-being.
- Investing in staff well-being.
- Offering targeted support and appropriate referrals for those showing signs or symptoms of mental health conditions.

What is the current policy response in South Africa?

The framework of services that should be available through primary and secondary schooling in South Africa are detailed in key documents such as the ISHP, the National School Safety Framework (NSSF) and the Care and Support for Teaching Learning (CSTL) Programme (the last two of which are described in more detail in the secondary school section below). These are aligned with the South African Mental Health Care Act and the Child and Adolescent Mental Health Policy Guidelines.³⁹

The ISHP positions schools as being important for addressing health challenges of learners, including mental health.²² It includes provision for school children to be

Case 13: Universal intervention to reduce anxiety

An information motivation and behavioural skills (IMB) based intervention programme was delivered to primary school learners to reduce levels of anxiety. The programme consists of six modules focusing on emotions, emotional triggers, empathy skills, emotional regulation skills, and self-esteem. The programme is delivered to learners aged 10 – 11 years by research assistants over four weekly sessions delivered to whole classes. The effectiveness of the programme was assessed using a cluster randomised control trial in Malaysia that found the IMB-based programme was effective in reducing levels of anxiety when compared to a school-as-usual control group.⁴²

screened for mental health problems and provided with psychosocial support at foundation and intermediate phase.²² Moreover, health education should be provided that focuses on related topics such as abuse (foundation phase), substance abuse and bullying (intermediate phase) and suicide (senior phase). Each school should be assigned to a primary health care facility with school health nurses acting as the primary referral agents. School-based support teams should be in place, comprising skilled teachers, health promoters (full-time members of the school health team or lay health workers based at facilities or part of primary health care (PHC) outreach teams), representatives of the school governing body, and non-governmental organisations.

Health education is a crucial component of the ISHP and is incorporated into the school curriculum and provided through Life Orientation. The subject of Life Orientation is intended to build learners' skills, knowledge, and values about the self, the environment, responsible citizenship, a healthy and productive life, social engagement, recreation and physical activity, careers and career choices. The content taught in lower grades serves as the foundation for later content introduced in higher grades.

In practice, the ISHP implementation is fragmented and inequitable. There are too few assigned health care workers and a lack of collaboration between health and education officials.⁴⁰ Recommendations for ensuring more effective implementation of ISHP include clarifying educators' role in the implementation of ISHP, providing training, introducing baseline standards for schools implementing the ISHP, and ensuring greater commitment to intersectoral collaboration.³⁹ This process includes establishing clear communication

Case 14: Whole-school health promotion

The Strengthening Evidence Base on School-Based Interventions for Promoting Adolescent Health (SEHER) is a whole-school health promotion intervention that aims to enhance the school climate and adolescent health and well-being.⁶⁷ SEHER is delivered by lay counsellors and teachers to Grade 9 learners (13 – 14 years) in Bihar, India. The intervention programme consists of three components: (1) whole-school activities, (2) group activities, and (3) individual activities. School-wide activities address a range of topics (hygiene, bullying, mental health, substance use, reproductive and sexual health, gender violence, rights and responsibilities, and study skills) each month. Group activities are delivered through peer groups and workshops. The peer groups consist of approximately 10 – 15 students from each class, who meet monthly to discuss the topic of the month and assist in organising various activities. Workshops focus on effective study skills for learners and on discipline practices for teachers. Lastly, problem-solving counselling is offered to learners who self-refer or who are referred by teachers. The effectiveness of the intervention programme was assessed through a cluster randomised trial. The intervention had beneficial effects on school climate, depression, bullying, violence victimization and perpetration, attitudes towards gender equity, and knowledge on sexual and reproductive health when delivered by lay counsellors, but no effect when delivered by teachers. This may be because lay counsellors were employed full-time to facilitate the programme, whereas teachers also had their full-time academic responsibilities to attend to.

systems within and between the DoH and DBE to engage all stakeholders, improving the management of financial, human and other forms of resources, and ensuring that they are equitably distributed and accounted for.

What are the promising opportunities for future service development?

Opportunities for future service development through primary schools include training health personnel to ensure effective implementation of school health policy at district and regional levels, and prioritising educator mental health through debriefing sessions and mentorship. Whole-school

approaches that address the school environment have been shown to be effective in school-based bullying prevention and intervention.⁴¹ Interventions that promote school connectedness (including a sense of belonging, school involvement and positive school climate) and offer structural dimensions, such as teacher support, have also been found to promote mental health during middle childhood.²⁷

Secondary schools

Secondary school runs from Grade 8 to Grade 12, from the ages of 13 – 18, culminating in the National Senior Certificate (or Matric) exams. Compulsory education is completed at the end of the senior phase (Grades 7 – 9), and school dropout increases with age during the Further Education and Training band (Grades 10 – 12).

What are the mental health concerns and risk and protective factors?

Secondary school is a critical period for adolescent development, with half of mental health conditions emerging by the age of 14 years. Common mental health conditions that emerge during adolescence are anxiety; mood, attention, and behaviour disorders; substance use; and suicidality.^{43,44}

Specific risk factors for mental health conditions during adolescence include poor socio-economic status,⁴⁵ parental depression,⁴⁶ poor family functioning,⁴⁷⁻⁴⁹ poor parental relationships,⁵⁰ poor interpersonal skills,⁵¹ bullying⁵² and low self-esteem.⁵³ Schools can be protective when they provide a safe environment (physical and emotional safety),⁵⁴ high connectedness,⁵⁵ nurturing relationships and interactions between learners and teachers,⁵⁵ and a supportive learning environment.⁵⁶

How can secondary schools promote and protect mental health?

Secondary schools can support the mental health of adolescents in several ways:

- Committing to a whole-school approach to being a HPS and interventions should reflect this. Will and commitment are needed from leadership, at an individual school level, to instil an inclusive and healthy institutional culture.¹⁶
- Providing parents, caregivers and local community members with opportunities to participate meaningfully in the governance, design, implementation and evaluation of HPS initiatives.¹⁶
- Implementing national policies against substance use and bullying behaviour.
- Supporting the physical, social-emotional and psychological health and well-being of learners.

- Providing programmes to enable staff to support their own well-being and those of their learners.
- Ensuring learners can access support or treatment when needed. This can include links with after-school programmes that provide psychosocial support. After-school or community-based programmes are also a promising avenue for reaching out-of-school children, including children and adolescents who face hardships in accessing or completing formal school.⁵⁷
- Providing platforms for peer-based and peer-led mental health interventions, as these have been shown to improve self-esteem in victims of bullying and positively improve learners' relationships.⁵⁸

What is the current policy response in South Africa?

The ISHP, NSSF and CSTL programme outline a package of services that should be available through primary and secondary schools. At a secondary school level, the ISHP states that adolescents should be screened for mental health issues and provided with psychosocial support during the senior phase.²² Health education should be provided through Life Orientation and additional life skills teaching should be provided in secondary schools where timetables may not provide adequate time to fully address health and social issues.¹⁵ Additional on-site services include sexual and reproductive health services and provision of HIV counselling and testing.

The CSTL Programme, a Southern African Development Community initiative adopted by the Minister of Education in 2008, was initiated to coordinate and expand care and support activities that improve education outcomes across school stages.^{59, 60} The initiative aims to remove health and social barriers that limit the potential of children. Key provisions include nutritional support, health promotion, infrastructure, water and sanitation, safety and protection, social welfare services, psychosocial support, material support, curriculum support, and co-curricular activities. At the school level, the essential package of services includes safety and protection policies against discrimination and bullying, identification and support of children who are exposed to abuse, and disaster risk reduction and sensitisation. Implementation of the CSTL at school level is facilitated through a school-based support team, which could take the form of a School Development Committee, a School Management Board, or Parent Teacher Association. These support structures include community development partners, community members and learners to promote child participation. As in primary schools, the NSSF, together with the Regulations for Safety

Measures in public schools, require every school to put in place a school safety policy, a school safety plan, a policy on non-violent discipline, and a code of conduct for learners. School safety interventions are monitored by the Safe School Committee in every school.⁶¹

The Department of Basic Education's National Policy on the Prevention and Management of Learner Pregnancy⁶³ asserts the Constitutional rights of pregnant learners to continue and complete their basic education without stigma or discrimination. Schools are required to provide counselling and support to pregnant learners, allow a short- to medium-term absence from school and enable them to return to school and complete their education up to Grade 12. An implementation plan is expected in 2022.

Despite these promising policies to promote psychosocial development and well-being among secondary students, there are several key challenges in implementing the existing policies. There are high levels of school dropout, with vulnerable adolescents most at risk, and dropout rates tripling during the first year of the COVID-19 pandemic.⁶⁴ There is also lack of a conducive environment for screening and examining children properly, including mental health assessment, due to lack of privacy.¹⁵ When a mental health issue is identified, support services are not always available to respond to identified health needs and follow-up is rarely conducted, as nurses generally visit schools once a year.¹⁵ There is also limited resource allocation for implementation, poor delivery of school health services as well as a lack of

Case 15: A whole-school approach to safety promotion

The Safe School Programme, a Western Cape Education Department initiative, is a provincial level response that uses a whole-school approach to safety promotion and violence prevention.⁶² This approach requires collaboration between principals, educators, school governing bodies and learners and cluster safety committees to develop, implement and monitor a sustainable integrated safety plan. The programme aims to promote safe learning environments and prevent violence through effective behaviour management, creative and constructive approaches to conflict resolution, mediation in school communities, gang prevention education, parent workshops, mentorship programmes, diversion programmes, youth development, victim empowerment, and multi-cultural education.

support from caregivers and communities, partly because caregivers are not certain of their role in the provision of school health services.

What are the promising opportunities for future service development?

Universal delivery of social and emotional learning programmes can promote positive mental health outcomes and reduce poor mental health and risk behaviours.⁶⁵ Interpersonal and social skills training can also assist in reducing violent and antisocial behaviour in youth.⁶⁶

Tertiary education

Tertiary education institutions are the responsibility of the Department of Higher Education and Training (DHET). DHET focuses on post-school education, skills development, and vocational training.

What are the mental health concerns?

Mental health problems common among South African university students include mood and anxiety disorders, post-traumatic stress disorder, and hazardous substance use.⁶⁸⁻⁷¹ Findings from a study to establish the prevalence of common mental disorders (CMDs) among first-year university students in South Africa found that CMD prevalence rates are higher among students than in the general population.⁶⁹ The transition to tertiary education institutions can be stressful as it usually involves leaving one's family and home, adapting to a new social environment, increased academic and financial pressure, and more opportunities for substance misuse.⁶⁹

How can tertiary institutions help?

Tertiary education institutions should focus on creating healthy, safe, secure, and inclusive environments that promote respect and value diversity.⁶⁹ Programmes should be implemented to enhance student health and wellness to increase the proportion of students who complete their degrees. Tertiary education institutions should also engage and collaborate with community-based services that can provide support and treatment to students.

What is the current policy response in South Africa?

There is no overarching policy response for mental health in higher education in South Africa. Mental health policies developed by South African universities generally include a commitment to providing professional, coordinated, accountable, fair and accessible services to students to support the prevention of mental health challenges and the promotion of mental health and wellness. Several universities

have a designated primary healthcare entity for registered students that regulates mental health care services and treatments. These facilities offer assessment and intervention to those experiencing mental health challenges. They offer mental health awareness, promotion and prevention activities to the campus community, and aid in providing motivations for reasonable accommodation for students with mental health difficulties.⁷²⁻⁷⁴

The lack of a national policy related to mental health in higher education poses a significant challenge to the implementation of programming. Lack of guidance from national government means that if provincial governments implement appropriate services, they are required to develop their own evidence-based guidelines and implementation plans – a time-consuming and costly process. In addition, the lack of effective prevention and early detection of mental health problems amongst students can cause bottlenecks in service delivery at the primary health care level.^{69, 75}

What are the promising opportunities for future service development?

Opportunities for developing services at a tertiary education level include linking to school-based programmes and improved access to adolescent psychiatric services. Other possibilities include adopting a public mental health approach to promoting student wellness with ongoing monitoring of the prevalence of mental health problems

Case 16: Digitally delivered psychological treatment

A web-based group cognitive behavioural therapy (GCBT) intervention was delivered to Stellenbosch University students to reduce symptoms of anxiety and depression during the COVID-19 pandemic, when access to traditional campus-based psychotherapy was restricted. The intervention was delivered remotely by graduate clinical psychology students (trainee psychologists) via Microsoft Teams in 10 weekly workshops of 60–75 minutes. Content is organised into five themes, with each theme spanning two workshops, and drawn from common elements identified from GCBT interventions that were shown to be effective among university students. The effectiveness of the intervention was assessed through a pragmatic open trial in South Africa that found significantly decreased symptoms of anxiety, depression and composite anxiety and depression in intervention participants compared to controls.⁷⁶

Case 17: Supported Education programme

Supported Education (SEd) is a programme model developed in the United States to assist people with psychiatric disabilities achieve their post-secondary education goals and to improve retention rates for tertiary education students with psychiatric disabilities. SEd is built on a resilience-based framework where students are taught how to cope more effectively with the complexities of tertiary education learning, which are often associated with dropout. They are also taught how to use internal and external protective factors in the tertiary education environment to increase resilience.⁷⁷ SEd programmes also offer the following services to students: (1) career planning, which includes vocational assessment, career

exploration, and course selection; (2) academic survival skills, which include information about the tertiary institution and different training courses, disability rights and resources, tutoring and mentoring services, and social support services; (3) direct assistance, which includes help with enrollment, financial aid, education debt, and contingency funds; and (4) outreach, which includes campus resources and mental health treatment. Research on the effectiveness of SEd programmes in high income settings has found higher levels of academic engagement in individuals with psychiatric disabilities, improved self-confidence and self-perception, and higher enrolment rates in tertiary education institutions.⁷⁷

on South African university campuses. This approach would require accurate epidemiological data that could then be used to plan and support the delivery of preventive mental health services, and the adopting of alternative, sustainable counselling approaches, such as the use of group therapy and/or internet-based psychotherapy.⁷⁶

How can we address cross-cutting issues?

There are several challenges as well as opportunities to improve mental health promotion and preventive services that cut across all levels of education.

Transitional periods

While the ISHP stipulates that mental health screening, assessment and education is incorporated into every school health package, from Grade R to 12, it provides limited focus on the transitions between the different stages of education.³⁹ Increased stress is characteristic of the transition, as learners are expected to adapt to new school, teacher and/or classroom demands, new peer groups, and, in some cases, the changing languages of instruction between phases. Various strategies could assist with transitioning processes. For example, within schools, efforts should be made to welcome and orientate new students by building relationships across grades, and information should be given to parents and caregivers on how best to support their child's transition from one school setting to another.¹⁶ Regular meetings and information sharing between schools within the same geographic area could be beneficial. These meetings could provide opportunities for educators to share important information about children (e.g., health

information or support services accessed) to ensure ongoing support, and to learn about the different programmes that each school stage offers and their connection with childcare programmes within the community.⁷⁸

Racism and discrimination

In the South African context, learners' exposure to interpersonal and institutional racism is an ongoing challenge. Experiences of alienation, discrimination, and racialised bullying are common at formerly white schools and universities across the country. The negative impact of these environments on learners' mental health, self-esteem and sense of belonging was well described by the #yousilenceweamplify campaign on social media which gained national prominence.⁷⁹ Explicitly capacitating schools to address issues of discrimination is critical. Examples of programmes include Teaching for All, which has been widely rolled out in South Africa and aims to equip teachers and schools with training on how to "teach inclusively in diverse classrooms in diverse communities".⁸⁰

Educator well-being

South African educators experience high levels of stress in their places of work and often do not feel equipped to deal with learner mental health issues themselves.^{81,82} This psychological load undermines educators' ability to respond to their learners and can interfere with positive educator-child relationships and effective social-emotional teaching.^{83,84} Student well-being could be positively influenced by improving educator well-being, through interventions such as task sharing that reduce job demands and increase job resources.^{67,85}

Disability

In South Africa, up to 70% of children of school-going age with disabilities do not attend school. Of those who do attend, most are still in separate schools for learners with special needs. This situation prevails despite the push for the educational inclusion of learners with disabilities since the publication of Education White Paper 6 in 2001.⁸⁶ Providing basic and higher education, let alone mental health services, for children and adolescents with disabilities may be challenging, especially in remote areas where infrastructure and support are lacking. Children with disabilities are at increased risk of developing mental health disorders. It is therefore essential to include them in mental promotion and prevention programmes and to ensure early referral for treatment to prevent the development of a secondary psychosocial disability. Treatment should have an emphasis on recovery and provide consistent follow-ups from a multi-disciplinary team that spans the health and education sectors.

What are the priorities for further research?

Two priority areas of research are policy implementation and programme evaluation. While the ISHP provides a national roadmap, provincial policy and implementation plans are lacking and need to provide feasible, relevant and evidence-based frameworks for service delivery.⁷⁵ Situational analyses should be conducted to assess the current implementation of the ISHP and how it relates to child and adolescent mental health at a provincial, district and school level. This includes

engagement with the users and providers to understand their lived experiences and perceptions of the mental health services that are currently offered through schools. This feedback should inform recommendations for policy and programming, and the research findings should be available for policy makers to spark discussion and encourage policy planning and implementation.⁷⁵

Rigorous evaluation designs are difficult to implement in educational settings, as randomised control trials often require rigid controls to minimise confounding factors, which may not be feasible.⁸⁷ Possible strategies to mitigate this include effectiveness studies (evaluating an intervention under usual conditions) or quasi-experimental and well-designed observational studies which rely on naturally occurring variation among schools or settings.

Conclusion

Schools and other educational institutions have the potential to be a powerful resource for promoting and protecting child, adolescent and youth mental health in South Africa. While national policy exists to support the mental health of learners and students, the implementation thereof, at a provincial, district and institutional level, is weak and requires attention. The COVID-19 pandemic and its far-reaching consequences for our society add another layer of complexity that needs to inform future research, policy and programming.

References

1. Thorley C. *Education, education, mental health: Supporting secondary schools to play a central role in early intervention mental health services*. IPPR. 2016.
2. Hall K. *Education: School attendance*. Children Count website. Cape Town: Children's Institute, University of Cape Town; 2019. Accessed: 10 April 2022. Available from: <http://childrencount.uct.ac.za/indicator.php?domain=6&indicator=15>.
3. The World Bank. *School enrollment, tertiary (% gross) - South Africa: 2021*. Accessed: 10 April 2022. Available from: <https://data.worldbank.org/indicator/SE.TER.ENRR?end=2019&locations=ZA&start=2003>.
4. Vostanis P, Humphrey N, Fitzgerald N, Deighton J, Wolpert M. How do schools promote emotional well-being among their pupils? Findings from a national scoping survey of mental health provision in English schools. *Child and Adolescent Mental Health*. 2013;18(3):151-157.
5. Ford T, Degli Esposti M, Crane C, Taylor L, Montero-Marín J, Blakemore S-J, Greenberg MT. The role of schools in early adolescents' mental health: Findings from the MYRIAD study. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2021.
6. Shochet IM, Dadds MR, Ham D, Montague R. School connectedness is an underemphasized parameter in adolescent mental health: Results of a community prediction study. *Journal of Clinical Child & Adolescent Psychology*. 2006;35(2):170-179.
7. Hsiao C, Richter LM. Early mental development as a predictor of preschool cognitive and behavioral development in South Africa: The moderating role of maternal education in the birth to twenty cohort. *Infants & Young Children*. 2014;27(1):74-87.
8. Springer P, Slogrove A, Kidd M, Kalk E, Bettinger J, Esser M, Kruger M. Neurodevelopmental and behavioural outcomes of HIV-exposed uninfected and HIV-unexposed children at 2-3 years of age in Cape Town, South Africa. *AIDS care*. 2020;32(4):411-419.
9. Miller-Lewis L, Searle A, Sawyer M, Baghurst P, Hedley D. Predictors of mental health resilience in early childhood: A multi-methods analysis. *Child and Adolescent Psychiatry and Mental Health*. 2013;7(6).
10. Cavioni V, Grazzani I, Ornaghi V. *Mental health promotion in schools: A comprehensive theoretical framework*. Report No.: 2073-7629. 2020.
11. Patel V, Flisher AJ, Nikapota A, Malhotra S. Promoting child and adolescent mental health in low and middle income countries. *Journal of Child Psychology and Psychiatry*. 2008;49(3):313-334.
12. Rigby K. Bullying in schools and the mental health of children. *Journal of Psychologists and Counsellors in Schools*. 2005;15(2):195-208.
13. Atkins MS, Hoagwood KE, Kutash K, Seidman E. Toward the integration of education and mental health in schools. *Administration and Policy in Mental Health and Mental Health Services Research*. 2010;37(1):40-47.
14. World Health Organization. *What is a health promoting school?* Geneva: World Health Organization. 2020. [<https://www.who.int/health-promoting-schools/overview/en/>]
15. World Health Organization. *Implementation Guidance for Health Promoting Schools, Draft 2, September 2020*. Geneva: World Health Organization. 2020.
16. World Health Organization. *Implementation Guidance for Health Promoting Schools Draft 2 September 2020*. Geneva: World Health Organization. 2020.
17. Oh DL, Jerman P, Silvério Marques S, Koita K, Purewal Boparai SK, Burke Harris N, Bucci M. Systematic review of pediatric health outcomes associated with childhood adversity. *BMC Pediatrics*. 2018;18(1):1-19.
18. von Klitzing K, Dönnert M, Kroll M, Grube M. Mental disorders in early childhood. *Deutsches Ärzteblatt International*. 2015;112(21-22):375.
19. Hall K, Sambu W, Almeleh C, Mabaso K, Giese S, Proudlock P. *South African Early Childhood Review 2019*. Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana. 2019.

20. Shonkoff JP, Garner AS. Committee on psychosocial aspects of child and family health committee on early childhood, adoption, and dependent care section on developmental and behavioral pediatrics the lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e232-e246.
21. Republic of South Africa. *National Integrated Early Childhood Development Policy*. Pretoria. 2015.
22. Department of Basic Education. *Integrated School Health Policy*. 2012. [https://serve.mg.co.za/content/documents/2017/06/14/integratedschoolhealthpolicybeanddoh.pdf]
23. Green BL, Malsch AM, Kothari BH, Busse J, Brennan E. An intervention to increase early childhood staff capacity for promoting children's social-emotional development in preschool settings. *Early Childhood Education Journal*. 2012;40(2):123-132.
24. Desta M, Deyessa N, Fish I, Maxwell B, Zerihun T, Levine S, Alem A. Empowering preschool teachers to identify mental health problems: A task-sharing intervention in Ethiopia. *Mind, Brain, and Education*. 2017;11(1):32-42.
25. Upshur C, Wenz-Gross M, Reed G. A pilot study of early childhood mental health consultation for children with behavioral problems in preschool. *Early Childhood Research Quarterly*. 2009;24(1):29-45.
26. *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*. Geneva. 2018.
27. Petersen I, Swartz L, Bhana A, Flisher AJ. Mental health promotion initiatives for children and youth in contexts of poverty: The case of South Africa. *Health Promotion International*. 2010;25(3):331-341.
28. Baker-Henningham H, Bowers M, Francis T, Vera-Hernández M, Walker SP. The Irie Classroom Toolbox, a universal violence-prevention teacher-training programme, in Jamaican preschools: A single-blind, cluster-randomised controlled trial. *The Lancet Global Health*. 2021;9(4):e456-e468.
29. Cortina MA, Fazel M, Hlungwani TM, Kahn K, Tollman S, Cortina-Borja M, Stein A. Childhood psychological problems in school settings in rural Southern Africa. *PLoS one*. 2013;8(6):e65041.
30. Marais L, Skinner D, Serekoane M, Sharp C, Lenka M. A qualitative study on teachers' perceptions of their learners' mental health problems in a disadvantaged community in South Africa. *Curationis*. 2019;42(1):1-7.
31. Caldwell LL, Patrick ME, Smith EA, Palen L-A, Wegner L. Influencing adolescent leisure motivation: Intervention effects of health wise South Africa. *Journal of Leisure Research*. 2010;42(2):203-220.
32. Manuel D, Adams S, Mpilo M, Savahl S. Prevalence of bullying victimisation among primary school children in South Africa: A population-based study. *BMC Research Notes*. 2021;14(1):1-6.
33. Breen A, Daniels K, Tomlinson M. Children's experiences of corporal punishment: A qualitative study in an urban township of South Africa. *Child Abuse & Neglect*. 2015;48:131-139.
34. South African Government. *Republic of South Africa: Government Gazette*. 1997. [https://www.gov.za/sites/default/files/gcis_document/201409/a33-97.pdf]
35. Jyoti S, Neetu S. Implications of corporal punishment on primary school children. *IOSR Journal of Humanities and Social Science (IOSR-JHSS)*. 2013;15(6):57-61.
36. Thumann BF, Nur U, Naker D, Devries KM. Primary school students' mental health in Uganda and its association with school violence, connectedness, and school characteristics: A cross-sectional study. *BMC Public Health*. 2016;16(1):1-11.
37. Rawatlal KV, Petersen I. Factors impeding school connectedness: A case study. *South African Journal of Psychology*. 2012;42(3):346-357.
38. Sefotho MM, Onyishi CN. In-school transition challenges among primary school learners with autism spectrum disorders in South Africa: Parents and teachers' perspectives. *Perspectives in Education*. 2021;39(2):283-302.
39. Ramukumba TS, Rasesemola RM, Matshoge GP. Compliance to the integrated school health policy: Intersectoral and multisectoral collaboration. *Curationis*. 2019;42(1):1-8.
40. Lenkokile R, Hlongwane P, Clapper V. Implementation of the integrated school health policy in public primary schools in Region C, Gauteng Province. *African Journal of Public Affairs*. 2019;11(1):196-211.
41. Lanigan AR. *A systematic review of bullying prevention programs in schools*. 2015.
42. Ghaffar A, Fatimah S, Mohd Sidik S, Ibrahim N, Awang H, Gyanchand Rampal LR. Effect of a school-based anxiety prevention program among primary school children. *International Journal of Environmental Research and Public Health*. 2019;16(24):4913.
43. World Health Organization. *Adolescent Mental Health 2020*. Accessed: 10 April 2022. Available from: https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health.
44. Kessler RC, Angermeyer M, Anthony JC, De Graaf R, Demyttenaere K, Gasquet I, Haro JM. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*. 2007;6(3):168.
45. Rao U, Ryan ND, Birmaher B, Dahl RE, Williamson DE, Kaufman J, Nelson B. Unipolar depression in adolescents: Clinical outcome in adulthood. *Journal of the American Academy of Child & Adolescent Psychiatry*. 1995;34(5):566-578.
46. Hammen C, Shih J, Altman T, Brennan PA. Interpersonal impairment and the prediction of depressive symptoms in adolescent children of depressed and nondepressed mothers. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2003;42(5):571-577.
47. Lee A, Hankin BL. Insecure attachment, dysfunctional attitudes, and low self-esteem predicting prospective symptoms of depression and anxiety during adolescence. *Journal of Clinical Child & Adolescent Psychology*. 2009;38(2):219-231.
48. Rönnlund M, Karlsson E. The relation between dimensions of attachment and internalizing or externalizing problems during adolescence. *The Journal of Genetic Psychology*. 2006;167(1):47-63.
49. Reinherz HZ, Giaconia RM, Pakiz B, Silverman AB, Frost AK, Lefkowitz ES. Psychosocial risks for major depression in late adolescence: A longitudinal community study. *Journal of the American Academy of Child & Adolescent Psychiatry*. 1993;32(6):1155-1163.
50. Field T, Miguel D, Sanders C. Adolescent depression and risk factors. *Adolescence*. 2001;36(143):491.
51. Garland M, Fitzgerald M. Social skills correlates of depressed mood in normal young adolescents. *Irish Journal of Psychological Medicine*. 1998;15(1):19-21.
52. Rudolph KD, Hammen C, Burge D, Lindberg N, Herzberg D, Daley SE. Toward an interpersonal life-stress model of depression: The developmental context of stress generation. *Development and Psychopathology*. 2000;12(2):215-234.
53. MacPhee AR, Andrews JJ. Risk factors for depression in early adolescence. *Adolescence*. 2006;41(163).
54. Thapa A, Cohen J, Guffey S, Higgins-D'Alessandro A. A review of school climate research. *Review of Educational Research*. 2013;83(3):357-385.
55. Joyce HD, Early TJ. The impact of school connectedness and teacher support on depressive symptoms in adolescents: A multilevel analysis. *Children and Youth Services Review*. 2014;39:101-107.
56. Stewart EB. School structural characteristics, student effort, peer associations, and parental involvement: The influence of school-and individual-level factors on academic achievement. *Education and urban society*. 2008;40(2):179-204.
57. Inoue K, Di Gropello E, Taylor YS, Gresham J. *Out-of-school youth in Sub-Saharan Africa: A policy perspective*: World Bank Publications; 2015.
58. García-Carrión R, Villarejo-Carballido B, Villardón-Gallego L. Children and adolescents mental health: A systematic review of interaction-based interventions in schools and communities. *Frontiers in Psychology*. 2019;10:918.
59. Department of Basic Education. *Care and Support for Teaching and Learning (CSTL) Programme* 2008. [https://www.education.gov.za/Programmes/HealthPromotion/CSTL.aspx]
60. Southern African Development Corporation. *Care and Support for Teaching and Learning: From Policy to Practice*. 2015. [http://www.cstlsadc.com/wp-content/uploads/2017/03/FROM-POLICY-TO-PRACTICE.pdf]
61. Centre for Justice and Crime Prevention. *The National School Safety Framework*. 2016.
62. Safer Spaces. *Safe schools programme*: n.d. Accessed: 22 April 2022. Available from: https://www.saferpaces.org.za/be-inspired/entry/safe-schools-programme.
63. Department of Basic Education. *Policy on the prevention and management of learner pregnancy in schools*. 2021. [https://static.pmg.org.za/211203policypreventionmanagement.pdf]
64. Shepherd D, Mohohlwane N. The impact of COVID-19 in education - More than a year of disruption. *National Income Dynamics (NIDS)-Coronavirus Rapid Mobile Survey (CRAM) Wave*. 2021;5.
65. Skeen S, Laurenzi CA, Gordon SL, du Toit S, Tomlinson M, Dua T, Servili C. Adolescent mental health program components and behavior risk reduction: A meta-analysis. *Pediatrics*. 2019;144(2).
66. Christle CA, Nelson CM, Jolivet K. *Prevention of antisocial and violent behavior in youth: A review of the literature*. National Center on Education, Disability and Juvenile Justice, University of Maryland. 2002.
67. Shinde S, Weiss HA, Varghese B, Khandeparkar P, Pereira B, Sharma A, Patel V. Promoting school climate and health outcomes with the SEHER multi-component secondary school intervention in Bihar, India: A cluster-randomised controlled trial. *The Lancet*. 2018;392(10163):2465-2477.
68. Hussain R, Guppy M, Robertson S, Temple E. Physical and mental health perspectives of first year undergraduate rural university students. *BMC Public Health*. 2013;13(1):1-11.
69. Bantjes J, Lochner C, Saal W, Roos J, Taljaard L, Page D, Kessler RC. Prevalence and sociodemographic correlates of common mental disorders among first-year university students in post-apartheid South Africa: Implications for a public mental health approach to student wellness. *BMC Public Health*. 2019;19(1):1-12.
70. Rousseau K-L, Thompson S, Pileggi L-A, Henry M, Thomas KGF. Trends in the prevalence and severity of depressive symptoms among undergraduate students at a South African University, 2016-2019. *South African Journal of Psychology*. 2021;51(1):67-80.

71. Bantjes JR, Kagee A, McGowan T, Steel H. Symptoms of posttraumatic stress, depression, and anxiety as predictors of suicidal ideation among South African university students. *Journal of American College Health*. 2016;64(6):429-437.
72. Stellenbosch University. *Policy: Staff and student mental health at Stellenbosch University* n.d.: [http://www.sun.ac.za/english/learning-teaching/student-affairs/cscd/Documents/Mental%20Health%20Policy%20Final%20for%20Consultation.pdf]
73. University of Cape Town. *University of Cape Town Student Mental Health Policy*. 2018. [https://www.uct.ac.za/sites/default/files/image_tool/images/328/about/policies/Student-Mental-Health-Policy.pdf]
74. University of the Free State. *Policy of the University of the Free State on student mental health*. n.d.: [https://www.ufs.ac.za/docs/librariesprovider43/student-affairs-documents/ufs-student-mental-health-policy-approved-by-council-language_final-version-1.pdf?sfvrsn=27069b21_2]
75. Mokitimi S, Schneider M, de Vries PJ. Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis. *International Journal of Mental Health Systems*. 2018;12(1):1-15.
76. Bantjes J, Kazdin AE, Cuijpers P, Breet E, Dunn-Coetzee M, Davids C, Kessler RC. A web-based group Cognitive Behavioral Therapy intervention for symptoms of anxiety and depression among university students: Open-label, pragmatic trial. *JMIR Mental Health*. 2021;8(5):e27400.
77. Hartley MT. Increasing resilience: Strategies for reducing dropout rates for college students with psychiatric disabilities. *American Journal of Psychiatric Rehabilitation*. 2010;13(4):295-315.
78. SERVE. *Terrific transitions: Ensuring continuity of services for children and their families*. Greensboro: The SERVE Center at the University of North Carolina. 2005.
79. Bhengu L. *Cape Town girls school sacks two teachers for racism; pupils and parents want full disclosure*:. 2021. Accessed: 10 April 2022. Available from: <https://www.news24.com/news24/southafrica/news/cape-town-girls-school-sacks-two-teachers-for-racism-pupils-and-parents-want-full-disclosure-20211216>.
80. British Council. *Teaching for All*. 2021. [https://www.britishcouncil.org.za/programmes/education/teaching-all]
81. Peltzer K, Shisana O, Zuma K, Van Wyk B, Zungu-Dirwayi N. Job stress, job satisfaction and stress-related illnesses among South African educators. *Stress and Health: Journal of the International Society for the Investigation of Stress*. 2009;25(3):247-257.
82. Mfidi FH. Mental health issues of school-going adolescents in high schools in the Eastern Cape, South Africa. *Africa Journal of Nursing and Midwifery*. 2017;19(3):13-pages.
83. Buettner CK, Jeon L, Hur E, Garcia RE. Teachers' social-emotional capacity: Factors associated with teachers' responsiveness and professional commitment. *Early Education and Development*. 2016;27(7):1018-1039.
84. Jackson LTB, Rothmann S, Van de Vijver FJR. A model of work-related wellbeing for educators in South Africa. *Stress and Health: Journal of the International Society for the Investigation of Stress*. 2006;22(4):263-274.
85. Harding S, Morris R, Gunnell D, Ford T, Hollingworth W, Tilling K, Brockman R. Is teachers' mental health and wellbeing associated with students' mental health and wellbeing? *Journal of Affective Disorders*. 2019;242:180-187.
86. Donohue D, Bornman J. The challenges of realising inclusive education in South Africa. *South African Journal of Education*. 2014;34(2).
87. Jaycox LH, McCaffrey DF, Ocampo BW, Shelley GA, Blake SM, Peterson DJ, Kub JE. Challenges in the evaluation and implementation of school-based prevention and intervention programs on sensitive topics. *American Journal of Evaluation*. 2006;27(3):320-336.
88. Kochanska G, Murray KT, Harlan ET. Effortful control in early childhood: Continuity and change, antecedents, and implications for social development. *Developmental Psychology*. 2000;36(2):220.
89. Blair C. School readiness: Integrating cognition and emotion in a neurobiological conceptualization of children's functioning at school entry. *American Psychologist*. 2002;57(2):111.
90. Vygotsky LS, Cole M. *Mind in society: Development of higher psychological processes*. Harvard University Press; 1978.
91. Whitebread D, Coltman P, Jameson H, Lander R. Play, cognition and self-regulation: What exactly are children learning when they learn through play? *Educational and Child Psychology*. 2009;26(2):40.
92. Lillard AS. Playing with a theory of mind. In: *Multiple perspectives on play in early childhood education*. 1998:11-33.
93. Savina E. Does play promote self-regulation in children? *Early Child Development and Care*. 2014;184(11):1692-1705.
94. Christie JF, Roskos KA. Play=learning: How play motivates and enhances children's cognitive and social-emotional growth. *Literacy Education*. 2006:57.
95. Robson S. Self-regulation and metacognition in young children's self-initiated play and reflective dialogue. *International Journal of Early Years Education*. 2010;18(3):227-241.
96. Andresen H. Role play and language development in the preschool years. *Culture & Psychology*. 2005;11(4):387-414.
97. Bivens JA, Berk LE. A longitudinal study of the development of elementary school children's private speech. *Merrill-Palmer Quarterly*. 1990:443-463.
98. Gilpin AT, Brown MM, Pierucci JM. Relations between fantasy orientation and emotion regulation in preschool. *Early Education and Development*. 2015;26(7):920-932.
99. Tominey SL, McClelland MM. Red light, purple light: Findings from a randomised trial using circle time games to improve behavioral self-regulation in preschool. *Early Education & Development*. 2011;22(3):489-519.

Health services and systems for child and adolescent mental disorders in South Africa: Towards a better future

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Few people know that mental illness represents one of the leading causes of disease and disability in children and adolescents worldwide.¹⁻³ Despite increasing global awareness about the importance of mental health services and systems for children and adolescents, their development lags behind.⁴ The majority of young people with mental disorders remain untreated – a phenomenon referred to as the ‘treatment gap’.^{4,5} This treatment gap is bigger for vulnerable groups such as children and adolescents, and for people living in low- and middle-income countries (LMICs).⁴ Considering that the majority of the world’s children and adolescents live in LMICs, children and adolescents with mental disorders in these countries are faced with a double disadvantage. In South Africa, the treatment gap for children and adolescents is about 90%;⁶ in other words, only one in 10 children with a diagnosable and treatable mental disorder is able to access care.

To address the treatment gap, it is important to understand the clinical and service needs of children and adolescents with mental disorders, and the systems in which these services are provided. This is not an easy task because health systems are complex, open to multiple influences, and changes to one part of the system may affect other parts in an unpredictable way.⁷ Child and adolescent mental disorders require active and integrated participation of multiple sectors including health, social services, education and non-governmental organisations (NGOs). In addition, the needs of children and adolescents may emerge or change over time, requiring different kinds of supports from the systems and communities around them.

This chapter: outlines the importance of child and adolescent mental health (CAMH) disorders and services, describes current services and systems for CAMH disorders in South Africa, and proposes a set of immediate, short-term and longer-term actions to strengthen child and adolescent mental health services and systems (CAMHSS) that should

support the shift towards a more integrated community CAMH service.

Why is it important to invest in CAMH services?

Even with the best possible mental health promotion and prevention strategies, approximately 10% - 20% of children and adolescents will develop a mental disorder and/or a neurodevelopmental disability.⁸⁻¹⁰ Each of these children will require identification and intervention strategies as appropriate to their level of severity, risk and complexity. The focus of this chapter is on the ‘illness’, ‘disorder’ or ‘disability’ end of the mental health continuum, with all three of these terms used throughout the chapter. We will therefore place an emphasis on systems strengthening requirements of curative services.

Prevalence of mental disorders and their treatment gap

It is difficult to give an exact number of children and adolescents in South Africa who live with mental disorders, given that no representative national epidemiological studies of CAMH disorders has been conducted to date. The only national study on the prevalence of mental disorders in South Africa (the South African Stress and Health or SASH study) did not include data on children and adolescents.¹¹ The likely rates of mental disorders in children and adolescents in the country, therefore, has to be deduced from other LMICs, from studies of specific ages or disorders, and from data in high-income countries. A 2012 review found that almost 20% of children and adolescents in sub-Saharan Africa scored above the cut-off values for risk of mental disorders on screening tools, and that 10% had a specific mental disorder diagnosed by clinical diagnostic tools.⁹ An authoritative review by Belfer concluded that about 20% of children and adolescents worldwide have a mental disorder that requires diagnosis and treatment.¹² In a South African study, Kleintjes and colleagues used international prevalence data to estimate

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Case 18: Enhancing support for children of parents with mental disorders

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The World Health Organization identifies parental mental disorders and the intergenerational transmission of mental disorders as two important public health priorities.⁶⁰

One in five children has a parent with a mental disorder.⁶¹ The impact of a persistent and disabling mental disorder on parents' ability to sustain themselves and their children increases the likelihood that their children will grow up experiencing poverty, housing problems, family disruptions, reduction of social and leisure activities, and social isolation. They are also more likely to be taken into care, have poor communication skills, drop out of school, and develop mental health problems and substance abuse issues themselves.^{62, 63} This is partly because people with mental health problems are more likely to drift into poverty, and partly because people living in poverty are at greater risk of developing a mental disorder (see Figure 9 on p45).

Over the past decade, more evidence has come to light showing how children of parents with mental disorders frequently experience the trauma of witnessing their parents' relapse into mental illness and admission to hospital, with children often taking on excessive responsibility at home, blaming themselves for their parent's mental illness, and living with the stigma of their parent's illness, in silence. Yet, children and their parents receive little coordinated support, information or exposure to safeguarding measures from health care professionals to address the challenges.^{64, 65}

In addition to providing treatment to parents with mental disorders, health care professionals should expand their treatment and support to include therapeutic support and safeguarding measures for their patients' children. This family-focused approach should aim to promote the mental health and well-being of children in a family where caregivers are living with a serious mental disorder, as well as address parental concerns about the impact of their illness on their children, barriers to their recovery which their parenting role presents, and equip them with parenting skills and advance directive planning skills to enhance their parenting roles. Further, a growing evidence base is emerging in low- and middle-income countries on how to improve the long-term outcomes of these children by increasing children's mental health literacy, reducing stigma and isolation, strengthening school and social

support, and including children in decisions about their parents' treatment programme.⁶⁶⁻⁶⁸

Over the past 30 years, children of parents with mental disorders have become a priority in the Dutch, Norwegian, Australian, and British prevention sector, and in some countries, health legislation has changed to identify these children, maximise their support networks, improve their competencies and understanding of mental illness, and minimise family dysfunction.^{69, 70} Yet, there are currently no guidelines in place that require South African health, educational and social service professionals to identify and support children of parents with mental disorders.

While child mental health services tend to take a family-oriented focus, this is generally not the case in adult mental health services, where the treatment focus tends to be on the individual patient and the patient's adult support system, with little concerted attention on the children of the patient. This should ideally include the extension of care and support to the children via referral to child mental health services where these might be available, or by engaging other relevant sectors such as social development and education to establish supports within other important settings in the child's life.

In other words, adult mental health care practitioners have a duty to ensure that their circle of care extends beyond their adult patients to actively promote the mental health, care and well-being of their children. This includes prevention and early intervention programmes, including therapeutic counselling and parenting programmes that are designed to improve family functioning and promote positive parenting.

Mental health professionals also need to be attuned to the risk of child abuse and neglect and recognise when family dysfunction is causing serious harm and it becomes mandatory to report children in need of care and protection to social services, as outlined in the Children's Act.⁷¹ This statutory duty to report cases of abuse and deliberate neglect to a designated social worker for investigation extends to educators, health, allied and social service professionals.⁷² They also have an ethical responsibility to report a broader category of children in need of care and protection, including those "living in circumstances that may seriously harm the child's physical, mental or social well-being".⁷³

ⁱ Department of Psychiatry and Mental Health, University of Cape Town

the number of children and adolescents in the Western Cape who might have mental disorders. They estimated that 17% of children and adolescents in the Western Cape would have a diagnosable and treatable mental disorder.¹³

Importantly, a situational analysis by Mokitimi and colleagues, also using Western Cape data, identified that fewer than 10% of children and adolescents in the province who need diagnosis and treatment for a mental disorder ever receive it.¹⁴ These data suggest that the vast majority of children and adolescents with mental disorders in South Africa still fall through the cracks and receive no or very limited support.

The impact of mental illness on children and adolescents

Mental disorders in young people not only cause distress and impair their functional abilities in daily life, they often have long-term ramifications that last into adulthood. It is estimated that half of adult mental illness starts before age 14, reinforcing the need for early detection and intervention to achieve the best possible outcomes.^{10, 15} In addition, inadequately treated and undiagnosed children and adolescents with mental disorders may develop secondary or additional disorders, e.g. substance use or resort to self-harm to cope with their symptoms. Mental illness in young people may also disrupt family relationships and routines, and the costs of care can affect the family's financial security.

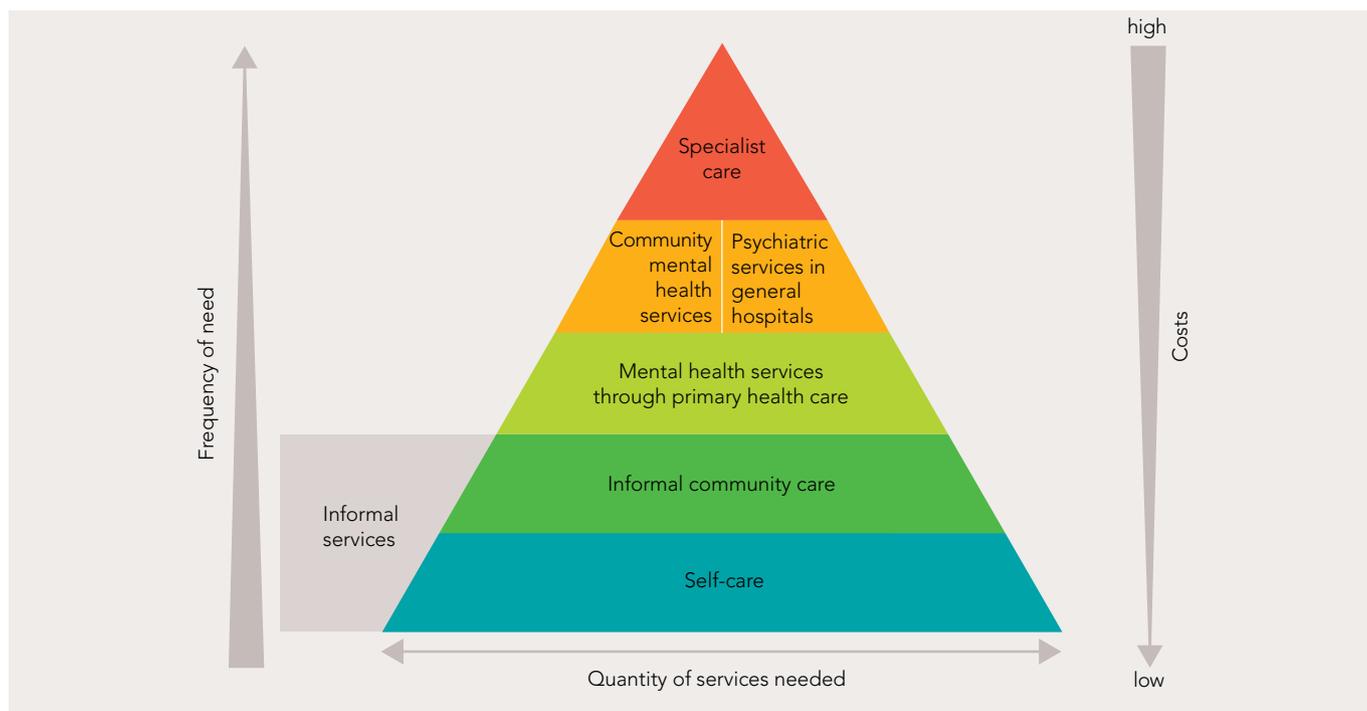
Importantly, the converse is also true, with mental illness in parents and caregivers significantly affecting the lives of children and adolescents in their care. Case 18 details why it is crucial for adult mental health services in South Africa to move towards a family-centred approach in the treatment of parents and caregivers with mental illness.

Children and adolescents with mental illness have significantly lower rates of school-readiness and higher rates of absenteeism, grade repetition and drop out¹⁶⁻¹⁸ undermining their economic potential and driving an intergenerational cycle of mental illness and poverty.^{12, 19}

In addition, children presenting with disruptive behaviour are often labelled as 'badly behaved' or 'difficult', and are more likely to experience difficulties with peer relationships and a likelihood of criminal behaviours.²⁰ Children and adolescents in the criminal justice and social service systems have higher rates of mental disorders than the general population.²¹⁻²³

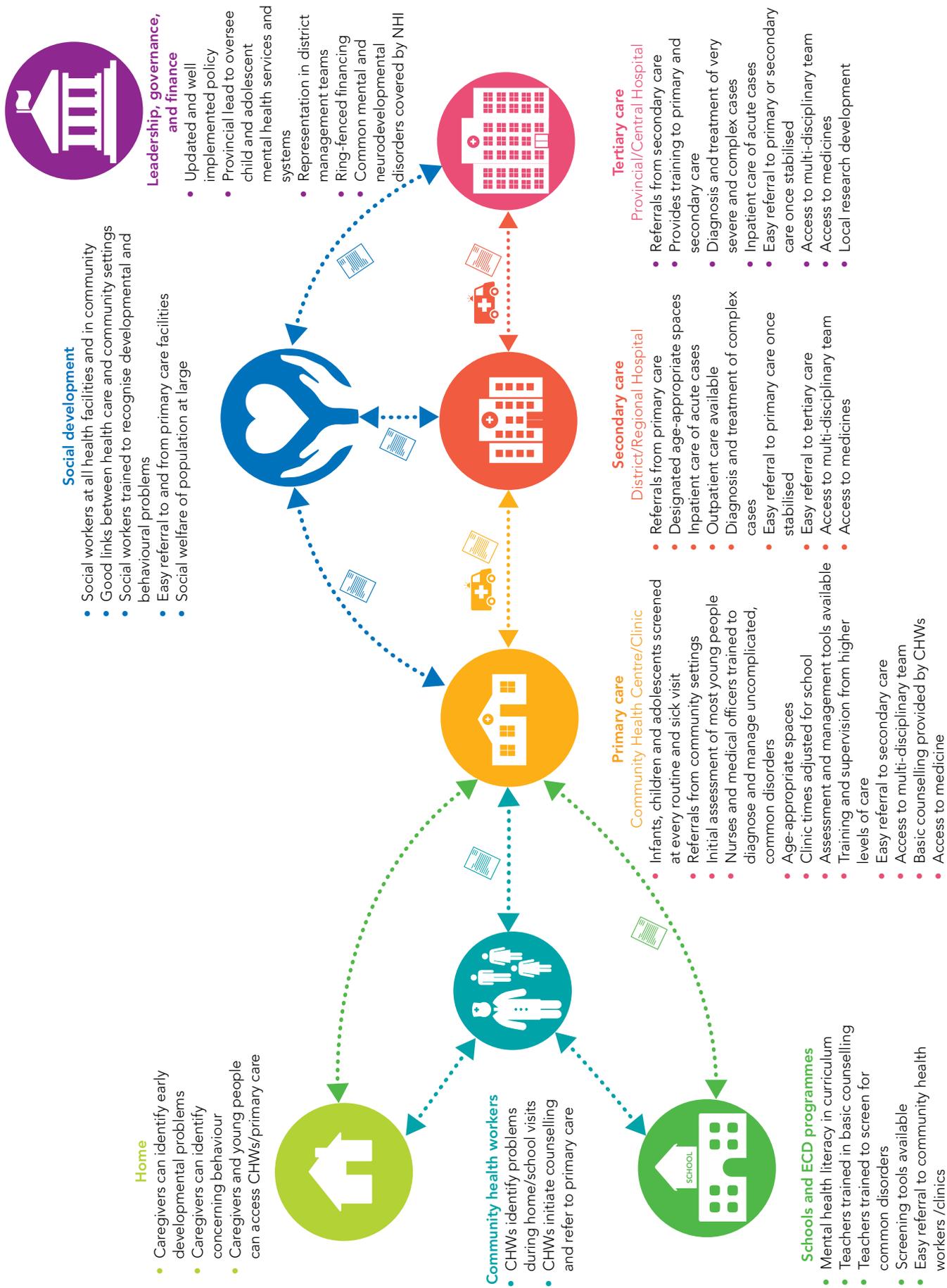
Taken together, it is clear that unidentified and untreated child and adolescent mental illness is a powerful driver of a vicious cycle of further mental health problems, poor family functioning, as well as poor educational and economic outcomes and high rates of criminality. It is therefore essential to intervene early to prevent and treat child and adolescent mental disorders if we wish to minimise the immediate and long-term costs for children, families and society.

Figure 22: WHO optimal mix of mental health services



Source: World Health Organization. *Improving Health Systems and Services for Mental Health*. Geneva: WHO. 2009.

Figure 23: Healthy integrated child and adolescent mental health services and systems



What should CAMH services look like?

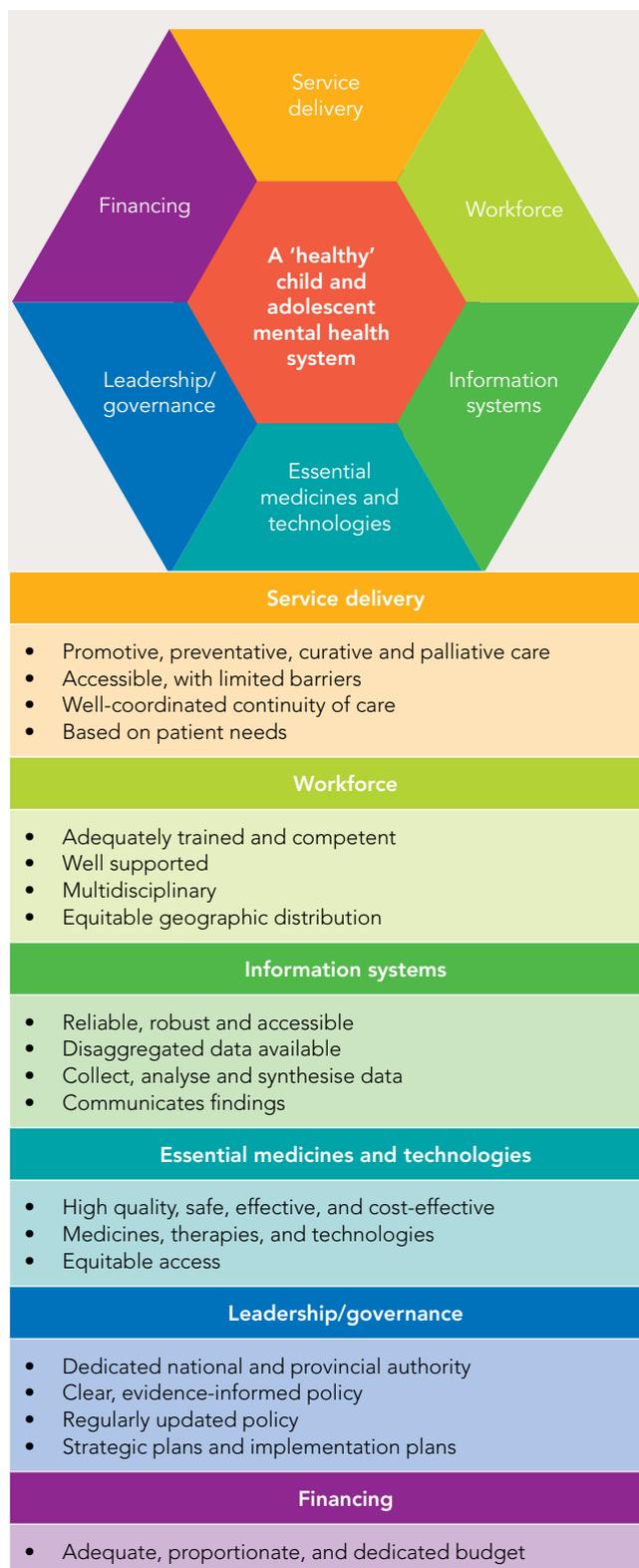
The South African government's goal is for mental health services to be decentralised and integrated into general health services, mainly at the primary care level.^{24, 25} This community-based model of care would promote more equitable access to health care which is crucial in South Africa given that most communities do not have access to specialist care.

According to the Norms for South African Child and Adolescent Mental Health Services (a report commissioned by the National Department of Health in 2004), the World Health Organization (WHO) three-tier approach should be available to all communities.²⁶ This model starts with community-based 'informal' services, supported by three tiers of formal care at primary, secondary and tertiary level as illustrated by Figure 22. The community-based services, which form the base of the pyramid, should be able to cater for the majority of children's mental health needs and have lower associated costs than specialised services in the higher levels of the pyramid.²⁷ In an ideal situation, children and adolescents should have access to mental health services which range from health promotion to preventative, curative and rehabilitative services. Promotion and preventative services should be offered mainly at the community level and can leverage environments that children and adolescents already access on a routine basis, such as schools and religious organisations. These activities would be aimed at all children and adolescents on the mental health continuum, with the aim of promoting resilience, positive coping skills and creating a supportive environment in which they can thrive.

As illustrated in Figure 23, a young person who is mentally ill should be identified early by a primary caregiver, school, community health workers or through screening in routine health services, supported by programmes to enhance mental health literacy in families and community stakeholders. They should then be able to access care at a primary care clinic or community health centre, which should be close to their home, and be offered services in their own language. The child should be assessed, diagnosed and managed at this level, with access to a range of health care professionals, including general medical practitioners trained in early detection and management according to their patients' needs.

If the child's condition is too complicated, they should be referred to secondary level services at their district or regional hospital to be assessed and managed by a team that includes a general psychiatrist. Tertiary services should be available to young people with complex or severe illness who require sub-specialist input from child and adolescent psychiatrists

Figure 24: The building blocks of a 'healthy' child and adolescent mental health system



and their multi-disciplinary teams. Once stabilised at the higher levels of care, children and adolescents should then be referred back to their secondary or primary community teams to continue their care. This pyramid of care structure

requires ongoing supervision and training of community and primary health care workers.

Adopting a health systems approach to CAMH

Child and adolescent mental health services function in the context of health (and other) systems. It is therefore important to approach CAMH from a health systems perspective and consider all the factors, organisations and people that ultimately shape the availability and quality of services. The WHO proposed six 'building blocks' of health systems including service delivery, the health workforce, health information systems, access to essential medicines and technologies, financing, and leadership/governance.²⁸ These components of the health system include both 'hardware' (resources, people, medicines etc.) and 'software' (knowledge, attitudes, beliefs etc.).²⁹ A 'healthy' system should have adequate hardware, positive software and a responsive and responsible interaction between the two.²⁹ Figure 24 outlines some of the key building blocks of a 'healthy' child and adolescent mental health system.^{28, 30}

A healthy CAMHSS needs to be rooted in a broader health care system that is healthy, responsive and well integrated with other systems in education, social development, justice and the NGO sector in order to ensure optimal child and adolescent mental health. Some of the links between sectors are shown in Figure 23.

What services and systems are currently in place?

Strengths

It is important to acknowledge the existing strengths in South African CAMHSS that can be leveraged for further system strengthening. South Africa has more child and adolescent psychiatry specialists than any other country in sub-Saharan Africa. In addition, CAMH has been on the radar of government and policymakers for over two decades. Although not yet implemented, the policy guidelines on CAMHSS were developed in 2003, and the norms for South African CAMHSS were commissioned in 2004.³¹ The publication of the Nurturing Care Framework³² and Sustainable Development Goals (SDGs) have further added impetus towards actions that support the mental health of children and adolescents.³³ Over the last two decades, medical, nursing, and allied health undergraduate training has evolved to include more mental health training (albeit with very limited exposure to CAMH). Furthermore, community service programmes, which are compulsory for all health disciplines, have attempted to improve distribution of

the health workforce by deploying junior staff to rural areas. In general, health care facilities have access to at least one drug in each class of psychotropic medication.

Weaknesses

Even though South Africa has the most child and adolescent psychiatrists in sub-Saharan Africa, there are currently fewer than 60. Of those, no more than 20 posts are in the public sector, and only five funded training posts exist nationally. Therefore, children and families only have access to multidisciplinary CAMH teams in a handful of centres where government-funded specialist CAMH services are available (Cape Town, Johannesburg, eThekweni and Tshwane). Child and adolescent psychiatrists practicing in the private sector are also concentrated in these cities. The National Mental Health Policy Framework and Strategic Plan 2013 – 2020 detailed the central role of district health services in strengthening general mental health services (including CAMHSS) in South Africa.²⁵ District health services were meant to be overseen by a specialist district mental health team (DMHT) responsible for a broad range of activities, including a) the implementation of collaborative care and task-sharing approaches, b) mental health training and supervision of staff at lower levels of care, with support from specialist mental health teams, c) the development of clinical protocols, community based rehabilitation programmes and inpatient mental units, and d) the facilitation of intersectoral collaboration.²⁵

Unfortunately, there were no clear provincial implementation plans for DMHTs, and by 2019, there were only two DMHTs in the country – one in the Free State and the other in Mpumalanga.³⁴ The policy was not accompanied by any ring-fenced budget, grants or guidelines on minimum expenditure.³⁴ Most provinces did not appoint mental health directorates to lead the implementation process, and training and supervision of primary care and community health workers (CHW) was not standardised.³⁴ There was also no process put in place to improve data collection and monitoring over the seven-year period to allow problems in implementation to be identified and addressed along the way.³⁴ In essence, there was a failure to engage all the WHO building blocks in a practical way. This, combined with a lack of stakeholder participation and buy-in into the development of the policy, meant that those on the ground were not committed to its implementation.

South Africa is currently reviewing the National Health Insurance (NHI) Bill. The Bill aims to provide universal health care coverage by ensuring access to quality health care

Table 6: Gap analysis of Child and Adolescent Mental Health Services and Systems in South Africa

WHO health system building block	Amajuba district, KwaZulu-Natal (KZN) ³⁸ and various Western Cape (WC) districts ^{14,39,40}
Service delivery	<ul style="list-style-type: none"> • Not age-appropriate* (KZN+WC) • No or limited psychosocial interventions* (KZN+WC) • No services at primary care facilities (KZN) • Limited space and lack of privacy (KZN) • Inappropriate referral pathways (KZN) • Limited community-based interventions (KZN) • Limited CAMH promotion and awareness (KZN) • Poor mental health literacy of school health teams (KZN) • No inpatient facilities (KZN) • No specialist services in rural districts (WC) • No dedicated hospitals or residential units (WC) • Limited CAMH forensic services (WC) • Low patient satisfaction (WC) • Emphasis on quantity of patients seen rather than quality of care (WC)
Health workforce	<ul style="list-style-type: none"> • Limited training* (KZN+WC) • No CAMH specialists (KZN) • No CAMH trained nursing staff (KZN) • No allied health staff at primary care facilities (KZN) • Lack of human resources (WC) • Inequitable geographical distribution (WC) • Excessive workload demands (WC) • Lack of supervision/support* (WC) • Lack of acknowledgement for innovations to improve services (WC) • Negative staff attitudes* (WC) • Siloed working (WC)
Information systems	<ul style="list-style-type: none"> • No age disaggregated data (KZN+WC) • Inadequate and inaccessible data (WC) • Limited research (WC)
Access to essential medicines and technologies	<ul style="list-style-type: none"> • Lack of equipment required for therapy e.g., toys for play therapy (KZN+WC) • Inconsistent availability of psychotropic medications (WC) • No technologies to support data collection (WC)
Leadership and governance	<ul style="list-style-type: none"> • No district or provincial CAMH policies or implementation plans (KZN +WC) • No functional intersectoral collaboration system (KZN +WC) • No reference to CAMH in general health policies (WC) • No involvement of CAMH experts/users in policy development or review (WC) • No dedicated provincial leadership (WC)
Financing	<ul style="list-style-type: none"> • No ring-fenced budget (KZN+WC) • Low priority compared to adult mental health and general health care (WC)

* Findings at primary and secondary levels of care

Sources:

Mokitimi S, Schneider M, de Vries PJ. A situational analysis of child and adolescent mental health services and systems in the Western Cape Province of South Africa. *Child and Adolescent Psychiatry and Mental Health*. 2022;16:6.

Babatunde, G. et al. Planning for child and adolescent mental health interventions in a rural district of South Africa: A situational analysis. *Journal of Child and Adolescent Mental Health*. 2020; 32, 45–65.

Mokitimi, S., Jonas, K., Schneider, M. & de Vries, P. J. Child and adolescent mental health services in South Africa - Senior stakeholder perceptions of strengths, weaknesses, opportunities, and threats in the Western Cape Province. *Frontiers in Psychiatry*. 2019; 10:841.

Mokitimi, S., Schneider, M. & de Vries, P. J. Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis. *International Journal of Mental Health Systems*. 2018; 12: 36.

for all South Africans without financial hardship.³⁵ The Bill notes that all children will have access to ‘basic health care services’, but does not define what will be included in the services.^{35, 36} This is particularly concerning because there are currently no CAMH-specific disorders on the chronic disease list or the minimum prescribed benefits in South

Africa, and these conditions may therefore be overlooked when the basic services are defined.³⁷ There are also no child and adolescent health experts represented on the benefits advisory committee that will decide what service benefits will be covered by the fund.³⁶ The Bill also notes that school health services will be available to cater for the physical and

Case 19: Three patient journeys into mental health services

Zachary was two years old when his mother noticed that he was not speaking any words. She was worried about this, and took him to the community clinic. At the clinic the nurses told her that 'he is just a boy' and that he will start to speak soon enough. Four years later Zachary was diagnosed with autism spectrum disorder with associated language disorder and many challenging behaviours because he did not know how to communicate with people. His mother had to stop working because no-one else was able to look after him. When the diagnosis was finally made by the specialist child and adolescent psychiatry team, she said: 'If only people had listened to my worries when he was two, our lives could have been so much better'.

Fatima is a 13-year old girl who suffered with anxiety symptoms since early childhood, but she was still able to go to school where she had very supportive teachers. When she started in secondary school, the anxiety became overwhelming. She started having severe panic attacks and was unable to go to school. She became so unwell that she needed to be admitted to hospital. However, she lived in a rural district and was admitted to a psychiatric

hospital ward with adults. Fatima found it a terrifying experience. Fatima said: "Why would the doctor send me to a hospital with adults? Why would the doctor send me to a hospital where people are tied up? I hate it here!"

Andile is a 15-year old boy who has attention deficit/hyperactivity disorder (ADHD) and lots of difficulties learning in school. He regularly needs to go to the community clinic to have a check-up for his medication. He is very motivated to do schoolwork, in spite of his difficulties. His mother has to take a day off work to bring him to the clinic every time. However, Andile and his mother are very frustrated by the services: "The last time I was there the nurse told me I must be there on Friday, but we only see the psychiatrist on Tuesday. So, I missed the school day and on that day we had to do a project. I could have done my project. It was a waste of money." Andile's mum also explained how files are not always available in the clinics, how they are told to come back the next day, and how they sometimes have to wait for a very long time at the pharmacy without staff seeming to realise that children need to get to school.

mental health of schoolgoing children.³⁵ However, there is no clarity on how these services will be structured, which is likely to hinder their successful implementation.

Recent studies in the Western Cape and KwaZulu-Natal have identified gaps in CAMHSS^{14, 38-40} and despite the different contexts, the findings were surprisingly similar, with critical gaps outlined in Table 6.

These weaknesses have severely undermined the quality of care for children and adolescents who present with emerging or definite mental disorders, as outlined in Case 19.

What can be done to strengthen systems and enhance quality of care?

With CAMHSS in crisis, there is an urgent need to progress from describing the problem to thinking how to strengthen services and systems for CAMH. This includes developing a long-term vision for CAMH services and identifying innovative ways to strengthen the system in the immediate, short and medium term.

A long-term vision

Given that one in five children and adolescents presents with a diagnosable and treatable mental disorder, we should ideally establish a multidisciplinary CAMH team in each

South African district to ensure a more equitable distribution of child and adolescent psychiatric services and to bring those services close to home.

An ideal district CAMH Team should include a child and adolescent psychiatrist, psychologist, speech and language therapist, occupational therapist, child and adolescent mental health nurse practitioner, social worker and dedicated link professionals from the departments of Basic Education and Social Development. These district CAMH teams would then guide and provide services across primary and secondary levels of care, and would be supported by – and refer to – specialist CAMH teams based at tertiary/university institutions. Specialist CAMH teams from tertiary hospitals and university institutions would lead the training of the CAMH workforce, guide development and delivery of services for highly complex disorders, support and supervise district CAMH teams, and conduct CAMH research relevant to the needs of South African communities.

To staff the district CAMH teams, child and adolescent psychiatry would need to be reclassified as a 'specialty' rather than as 'sub-specialty' in the same way that Paediatrics became distinct from General Medicine. This would reconceptualise Child and Adolescent Psychiatry as a community specialty, rather than as a highly specialised ('sub-specialist') discipline.

Table 7: Strengthening child and adolescent mental health services and systems in South Africa^{41, 42}

Health system building block	Immediate action	Short-term actions (1 – 5 years)	Medium to long-term actions (5 – 10 years)
Service delivery	<p>Create separate clinic days with guidelines for how to run a child/adolescent friendly clinic</p> <ul style="list-style-type: none"> • Times adjusted to suit school times • Limit number of visits • Have medication and folders ready <p>Set up designated room for children and adolescents with mental disorders admitted at secondary level</p>	<p>Develop appropriate screening tools for common CAMH disorders</p> <p>Improve use of routine developmental screening in Road to Health booklets by caregivers, community health workers and nurses</p> <p>Train community (e.g. early childhood development (ECD) workers and teachers) on early symptoms of CAMH and neurodevelopmental disorders</p> <p>Establish mental health literacy training for local teachers and youth leaders, and provide them with basic counselling skills for children and adolescents</p> <p>Rollout of established caregiver interventions (such as WHO caregiver skills training)</p> <p>Establish clear referral pathways from schools (including ECD centres) to community and primary care health services</p> <p>Establish clear, transparent referral pathways across all levels of care in urban and rural districts</p>	<p>Determine and implement standards for age-appropriate infrastructure in facilities at all levels</p> <p>Develop and implement packages of services and competencies expected at each level of care</p> <p>Develop and implement clear clinical guidelines/protocols for common CAMH disorders and emergencies for each level of care</p> <p>Develop and implement school-based interventions that can be added to curriculum e.g. in life orientation</p> <p>Develop counselling skills of CHWs to deliver psychosocial support at primary care level</p> <p>Develop digital clinical decision support systems</p>
Health workforce	<p>Introduce supervision for primary care staff with designated, ring fenced supervision time</p>	<p>Allocate a provincial/central hospital to supervise each regional hospital</p> <p>Allocate a regional hospital to supervise each district hospital</p> <p>Allocate a district hospital to supervise each Community Health Centre/clinic</p> <p>Establish nationwide training of all primary care providers using existing guidelines e.g. Practical Approach to Care Kit and mental health Gap Action Programme. Training could be provided using various modalities including online, self-paced learning</p>	<p>Develop accredited CAMH short courses for community and primary health workers (e.g. CHWs, nurses, medical officers, general practitioners, occupational, speech and language therapists, psychologists etc.)</p> <p>Establish specialist CAMH teams in provincial hospitals in all provinces</p> <p>Re-evaluate existing health science curricula to increase academic training and practical exposure to CAMH</p> <p>Develop postgraduate diplomas and masters programmes for non-specialised health professionals</p> <p>Establish specialist integrated CAMH teams at district level</p> <p>Re-classify child and adolescent psychiatry as a speciality instead of a sub-speciality</p>
Information systems	<p>Set up regular (monthly) facility and (quarterly) subdistrict-based meetings, where the compiled statistics are presented and poor outcomes discussed</p>	<p>Develop clear indicators specific to CAMH and tools to gather these data</p> <p>Create disaggregated data systems for under 18-year olds vs over-18-year olds</p> <p>Make the generation and provision of CAMH statistics mandatory for facilities</p>	<p>Capture and analyse CAMH indicators at a provincial and national level</p> <p>Establish annual reporting of CAMH indicators</p>
Access to medicines and technologies	<p>Ensure good and continuous supply chains for all essential medicines used in CAMH</p>		<p>Allow some medications that are traditionally only be dispensed at tertiary level to be dispensed at secondary and primary level</p>

Health system building block	Immediate action	Short-term actions (1 – 5 years)	Medium to long-term actions (5 – 10 years)
Leadership and governance		Introduce provincial CAMH Lead Professionals in all South African provinces	<ul style="list-style-type: none"> Review and revise the national CAMH guidelines/policy) Develop provincial CAMH implementation plans Make national policies and provincial plans easily accessible, including to the public Government to create suitable communication mechanisms for interaction with service providers and service users
Financing		Disaggregate budgets to allow calculation of CAMH-specific budgets and costings	<ul style="list-style-type: none"> Establish representation of CAMH in National Health Insurance Benefits Advisory Committee(s) Advocacy to add more child and adolescent mental disorders to the Chronic Disease and Prescribed Minimum Benefits lists Implement universal basic income grant

Immediate, short and medium term goals

We acknowledge that the ideal vision of a community CAMHSS is unlikely to be realised in the short-term, given the current context of staff shortages and budget cuts. It is therefore important to identify strategies that could strengthen CAMHSS in South Africa in the immediate, short and medium term. Table 7 outlines a set of immediate, short-term (1 – 5 years) and medium-term (5 – 10 years) CAMHSS strengthening actions across the building blocks of health systems.

Existing and potential CAMHSS strengthening activities in South Africa

Case 20 describes local initiatives to make immediate improvements in the CAMH system in the Khayelitsha Eastern Substructure in Cape Town. This provides a very inspiring example of how local enthusiasm and coordination combined with good and clear evidence-based information can transform clinical services and systems without any significant additional resources.

A recent review by Simelane and de Vries examined a range of CAMH strengthening innovations from various LMICs to inform potential CAMHSS strengthening activities in South Africa.⁴³ Innovations identified included interventions to promote mental health at a broader socio-economic level, to develop intersectoral collaboration, to build the CAMH workforce, to use digital technologies and develop tools and guidelines for clinical use. Here we summarise some of the key findings from the review and their relevance to the South

African context, and list some local initiatives of potential relevance.

Upstream socio-economic intervention

There is a clear association between poverty and mental illness, and ‘economic’ interventions are emerging as intervention modalities alongside pharmacological and ‘talking’ treatments for mental health problems.¹⁹ Recent studies in Malawi and Uganda have shown cash transfers to be effective in reducing symptoms of depression in adolescents.^{44, 45} South Africa has one of the highest rates of unemployment in the world, with an official national unemployment rate of over 30% in 2021.⁴⁶ It is therefore important to consider the broader socio-economic context of young people living in South Africa when thinking about their mental health. This may provide an important argument for the implementation of the universal basic income grant in South Africa.

Intersectoral collaboration

School mental health programmes and mental health literacy initiatives may have an important role in improving the health-seeking behaviour and coping skills of schoolgoing children and adolescents and their teachers.⁴⁷⁻⁴⁹ Findings from Malawi showed improvement in the self-confidence of learners and improved detection of at-risk learners. Such programmes may, therefore, represent another important strategy to strengthen CAMHSS in South Africa.⁴³ However, school mental health and mental health literacy programmes require

As described in previous research, there are a lack of dedicated CAMH services at primary health care (PHC) facilities in the Khayelitsha Eastern Substructure (KESS). Services for children and adolescents with mental disorders are mixed with adult mental health services at primary and secondary care level, with age-appropriate services only available at tertiary level. Children aged 12 and under are admitted to paediatric medical wards, exposing them to potentially contagious medical conditions, while adolescents are admitted to adult emergency psychiatry units which may exacerbate psychological trauma and reduce compliance to treatment.

Considering these challenges, KESS set out to establish age-appropriate CAMH services within their resource constraints. A stakeholder engagement process was initiated in August 2021 with community mental health nurses and district hospital facility managers. As a result, community mental health nurses were trained on how to develop a mental health service structure with separate child and adolescent and adult services. Facility and operational managers of primary health care (PHC) clinics were also engaged to ensure buy-in of management for the implementation of the new service structure.

By January 2022, only five months after the initiation of the process, all nine of the PHC facilities which fall within KESS had confirmed that they had created a separate service for CAMH within their existing service structures (100% implementation). CAMH services are offered either in the morning (7am – 1pm) or in the afternoon (1 – 4pm) in different facilities depending on their contexts and user needs. As caseloads increase, service hours will also increase. Following ongoing discussions and hospital walkabouts to try and identify possible locations

for children and adolescents requiring inpatient care, some progress has also been made at the secondary level of care. At least one hospital now has a dedicated adolescent room in the emergency psychiatry ward. This room will be available for all adolescents in KESS who require admission. Two other hospitals have identified 'low-risk' areas in their adult psychiatric wards. These 'low risk' areas are close to the nurse's station and can be used for vulnerable adolescents to ensure better monitoring and visibility. These 'low risk' beds will act as overflow admission areas, should the dedicated adolescent room be full. Shortcomings in ward infrastructure have also been identified, with plans in place to make the spaces more youth friendly.

To formalise this process, a first draft of the standard operating procedures for developing separate CAMHS at primary and secondary level has been circulated to facility managers in KESS for comment and approval. The new service structure will be monitored to measure progress and effectiveness. Important next steps for the programme include training of providers and provision of CAMH resources for assessment and intervention.

This initiative by the KESS service providers and facility managers is an example of how services can be optimised within existing resource constraints. Furthermore, it illustrates the importance of buy-in from all stakeholders to ensure successful uptake and implementation. The documentation and monitoring of this process is an important step towards creating practical guidelines and providing quality care that is feasible in such settings. This may be scaled up to other parts of the province in collaboration with the provincial CAMH coordinator should it prove to be successful.

strong and sustained collaboration between the health and education sector, with clarity about roles, responsibilities and funding, as well as buy-in and support from the highest levels of government.

In South Africa, the First Thousand Days of Life Initiative represents an example of a promotive, intersectoral activity focused on maternal mental health, parenting and the nurturing care of infants and young children.⁵⁰ This involved collaboration between the Department of Basic Education, Department of Social Development, and Department of Health. The initiative provides important lessons about the complexities of intersectoral work and the importance of buy-

in and agreement across stakeholders.^{43, 51} Even though the First Thousand Days of Life Initiative stops at age two (which is far from schoolgoing age), principles of implementation and lessons learnt from the initiative could provide a foundation on which school mental health programmes, as proposed in the NHI Bill, can be built.⁵²

Capacity building and supervision

Capacity building is another priority area and can be used to promote task-sharing through the training of non-specialist health workers. This was done in Uganda, where general health workers from different disciplines were purposively

Case 21: A better future for children and adolescents with mental disorders

Zachary (introduced in Case 19) has a younger brother, Sam. Since Zachary's diagnosis of autism spectrum disorder at the age of six, a programme had been introduced to train community-based and primary care staff on 'red flags' or risk markers for autism. When mum took Sam to the clinic worried about his language development, the nurse immediately recognised his language delay and family history of autism. She used a screening tool which identified many other developmental concerns, and referred Sam to the neurodevelopmental team, who diagnosed his autism within a few months. Sam's mother was offered home-based coaching by a community health worker (who was supervised by an expert from the district team) to help him with his development and communication. She said it was very helpful to do the coaching at home, and that it also helped her with Zachary's communication. In spite of having two children with autism, she felt supported, understood and empowered.

Fatima continued to need support for her anxiety, but the local district hospital created a dedicated 'adolescent-friendly' area and bed for young people like her who

needed admission. Fatima said it made a huge difference knowing that she did not have to fear going into hospital with severely mentally ill adults.

Andile's community health clinic got a new nurse who was passionate about the mental health of children and adolescents. The nurse negotiated a dedicated day for CAMH, made sure that files were ready and prepared the day before, and checked with families whether they would prefer a morning or afternoon appointment to cause the least disruption to school attendance. She also organised that on those days the pharmacy would be ready to dispense medications to children and families in a dedicated queue. Andile and his mum were very impressed. The clinic nurse realised that Andile's ADHD medication was not optimal and, through a new collaborative care plan, referred him to secondary and tertiary care. He received an additional multidisciplinary intervention from the specialist CAMH team, where his medication was also adjusted. He is now back at his local community clinic for regular check-ups without interrupting his schooling. He is doing very well.

selected from different regions in the country for a two-year training programme.⁵³ The programme resulted in increased CAMH expertise in the peripheral regions of the country and a more than 10-fold increase in the number of children who were seen and treated for mental disorders.⁵³ The Ugandan study adopted a trainees-become-trainers model to increase the sustainability of the initiative, with increasing numbers of trainees each year.⁵³ Adopting a similar approach would not require increased numbers of staff in South African public health facilities, but could increase the efficiency and quality of services offered by those already working in the health system.

Digital technologies

One of the emerging innovations in CAMHSS is the use of digital technologies. In an innovative study in India, a digital clinical decision support system was developed.⁵⁴ This meant that general practitioners at a primary level of care were able to access supervision from a digital platform, with prompts to guide them through the assessment and management of children and adolescents.⁵⁴ It was less labour intensive than one-on-one supervision from a child psychiatrist, and had the dual purpose of being a training tool for the clinicians.⁵⁴ Such technologies have great potential to increase the reach of

CAMH services in South Africa, but it will be important to consider potential barriers to the implementation of digital technologies very carefully to ensure that the pre-existing digital divides between rich and poor, and between urban and rural communities, are not inadvertently increased.⁴³

Clinical service toolkits

Although clinical toolkits were not included in the review by Simelane and de Vries, a scoping review by Babatunde and colleagues identified the lack of contextually relevant screening and assessment tools as a major barrier to improving CAMH services in South Africa.⁵⁵ The WHO developed the mental health Gap Action Programme (mhGAP) as a tool to support primary care training and clinical decision-making across a range of mental health presentations, and includes child mental health modules.⁵⁶ The PACK Child programme, developed by the Knowledge Translation Unit at the University of Cape Town, was developed to provide primary care clinicians with a basic guide on the identification and management of a range of childhood conditions, including some mental health presentations (such as the depressed or disruptive child).⁵⁷ These kind of tools may have the potential to be implemented in South Africa. However, it is crucial first to understand which conditions should be managed at which

levels of care and in which sectors, then to identify the most appropriate people to perform the tasks, to ensure that the training tools provided are a good ‘fit’ to the practitioner’s needs and baseline knowledge. Such training programmes, therefore, need to be accompanied by clear guidelines on what services and competencies are expected at each level of care, including the roles and responsibilities of different members of the team and the referral criteria between each level of care to ensure continuity of care and a smooth functioning CAMH system.

These investments in strengthening CAMH systems in South Africa have the potential to enhance the quality of care and to improve outcomes for children, adolescents and their families, as outlined in Case 21.

Conclusion

We do not underestimate the procedural requirements of the changes and strengthening innovations proposed in this chapter. However, the paradigm shift from hospital-based, highly-specialist CAMH services to community-based specialist services may represent our best chance to meet the urgent and increasing mental health care needs of children and adolescents in South Africa, and to ensure parity for the mental health of children and adolescents alongside their physical health. We argue that investing in CAMHSS now will

provide the early interventions needed to prevent the long-term, multi-level costs associated with poorly functioning CAMHSS.

We acknowledge that comprehensive strengthening of CAMH services and systems in South Africa does not depend on a single action, but rather on sustained action across multiple services, systems and levels of care. Crucially, the journey towards sustainable and scalable systems strengthening will require participatory engagement with stakeholders across all levels of the health care system, including senior government policy-makers, funders, grassroots service providers, and families and young people themselves^{58, 59}

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References

- Murray CJ, Vos T, Lozano R, Naghavi M, Flaxman AD, Michaud C, Abdalla S. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: A systematic analysis for the Global Burden of Disease Study 2010. *The Lancet*. 2012;380(9859):2197-2223.
- Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJ. Global and regional burden of disease and risk factors, 2001: Systematic analysis of population health data. *The Lancet*. 2006;367(9524):1747-1757.
- Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, Mathers CD. Global burden of disease in young people aged 10–24 years: A systematic analysis. *The Lancet*. 2011;377(9783):2093-2102.
- World Health Organization. *Mental Health Atlas 2020*. WHO; 2020. Accessed: 19 April 2022. Available from: <https://www.who.int/publications/item/9789240036703>.
- Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. *Bulletin of the World Health Organization*. 2004;82:858-866.
- Docrat S, Besada D, Cleary S, Daviaud E, Lund C. Mental health system costs, resources and constraints in South Africa: A national survey. *Health Policy and Planning*. 2019;34(9):706-719.
- Plsek PE, Greenhalgh T. The challenge of complexity in health care. *BMJ*. 2001;323(7313):625-628.
- Patel V, Flisher AJ, Hetrick S, McGorry P. Mental health of young people: A global public-health challenge. *The Lancet*. 2007;369(9569):1302-1313.
- Cortina MA, Sodha A, Fazel M, Ramchandani PG. Prevalence of child mental health problems in sub-Saharan Africa: A systematic review. *Archives of Pediatrics & Adolescent Medicine*. 2012;166(3):276-281.
- Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, Rahman A. Child and adolescent mental health worldwide: Evidence for action. *The Lancet*. 2011;378(9801):1515-1525.
- Herman AA, Stein DJ, Seedat S, Heeringa SG, Moomal H, Williams DR. The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal*. 2009;99(5).
- Belfer ML. Child and adolescent mental disorders: The magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry*. 2008;49(3):226-236.
- Kleintjes S, Flisher A, Fick M, Railoun A, Lund C, Molteno C, Robertson B. The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *South African Psychiatry Review*. 2006;9(3):157-160.
- Mokitimi S, Schneider M, de Vries PJ. A situational analysis of child and adolescent mental health services and systems in the Western Cape Province of South Africa. *Child and Adolescent Psychiatry and Mental Health*. 2022;16(1):1-22.
- Kessler RC, Angermeyer M, Anthony JC, De Graaf R, Demyttenaere K, Gasquet I, Haro JM. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization’s World Mental Health Survey Initiative. *World Psychiatry*. 2007;6(3):168.
- Finning K, Ford T, Moore DA, Ukoumunne OC. Emotional disorder and absence from school: Findings from the 2004 British Child and Adolescent Mental Health Survey. *European Child & Adolescent Psychiatry*. 2020;29(2):187-198.
- Raver CC. Emotions Matter: Making the Case for the Role of Young Children’s Emotional Development for Early School Readiness. Social Policy Report. Volume 16, Number 3. *Society for Research in Child Development*. 2002.
- Breslau J, Lane M, Sampson N, Kessler RC. Mental disorders and subsequent educational attainment in a US national sample. *Journal of Psychiatric Research*. 2008;42(9):708-716.
- Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, Patel V. Poverty and mental disorders: Breaking the cycle in low-income and middle-income countries. *The Lancet*. 2011;378(9801):1502-1514.
- Juvonen J, Graham S, Schuster MA. Bullying among young adolescents: The strong, the weak, and the troubled. *Pediatrics*. 2003;112(6):1231-1237.
- Colins O, Vermeiren R, Vreugdenhil C, van den Brink W, Doreleijers T, Broekaert E. Psychiatric disorders in detained male adolescents: A systematic literature review. *The Canadian Journal of Psychiatry*. 2010;55(4):255-263.
- Kutcher S, McDougall A. Problems with access to adolescent mental health care can lead to dealings with the criminal justice system. *Paediatrics & Child Health*. 2009;14(1):15-18.

23. McMillen JC, Zima BT, Scott LD, Auslander WF, Munson MR, Ollie MT, Spitznagel EL. Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2005;44(1):88-95.
24. Petersen I, van Rensburg A, Kigozi F, Semrau M, Hanlon C, Abdulmalik J, Gurung D. Scaling up integrated primary mental health in six low-and middle-income countries: Obstacles, synergies and implications for systems reform. *BJPsych Open*. 2019;5(5).
25. National Department of Health. *National Mental Health Policy Framework and Strategic Plan 2013 - 2020*. 2013.
26. Dawes A, Lund C, Kafaar Z, Brandt R, Flisher A. *Norms for South African Child and Adolescent Mental Health Services*. 2004.
27. Funk M, Saraceno B, Drew N, Lund C, Grigg M. Mental health policy and plans: Promoting an optimal mix of services in developing countries. *International Journal of Mental Health*. 2004;33(2):4-16.
28. World Health Organization. *Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action*. Geneva: WHO. 2007. [<https://apps.who.int/iris/handle/10665/43918>]
29. Gilson L. *Health policy and system research: A methodology reader. The abridged version*: World Health Organization; 2013.
30. World Health Organization. *World Health Organization assessment instrument for mental health systems-WHO-AIMS version 2.2*. WHO. 2005.
31. Flisher AJ, Dawes A, Kafaar Z, Lund C, Sorsdahl K, Myers B, Seedat S. Child and adolescent mental health in South Africa. *Journal of Child & Adolescent Mental Health*. 2012;24(2):149-161.
32. World Health Organization, United Nations Children's Fund, World Bank Group. *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*. *Medico e Bambino*. 2018;37.
33. United National General Assembly, Cf O. *Transforming our world: The 2030 Agenda for Sustainable Development* New York: United Nations, Department of Economic and Social Affairs; 2015. Accessed: 9 October 2021. Available from: <https://www.refworld.org/docid/57b6e3e44.html>.
34. South African Human Rights Commission. *Report of the National Investigative Hearing Into the Status of Mental Health*. 2019. [<https://www.sahrc.org.za/home/21/files/SAHRCMentalHealthReportFinal25032019.pdf>]
35. Republic of South Africa. *Republic of South Africa. National Health Insurance Bill. Bill 11 of 2019*. 2019.
36. Children's Institute. *Where are the children? Submission on the National Health Insurance Bill Opportunities and concerns for child and adolescent health*. Cape Town: Children's Institute, University of Cape Town. 2019.
37. Discovery Health Medical Scheme. *Prescribed Minimum Benefits List of Conditions*. 2021. Accessed: 4 October 2021. Available from: <https://www.discovery.co.za/wcm/discoveycoza/assets/medical-aid/benefit-information/2021/pmb-conditions-list-2021.pdf>.
38. Babatunde GB, Bhana A, Petersen I. Planning for child and adolescent mental health interventions in a rural district of South Africa: A situational analysis. *Journal of Child & Adolescent Mental Health*. 2020;32(1):45-65.
39. Mokitimi S, Jonas K, Schneider M, De Vries PJ. Child and Adolescent Mental Health Services in South Africa - Senior stakeholder perceptions of strengths, weaknesses, opportunities, and threats in the Western Cape Province. *Frontiers in Psychiatry*. 2019;10:841.
40. Mokitimi S, Schneider M, de Vries PJ. Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis. *International Journal of Mental Health Systems*. 2018;12(1):1-15.
41. Babatunde GB, van Rensburg AJ, Bhana A, Petersen I. *Mapping out multilevel and multisectoral strategies for improving child and adolescent mental health services in KwaZulu-Natal: Virtual Webinar*. 2022. [<https://www.youtube.com/watch?v=CoOEpzPzHJs>]
42. Mokitimi S. *Child and adolescent mental health services in the Western Cape of South Africa: Policy evaluation, situational analysis, stakeholder perspectives, and implications for health policy implementation [dissertation]*. Cape Town: University of Cape Town; 2020.
43. Simelane S, de Vries PJ. Child and adolescent mental health services and systems in low and middle-income countries: From mapping to strengthening. *Current Opinion in Psychiatry*. 2021;34(6):608-616.
44. Kivumbi A, Byansi W, Ssewamala FM, Proscovia N, Damulira C, Namatovu P. Utilizing a family-based economic strengthening intervention to improve mental health wellbeing among female adolescent orphans in Uganda. *Child and Adolescent Psychiatry and Mental Health*. 2019;13(1):1-7.
45. Angeles G, de Hoop J, Handa S, Kilburn K, Milazzo A, Peterman A, Team MSCTE. Government of Malawi's unconditional cash transfer improves youth mental health. *Social Science & Medicine*. 2019;225:108-119.
46. Statistics South Africa. *Quarterly Labour Force Survey (QLFS) – Q3:2021*. 2021. Accessed: 4 April 2022. Available from: <https://www.statssa.gov.za/?p=14957>.
47. Alonge O, Chiumento A, Hamoda HM, Gaber E, Huma Z-e-, Abbasinejad M, Saeed K. Identifying pathways for large-scale implementation of a school-based mental health programme in the Eastern Mediterranean Region: a theory-driven approach. *Health Policy and Planning*. 2020;35(Supplement_2):ii12-ii123.
48. Hamdani SU, Muzaffar N, Huma Z, Hamdani A, Rauf R, Farzeen M, Rahman A. Using technology to advance school mental health: Experience from the Eastern Mediterranean region. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2019;58(10):S22-S22.
49. Kutcher S, Perkins K, Gilberds H, Udedi M, Ubugu O, Njau T, Hashish M. Creating evidence-based youth mental health policy in sub-Saharan Africa: A description of the integrated approach to addressing the issue of youth depression in Malawi and Tanzania. *Frontiers in Psychiatry*. 2019:542.
50. Bamford L. The first 1,000 days: Ensuring mothers and young children thrive. In: Shung-King M, Lake L, Sanders D, Hendricks M, editors. *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town; 2019. p. 71-80.
51. Okeyo I, Lehmann U, Schneider H. The impact of differing frames on early stages of intersectoral collaboration: The case of the First 1000 Days Initiative in the Western Cape Province. *Health Research Policy and Systems*. 2020;18(1):1-14.
52. Okeyo I, Lehmann U, Schneider H. Policy adoption and the implementation woes of the intersectoral First 1000 Days of Childhood initiative in the Western Cape province of South Africa. *International Journal of Health Policy and Management*. 2021;10(Special Issue on Analysing the Politics of Health Policy Change in LMICs):364-375.
53. Rukundo GZ, Nalugya J, Otim P, Hall A. A collaborative approach to the development of multi-disciplinary teams and services for child and adolescent mental health in Uganda. *Frontiers in Psychiatry*. 2020;11:61.
54. Malhotra S, Chakrabarti S, Shah R. A model for digital mental healthcare: Its usefulness and potential for service delivery in low-and middle-income countries. *Indian Journal of Psychiatry*. 2019;61(1):27.
55. Babatunde GB, van Rensburg AJ, Bhana A, Petersen I. Barriers and facilitators to child and adolescent mental health services in low-and middle-income countries: A scoping review. *Global Social Welfare*. 2021;8(1):29-46.
56. World Health Organization. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental health Gap Action Programme (mhGAP)*: World Health Organization; 2016.
57. Knowledge Translation Unit. *PACK Child* Accessed: 1 March 2022. Available from: <https://knowledgetranslation.co.za/pack/pack-child/>.
58. Breuer E, De Silva MJ, Fekadu A, Luitel NP, Murhar V, Nakku J, Lund C. Using workshops to develop theories of change in five low and middle income countries: lessons from the programme for improving mental health care (PRIME). *International Journal of Mental Health Systems*. 2014;8(1):1-13.
59. Erismann S, Pesantes MA, Beran D, Leuenberger A, Farnham A, Berger Gonzalez de White M, Kuwawenaruwa A. How to bring research evidence into policy? Synthesizing strategies of five research projects in low-and middle-income countries. *Health Research Policy and Systems*. 2021;19(1):1-13.
60. World Health Organization. *Prevention of Mental Disorders: Effective interventions and policy options. Summary report/A report of the World Health Organization Dept. of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht*. Geneva: WHO. 2004. [<https://apps.who.int/iris/handle/10665/43027>]
61. Maybery D, Reupert AE. The number of parents who are patients attending adult psychiatric services. *Current Opinion in Psychiatry*. 2018;31(4):358-362.
62. Meinck F, Cluver LD, Orkin FM, Kuo C, Sharma AD, Hensels IS, Sherr L. Pathways from family disadvantage via abusive parenting and caregiver mental health to adolescent health risks in South Africa. *Journal of Adolescent Health*. 2017;60(1):57-64.
63. Hosman CM, van Doesum KT, van Santvoort F. Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. The scientific basis to a comprehensive approach. *Australian e-Journal for the Advancement of Mental Health*. 2009;8(3):250-263.
64. Turner R, Honikman S. Maternal mental health and the first 1 000 days. *South African Medical Journal*. 2016;106(12):1164-1167.
65. Reupert A, Maybery D, Nicholson J, Göpfert M, Seeman MV. *Parental Psychiatric Disorder: Distressed parents and their families*: Cambridge University Press; 2015.
66. Fudge E, Mason P. Consulting with young people about service guidelines relating to parental mental illness. *Australian e-Journal for the Advancement of Mental Health*. 2004;3(2):50-58.
67. Maybery D, Ling L, Szakacs E, Reupert A. Children of a parent with a mental illness: Perspectives on need. *Australian e-Journal for the Advancement of Mental Health*. 2005;4(2):78-88.
68. Reupert AE, Cuff R, Drost L, Foster K, Van Doesum KT, Van Santvoort F. Intervention programs for children whose parents have a mental illness: A review. *Medical Journal of Australia*. 2013;199:S18-S22.
69. Reedt C, Lauritzen C, van Doesum KT. Evaluating workforce developments to support children of mentally ill parents: Implementing new interventions in the adult mental healthcare in Northern Norway. *BMJ Open*. 2012;2(3):e000709.
70. *The UK Children's Commissioner's 2018 Report into Childhood Vulnerability*. 2018.
71. Children's Act 38 of 2005.
72. Children's Act 38 of 2005. Section 110.
73. Children's Act 28 of 20015. Section 150.

Child and adolescent mental health and the digital world: A double-edged sword

Rachana Desaiⁱ and Patrick Burtonⁱⁱ

The fourth industrial revolution has increasingly blurred the boundaries between the physical and digital worlds, leading to dramatic shifts in daily life and changing the way children and adolescents live, socialise, move around and learn.¹ Never before has this been so evident than at the onset of the COVID-19 outbreak and the subsequent unprecedented exponential rise in technology and internet use.² Global estimates suggest that one in three internet users is a child and that the proportion of child internet users is likely to be higher in developing countries.³

Digital technology, especially social media use, has provided access to information, social connection, education, online support groups and professional help. There is also increasing public debate and concern that digital technologies may influence a child's ability to interact with others in 'real life' and that too much time spent on social media may contribute to mental health problems such as depression, self-harm and suicide. There are substantial research gaps in understanding the possible benefits and harms of the evolving digital world. To contribute to the collective understanding of the experiences and consequences of growing up in a digital world, this chapter aims to bring together diverse perspectives and interrogate the impact of digital worlds on children's mental health and to provide recommendations for policy and practice.

How do South Africa's children use digital technology?

South Africa has approximately 38 million internet users (1.5 million households).⁴ Children most often go online on smartphones, using mobile data at home, and the level of online engagement increases with age.⁵ Home computer and tablet access at home is relatively rare in lower socio-economic contexts.^{3,6} Cell phone plans in South Africa also provide free or cheaper access to social media platforms, resulting in social media use being much more prevalent than any other online activity, driving the content that children engage with online. For children, access is not only mediated

by device and cost, but also by parents, who play the greatest role in determining when, how and where their children can use devices and connect to the internet.

Through the COVID-19 pandemic, access to reliable internet access became even more important, as teaching, connection with friends, play, and access to support services increasingly moved online. While significant progress may have been made to extend internet access to under-served areas prior to the COVID-19 pandemic,^{7,8} children across the country did not have equitable access to the internet during the lockdown periods. Socio-economic barriers to accessing the internet prior to the pandemic, which included the high cost of mobile data, the price of devices, and poor signal, were exacerbated during the COVID-19 lockdowns, deepening existing social and digital inequalities or the 'digital divide'.⁹

Globally, regional differences in internet access during the lockdowns associated with the COVID-19 pandemic were also found, with only 20% of children in Africa being able to access the internet often and very often compared to 86% of children in Eastern Europe.¹⁰ A generational digital divide is also evident in digital skills and knowledge between parents and children. One in two children report being better internet users than their parents in South Africa.⁶ Parents may have limited knowledge of the risks and opportunities that the digital world may offer, which in turn may prevent parents from appropriately intervening and guiding their child's online activities in line with their evolving capacities.^{8,11}

How does the digital environment impact on child and adolescent mental health?

Understanding the impact of the digital environment on children's mental health requires a balanced consideration of the risks, opportunities, and full range of children's rights in a digital world. Using a child-centred approach developed by EU Kids Online,¹² online risks and opportunities can be classified according to four criteria, as outlined in Figure 25.

While access to and affordability of reliable high-speed

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Figure 25: Classification of online risks and opportunities

<p>Content: The child is a recipient of digital content that is either mass-produced or user-generated (including by the child), which may or may not be shared widely.</p>	<p>Contact: The child is a participant of an interactive encounter.</p>	<p>Conduct: The child as actor in a peer-to-peer exchange.</p>	<p>Contract: The child is an active participant in the digital market. This can be mediated by the automated (algorithmic) processing of data.</p>
<p>Content risks include: Violent, hateful or pornographic content that may be illegal and age inappropriate. Receiving misleading information or "fake news", advertising and spam.</p>	<p>Contact risks include: The child experiences or is targeted by contact in a adult-initiated interaction resulting in harms, harassment (including sexual), stalking, hateful behaviour, sexual grooming⁺ and sextortion.</p>	<p>Conduct risks include: Bullying, hateful peer activity, trolling*, sexual messages, pressures or harassment, participation in potentially harmful user communities (e.g., self-harm or eating disorders).</p>	<p>Contract risks include: Digital fraud, identity theft and age-inappropriate marketing messages.</p>
<p>Content opportunities include Seeking out educational material, mental health information and support e.g. resources from the South African Depression and Anxiety Group (SADAG).</p>	<p>Contact opportunities include Digital health interventions such as computerised cognitive behavioural therapy (CBT) for depression and anxiety for adolescents¹⁴, and access to digital playgrounds that mimic offline play¹⁵.</p>	<p>Conduct opportunities include Fostering a sense of social inclusion and connection. Children enjoy, express themselves, develop, learn, and participate in the digital world.</p>	<p>Contract opportunities include Social media uses search words such as 'suicide' and 'depression' to access contact details of local organisations that provide critical mental health resources.</p>

Notes: ⁺ Tactics abusers deploy through the internet to sexually exploit children ^{*}To instigate conflict, hostility, or arguments in an online social community. Adapted from: Livingstone S, Stoilova M. The 4Cs: *Classifying Online Risk to Children*. 2021.

internet remains a challenge for large sections of South African society, the digital environment can offer significant opportunities for enhancing child health and well-being through the provision of psychosocial support, mental health services and information to children, particularly where few physical resources or services are available, or where children may feel threatened or otherwise uncomfortable seeking physical services or consulting offline sources of information.¹³

Yet, children in the digital world are also exposed to a range of threats to their emotional, physical or mental well-being. The degree of potential harm depends on:

- The nature and severity of the online risk
- The design, regulation and management of the digital environment (privacy settings, moderation servicesⁱⁱⁱ and access to mental health support)
- Offline risk and protective factors (including the child's age, gender, digital skills, resilience, personality, socio-economic situation)
- Family relationships (harsh discipline, neglect, parent-child conflict, positive parent-child relationships),

- School environment (poor teacher and peer relationships, bullying) and
- Community context (exposure to violence, lack of green spaces for play)

It is therefore useful to consider how to foster the (digital) resilience of children so that they understand what risks they are likely to encounter at different ages and know when they are at risk, what to do when they encounter risks, how to seek help, and how to recover – and learn – from adverse experiences.

How can a child rights approach be used to strike the optimal balance between children's rights to protection and participation?

Much of the initial focus of legislation and policy within South Africa has been focused on protecting children from exposure to online risks and harms, often at the expense of participation and privacy.

Yet, the United Nations Committee on the Rights of the Child's General Comment No. 25, issued in 2021, provides

iii Moderation services refers to the reviewing, filtering and monitoring of user-generated content online, often undertaken by the organizations or companies on whose platforms the content is posted.

substantive guidance to states and other duty bearers on what the digital environment means for children’s civil rights and freedoms, and their rights to privacy, non-discrimination, protection, education, play and more. It also explains why and how states should give effect to children’s rights in the digital environment.¹⁶

Notably, the Committee conducted consultations with children around the globe who expressed their lived experiences, opinions and hopes for a safer and more inclusive digital world. In acknowledging the important role of children’s participation, the General Comment begins by sharing some of the children’s views:

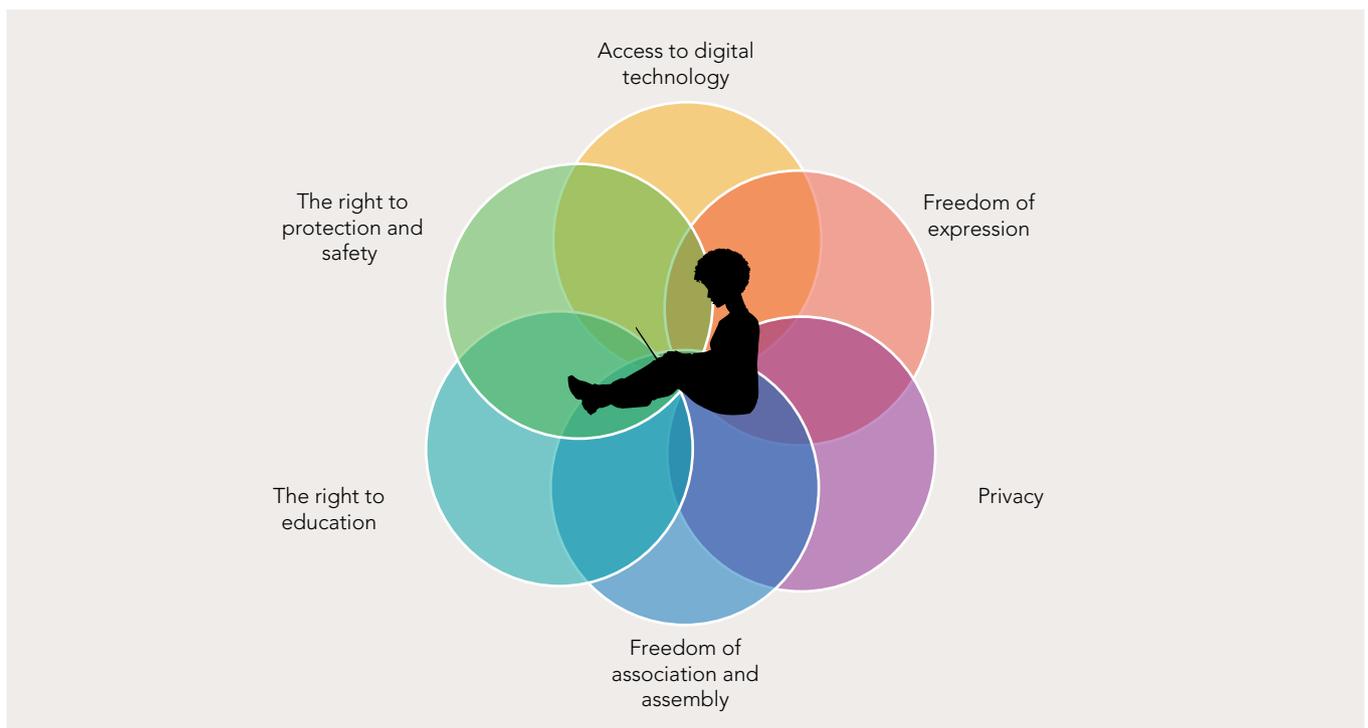
Children in diverse contexts see digital technology as critical to their current lives, and the future. They find benefits in using digital technology: “By the means of digital technology, we can get information from all around the world”; “When you are sad, the internet can help you see something that brings you joy”. Children also called for action to support, promote and protect their safe engagement with these technologies: “I would like the government, technology companies and teachers to help us manage untrustworthy information online”; “I would like to obtain clarity about what really happens with my data ... Why collect it? How is it being collected?”^{16(p.1)}

The General Comment then identifies six principles that should inform state-led efforts to respect, protect and fulfil the rights of the child in the digital environment as outlined in Figure 26:

In addition, the following rights should be applied to all stages of the policy, implementation and intervention development process:

- **Best interests of the child**
Legislation and policies should not focus on the protection and safeguarding of children in a way that undermines or restricts children’s other rights within the digital environment – such as their rights to privacy, information and participation.
- **Evolving capacities**
Laws, policies and interventions should adopt a more active and empowering approach that recognises how children’s need for protection diminishes and their capacity to take responsibility for decisions affecting their lives grows across the life course.
- **Non-discrimination**
Interventions and policy guidelines should be attuned to the diverse experiences of children which affect their access to, and experience of, digital technology and take care that the measures introduced do not exclude or discriminate against particular groups of children, such as children living with disabilities or those who do not have access to the internet.¹⁷
- **Child participation**
Children have a right to be heard on matters that affect them and children’s participation is essential to ensure that policies and programmes are attuned and responsive

Figure 26: Six principles that should guide the realisation of children’s rights in the digital environment



to children's needs. Policies and programmes should also foreground and foster children's own agency, but without placing an undue burden on children for their own safety and well-being.

What are the opportunities to strengthen policy and practice?

Realising the potential of digital technology to enhance children's mental health and well-being requires a whole-of-society approach and will require interventions to transform both policy and practice.

Legislation and policy

Children's access to digital technology and their digital literacy and skills impact on their safety online, their ability to successfully navigate risks, manage and balance healthy digital technology use, and bounce back from adversity.¹⁸ Therefore, policies at a national and provincial level should explicitly focus on prioritising universal broadband access and accompany this with obligatory training and skills development for children, educators, parents and caregivers.

While there is not yet a substantive body of evidence from South Africa on the interaction of online and offline risk, there is sufficient global evidence and evidence-informed guidance^{16, 19} to justify the integration of children's online protection, including the addressing of online risks to children's mental health and well-being, as a substantive aspect of policies and legislation addressing violence against children. Therefore, all policies and legislation relating to the provision of digital technology and services, and to the prevention of violence and promotion of safety, should explicitly integrate steps to ensure the safety and well-being of children online.

Steps taken should be integrated into the regulatory framework of all digital technology services that children may encounter. The White Paper on Audio and Audio-visual Content Services, for example, provides a framework to protect children from harmful and exploitative marketing practices by commercial enterprises. This policy approach could be strengthened by placing further obligations on industry to ensure that products and services take into account the fact that children may access services not directly intended for use by children. This could include the introduction of mandatory Child Rights Impact Assessments on all digital services, the implementation of an Age-

Appropriate Design Code,^{iv} and strengthening reporting and accountability mechanisms to ensure that swift action is taken to address user complaints and remove inappropriate content.

Educational institutions

Schools offer a critical platform for intervention and engagement with teachers, learners and the wider school community. School policies, regulations and guidelines should aim to balance the protection of children with their rights to privacy and to use technology in a way that is appropriate to their age and evolving capacities.^v Such policies should promote positive use of digital technologies, while taking steps to restrict access to harmful content.¹⁶

The Department of Basic Education has revised its Guidelines on E-safety in schools, which is intended as a framework and resource for schools, governing bodies and parents.²⁰ However, these guidelines, even in their revised form, are dated, and fail to integrate more recent evidence on children's use of technology, the critical issues and challenges facing schools and children, and emerging best practice on how to address these challenges. This includes the failure to address data protection and management which may result in harmful outcomes – mental and physical – to learners, particularly as schools adopt EdTech and various forms of e-learning and school-parent communication platforms. There is similarly no uniform integration of online safety and digital well-being into the formal curriculum, although there is emerging good-practice available from interventions offered by NGOs as outlined in Case 22.

In their efforts to keep children safe, schools may inadvertently collect or utilise data in ways that may pose a risk to children's mental health and well-being.²¹ For example, digital technology intended to aid communication with parents and children may lead to direct harm if children are identified and their behaviour discussed in a public forum (an unintentional 'shaming' exercise). Similarly, as learning has gone online, the systems that schools use may expose children to risks through unregulated data collection by education technology companies. Institutional policies are thus required to manage the use of digital technologies and social media in a way that promotes their utility and opportunities while safeguarding and protecting children. Interventions aimed at developing cognitive functioning and socio-emotional learning skills of younger children, including

iv See for example, <https://5rightsfoundation.com/our-work/design-of-service/age-appropriate-design-code.html>.

v While it is recognised that schools and other institutions function in very different contexts, and have variable access to resources (including in some instances having limited or no access to digital technology), a model set of guidelines and policies are important to ensure that those schools who are well-connected implement the most appropriate policies, and that as more schools are connected and introduce digital technology, they adopt and implement evidence-based policies and guidelines from the outset.

early childhood development programmes, should consider integrating digital literacy. This ranges from the inclusion of material targeting parents and caregivers on age-appropriate internet and device access and usage, to digital literacy programming for parents and caregivers themselves.

Training for educators is also needed so that they are able to identify children who exhibit symptoms of trauma or distress as a result of online harm and can refer them to psychosocial support services. This should be incorporated into broader care and support for teachers and learners programming, rather than being seen as a distinct symptomology.

Health care services

Digital technology has the potential to expand access to much needed psychosocial support and mental health services for children in South Africa. This includes digital mental health services from the state as well as psychosocial support and trauma counselling from non-governmental organisations (NGOs) and civil society.

These investments are particularly pressing given the treatment gap for children in South Africa, as they have the potential to extend the reach of specialist child and adolescent mental services which remain extremely limited

Case 22: Web Rangers – Building the digital literacy skills of South Africa’s children

Phakamile Khumalo and William Bird

The Web Rangers programme is led by Media Monitoring Africa (MMA) and partnersⁱⁱ in South Africa and aims to empower children (aged 12 – 17 years old) with digital and media literacy skills so they can become active digital citizens. This means having the tools and skills to use the internet, social media and other digital tools in a responsible and ethical way.

Since 2016, the programme has trained over 1,300 children using MMA’s Web Rangers curriculum.²³ Once trained, Web Rangers are tasked with creating innovative online safety videos that promote active digital citizenry within their schools and communities. They also host online safety webinars, school presentations and engage in high-level information and communications technology (ICT) related policy discussions and submissions to ensure that children’s voices are heard, and their participation prioritised.

The programme uses a child rights approach and combines training, advocacy work and policy engagement opportunities to challenge the mindset that children are just vulnerable victims with little or no agency. For example, key highlights include the Web Rangers representing South Africa at the 2019 Internet Governance Forum in Berlin, and creating the first ever South African comic book educating children about misinformation and disinformation²⁴.

Tumelo, a 2017 Web Ranger ambassador, tells a beautiful story of the impact of the programme:

“The Web Rangers is unique because the education system does not teach this or parents at home.

There are reported suicides, molestation, human trafficking that happens through social media and it happens at a high rate because children are not responsible and that’s where the Web Rangers fit, to educate and shape our view on social media. I do not reply to a lot of messages from strangers. I avoid negative comments even on my posts because I know people are angry with themselves and they try to make everyone angry as well so they can feel better. Unfortunately for them, I am a Web Ranger, and it has made me a hard nut to crack. I do not succumb to the social media world of being reckless.”

This is one of many powerful quotes from programme participants that illustrate how becoming an active digital citizen helps challenge children’s violent online behaviour patterns, offers them ways to manage conflict, build core skills and resilience, and helps strengthen children’s mental health.

A systematic review of the impact of digital skills training for young people in the United Kingdom²⁵ confirms the positive link between digital literacy and mental health. The research found that digitally skilled children aged 12 – 17 years experienced less distress after facing online harm.

This by no means makes Web Rangers immune from potential harm online, but they are equipped with the tools and resources to take advantage of new opportunities that technology and the internet offers, and they have the knowledge and skills to successfully navigate the challenges they encounter online.

i Media Monitoring Africa

ii Web Ranger partners include Google, Meta, TikTok, Department of Communications and Digital Technologies, the Film and Publications Board, Walt Disney and Dentons.

Case 23: Human-centred design of apps to support adolescent mental health

Alastair van Heerdenⁱ

The phenomenal growth of mobile technologies over the past 15 years has stimulated innovation and the development of digital interventions to support child and adolescent mental health. Understanding the needs, wants and limitations of end users is a critical component of any human-centred design (HCD) process. Key elements of HCD include:

- Developing personas or fictional characters based on research and data that describe the generic types of people involved in or benefiting from a digital intervention. The persona is then used to help the project team understand the needs and motivations of the target user.
- Using cards to help visualise the journeys or the sequence of steps that users take to complete a task or use the service.
- Convening co-design workshops to bring the intended users into the design process and build trust. It is a more creative approach to public engagement that allows people to work together to explore the design of digital solutions.²⁶

An example of how these principals lead to very different real-world outcomes can be seen in a recent set of apps designed to support adolescent mental health – the STARS²⁷ and step-by-step²⁸ apps.

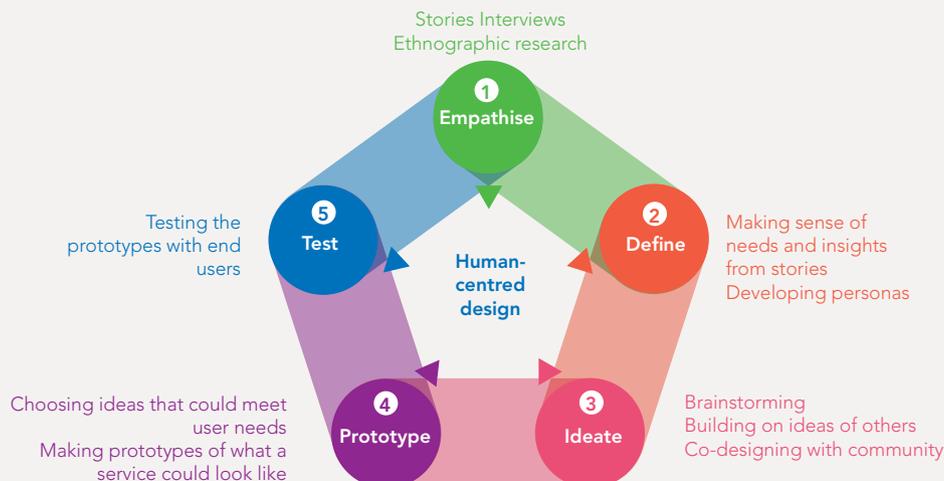
Sustainable Technology for Adolescents and youth to Reduce Stress (STARS) used an HCD process to design a digital mental health intervention for adolescents. The intervention was created through an iterative cycle of idea creation, prototype development and feedback from

adolescents. The end product was not pre-determined, but rather allowed to evolve through the design process. The final product was a chatbot intervention delivering transdiagnostic cognitive behavioural therapy content to adolescents aged 15 – 18 years. The intervention was designed to be adaptable across different settings, including low- and middle-income countries (LMICs).

The Step-by-Step study had a similar goal to design a digital mental health intervention that could be rolled out to adolescents in LMICs. The design process began by engaging key stakeholders and experts and included formative qualitative work with populations in Lebanon. These consultations provided important information that went on to inform the development of the content, the guidance model and the delivery system (e.g., app or website). The result was an illustrated narrative game that used animated characters to provide psychoeducation and training in behavioural activation therapy. The characters and story are provided in four “flavours”, with users selecting the one they preferred (e.g. a man with or without a beard).

While both had the same goal, using an HCD process resulted in two very different digital health tools. Often described as contextual adaptation, the co-design of digital tools using HCD principles ensures that the end product is fit for purpose and relevant to the culture and context in which it will be used, thereby maximising the likelihood of success. A library of mental health apps is available at the following link: <https://mindapps.org/Apps>.

Figure 27: Key components of a human-centred design process



ⁱ Human and Social Development Programme, Human Sciences Research Council

Case 24: The potential to use digital technologies to reduce youth suicide risk

Jason Bantjesⁱ

Improving access to effective, age-appropriate, and acceptable psychological treatments for common mental disorders is integral to youth suicide prevention in South Africa. However, this is not as simple as it sounds because of the large number of adolescents who require psychological support and because of the shortage of mental health professionals and the lack of accessible adolescent psychiatric services in the public health care system. Digital technologies could be one cost-effective way to scale-up interventions and improve access to adolescent mental health care in South Africa. Indeed, there are effective digital interventions for most common mental disorders²⁹⁻³² and young people in particular seem to be open to using technology to access psychological support.³³

A recent pragmatic trial of an online group intervention for South African university students with depression and anxiety is an apt example of how technology could be utilised to scale up treatment on university campuses.³⁴ This intervention was developed as part of the ongoing work of the WHO World Mental Health Surveys International College Student initiative to develop scalable and effective interventions to promote the well-being of university students globally.³⁴

The intervention, which is based on cognitive behavioural therapy (CBT), was delivered remotely to groups of 8 – 12 students via a video conferencing platform in weekly one-hour workshops over 10 weeks. The groups were facilitated by registered counsellors and psychology masters students, under supervision of a psychologist. The content was organised into five themes with each theme spanning two workshops. Themes included problem solving, recognising emotional triggers, identifying unhelpful thoughts, emotional regulation skills, behaviour activation, and stress management.

The intervention materials were developed in consultation with students, who gave advice about the format, exercises and examples used in the intervention. Participants were provided with electronic interactive PDF workbooks consisting of exercises and brief summaries of

the main ideas and skills for each session. Students were also invited to use the web-based chat function to type comments, questions, or responses during the sessions if they felt uncomfortable speaking in the group. Strategies used to improve retention included giving participants permission to miss sessions but encouraging attendance at each new session, sending follow-up emails to students who missed sessions prompting them to join the following week, and giving a brief recap of the previous workshop at the start of each new session.

In 2020, during the covid pandemic, 175 students were enrolled in the intervention, 90% of whom initiated treatment. The level of engagement was good with most students attending sessions regularly, and with very low attrition rates. Crucially, students who participated in the intervention showed significant reductions in symptoms of depression and anxiety. Remission rates among participants with clinically significant baseline symptoms were 68%-79% and were not associated with baseline symptom severity.

Students reported high levels of satisfaction with the online intervention. Most of the participants rated intervention quality as good or excellent (91%), were satisfied with the kind (86%) and amount (86%) of help received and reported being better able to deal effectively with their problems following the intervention (90%). These high rates of satisfaction with treatment support the idea that digital interventions may be appealing to some university students and could be integrated into existing student counselling services.

It remains to be seen if the good outcomes observed in the initial pragmatic trial will also be seen in well controlled clinical trials and if the reductions observed in symptoms of depression and anxiety will translate into lower rates of fatal and non-fatal suicidal behaviour. Nonetheless, the pragmatic trial conducted in 2020 serves as a proof of concept for the use of web-based group CBT to promote the mental health of university students in South Africa. The intervention is currently being tested in a randomised control trial in South Africa.

ⁱ Alcohol, Tobacco and Other Drug Research Unit, South African Medical Research Council; and the Institute for Life Course Health Research, Department of Global Health, Stellenbosch University.

and concentrated in a handful of urban centres. For example, a digital clinical decision support system that was developed in India enables general practitioners working in primary care settings to access supervision and guides them through the assessment and management of children and adolescents with mental disorders.⁵⁴

There is also growing evidence of how digital platforms can be used effectively to provide therapeutic programmes to children and young people, including an online intervention for South African university students that has shown promise in alleviating symptoms of depression and anxiety (Case 24). Key to successful programming is the adoption of human-centred design principles which actively engage with children and young people in the design and co-creation of digital solutions (Case 23). Strict data control and security measures also need to be put in place to limit and safeguard the data collected to ensure that this poses no inadvertent risks to children.

Building capacity and transforming practice

What happens online is a broader reflection of societal and community attitudes and behaviours. Just as schools are microcosms of communities, so the online space reflects values, attitudes and norms that are espoused in the offline space. While specific intervention and programming areas are required, these should be framed within a broader approach to modelling appropriate behaviours and attitudes. This ranges from the modelling of healthy digital habits by adults, including the management of time spent on devices within family or social contexts, to the language and behaviours that adults, including parents and caregivers, engage in themselves online, and the tolerance or intolerance towards unacceptable behaviour and language both on- and offline.

Support to parents and caregivers on parenting practices within a digital world should be prioritised, including through the inclusion of digital parenting into existing parenting programmes offered by the state and NGOs. Restrictive parenting practices, which prevent children from developing

the necessary skills and capacities to both stay safe online and to realise the benefits and opportunities that the internet and technology offer, are often fuelled by fear and a sense of disempowerment on the part of parents and caregivers.²² Yet, these parenting styles and approaches to keeping children safe also undermine children's own sense of agency, and ultimately, their safety. Programmes are therefore needed to empower parents and caregivers, foster their own digital literacy and competencies, and support them in fostering healthy, resilient and positive online behaviours in their children.

Finally, and most importantly, children need access to information, education and training to support the development of their own digital literacy skills and ensure that they are equipped with age-appropriate knowledge and skills to successfully navigate both threats and opportunities online, and with the confidence and knowledge to seek help and assistance when needed, and know that it will be provided.

Conclusion

The COVID-19 pandemic and the digital revolution has led to an exponential rise in technology and internet use. Growing up in a digital world has offered children opportunities as well as exposure to risk. To comprehensively understand children's mental health in relation to the digital environment, a balanced consideration of both risks and opportunities is required, recognising the full range of children's rights in a digital world. This balance should inform the provision of services to children to manage the risks and fully realise the potential benefits that digital technology and social media offer for children's well-being and mental health. This includes recognising the role that parents and caregivers, educators, government regulators and industry, and children themselves have to play in promoting children's mental health and well-being in all aspects of children's online engagement, from online play to learning to civic participation.

References

1. World Health Organization. *Critical preparedness, readiness and response actions for COVID-19: Interim guidance*, 22 March 2020: WHO; 2020. Accessed: 19 April 2022. Available from: <https://www.who.int/publications-detail/critical-preparedness-readiness-and-response-actions-for-covid-19>.
2. UNICEF. *COVID-19 and its implications for protecting children online*: 2020. Accessed: 27 May 2020. Available from: <https://www.unicef.org/media/67396/file/COVID-19%20and%20its%20Implications%20for%20Protecting%20Children%20Online.pdf>.
3. Livingstone S, Winther DK, Saeed M. *Global Kids Online Comparative Report*. 2019. [<https://ideas.repec.org/p/ucf/inorer/inorer1059.html>]
4. Kemp S. *Digital 2021: South Africa*: 2021. Accessed: 1 December 2021. Available from: <https://datareportal.com/reports/digital-2021-south-africa>.
5. Phokeer A, Densmore M, Johnson D, Feamster N, editors. *A first look at mobile internet use in township communities in South Africa*. Proceedings of the 7th Annual Symposium on Computing for Development; 2016.
6. Burton P, Leoschut L, Phyfer J. *South African Kids Online: A glimpse into children's internet use and online activities*. Cape Town: The Centre for Justice and Crime Prevention. 2016.
7. Singh A. Bridging the digital divide: The role of universities in getting South Africa closer to the global information society. *South African Journal of Information Management*. 2004;6(2).
8. Beger G, Sinha A, Pawelczyk K. *South African mobile generation: Study on South African young people on mobiles*. New York: UNICEF. 2012.
9. Stewart R, El-Harakeh A, Cherian SA. Evidence synthesis communities in low-income and middle-income countries and the COVID-19 response. *The Lancet*. 2020;396(10262):1539-1541.

10. Terre des Hommes. #CovidUnder19: Life under coronavirus – results of the survey. 2021. Accessed: 20 August 2021. Available from: <http://globalkidsonline.net/covidunder19-summit/>.
11. Byrne J, Burton P. Children as internet users: How can evidence better inform policy debate? *Journal of Cyber Policy*. 2017;2(1):39-52.
12. Livingstone S, Stoilova M. *The 4Cs: Classifying Online Risk to Children*. 2021.
13. Drouin M, McDaniel BT, Pater J, Toscos T. How parents and their children used social media and technology at the beginning of the COVID-19 pandemic and associations with anxiety. *Cyberpsychology, Behaviour and Social Networking*. 2020;23(11):727-736.
14. Stasiak K, Fleming T, Lucassen MF, Shepherd MJ, Whittaker R, Merry SN. Computer-based and online therapy for depression and anxiety in children and adolescents. *Journal of Child and Adolescent Psychopharmacology*. 2016;26(3):235-245.
15. Livingstone SP, K. *Playful by Design: A vision of free play in a digital world*. London: 5Rights Foundation, Digital Futures Commission; 2021.
16. United Nations Committee on the Rights of the Child. *General Comment No. 25 (2021) on children's rights in relation to the digital environment*. New York: United Nations. 2021.
17. UNICEF. *Our lives online: Use of social media by children and adolescents in East Asia—Opportunities, risks and harms*. UNICEF. 2020. [<https://www.unicef.org/eap/media/4691/file/Our%20lives%20online.pdf>]
18. UK Council for Internet Safety. *Digital Resilience Working Group Policy Paper*: 2021. Accessed: 12 December 2021. Available from: <https://www.drwg.org.uk/the-framework>
19. Kardefelt-Winther D, Maternowska C. Addressing violence against children online and offline. *Nature Human Behaviour*. 2020;4(3):227-230.
20. Department of Basic Education. *Guidelines on e-safety in schools: Educating towards responsible, accountable and ethical use of ICTs in education. (Updated)*. Pretoria: DBE. [Accessed 3 May 2022: [https://wcedonline.westerncape.gov.za/documents/eLearning/eLearningCircMins/minutes/del4_18.pdf]
21. Livingstone S, Atabey, A., Pothong, K. *Addressing the problems and realising the benefits of processing children's education data: Report on an expert roundtable*. Digital Futures Commission: 5Rights Foundation; 2021.
22. Livingstone S, Blum-Ross A. *Parenting for a digital future: How hopes and fears about technology shape children's lives*: Oxford University Press, USA; 2020.
23. See <https://webrangers.co.za/web-ranger-curriculum/>.
24. See <chrome-extension://efaidnbmninnkpcjpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fmediamonitoringafrica.org%2Fwp-content%2Fuploads%2F2021%2F11%2FDisinformation-Comic-Book.pdf&clen=23059661&chunk=true>.
25. Livingstone S, Mascheroni G, Stoilova M. The outcomes of gaining digital skills for young people's lives and wellbeing: A systematic evidence review. *New Media & Society*. 2021:14614448211043189.
26. World Health Organization. *Youth-centred digital health interventions: A framework for planning, developing and implementing solutions with and for young people*. Report No.: 9240011714. Geneva: WHO. 2020.
27. Hall J, Jordan S, van Ommeren M, Au T, Sway RA, Crawford J, Malik A. Sustainable Technology for Adolescents and youth to Reduce Stress (STARS): A WHO transdiagnostic chatbot for distressed youth. *World Psychiatry*. 2022;21(1):156.
28. Carswell K, Harper-Shehadeh M, Watts S, van't Hof E, Abi Ramia J, Heim E, van Ommeren M. Step-by-Step: A new WHO digital mental health intervention for depression. *mHealth*. 2018;4.
29. Lecomte T, Potvin S, Corbière M, Guay S, Samson C, Cloutier B, Khazaal Y. Mobile apps for mental health issues: Meta-review of meta-analyses. *JMIR mHealth and uHealth*. 2020;8(5):e17458.
30. Torous J, Wisniewski H, Liu G, Keshavan M. Mental health mobile phone app usage, concerns, and benefits among psychiatric outpatients: Comparative survey study. *JMIR Mental Health*. 2018;5(4):e11715.
31. Firth J, Torous J, Nicholas J, Carney R, Pratap A, Rosenbaum S, Sarris J. The efficacy of smartphone-based mental health interventions for depressive symptoms: A meta-analysis of randomized controlled trials. *World Psychiatry*. 2017;16(3):287-298.
32. Firth J, Torous J, Nicholas J, Carney R, Rosenbaum S, Sarris J. Can smartphone mental health interventions reduce symptoms of anxiety? A meta-analysis of randomized controlled trials. *Journal of Affective Disorders*. 2017;218:15-22.
33. Gericke F, Ebert DD, Breet E, Auerbach RP, Bantjes J. A qualitative study of university students' experience of Internet-based CBT for depression. *Counselling and Psychotherapy Research*. 2021;21(4):792-804.
34. Bantjes J, Kazdin AE, Cuijpers P, Breet E, Dunn-Coetzee M, Davids C, Kessler RC. A web-based group cognitive behavioral therapy intervention for symptoms of anxiety and depression among university students: Open-label, pragmatic trial. *JMIR Mental Health*. 2021;8(5):e27400.
35. Cuijpers P, Auerbach RP, Benjet C, Bruffaerts R, Ebert D, Karyotaki E, Kessler RC. Introduction to the special issue: The WHO world mental health international college student (WMH-ICS) initiative. *International Journal of Methods in Psychiatric Research*. 2019;28(2):e1762.

Violence and child and adolescent mental health: A whole-of-society response

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Violence, as a way of solving the problems of daily life, is ubiquitous in South Africa. Harsh parenting, harmful social norms on parenting and children's position within the family, and high levels of substance abuse leave children extremely vulnerable in their homes and communities. We urgently need to engage all of society to shift the social norms that legitimise and normalise violence against children, to combine this with a comprehensive suite of interventions across the life course to prevent violence in children's home, schools and communities, and to ensure that children are able to access the care, protection and therapeutic support they need.

In this chapter, we examine the nature and impact of violence and trauma in childhood and adolescence, and identify risk and protective factors across a variety of settings, drawing attention to the intersections between violence against children (VAC) and violence against women (VAW). We highlight how interventions need to extend beyond treatment to include an emphasis on prevention and breaking the intergenerational cycle of violence. Finally, given the pervasiveness of violence in South African society, we call for the adoption of a trauma-sensitive approach to the delivery of education, health and social services for children, adolescents and their families.

What is the nature of the problem?

Violence against children in South Africa is all-pervasive. The 2016 Optimus Study, which provided the first national prevalence data on child abuse, violence and neglect, found that 42% of children have experienced some form of violence – including sexual abuse (35%), physical violence (35%), emotional abuse (26%) and neglect (15%).⁵ This is echoed in work from a cohort study of young children in South Africa which found that 43% of eight-year-olds had been exposed to violence in their community.⁶ Data from the Birth to Thirty cohort study of more than 2,000 children born in Soweto found

that by age 22 years, 99% of children had either experienced or witnessed some form of violence in their homes, schools and/or communities.⁷ While in Khayelitsha, more than 80% of youth reported that they had been exposed to a severe trauma.⁸

Violence results not only in physical scars but also in psychosocial effects that are often hidden, with debilitating, long-lasting consequences. For example, post-traumatic stress disorder (PTSD) results in a variety of negative long-term outcomes in children. While PTSD is one of the most prevalent diagnoses presenting to local psychiatric services in South Africa,⁹ there are no national prevalence data on the link between violence or trauma and PTSD in children.¹⁰ Yet, community-based surveys have consistently reported PTSD rates of 20% – 38%,^{11,12} and in a community-based sample of children who had experienced sexual abuse, nearly a third (32%) had full symptom PTSD, while a further 50% had partial symptom PTSD.¹³

Violence across the life course

Violence shifts in its patterns and forms across the life course. In younger children in South Africa, violence in the home creates a significant risk for a range of mental health difficulties. Infanticide, abuse and neglect are common in the early years, but are likely to be under-reported as infants and most young children have limited capacity to seek help.¹⁴ Young children are particularly vulnerable to violence in the home, including harsh physical punishment and witnessing domestic violence. For example, nearly 60% of caregivers reported hitting their children, with young children (aged 3 – 4) most likely to experience harsh physical punishment, including being hit with a stick, belt or hard object.^{7,15} Harsh discipline is often accompanied by verbal and emotional abuse¹⁶ – with boys likely to receive higher levels of harsh verbal and physical discipline than girls.¹⁷ For young children, the absence of a domestic 'island' of safety (and safe primary attachment

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Table 8: Definitions of key terms

Violence	The World Report on Violence and Health defines violence ‘as the intentional use of physical force or power, threatened or actual, that results or is likely to result in injury, death, psychological harm, maldevelopment or deprivation (p5)’, ¹ while the United Nations Committee on the Rights of the Child defines violence against children as ‘all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse’ ² . The World Health Organization extends this definition to include ‘the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting in actual or potential harm to the child’s health, survival, development or dignity (p29)’. ¹
Trauma	The Diagnostic and Statistical Manual of Mental Disorders V defines trauma as ‘exposure to actual or threatened death, serious injury, or sexual violation’. ³ When a child experiences a deeply distressing, life-threatening or stressful event such as violence or injury (traumatic event), both acute and chronic stress responses such as fear, anxiety, panic, and shock commonly ensue. ³ Three main types of trauma exposure have been described, namely acute trauma (the immediate response to a single traumatic event), chronic trauma (recurrent and prolonged trauma) and complex trauma (exposure to multiple traumatic events, often severe, pervasive and of an interpersonal nature). ³
Polyvictimization	Polyvictimization is defined as experiences of multiple forms of victimisation, not only child maltreatment but also victimisation perpetrated by peers and siblings; conventional crimes including property vandalism, robbery, theft, physical assault, and abduction; witnessing of family and community violence; and cyber bullying. ⁴
Post-traumatic stress disorder (PTSD)	PTSD is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, serious accident or rape, or who have been threatened with death, sexual violence or serious injury. Symptoms can vary in severity and fall into four categories: <ol style="list-style-type: none"> 1. Intrusion: Intrusive thoughts such as repeated, involuntary memories, distressing dreams or flashbacks of the traumatic event. 2. Avoidance: Avoiding reminders of the traumatic event may include avoiding people, places, activities, objects or situations that may trigger distressing memories. 3. Alterations in cognition and mood: Inability to remember important aspects of the traumatic event, negative thoughts and feelings leading to ongoing and distorted beliefs about oneself or others; thoughts about the cause or consequences of the event leading to wrongly blaming self or other; or ongoing fear, horror, anger, guilt or shame. 4. Alterations in arousal and reactivity: Arousal and reactive symptoms may include being irritable and having angry outbursts, behaving recklessly or in a self-destructive way, or being easily startled. <p>Many people who are exposed to a traumatic event experience symptoms like those described above in the days following the event. For a person to be diagnosed with PTSD, however, symptoms must last for more than a month and must cause significant distress or problems in the individual’s daily functioning. Many individuals develop symptoms within three months of the trauma, but symptoms may appear later and often persist for months and sometimes years.</p>

relationships) may significantly increase the risk for a range of mental health difficulties. On the other hand, parental warmth may protect children from poor outcomes and from adversity.^{17, 18}

As children get older and engage in activities outside of the home, they are more likely to be exposed to violence in their schools and wider community – including corporal punishment, bullying and sexual violence from both known and unknown perpetrators. Boys who have, for example, been the victim of neglect and harsh punishment are more likely to engage in bullying behaviour, while girls may become withdrawn and isolated from their peer group.^{6, 19} These differences are commonly referred to as ‘internalising’ and ‘externalising’ behaviours.

For adolescents, who spend more time outside the home and typically have more emotional separateness from their families, violence in the community is a more consistently

toxic experience.^{20, 21} Girls are twice as likely to be victims of forced penetrative sex, yet boys are also exposed to high levels of sexual abuse, including unwanted touching and coerced sex.¹⁰ The prevalence of sexual violence also increases with age, with the Birth to Thirty cohort study noting an increase from 10% of children during primary school to 30% of adolescents and older youth.⁷ Sexual victimisation rarely occurs in isolation and is often associated with other forms of violence such as physical abuse, emotional abuse, neglect and family violence,^{10, 22} with 25% – 45% of children in South Africa witnessing domestic violence perpetrated by their mother’s intimate partner¹⁰.

Interpersonal violence amongst boys rises sharply during adolescence, with male-on-male violence being the leading cause of death amongst adolescent boys aged 15 – 17 years.²³ Older adolescent boys are more likely to be the victim of homicide than girls, while adolescent girls are at increased

risk of dating violence – with nearly one in three adolescent girls in community surveys reporting forced sexual initiation²⁴. The ubiquity of violence, coupled with patriarchal social norms and violent masculinities, leads many adolescents to perceive sexual violence as a normal part of their intimate relationships.²⁵ Rates of polyvictimization⁴ are also high among children in South Africa, with as many as 40% of children in the Birth to Thirty cohort being exposed to five or six categories of violence⁷. In short, South Africa’s children are exposed to extremely high levels and multiple forms of violence, across multiple settings throughout their life course.

What are the drivers of VAC?

Violence against children is seldom random. The socio-ecological model illustrates how children’s exposure to violence is shaped by a complex interplay of risk and protective factors that include the child’s individual characteristics and the nature of their relationships, their communities and other factors within South African society, as illustrated in Table 9.

Violence exposure and mental health problems share many of the same risk and protective factors. A stable family, characterised by secure and caring relationships, creates an enabling environment for children to thrive and is hugely protective in the event of trauma or community violence. On

the other hand, living in a home and community characterised by high levels of interpersonal and community violence increases the risk of mental health problems, and of children becoming victims or perpetrators of violence later in life. Where children live also has an impact. The majority of South Africa’s children live in townships, informal settlements and deep rural areas of the country where high levels of unemployment, poverty and food insecurity, coupled with overcrowding and inadequate infrastructure, policing and social services, increase the risk of interpersonal and gang violence and crime.

Many of these local challenges are shaped by broader societal and structural inequalities, and the ways in which apartheid policies such as the Group Areas Act and migrant labour system fractured family and community life.²⁶ More than 25 years into democracy, South Africa remains the most unequal country in the world, and the link between inequality and levels of crime in a society are true in South Africa as well as globally. Poverty increases stress and tension in the home and compromises families’ mental health and capacity to care, protect and provide for their children’s basic needs. And in many cities in South Africa, it also increases the risk of adolescents being drawn into gangs, engaging in criminal behaviour and using illegal substances.²⁷

Figure 28: Types of violence across the life course

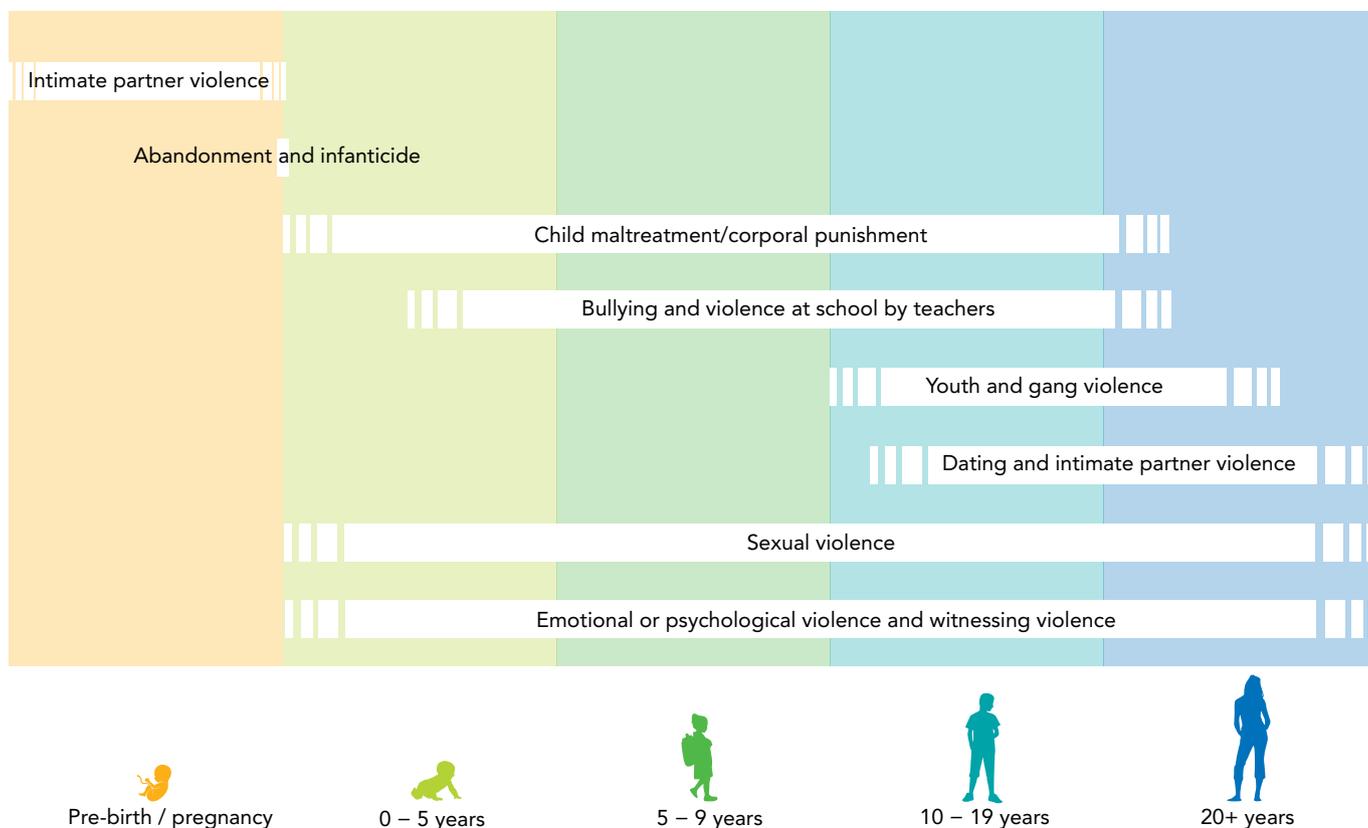


Table 9: Risk and protective factors for violence against children

	Societal	Community	Relationship/ family	Individual
Risk factors	<ul style="list-style-type: none"> • High unemployment rates • High inequality and social exclusion • Availability of firearms • Weak legal, policy and regulatory framework • Gender inequality and discrimination • Social and cultural norms that justify violence • Weak law enforcement 	<ul style="list-style-type: none"> • High level of crime in communities • Poor and/or inadequate social services • High level of substance abuse 	<ul style="list-style-type: none"> • Domestic violence • Substance abuse in the family • Friends that engage in violence • Harsh parenting • Parents with mental health problems • Food insecurity in households 	<ul style="list-style-type: none"> • Biological and personal history factors such as: • Gender, age, income • Substance abuse • Personal history of violence • Unwanted pregnancy • Physical and mental disability
Protective factors	<ul style="list-style-type: none"> • Legal and policy frameworks to create an enabling environment to support victims of violence • Enforced criminal justice sanctions for perpetrators of violence • Policies to regulate gun ownership and alcohol use • Gender equity promoted at highest level • Job creation programmes • Social norms challenged through media 	<ul style="list-style-type: none"> • Accessible health and social services to support families • Social protection programmes to mitigate poverty and unemployment • Cohesive communities with accountable community leadership and structures • Responsive policing and functional criminal justice system with trained specialists • Adequate childcare facilities Supportive school environment with an inclusive teaching approach Child-focused support services • Trauma-informed services 	<ul style="list-style-type: none"> • A cohesive and stable family unit • Adequate, accessible support for families • Healthy communication between parent and child; etc. 	<ul style="list-style-type: none"> • Strong attachment • Responsive caregiving • Increased knowledge of protection against abuse • Education and literacy

Adapted from: Mathews S & Benvenuti P. Violence against children in South Africa: Developing a prevention agenda. In: Mathews S, Jamieson L, Lake L & Smith C (eds) *South African Child Gauge 2014*. Cape Town: Children’s Institute, UCT. 2014.

Children’s relationships with their peers, partners and family members can either be protective or increase children’s exposure to violence. For example, a study on the determinants of VAC in South Africa has shown that conflict in the household, substance abuse by a family member and a family member involved in crime, all increase the risk for children to become victims of violence and for boy children to become perpetrators of violence.²⁸

Intergenerational violence and the Intersections of violence against women and violence against children

Already we have seen how a child’s age and sex have an impact on the types of violence they are exposed to, with early exposure to corporal punishment and domestic violence increasing the risk of girls becoming victimised later in life, and boys becoming perpetrators of violence. This also fuels an intergenerational cycle of violence by increasing the

risk of both boys and girls using harsh physical punishment on their own children.³³

The intergenerational cycle of violence is also driven by the intersections of VAC and VAW.²⁹ VAC and VAW co- occur in the same households, share similar risk factors and are more prevalent in communities where social norms condone violent discipline and promote violent masculinities, both of which are underscored by gender inequality.^{30, 31} In South Africa, a gendered hierarchy places men in a position of power over women and children. In this milieu, men’s violence towards women and children is widely tolerated, men then use violence to assert their masculinity, enforce gender norms and practices through violent discipline of children and IPV in the home.³²

Research from a United Nations multi-country study in Asia and the South Pacific points to the pathways that drive

Case 25: The intergenerational effects of violence and trauma

A 17-year-old young woman disclosed sexual abuse by a male friend (a police officer), who was in his early thirties. It took her months to disclose the rape because she blamed herself. Her family life was fraught due to IPV between her parents and constant instability in the home. Her parents went through a difficult divorce a few months before her rape. This led to major behaviour changes in the young girl as she started mixing with the wrong friends, abusing substances and her grades dropped. Her mother noticed the behavioural changes but thought it was related to the divorce. When the young woman started counselling, the mother disclosed her own rape as a teenager for the first time. Although the young woman attended counselling sessions, she did not find them useful. She had intense anger towards the perpetrator, whom she had trusted, and she feared that he would not be convicted. The counselling service focused on the young woman's recovery and did not engage the mother in counselling, even though this had surfaced her own unresolved trauma. The mother's inability to support her child emotionally is of concern as it may be one of the factors undermining her daughter's recovery, as she continues to have severe psychosomatic symptoms with suicidal ideation.

an intergenerational cycle of violence for both girls and boys.³³ IPV and corporal punishment in the home can lay the foundations for later victimisation by girls and perpetration of violence against women and children by boy children.³⁴ Childhood trauma has also been shown to increase the risk for IPV victimisation and perpetration in adulthood.³³ In a study in Durban, more than two-thirds of women who had experienced childhood trauma had also experienced interpersonal violence in the past year.^{34, 35} The pattern is the same in men, where almost 60% of men who had experienced some form of childhood trauma were also perpetrators of interpersonal violence.^{34, 35} A community-based survey with men in South Africa also showed how exposure to childhood trauma increased the risk for perpetration of IPV,³⁴ while women who experience IPV are more likely to use corporal punishment in the home.³⁶ Children's experiences of violence and abuse are therefore likely to re-trigger their caregivers own experiences of trauma as illustrated in Case 25.

What are the mechanisms linking violence to negative outcomes?

When a child experiences a deeply distressing or stressful event such as violence, injury, or a life-threatening event, they may experience both acute and chronic stress responses such as fear, anxiety, panic, and shock.³ Children may be exposed to acute trauma (usually resulting from a single incident), chronic trauma (recurrent and prolonged traumatic event) or complex trauma (where they are exposed to multiple traumatic events, often of an interpersonal nature, that are severe and pervasive).³ Given the widespread nature of violence and the extent to which it has become normalised in South Africa, acute traumas may not be responded to appropriately, leading to a variety of physiological and psychological consequences (as illustrated in Case 25).

Children and adolescents who have been subjected to trauma may experience intrusive thoughts, dreams and flashbacks of the traumatic event; avoid people, places, activities and situations that remind them of the traumatic event; experience ongoing feelings of fear, anger, guilt or shame; wrongly blame themselves or others; feel detached or estranged from others and unable to feel joy and satisfaction; feel irritable, behave recklessly and self-destructively or become hypervigilant, easily startled and struggle to sleep or concentrate. These physical symptoms, thoughts and feelings may – without appropriate intervention and support – persist and give rise to PTSD, which undermines daily functioning and is often associated with depression, substance use and other mental health challenges. The same stress response may be triggered by further exposure to violence or give rise to a pervasive state of fear and hyperarousal due to threat of imminent violence, for example if a perpetrator is still present in the child's home or community.

Among youth in South Africa, cumulative exposure to multiple forms of violence also increases the likelihood of children engaging in aggressive behaviour,^{19, 37} which may, in turn, elicit aggression from others. Children who are socialised into violence learn to condone or accept violence through verbal reinforcement of violence, being a witness to violence, and being victimised by violence perpetrated by others, such as members of the family and community.³⁸⁻⁴⁰ In this manner, a vicious cycle emerges, where the aggressive behaviour of the developing child, which is both a function of psychological disorder and social learning, is typically met with an onslaught of violent learning experiences in multiple settings, often in the context of diminished examples of non-violent patterns of engagement and problem-solving.⁴¹

What needs to be done?

South Africa is one of the most violent countries in the world. Violence has become so ubiquitous as a response to solving problems and dealing with conflict, and is so intergenerational in nature, that any response needs to be preventive and promotive, as well as curative. In addition, the response must be multisectoral and include a whole-of-society and whole-of-government approach⁴² to address the complex interplay of risk and protective factors at each level of the socio-ecological system. Most importantly, violence against children is preventable, and breaking the myriad links between violence in all its forms and the poor mental health of children and adolescents, will have multiple benefits for our country.

We need to integrate trauma-informed approaches in the delivery of services and move from the notion that the effects of violence and trauma can only be managed through dedicated psychological and/or psychiatric services. Services and settings where children find themselves, including health, education (schools, early childhood development programmes

and universities), social services and the criminal justice system (police and courts), amongst others, must consider this approach in working with children and their families to break the intergenerational cycle of trauma. A trauma-informed approach begins with an understanding of the physical, social, and emotional impact of trauma on the individual, as well as on the professionals and caregivers who are there to help them.⁴³ Trauma-informed approaches to care shift the focus from “What’s wrong with you?” to “What happened to you?”, by considering the widespread impact of trauma; recognising the signs and symptoms of trauma in children, caregivers, and staff; and integrating knowledge about trauma and potential pathways to recovery into policies, procedures, and practices to prevent re-traumatisation.⁴⁴

From prevention to treatment

Ideally, our first response should be to prevent violence and trauma, acting early in a child’s life given our knowledge of how most mental health conditions in adult life have their roots in childhood.

Case 26: Using parenting programmes to promote positive parenting

Inge Vallanceⁱ and Cathy Wardⁱⁱ

Parenting for Lifelong Health (PLH) for Young Children is a group-based parenting programme for caregivers of 2 – 9-year-olds that aims to establish and sustain positive parenting, reduce harsh parenting and promote children’s well-being.

The original, South African, version is twelve sessions long. The first six sessions focus on developing a positive parent-child relationship and include content on establishing parent goals around child behaviour, spending quality time with children through child-led play, descriptive commenting,ⁱⁱⁱ communicating about emotions, using labelled praise,^{iv} and using rewards to encourage positive behaviour. The final six sessions then move on to limit setting and non-violent discipline strategies. These strategies include giving positive and clear instructions, establishing household rules, ignoring negative attention-seeking behaviour, using a 5-minute cool-down period after aggressive behaviour or non-compliance before discussing it, using realistic consequences, and involving children in problem-solving.

The sessions begin with a discussion where caregivers report on their experience of practicing the parenting skills that they learnt the previous week. Parents are then introduced to the session’s core skill through the use of illustrated stories (i.e., cartoon strips depicting scenes of families using the parenting skills either correctly or incorrectly), and role plays (where they have the opportunity to practice these new skills). The sessions close with parents receiving exercises to practice at home with their children as this is considered to be a key mechanism in supporting a change in parenting practices.^{66,67}

A randomised control trial, which enrolled caregivers who identified their children’s behaviour as problematic, found that caregivers on the programme reported increases in positive parenting and decreases in harsh parenting and child conduct problems (relative to those who had not received the programme), with some positive effects enduring at a one-year follow-up.⁶⁸ Where those on the programme also reported more non-violent discipline than parents in the control arm of the study.

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ii Department of Psychology and Safety and Violence Initiative, University of Cape Town

iii Describing aloud what you see the child doing (e.g., “You’re pushing your blue car on the red mat”), without comment or direction.

iv Giving clear and specific praise (e.g., “Thanks for tidying up your toys!”, rather than something non-specific – “You’re such a good boy!”).

Trauma impacts children's immediate and long-term physical and emotional health, behaviours, relationships, and their ability to learn. The impact of trauma is different for every child. The first supportive response to trauma significantly impacts a child's perceptions and experience of how adults could provide safe and caring spaces for children's healing. Psychological First Aid provides support at a critical point in time that can minimise the long-term impact of the trauma on the child and family.

Most clinicians in South Africa have received training in one or more models of 'trauma debriefing'. One form is called 'critical incident debriefing'. Not only does this not work, in fact it worsens symptoms. Trauma debriefing does not reduce the prevalence of post-traumatic stress disorder (PTSD) and may in fact increase the possibility of PTSD. The World Health Organization does not support the use of trauma debriefing as an intervention.⁶⁹

Psychological First Aid (PFA) on the other hand, is an empirical, evidence-informed, step-by-step approach to provide help in the immediate aftermath of disasters such as the loss of a parent or sibling, loss of the child's home and possessions through a fire or flood, or exposure to violent incidents in the home, school or community.⁷⁰⁻⁷²

Just like medical first aid is needed to address physical injuries at the scene of an accident, PFA provides immediate psychological care and support in response to trauma. It also offers long-term benefits enabling children and adults to cope more effectively after a trauma.

PFA should be provided by the first people to arrive on the scene of the trauma and who are able to assist. This could include health workers, teachers, early childhood development practitioners, child and youth care workers, community and religious leaders as well as first responder emergency personnel.

The impact of trauma is complex and PFA responders need to understand that when people feel threatened, they react with a fight-flight-freeze response: 'fight' (fight to protect themselves), 'flight' (try to get away) or 'freeze' (as if frozen on the spot, not able to quickly think of ways to get away or protect themselves). This neurobiological process is not something people are able to control and they may react in unpredictable ways. Some children may become hyper-aroused, overly emotional and irritable, exhibit difficult behaviour, or become aggressive and hard to reason with. Other children may be hypo-aroused or

withdrawn, extremely anxious, or go into a complete shut down and dissociate. This may lead to poor concentration, cooperation and connections. First responders therefore need to know how to approach traumatised children in a way that helps soothe and calm the child. Given that many children in South Africa live in a constant state of arousal due to violent environments, such skills are vital for those working with and responding to crises.

There are multiple models of PFA that have been developed. Jelly Beanz is a non-profit organization that provides direct therapeutic support to children who have experienced trauma, abuse and neglect. It also develops resources to build the capacity of professionals working with children and their training programme focuses on the following key elements of PFA:

1. **Contact** with the child and adults must be done in a way that feels safe and supported and that is underpinned with an understanding of the body's neurobiological responses to threat.
2. **Containment** provides practical and psychological safety to calm the neurobiological threat system of the brain. This includes addressing the immediate physical needs, e.g., sitting next to the child and talking in a soothing voice, offering a hug, moving to a more comfortable space where the distressing sensory experiences may not be so overwhelming, connecting the child with their parent or caregiver, or helping the child focus on safe aspects of their environment.
3. **Current concerns** focus on identifying what the child and adults see as their immediate concerns so that the support offered respects their needs in the crisis.
4. **Connecting** children to formal and informal support systems for continued support is important, especially if the person providing the PFA will not be able to support the child long-term.
5. **Continued collaboration** with formal and informal support systems ensures that the child continues to benefit in the longer term from appropriate support.

PFA is important in providing psychological and practical support to children who are exposed to trauma and helps improve outcomes by minimising trauma, building children's internal resources and linking them with external support systems. For more information, see: *Psychological First Aid for children, Adolescents and Families – A guide for first responders*.⁷³

i Jelly Beanz

ii Consultant: Child Protection

Prevention includes:

- Primary prevention to prevent violence before it starts;
- Secondary prevention, which focuses on the immediate response to violence including emergency services and holistic care; and
- Tertiary prevention, to reduce the impact of trauma in victims and rehabilitate offenders.

Primary prevention targets risk factors to prevent later negative outcomes. For example, universal parenting programmes that support the ban on corporal punishment in the home and promote positive discipline, as illustrated in Case 26. Multi-component, school-wide programmes have the potential to reach large numbers of children with good success.⁴⁵ Such programmes involve multiple stakeholders such as teachers, school administrators, parents, learners and community-based organisations in the planning and implementation of the programme, with a focus on shifting power relations, school culture and norms using a range of strategies.⁴⁶ For example, the 'Classrooms in Peace' (Aulas en Paz) elementary school programme in Colombia has shown success in preventing aggression and promoting peaceful relationships.⁴⁷ The programme promotes empathy, anger management, creative generation of alternatives and assertiveness. Gender transformative programming with men and boys is also critical to shift the gendered social norms that drive violence in South Africa. There are some promising programmes such as the Stepping Stones and Creating Futures programme targeting young men and women through a group approach, which has shown success in shifting men's use of violence.⁴⁸

Secondary prevention involves the early detection of risk and difficulties and focuses on intervening to reduce impact. A good example of this is the use of psychological first aid to help children and families cope with the immediate impact of trauma (see Case 27). Targeting of at-risk families has also proved effective through programmes such as Sinovuyo Kids (see Case 26), which targets families and children who have screened positive for behavioural difficulties and aims to improve positive parenting and reduce harsh discipline. By intervening at the early signs of behavioural difficulty, the programme aims to prevent children engaging in ever more disruptive and aggressive behaviour.

Tertiary prevention uses treatment and care to manage disorders, to improve quality of life and to attempt to ensure that an acute response or disorder does not become chronic and can target both survivors and perpetrators. One such programme is the Support Programme for Abuse Reactive Children (SPARC), a diversion programme for young sexual

Case 28: Poor tertiary responses and barriers to therapeutic services

A female aged 15 reported to the South African Police Services that she had been abducted and raped. The perpetrator claimed that the sex was consensual and that, as he met the girl at a tavern, he had assumed she was an adult. The forensic science laboratory report was inconclusive and there was no physical evidence of, or witnesses to, the rape. Two months later, the perpetrator was arrested and charged with statutory rape, but bail was not opposed by the state so two days later he walked free. The child attempted suicide and was taken to the nearest psychiatric hospital in the neighbouring province.

She was discharged after four days with a recommendation that she get psychiatric support. Even though there was a psychiatrist one hour away, he was in the neighbouring province. The 'local' services were at least a four-hour drive each way. The local police could not spare an officer to drive her there for treatment. The final entry in the case file records that charges against the perpetrator were withdrawn by the prosecutor, whilst the girl's caregiver, her sister, reported behavioural changes and a drop in school performance. Despite showing clear signs of trauma, she was not referred to social services or mental health services.

Source: Jamieson L, Sambu W, Mathews S. Out of harm's way? Tracking child abuse cases through the child protection system at five selected sites in South Africa-Research Report. Cape Town: Children's Institute, University of Cape Town; 2017.

offenders offered by the Teddy Bear Clinic in Gauteng, which has proven effective in disrupting the cycle of abuse and preventing long-term abusive behaviour.⁴⁹ However, access to secondary and tertiary treatment is often unattainable.^{50a} Accessibility to services for survivors of trauma remains a key concern given that child and adolescent mental health services are critically under-resourced⁵¹ (see health chapter).

First-line treatments for traumatic stress in children and adolescents in high-income countries involve repeated exposure to the traumatic memory in the safety of a therapeutic relationship and helping the child to reprocess unhelpful thoughts and feelings about the trauma.⁵² There is growing evidence that such interventions can be successfully adapted for lower-income settings, including on the African continent^{53, 54} but there is little evidence from South Africa to date. Only one local randomised control trial has been published. Roussow and colleagues found that 7 – 14 sessions

of prolonged exposure therapy, delivered by nurses in a school setting, was more effective than supportive therapy in reducing PTSD in adolescents.⁵⁵ Another recently completed but as yet unpublished study, conducted jointly by the University of Cape Town and Stellenbosch University, found that eight sessions of trauma-focused cognitive behavioural therapy (CBT) significantly reduced PTSD and depression in trauma-exposed adolescents. Growing this small local evidence base will be important for guiding mental health services for traumatised children and adolescents going forward.⁵⁶

It is crucial to remember that treatments such as this – even when available – cannot be implemented on their own. Families require significant support to ensure that they have the capacity to manage the child. In addition, caregivers and families are themselves usually dealing with the same traumatic event (or at the very least the shock of what has happened to their child), and they require significant support. Hence, there is also a need to deal with the trauma of caregivers. Interventions to deal with trauma therefore need to be multi-dimensional. In addition, Titi has shown that children can articulate personal narrative accounts and rich descriptions of their lives, and that an African-centred, child-centric psychological approach can improve the experience of therapy for African children who are exposed to the most extreme forms of polyvictimization.⁶⁵

While South African evidence may be thin, it is surely possible to adapt evidence-based programmes from other low- and middle-income countries for use in the South African setting. Mental health interventions for children include attachment-based therapies, intensive family supports, CBT and psychosocial treatments. Evidence-based, trauma-focused treatments have shown CBT techniques to be most effective in reducing serious trauma reactions, such as PTSD and behavioural problems.⁵⁷

What are the implications for policy and practice?

While South Africa has put in place a suite of progressive laws and policies designed to promote children's optimal development and protect them from harm, implementation and enforcement remains weak and patchy.⁵⁸ Many crimes go unpunished – especially in poor communities where police services are under-resourced. For example, a study in KwaZulu-Natal and the Eastern Cape found that only 12% of reported cases resulted in a guilty verdict and only a handful of children were able to access therapeutic services,⁵⁸ as illustrated in Case 28.

The Children's Act gives effect to children's rights to protection from abuse, maltreatment and neglect and the

right to social services. The Act and the supporting policy, namely the National Child Care and Protection Policy, provide for a continuum of care from primary prevention and early intervention programmes to child protection services, alternative care options such as foster care and rehabilitation and family reunification programmes. The Act also provides for intersectoral collaboration and, in theory, supports multi-disciplinary teamwork. However, the criminal justice system, school-based programmes and services for women are regulated by a largely separate and distinct policy framework, as are mental health services for children. As discussed above, the levels of intergenerational trauma and the high degree of exposure to violence require a holistic response. The National Strategic Plan on Gender-Based Violence and Femicide (NSP) claims to target both women and children but a detailed analysis reveals that children are a subsidiary focus.⁵⁹

In addition to these conceptual weaknesses, service provision has always been hampered by a lack of human and financial resources.⁶⁰ The problem was exacerbated during the COVID-19 pandemic as funds were repurposed and many child protection services were refocused on humanitarian assistance.⁶¹ Despite the high-level commitment to the NSP, it has not been backed with sufficient resources to improve services⁶¹ and there are insufficient social service practitioners to support even the most basic level of implementation of the Children's Act⁶⁰. The majority of professionals within the criminal justice system lack specialist training⁶² and although most of the clients seen at Thuthuzela Care Centres are children, the centres are not child-friendly and offer only containment counselling services.⁶³ Children are referred to counselling services for longer-term care but typically have to wait months to be seen,⁵⁸ while integrated services for women and children who have experienced or witnessed violence are limited in the large metros and virtual non-existent in rural communities.⁶⁴

Recommendations

- Interventions across the life course are needed to build resilience, prevent violence and trauma, promote healing and reduce the long-term psychosocial effects of exposure to violence.
- Early intervention is necessary to identify and support vulnerable parents, promote positive parenting and child development, with early childhood development programmes having a potential role in this process.
- School-based interventions are another essential part of the continuum to reduce the risks of violence and trauma to children in the school as well as in their homes and

Case 29: Young people's suicidal behaviour in South Africa

Jason Bantjesⁱ

Suicide is a leading cause of death among adolescents globally,⁷⁴⁻⁷⁷ accounting for 6% of fatalities among young people.⁷⁸ Worldwide, one-third of suicides occur among adolescents, with suicide being the second leading cause of death among 15 – 29-year-olds and the leading cause of death for females aged 15 – 19 years. Suicide among pre-pubescent children is relatively rare, partly because younger children typically lack the knowledge and agency to follow through with a lethal suicide plan. Non-fatal suicidal behaviours (i.e., suicidal ideation, plans and attempts) are also common among adolescents and are associated with significantly increased risk of future self-harm and suicide.^{77,79,80} The first onset of suicidal behaviour invariably occurs in late adolescence, highlighting the importance of early identification and intervention in this developmental period.⁸¹ In part, the emergence of suicide as a leading cause of death among young people is a consequence of the considerable medical and economic advances that have improved the physical health of children.

There is a dearth of reliable epidemiological data about suicidal behaviour among adolescents in South Africa, beyond descriptive studies which suggest that youth suicide prevention should be an important public mental health priority.⁸²⁻⁸⁴ In the absence of reliable local data, policy makers in South Africa are mostly reliant on global data to inform suicide prevention policy and practices. Collecting accurate data about the prevalence and risk factors for youth suicidal behaviour is thus one of the most important priorities to advance evidence-based suicide prevention programmes in South Africa.

The Youth Risk Behaviours Surveys (YRBSs) are the most widely cited sources of data on youth suicidal behaviour in South Africa, however there are some inconsistencies

in the survey data which raise questions about their accuracy. The YRBS data are presented in Table 10 along with a calculation of the mean prevalence estimates across the three surveys conducted to date. The mean 6-month prevalence rates for suicidal ideation, suicide plan and suicide attempt are 19%, 16% and 19%, respectively. It is not surprising that, on average, 19% of participants in the YRBSs reported suicidal ideation in the past 6-months, as this is congruent with international studies.⁷⁹ But the data for suicide plans and attempts should be treated with caution as it is highly improbable that every ideator made a suicide attempt, as is implied by the YRBS data.

Other South African data on youth suicidal behavior are more consistent with international trends. For example, data collected from first-year students at two universities yielded lifetime prevalence estimates for suicide plan, and attempt of 26.5% and 8.6% respectively,⁸² while data from the South African National Mortality Surveillance System database show that 10% of all suicides occur among individuals younger than 20 years of age and that suicide in children younger than 11 is rare in South Africa.⁸⁵

Understanding the risk factors and drivers of youth suicidal behaviour in South Africa is essential for planning effective programmes. Globally, suicidal behaviour is variably associated with a wide range of risk factors⁸⁶ and causes.⁸⁷ Psychopathology is strongly associated with adolescent suicidal behaviour,⁸⁸ therefore efforts to promote the mental health of children and adolescents should probably be the cornerstone of a national youth suicide prevention programme in South Africa. Actuarial analysis of non-fatal suicidal behaviour among first-year university students in South Africa showed that increased risk of suicidal behaviour was associated with major depressive disorder, generalised anxiety disorder and

Table 10: Prevalence rates for adolescent suicidal behaviour from the South African Youth Risk Behaviour Surveys

	2002 (N=10,699)	2008 (N=10,270)	2011 (N=10,997)	Mean prevalence rate (and range) across all three surveys
Considered attempting suicide ^a	19%	21%	18%	19% (18%-21%)
Made a plan to attempt suicide ^a	16%	17%	16%	16% (16%-17%)
Made 1 or more suicide attempts ^a	17%	21%	18%	19% (17%-21%)

^a During the 6 months preceding the survey

ⁱ Alcohol, Tobacco and Other Drug Research Unit, South African Medical Research Council, South Africa.
Institute for Life Course Health Research, Department of Global Health, Stellenbosch University, South Africa.

bipolar spectrum disorder, and that treating common mental disorders could yield absolute reductions in suicide ideation, planning, and attempt of 17.0%, 55.0% and 73.8% respectively.⁸³ However, psychopathology is not the only driver of suicidal behaviour; other risk factors for youth suicide include HIV infection, poverty, substance use, exposure to violence, and adverse childhood events, all of which are endemic in South Africa.¹⁷⁹⁻⁹¹ Other modifiable risk factors include bullying, sexual assault, and impulsivity.⁹²⁻⁹⁴ Given the array of risk factors, it seems improbable that any South African youth suicide prevention programme focused narrowly on increasing access to mental health care will be completely effective. Increasing adolescents' access to mental health care services will also not be easy to achieve given the marked mental health treatment gap among South African youth.⁹⁵

Socio-cultural and contextual factors, such as gender norms and societal expectations can also play a role in youth suicidal behaviour. For example, qualitative studies have illustrated how young men in South Africa attribute suicidal behaviour to feelings of disconnectedness, thwarted belonging, pressure to conform to the gender regime, and feelings of shame when unable to achieve masculine ideals.⁹⁶ Young men in South Africa describe restrictive heteronormative gender roles that create a rigid gender regime which prevents authentic relating, disconnects young men from each other, and makes it difficult to receive emotional support when suicidal.^{96, 97} Qualitative studies like these suggest that youth suicide prevention programmes should include systemic interventions that seek to disrupt the gender regime.

In the absence of local data, we need to rely on evidence from other countries to inform suicide prevention interventions for adolescents and children in South Africa.⁹⁸ These include:

- Increasing access to evidence-based treatments for common mental disorders and establishing accessible child and adolescent psychiatric services.
- Establishing community-based "child- and adolescent-friendly" counselling centres.
- Building the capacity of health workers to recognise and manage common childhood and adolescent mental health problems.
- Helping children and adolescents learn affect regulation, impulse control, and problem-solving skills.
- Reducing bullying and promoting belonging in schools.
- Reducing adolescent substance use.
- Training gatekeepers (such as teachers and youth workers) to recognise the warning signs of suicide, provide psychological first aid, and refer at risk youth to appropriate services.
- Providing children and adolescents with access to 24-hour anonymous helplines and text messaging services to access emotional support and guidance.
- Reducing stigma about mental illness and prompting adaptive help seeking.
- Using digital technologies to scale up access to effective treatments for common mental disorders as illustrated in Case 24.

While gatekeeper training is one of the most common suicide prevention strategies in high schools and universities, the evidence supporting these programmes is contradictory, suggesting that these programmes need to be context-sensitive.⁹⁸ At the same time many gatekeeper training programmes assume that there are appropriate and accessible community-based services for at-risk youths, but this is not the case in many parts of South Africa.

Similarly, introducing screening systems to identify and refer children and adolescents who are at risk of suicide is unlikely to be feasible in South Africa. Screening for suicide risk is very unreliable and most screening instruments produce an inordinate number of false positives.^{99, 100} In addition, the South African health care system simply does not have the resources to respond to appropriately.

If you are concerned about a young person who is displaying warning signs for suicidal behaviour you can:

- Reach out to them and try to establish a connection.
- Offer them emotional support (listen empathetically, encourage them to express their feelings, don't minimise what they are saying, validate their experience, and remind them that help is available).
- Ask them directly if they are thinking about suicide. Talking to young people about suicide does not increase risk. Likewise, it is a myth that if someone is talking about suicide they are not going to act on their intention. If anyone expresses a desire to die and they say that they have a plan which they intend to carry out, you should take them immediately to the closest hospital emergency room.
- Encourage them to seek help from a professional.
- Provide them with contact details for 24-hour help lines (for example, Lifeline and SADAG).

communities. They can also run gender transformative programmes to help change gendered practices and entrenched gender roles.

- Integrated services for women and children are needed to respond to intergenerational trauma and support caregivers to help children heal.
- Trauma-informed approaches to services across a range of settings, including education, social services, the criminal justice system (police and courts) and health, amongst others, are critical for children, families and frontline workers to recover from trauma.

Conclusion

One of the most critical dynamics explored in this chapter is the intergenerational nature of violence and the impact on children's mental health and well-being across the life course. Children and adolescents who are exposed to violence tend to develop violent ways of interacting with others as a learned behaviour, and so violence is perpetuated. We note that measures identified to prevent and respond to violence need to adopt a life-course approach to ensure that the needs of children are adequately addressed and supported at each stage of development; and that there is a need to intervene early to disrupt the cycle of violence and re-traumatisation. We also have to address the risk factors that increase children's vulnerability, such as poverty, unemployment, parental alcohol and substance misuse, poor caregiver-child attachments, family conflict and high levels of community dysfunction, as they all interrelated.

References

1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. *World Report on Violence and Health*. Geneva: World Health Organization. 2002.
2. Office of the High Commissioner on Human Rights. *Convention on the Rights of the Child, United Nations General Assembly Resolution 44/25, Article 19*. Geneva: United Nations. 1989.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, DC: APA; 2013.
4. Minh TH Le, Holton S, Romero L, Fisher J. Polyvictimization among children and adolescents in low-and lower-middle-income countries: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*. 2018;19(3):323-342.
5. Burton P, Ward C, Artz L, Leoschut L. *The Optimus Study on Child Abuse, Violence and Neglect in South Africa (Research Report)*. Cape Town: Centre for Justice and Crime Prevention & University of Cape Town. 2016.
6. Skeen S, Macedo A, Tomlinson M, Hensels I, Sherr L. Exposure to violence and psychological well-being over time in children affected by HIV/AIDS in South Africa and Malawi. *AIDS Care*. 2016;28(sup1):16-25.
7. Richter L, Mathews S, Kagura J, Nonterah E. A longitudinal perspective on violence in the lives of South African children from the Birth to Twenty Plus cohort study in Johannesburg-Soweto. *South African Medical Journal*. 2018;108(3):181-186.
8. Shields N, Nadasen K, Pierce L. The effects of community violence on children in Cape Town, South Africa. *Child Abuse & Neglect*. 2008;32(5):589-601.
9. Traut A, Kaminer D, Boshoff D, Seedat S, Hawkrigde S, Stein DJ. Treatment utilisation and trauma characteristics of child and adolescent inpatients with posttraumatic stress disorder. *Curationis*. 2002;25(4):67-72.
10. Ward CL, Artz L, Leoschut L, Kassanjee R, Burton P. Sexual violence against children in South Africa: a nationally representative cross-sectional study of prevalence and correlates. *Lancet Global Health*. 2018;6(4):e460-e468.
11. Seedat S, Nyamai C, Njenga F, Vythilingum B, Stein DJ. Trauma exposure and post-traumatic stress symptoms in urban African schools. Survey in CapeTown and Nairobi. *British Journal of Psychiatry*. 2004;184:169-175.
12. Das-Munshi J, Lund C, Mathews C, Clark C, Rothon C, Stansfeld S. Mental health inequalities in adolescents growing up in post-apartheid South Africa: Cross-sectional survey, SHaW study. *PLoS One*. 2016;11(5):e0154478.
13. Mathews S, Berry L, Marco J. *An outcome assessment of a residential care programme for sexually-abused children in South Africa*. Cape Town: Children's Institute, UCT. 2016.
14. Mathews S, Abrahams N, Jewkes R, Martin LJ. Underreporting child abuse deaths: Experiences from a national study on child homicide. *South African Medical Journal*. 2013;103(3):132-133.
15. Dawes A, De Sas Kroppiwnicki Z, Kafaar Z, Richter L. *Corporal punishment of children: A South African national survey. Paper prepared for distribution at the Regional Consultation of the United Nations Study on Violence against children*. Pretoria: Human Sciences Research Council and Save the Children Sweden. 2005. [http://hdl.handle.net/20.500.11910/7142]
16. Röhrs S. *Shifting Attitudes and Behaviours Underpinning Physical Punishment of Children. Briefing Paper*. Cape Town: Children's Institute, University of Cape Town. 2017.

Resources are therefore needed to support an integrated programme of prevention and response interventions in addition to the traditional treatments to disrupt the long-term, intergenerational effects of violence and trauma. Equipping parents to reduce harsh forms of parenting and promote nurturing care is critical in the early years. These interventions also provide an opportunity to consider how gender transformative programming can reduce violence towards intimate partners and children in the home. Schools present a unique opportunity to reach large numbers of children and to prevent VAC through the delivery of innovative interventions. For example, trauma-informed schools have the potential to identify children who need support, to prevent aggression and bullying, and to promote gender equitable attitudes and behaviours and prevent dating, intimate partner and sexual violence.

Most children and young people in South Africa experience ongoing violence and multiple adversities. There is therefore no easy solution or quick fix in terms of violence prevention and treatment of the effects of violence on child and adolescent mental health. The response should be systemic and trauma-informed, based on multi-component interventions across different levels of the socio-ecological system. We need to invest in the promotion of evidence-based programming that promotes resilience and recovery for children while enhancing the capabilities of families to protect children and young people and to unlock their full potential.

17. McKee L, Roland E, Coffelt N, Olson AL, Forehand R, Massari C, Zens MS. Harsh discipline and child problem behaviors: The roles of positive parenting and gender. *Journal of Family Violence*. 2007;22(4):187-196.
18. Rothenberg WA, Lansford JE, Bornstein MH, Chang L, Deater-Deckard K, Di Giunta L, Pastorelli C. Effects of parental warmth and behavioral control on adolescent externalizing and internalizing trajectories across cultures. *Journal of Research on Adolescence*. 2020;30(4):835-855.
19. du Plessis B, Kaminer D, Hardy A, Benjamin A. The contribution of different forms of violence exposure to internalizing and externalizing symptoms among young South African adolescents. *Child Abuse & Neglect*. 2015;45:80-89.
20. Schwartz B, Kaminer D, Hardy A, Nöthling J, Seedat S. Gender differences in the violence exposure types that predict PTSD and depression in adolescents. *Journal of Interpersonal Violence*. 2021;36(17-18):8358-8381.
21. Sui X, Massar K, Kessels LT, Reddy PS, Ruiter RA, Sanders-Phillips K. Violence exposure in South African adolescents: Differential and cumulative effects on psychological functioning. *Journal of Interpersonal Violence*. 2021;36(9-10):4084-4110.
22. Titi NV. *How children make meaning of sexual trauma: Towards decolonized African centered child-centric psychological interventions*. Unpublished thesis. Pretoria: University of South Africa; 2021.
23. Institute of Health Metrics and Evaluation. *Global Burden of Disease Study 2010. Southern Sub-Saharan Africa Results by Risk Factor 1990 – 2010*. 2012. Accessed: 1 August 2021. Available from: <http://viz.healthmetricsandevaluation.org/gbd-compare/>.
24. Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science & Medicine*. 2002;55(7):1231-1244.
25. Wood K, Lambert H, Jewkes R. "Showing roughness in a beautiful way": Talk about love, coercion, and rape in South African youth sexual culture. *Medical Anthropology Quarterly*. 2007;21(3):277-300.
26. Amoateng A, Heaton T, Kalule-Sabiti I. Living arrangements in South Africa. In: Amoateng AY, Heaton TB, editors. *Families and households in post-apartheid South Africa: Socio-demographic perspectives*. Cape Town: HSRC Press; 2007.
27. Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet*. 2009;374(9694):1011-1022.
28. Mathews S, Govender R, Lamb G, Boonzaier F, Dawes A, Ward C, Röhrs S. *Towards a more comprehensive understanding of the direct and indirect determinants of violence against women and children in South Africa with a view to enhancing violence prevention*. Cape Town: Safety and Violence Initiative, University of Cape Town. 2016.
29. Guedes A, Bott S, Garcia-Moreno C, Colombini M. Bridging the gaps: A global review of intersections of violence against women and violence against children. *Global Health Action*. 2016;9(1):31516.
30. Namy S, Carlson C, O'Hara K, Nakuti J, Bukuluki P, Lwanyaaga J, Naker D. Towards a feminist understanding of intersecting violence against women and children in the family. *Social Science & Medicine*. 2017;184:40-48.
31. Lansford JE, Deater-Deckard K, Bornstein MH, Putnick DL, Bradley RH. Attitudes justifying domestic violence predict endorsement of corporal punishment and physical and psychological aggression towards children: A study in 25 low- and middle-income countries. *Journal of Pediatrics*. 2014;164(5):1208-1213.
32. Mathews S, Delany A, Makola L, October L, Titi N, Hendricks N, Rehse K. *Understanding the intersections of violence against women and violence against children in two communities in the Western Cape, South Africa*. Cape Town: Children's Institute, University of Cape Town. 2022.
33. Fulu E, Miedema S, Roselli T, McCook S, Chan KL, Haardörfer R, Naved RT. Pathways between childhood trauma, intimate partner violence, and harsh parenting: Findings from the UN Multi-country Study on Men and Violence in Asia and the Pacific. *The Lancet Global Health*. 2017;5(5):e512-e522.
34. Machisa MT, Christofides N, Jewkes R. Structural pathways between child abuse, poor mental health outcomes and male-perpetrated intimate partner violence. *PLoS One*. 2016;11(3):e0150986.
35. Abrahams N, Jewkes R. Effects of South African men's having witnessed abuse of their mothers during childhood on their levels of violence in adulthood. *American Journal of Public Health*. 2005;95(10):1811-1816.
36. Woollett N, Thomson K. Understanding the intergenerational transmission of violence. *South African Medical Journal*. 2016;106(11):1068-1070.
37. Sommer J, Hinsberger M, Elbert T, Holtzhausen L, Kaminer D, Seedat S, Weierstall R. The interplay between trauma, substance abuse and appetitive aggression and its relation to criminal activity among high-risk males in South Africa. *Addictive Behaviors*. 2017;64:29-34.
38. Delaney AX. *Violent socialization and youth violence across different nations: International variations in familial and contextual factors. Violence and Crime in the Family: Patterns, Causes, and Consequences*: Emerald Group Publishing Limited; 2015.
39. Mattingly M, Straus MA. Violence socialization and approval of violence: A world perspective on gender differences and American violence. *American Society of Criminology*. 2008.
40. Owens DJ, Straus MA. The social structure of violence in childhood and approval of violence as an adult. *Aggressive Behavior*. 1975;1(3):193-211.
41. Mathews S, Benvenuti P. Violence against children in South Africa: Developing a prevention agenda. In: Mathews S, Jamieson L, Lake L, Smith C, editors. *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town; 2014. p. 26-34.
42. Matzopoulos R, Bowman B, Mathews S, Myers J. Applying upstream interventions for interpersonal violence prevention: An uphill struggle in low-to middle-income contexts. 10. 2010;97(1):62-70.
43. Centre for Disease Control. *Six guiding principles to a trauma-Informed approach*. 2020. [Accessed 16 May 2022: https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm]
44. Schulman M, Menschner C. *Laying the groundwork for trauma-informed care. Center for Healthcare Strategies, Trenton, NJ*. 2018.
45. Mathews S, Makola L, Megganon V. *Connecting the Dots: Informing our understanding and response to the intersections between violence against women and violence against children*. Cape Town: Children's Institute, University of Cape Town. 2021.
46. Mathews S, Achyut P, October L, Makola L. *Evidence Review: Prevention of violence against children through schools in the Global South*. Raising Voices, Uganda and University of Cape Town, South Africa. 2021.
47. Chaux E, Barrera M, Molano A, Velásquez AM, Castellanos M, Chaparro MP, Bustamante A. Classrooms in peace within violent contexts: Field evaluation of Aulas en Paz in Colombia. *Prevention Science*. 2017;18(7):828-838.
48. Gibbs A, Washington L, Abdelatif N, Chirwa E, Willan S, Shai N, Jewkes R. Stepping Stones and Creating Futures intervention to prevent intimate partner violence among young people: Cluster randomized controlled trial. *Journal of Adolescent Health*. 2020;66(3):323-335.
49. Rangasami J, Stewart M, Maharaj S. *Impact Evaluation of the Teddy Bear Clinic's Support Programme for Abuse Reactive Children (SPARC)*. Impact Consulting. 2013. [http://ttbc.org.za/wp-content/uploads/2014/07/TTCB_SummaryReport.pdf]
50. Falconer NS, Casale M, Kuo C, Nyberg BJ, Hillis SD, Cluver L. Factors that protect children from community violence: applying the INSPIRE model to a sample of South African children. *Journal of Interpersonal Violence*. 2021;36(23-24):11602-11629.
51. Mokitimi S, Schneider M, de Vries PJ. Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis. *International Journal of Mental Health Systems*. 2018;12(1):1-15.
52. Forbes D, Bisson JI, Monson CM, Berliner LA. *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies (3rd ed)*. The Guildford Press; 2020.
53. Dorsey S, Lucid L, Martin P, King KM, O'Donnell K, Murray LK, Wetten K. Effectiveness of task-shifted trauma-focused cognitive behavioral therapy for children who experienced parental death and posttraumatic stress in Kenya and Tanzania: A randomized clinical trial. *JAMA Psychiatry*. 2020;77:464-473.
54. Murray LK, Skavenski S, Kane JC, Mayeya J, Dorsey S, Cohen JA, Bolton PA. Effectiveness of trauma-focused cognitive behavioral therapy among trauma-affected children in Lusaka, Zambia: A randomized clinical trial. *JAMA Pediatrics*. 2015;169(8):761-769.
55. Rossouw J, Yadin E, Alexander D, Seedat S. Prolonged exposure therapy and supportive counselling for post-traumatic stress disorder in adolescents: Task-shifting randomised controlled trial. *The British Journal of Psychiatry*. 2018;213(4):587-594.
56. Debbie Kaminer, personal communication.
57. Bennett RS, Denne M, McGuire R, Hiller RM. A systematic review of controlled-trials for PTSD in maltreated children and adolescents. *Child Maltreatment*. 2021;26(3):325-343.
58. Jamieson L, Sambu W, Mathews S. *Out of harm's way? Tracking child abuse cases through the child protection system at five selected sites in South Africa-Research Report*. Cape Town: Children's Institute, University of Cape Town. 2017.
59. Centre for Child Law. *An assessment of the National Strategic Plan on Gender Based Violence & Femicide: A child rights perspective*. Pretoria. 2022. [https://centreforchildlaw.co.za/wordpress21/wp-content/uploads/2022/03/WEB_CFCL-Assessment-of-NSP-on-GBV-and-Femicide.pdf]
60. Jamieson L, Wakefield L, Briedé M. Towards effective child protection: Ensuring adequate financial and human resources. In: Mathews S, Jamieson L, Lake L, Smith C, editors. *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town; 2014. p. 51.
61. Budlender DJ, L; Proudlock, P; Berry, L. *The 2020 Supplementary Budget: Observations from a child perspective*. Cape Town: University of Cape Town. 2020.
62. Centre for Child Law. *Adjudicating Sexual Offence Matters Involving Children as Victims*. Pretoria. 2022. [https://centreforchildlaw.co.za/wordpress21/wp-content/uploads/2022/03/WEB-REPORT_CFCL_Sexual-Offence-matters-involving-Children-Report.pdf]

63. Louwrens C, Slaven F, Jordaan S, Sodo P, van den Broek L, Klapwijk J, Ncongwane H. *Thuthuzela Care Centres Compliance Audit and Gap Analysis*. Shukumisa Coalition. 2016. [https://doi.org/10.13140/RG]
64. Nagia-Luddy F, Mathews S. *Service responses to the co-victimisation of mother and child: missed opportunities in the prevention of domestic violence (technical report)*. Cape Town. 2011.
65. Titi N. How Children make Meaning of Sexual Trauma: Towards Decolonised African-centered Child-centric Psychological Interventions (Unpublished thesis). Pretoria: University of South Africa. 2021
66. Berkel C, Sandler IN, Wolchik SA, Brown CH, Gallo CG, Chiapa A, Jones S. "Home practice is the program": Parents' practice of program skills as predictors of outcomes in the new beginnings program effectiveness trial. *Prevention Science*. 2018;19(5):663-673.
67. Chacko A, Jensen SA, Lowry LS, Cornwell M, Chimklis A, Chan E, Pulgarin B. Engagement in behavioral parent training: Review of the literature and implications for practice. *Clinical Child and Family Psychology Review*. 2016;19(3):204-215.
68. Ward CL, Wessels IM, Lachman JM, Hutchings J, Cluver LD, Kassarjee R, Gardner F. Parenting for Lifelong Health for Young Children: A randomised controlled trial of a parenting program in South Africa to prevent harsh parenting and child conduct problems. *Journal of Child Psychology and Psychiatry*. 2020;61(4):503-512.
69. Richins MT, Gauntlett L, Tehrani N, Hesketh I, Weston D, Carter H, Amlöt R. Early post-trauma interventions in organizations: A scoping review. *Frontiers in Psychology*. 2020:1176.
70. Fox JH, Burkle FM, Bass J, Pia FA, Epstein JL, Markenson D. The effectiveness of psychological first aid as a disaster intervention tool: Research analysis of peer-reviewed literature from 1990-2010. *Disaster Medicine and Public Health Preparedness*. 2012;6(3):247-252.
71. McCabe OL, Everly Jr GS, Brown LM, Wendelboe AM, Abd Hamid NH, Tallchief VL, Links JM. Psychological first aid: A consensus-derived, empirically supported, competency-based training model. *American Journal of Public Health*. 2014;104(4):621-628.
72. Uhernik JA, Husson MA. Psychological first aid: An evidence informed approach for acute disaster behavioral health response. *Compelling Counseling Interventions: VISTAS*. 2009;200(9):271-280. <http://www.jellybeanz.org.za/psychological-first-aid/>
73. Hawton K, Fagg J. Deliberate self-poisoning and self-injury in adolescents: A study of characteristics and trends in Oxford, 1976-89. *The British Journal of Psychiatry*. 1992;161(6):816-823.
74. McLoone P, Crombie IK. Hospitalisation for deliberate self-poisoning in Scotland from 1981 to 1993: Trends in rates and types of drugs used. *The British Journal of Psychiatry*. 1996;169(1):81-85.
75. Värnik A, Wasserman D, Dankowicz M, Eklund G. Age-specific suicide rates in the Slavic and Baltic regions of the former USSR during perestroika, in comparison with 22 European countries. *Acta Psychiatrica Scandinavica*. 1998;98:20-25.
76. Nock MK, Green JG, Hwang I, McLaughlin KA, Sampson NA, Zaslavsky AM, Kessler RC. Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *JAMA Psychiatry*. 2013;70(3):300-310.
77. Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, Mathers CD. Global patterns of mortality in young people: A systematic analysis of population health data. *The Lancet*. 2009;374(9693):881-892.
78. Nock MK, Borges G, Bromet EJ, Alonso J, Angermeyer M, Beautrais A, Gluzman S. Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *The British Journal of Psychiatry*. 2008;192(2):98-105.
79. Kokkevi A, Rotsika V, Arapaki A, Richardson C. Adolescents' self-reported suicide attempts, self-harm thoughts and their correlates across 17 European countries. *Journal of Child Psychology and Psychiatry*. 2012;53(4):381-389.
80. Cha CB, Franz PJ, M. Guzmán E, Glenn CR, Kleiman EM, Nock MK. Annual Research Review: Suicide among youth—epidemiology, (potential) etiology, and treatment. *Journal of Child Psychology and Psychiatry*. 2018;59(4):460-482.
81. Bantjes J, Breet E, Saal W, Lochner C, Roos J, Taljaard L, Kessler RC. Epidemiology of non-fatal suicidal behavior among first-year university students in South Africa. *Death Studies*. 2019:1-8.
82. Bantjes J, Breet E, Lochner C, Roos J, Kessler RC, Stein DJ. Reducing nonfatal suicidal behaviour among university students: Actuarial analysis of potential effects of treating common mental disorders. *South African Journal of Psychology*. 2021;51(1):21-34.
83. Shilubane HN, Ruiter RA, van den Borne B, Sewpaul R, James S, Reddy PS. Suicide and related health risk behaviours among school learners in South Africa: Results from the 2002 and 2008 national youth risk behaviour surveys. *BMC Public Health*. 2013;13(1):1-14.
84. Butchart A, Peden M, Matzopoulos R, Phillips R, Burrows S, Bhagwandin N, Cooper A. The South African national non-natural mortality surveillance system rationale, pilot results and evaluation. *South African Medical Journal*. 2001;91(5):408-417.
85. Franklin JC, Ribeiro JD, Fox KR, Bentley KH, Kleiman EM, Huang X, Nock MK. Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*. 2017;143(2):187.
86. Turecki G, Brent DA. Suicide and suicidal behaviour. *The Lancet*. 2016;387(10024):1227-1239.
87. O'Reilly LM, Petterson E, Quinn PD, Klonsky ED, Lundström S, Larsson H, D'Onofrio BM. The association between general childhood psychopathology and adolescent suicide attempt and self-harm: A prospective, population-based twin study. *Journal of Abnormal Psychology*. 2020;129(4):364.
88. Flisher AJ, Dawes A, Kafaar Z, Lund C, Sorsdahl K, Myers B, Seedat S. Child and adolescent mental health in South Africa. *Journal of Child & Adolescent Mental Health*. 2012;24(2):149-161.
89. Quarshie EN, Waterman MG, House AO. Self-harm with suicidal and non-suicidal intent in young people in sub-Saharan Africa: a systematic review. *BMC Psychiatry* 2020;20(1):1-26.
90. Myers B, Bantjes J, Lochner C, Mortier P, Kessler RC, Stein DJ. Maltreatment during childhood and risk for common mental disorders among first year university students in South Africa. *Social Psychiatry and Psychiatric Epidemiology*. 2021;56(7):1175-1187.
91. Aggarwal S, Patton G, Reavley N, Sreenivasan SA, Berk M. Youth self-harm in low-and middle-income countries: Systematic review of the risk and protective factors. *International Journal of Social Psychiatry*. 2017;63(4):359-375.
92. McHugh CM, Lee RSC, Hermens DF, Corderoy A, Large M, Hickie IB. Impulsivity in the self-harm and suicidal behavior of young people: A systematic review and meta-analysis. *Journal of Psychiatric Research*. 2019;116:51-60.
93. Koyanagi A, Oh H, Carvalho AF, Smith L, Haro JM, Vancampfort D, DeVylder JE. Bullying victimization and suicide attempt among adolescents aged 12-15 years from 48 countries. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2019;58(9):907-918. e904.
94. Bantjes J, Saal W, Lochner C, Roos J, Auerbach RP, Mortier P, Stein DJ. Inequality and mental healthcare utilisation among first-year university students in South Africa. *International Journal of Mental Health Systems*. 2020;14(1):1-11.
95. Bantjes J, Kagee A, Meissner B. Young men in post-apartheid South Africa talk about masculinity and suicide prevention. *South African Journal of Psychology*. 2017;47(2):233-245.
96. Bantjes J, Mapaling C. "I'm not afraid of dying because I've got nothing to lose": Young men in South Africa talk about nonfatal suicidal behavior. *American Journal of Men's Health*. 2021;15(2):1557988321996154.
97. Breet E, Matooane M, Tomlinson M, Bantjes J. Systematic review and narrative synthesis of suicide prevention in high-schools and universities: A research agenda for evidence-based practice. *BMC Public Health*. 2021;21(1):1-21.
98. Simpson SA, Loh RM, Goans CR. New data on suicide risk assessment in the emergency department reveal the need for new approaches in research and clinical practice. *Psychological Medicine*. 2021:1-2.
99. Rudd MD. Recognizing flawed assumptions in suicide risk assessment research and clinical practice. *Psychological Medicine*. 2021:1-2.

Disability and mental health: Addressing discrimination and enhancing participation

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The global understanding of disability has shifted radically over several decades, away from a purely medical understanding of impairment as the direct cause of any disability. Instead, there is a growing recognition that disability arises when persons with 'long-term physical, mental, intellectual or sensory impairments encounter various barriers that hinder their full and effective participation in society on an equal basis with others'¹

This chapter critically examines the link between physical, mental, intellectual, or sensory impairments and the development of psychosocial disability, and explores how to enhance the mental health of children with disabilities by addressing the following questions:

- What is the prevalence of disability and mental disorders?
- How do impairment and the associated discrimination and exclusion impact on mental health?
- How does participation enhance mental health?
- What are the opportunities to strengthen policy and programming?

What is the prevalence of disability and mental disorders

The World Report on Disability estimates that about 15% (over a billion) of the world's population has some type of disability.² Of these, it is estimated that between 110 and 190 million are children under 15 years old and that the overwhelming majority of these children are located in low- and middle-income countries (LMICs). This prevalence appears to be increasing and is likely related to the increased neonatal survival rates in LMICs.³

Underreporting and discrepancies in population-based survey questions mean that there are no reliable prevalence data on childhood disability in South Africa.⁴ The 2011 South African census addressed six domains of functioning: seeing, hearing, communication, remembering/concentrating, walking and self-care. An individual was identified as having a

disability if they experienced moderate to severe limitations in a specific domain or if there were limitations across different domains.⁵ Yet this approach cannot be satisfactorily applied to developmental disabilities or children under the age of five.⁶ Considering these limitations, the national prevalence rate for disability was found to be 7.5%, while prevalence rates for children decreased with age, from 11% of 5 – 9-year-olds to 4% of 10 – 14-year-olds, and 3% of 15 – 19-year-olds. The most common impairments are loss of vision, 'cognitive difficulties', and loss of hearing.⁵

In addition, it is estimated that one in five children under 14 years of age worldwide are affected by mental disorders.⁷ Without proper treatment and environmental supports, children struggling with mental health problems or mental disorders may go on to develop a temporary or long-term psychosocial disability that impairs their ability to function and participate in society. But this is not inevitable and depends on whether the child's environment is enabling or disabling.⁸ For example, children with mental disorders living in the rural areas of the Western Cape may face far greater difficulties in accessing services and support than those living in a well-resourced metropolitan centre such as Cape Town.

At the same time, children and adolescents with physical, sensory or intellectual impairments are at increased risk of developing mental health problems and psychosocial disabilities when exposed to environmental barriers such as stigma and social isolation. Yet, a supportive environment and positive social interactions can prevent an impairment from becoming a disability.⁹ For example, children with cerebral palsy (CP) in various LMICs have been found to have poorer mental health and self-esteem than their typically developing peers,¹⁰ and in some studies over one-third of children with CP have reported mental health symptoms.¹¹ High rates of mental disorders are reported amongst children and youth with intellectual disability, with studies from the United Kingdom suggesting that 36% of this population

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have a mental disorder, compared to 8% of children without disabilities.¹² Similarly, there are indications that children and youth with visual impairment had more emotional problems than sighted children.¹³

How do disability, discrimination and exclusion impact on mental health?

The World Health Organization (WHO) views mental health as 'a state of well-being in which children and adolescents can fulfil their potential, cope with life stressors, be productive in their learning, and contribute to their communities'.¹⁴ Such a state of well-being is only possible when children are supported by a nurturing and responsive environment. Such environments not only meet children's basic physical, emotional and social needs, they also ensure that children enjoy emotionally responsive relationships with primary caregivers within a family-oriented setting which protects them from harm and encourages their efforts to cope with life's challenges and grow their talents within their community.

Yet, common responses to children with disabilities undermine this. Children with disabilities and their families often face ongoing battles for access to health care, education, transport, and other services, as well as stigma, bullying¹⁵ and discrimination, on top of the everyday demands of coping with an impairment.⁶ Confronting these challenges daily can readily give rise to feelings of anxiety and depression in both children and parents, and the very real sense of being alone in one's struggle. For many children and families, the experience is one of living in 'survival mode', where inner distress must be managed while continuing to negotiate a world which is often unwelcoming, and even hostile.¹⁶ All of this works against thriving and increases the risk of the emergence of diagnosable mental disorders.

The experience of impairment is shaped in powerful ways by children's environments and living conditions. Therefore, two individuals may have the same impairment (medically speaking), but the level of disability they experience becomes significantly different, depending on environmental factors such as spatial and income inequalities.⁹ These differences are also more pronounced in countries with high levels of inequality, such as in South Africa, with its brutal legacy of apartheid and colonialism coupled with inequality that continues to limit children's life chances. Exclusion from social contexts and lack of access to social networks leads to poorer health.¹⁷ While this may be true for the general population,¹⁸ the magnitude of the problem is compounded for persons with disabilities because of the lack of assistive devices and reasonable accommodation for their impairments,¹⁹⁻²¹

their frequent marginalisation in society, and increased vulnerability to neglect, abuse, poverty, and violence,¹ as well as disability-related stigma and discrimination.^{19, 22} Similarly, the social isolation and disruptions in social networks and support systems caused by the COVID-19 pandemic further intensifies mental distress, stress and anxiety among people with disabilities¹⁷ and additional efforts are needed to make sure that the needs of these children are met.

In addition to widespread inequalities and discrimination on the basis of race, class and gender, children and youth with disabilities may experience discrimination on the basis of disability, including poorer access to quality education²³ and healthcare²⁴. It must be borne in mind that with nearly two in three children in South Africa are living below the poverty line,²⁵ and that poverty is likely to have a disproportionate effect on children with disabilities.²⁶ It is imperative to recognise that impairment in and of itself does not cause mental disorders. This is not to say that the personal experience of impairment, including functional limitation, pain and fatigue, are not in themselves factors which also threaten mental health.^{22, 27} But, as noted above, the impact of these issues is best understood as the product of their interaction with environmental factors, and both these elements need to be considered to understand the origins of psychosocial disability and to design effective interventions.

How does participation enhance mental well-being?

We have already established how discrimination and stigma undermine the right of children with disabilities to 'full and effective participation and inclusion in society' as enshrined in the United Nations Convention on the Rights of Persons with Disabilities (UNCRDP).¹ Participation is considered both a basic human right and a critical health outcome for children with disabilities. Imms and colleagues capture the tensions in defining participation in their family of participation-related constructs framework, which distinguishes between attendance ('being there') and involvement ('the experience of participation while attending').²⁸ For example, children attending school are simply 'being there', while what the child actually does during a maths lesson is their 'involvement' or 'engagement' in the learning process. Participation, therefore, not only addresses barriers that prevent the attendance of children with disabilities, but it also aims to address the ways in which they are included or involved in life situations.

As noted above, having a disability does not necessarily lead to the development of mental health problems, and it has

Figure 29: Levels of intervention and support from the Nurturing Care Framework



Adapted from: World Health Organization. *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*. 2018.

been argued that participation helps improve the well-being of children and adolescents with developmental disabilities.²⁹ A cluster of studies report that there is a strong association between exclusion and mental health problems.³⁰ It may be the case that, were participation possible in all aspects of one's life, the prevalence of mental health problems would be the same between children with and without a disability.

A study led by the Centre for Augmentative and Alternative Communication at the University of Pretoria used the Picture my Participation measure to evaluate the participation patterns of children with intellectual disabilities. The study found that both children with intellectual disabilities and their primary caregivers reported that the child had high levels of attendance in formal learning, family mealtimes, interactions with families and celebrations.³¹ Yet, children with intellectual disabilities participated significantly less in social, community, leisure, and self-care activities than their peers.^{32, 33}

Similarly, a study with children with intellectual disabilities in South Africa using the Children's Assessment

of Participation and Enjoyment (CAPE) scale³⁴ found that children reported participating most in the informal domain, social activities, and skills-based and self-improvement activities. Children in South Africa were most likely to participate in activities once a week, with other relatives, and at a relative's house, and enjoyed participating in activities 'very much'. Another important consideration in enhancing participation of children with intellectual disabilities is the social support received by caregivers, with increased social support for caregivers resulting in increased intensity of participation for children with intellectual disabilities.^{35, 36} This cluster of studies makes an important contribution to the argument for i) including the self-reported perceptions of children with intellectual disabilities (the child's perspective) in clinical practice and future research, and ii) the importance of participation-focused interventions for children with intellectual and other disabilities to ensure that they have the same opportunities to 'be there' (attendance) and 'engage in activities' (participation).

What are the opportunities to strengthen policy and programming?

Nurturing care

The Nurturing Care Framework (NCF) draws on state-of-the-art evidence to strengthen policies and programmes to help children thrive.³⁷ The five domains of nurturing care include nutrition, responsive caregiving, security and safety, learning and stimulation, and health. Providing nurturing care to children with impairments may pose additional challenges across each of these domains, so it is important to adopt an inclusive approach and make a deliberate attempt to ensure that all children have equal access to services and support.⁶ While efforts to promote mental health and well-being, and prevent mental disorders, apply equally to children and youth with disabilities, targeted and indicated support is also needed as illustrated in Figure 29.

Reasonable accommodation

While all children need universal support regardless of impairments or health conditions, a smaller number require targeted support that addresses areas of potential risk, and indicated support is required for those who have demonstrable

additional needs. An important aspect of indicated support is the provision of reasonable accommodation for children with impairments.³⁸ This includes the provision of assistive devices to enable inclusion and participation. Examples include digital devices for children with visual impairments, quieter spaces at school for children on the autism spectrum, and adjusted work or schoolwork programmes to allow access to ongoing therapeutic support or catch up following an episode of illness where schoolwork was interrupted. (see Figure 30) The absence of such supports not only constructs a barrier to learning and development but also has an impact on mental well-being, as this sends a message that the child's needs are not thought about and prioritised, leading to feelings of low self-esteem, depression and anxiety.³⁹ Lack of attention and accommodation to the child's school programme can also lead to child and family concerns about progression and career development, further impacting on mental health and well-being.

A twin track approach

In response, one of the recommendations has been to adopt a twin track approach.⁴⁰ A twin track approach includes a mainstreaming track to ensure that children with disabilities

Figure 30: Illustration of the twin track approach



Source: CBM and the Twin-Track Approach to Disability and Development. *Twin-Track_Paper_final_version_October2008 2/10*. 2008.

are included in all forms of service provision, and an empowerment track that recognises the need for disability-specific supports and reasonable accommodations with a strong emphasis on participation and respecting the views of children and adolescents with disabilities.

In the following section, we will review the opportunities for intervention through the lens of the NCF under the following categories – child participation, caregiver capabilities, empowered communities, supportive services, and enabling policies. This framework should be linked to a life-course approach to mental health and disability, as risk and protective factors are cumulative rather than unrelated discrete events, and priorities differ during critical transitional periods of the life course.⁸ The strong connection between impairments and the development of psychosocial disability should therefore be considered through the different developmental stages.

Child participation

In line with the UNCRPD perspective on self-representation, the voice of children and adolescents with disabilities needs to be heard and play a central role in service provision and community building. The Lancet Commission on the Future of the World's Children argues that meaningful participation leads to 'improved social cohesion, more egalitarian communities, and helps adolescents make a better informed, healthier, and more empowered transition into adulthood'.⁴¹ The United Nations Convention on the Rights of the Child notes that children have the right to be involved in decisions and actions that affect them, and that they should be able to express their views which should be heard and taken seriously by adults.⁴²

Children and youth can indicate their preferences for what works for them and help identify and address 'barriers to doing' and 'barriers to being'. For example, children with physical disabilities identified 'barriers to doing', such as physical or material barriers that restricted their participation, as well as 'barriers to being', such as bullying and hostile behaviour.⁴³ Parents can also be over-protective and have low expectations, which is why children with psychosocial disabilities should be supported to advocate for their own needs.⁴⁴

Family strengthening

Families are best placed to understand the experiences and needs of their children, and these insights are crucial in providing a responsive, attuned and nurturing environment.⁴⁵ This is because parents and/or families of children with disabilities have insight into what activities their child will

find enjoyable and meaningful, and can help recommend strategies to support their children's participation and emotional well-being.⁴⁶ However, support for caregivers and children with disabilities is often lacking in both primary and community levels of health care.

Family strengthening programmes, such as the Caregivers Skills Training programme outlined in Case 30, aim to respond to two distinct but related challenges. The first challenge is to develop caregivers' knowledge and skills so that they are able to provide the interventions needed to promote their children's development,⁴⁷ and to do so in a way that affirms – and does not negate – their existing knowledge and skills. The second challenge is to provide psychosocial support, as the economic, physical and emotional stressors of caring for a child with a disability render parents vulnerable to mental disorders such as depression or anxiety disorders. Stress experienced by parents and caregivers should be prioritised because their well-being is pivotal to the provision of nurturing care for children with disabilities.⁴⁸

Empowered communities

Empowering communities to facilitate the inclusion of children with disabilities is a critical element in promoting mental well-being. Services should ideally support community members and organizations to become agents of change to enable children with disabilities to participate in community life and recreation.⁵⁰ This goes beyond service provision to a situation where community members are supported to take responsibility and make the changes they want, through consultation and training, and the sharing of physical and educational resources. This would include addressing some of the pressing safety issues, especially for children with developmental disabilities, that prevent them from venturing into their community spaces.⁵¹

A study across three countries (South Africa, Botswana and Malawi) identified the benefits of community programmes in enabling access, participation and inclusion.⁵² The development of parent support groups has also been found to be very effective in advocating for changes in the community. For example, Kambowe found that a parent advocacy support group was effective in enhancing community participation and social inclusion of adolescents with Down Syndrome in Namibia.⁵³ In addition, parent training programmes have been found to be effective in enhancing the self-efficacy of caregivers so that parents are better able to 'think and act in ways that will optimise the developmental outcomes of their children'.⁵⁴

Case 30: WHO Caregivers Skills Training Programme

Given that most children with developmental disorders do not have equitable access to care, the WHO launched the Caregivers Skills Training (CST) for families of children with developmental delays and disorders.⁴⁹ This aims to strengthen access and quality of health services and support to families, and forms part of a broader Mental Health Gap Action Plan to address the treatment gap for priority mental, neurological and substance used conditions.

Taking a family-oriented approach and designed to be delivered by trained non-specialists (such as peer caregivers and community-based workers), CST's primary goal is to promote better understanding and acceptance of developmental delays and disorders and to help caregivers promote child development, communication and functioning. The secondary aims of the programme include strengthening caregivers' coping skills and psychological well-being. CST builds on existing resources and services to maximise sustainability. The WHO CST consists of nine group weekly sessions of 2.5 hours each

and three 90-minute individual sessions in caregivers' homes, focused on training the caregiver on how to use every day play and home activities and routines as opportunities for learning and development. The home sessions are geared towards assessing the child's development, engaging the family, determining needs and setting goals. Thereafter, caregivers participate in various modules including getting and keeping children engaged, understanding and promoting communication as well as skills for daily living, preventing and responding to challenging behaviour, and a separate module on caregiver well-being, self-care and problem solving. Specific sessions cover communication, engagement, daily living skills, challenging behaviour and caregiver coping strategies.

A key feature of the CST is that it can be delivered by non-specialists and can be adapted linguistically and culturally to ensure that it is understandable, culturally relevant, acceptable and feasible for use in low resource settings.⁴⁸

Supportive services

Children with disabilities are entitled to access inclusive health and educational services. Additionally, social assistance is available to caregivers of children with disabilities in need of permanent care or support services in the form of the Care Dependency Grant (CDG).

Yet, early identification and early intervention for children with intellectual and psychosocial disabilities can be difficult as current measures do not easily detect the more subtle or 'invisible' neurological or psychosocial disabilities. This leads to the exclusion of these children from early intervention strategies, which are essential for improving outcomes and preventing secondary disabilities. Children with 'invisible disabilities' are also excluded from other important domains, such as the statistics used to inform planning and budgeting for services. For instance, disability prevalence rates in South Africa exclude children under the age of five, as well as children with psychosocial and certain neurological disabilities. It is therefore important to review the medical assessment criteria to enhance the identification of children with intellectual and psychosocial disabilities, to ensure that these children and their caregivers are able to access a basket of support services including the CDG.

Already scarce services for children and adolescents with disabilities, such as rehabilitation services in hospitals, special care centres and schools, faltered during COVID-19, creating difficult times for both families and children with disabilities, and many mothers have been unable to see their children during the pandemic due to isolation measures introduced at residential care facilities.⁵⁵ The closure of special schools for children with disabilities, who require daily therapeutic services, similarly left most parents and caregivers with no or limited resources, and little or no training on how to assist their own children adequately at home. Furthermore, in the context of having to share a one-roomed dwelling, many children may have found playing and learning extremely difficult during lockdowns in households.⁵⁶ This is where targeted responses are needed. The best practice would have been to ensure continuity of care by extending services to children at home, and supporting carers through online training, mentoring and supervision, yet these efforts were unlikely to reach those most vulnerable given the digital divide in South Africa. The case study on the following page outlines how alternative and augmentative modes of communication have an important place in bridging one of the gaps in service provision.

Case 31: Closing the gap through augmentative and alternative communication

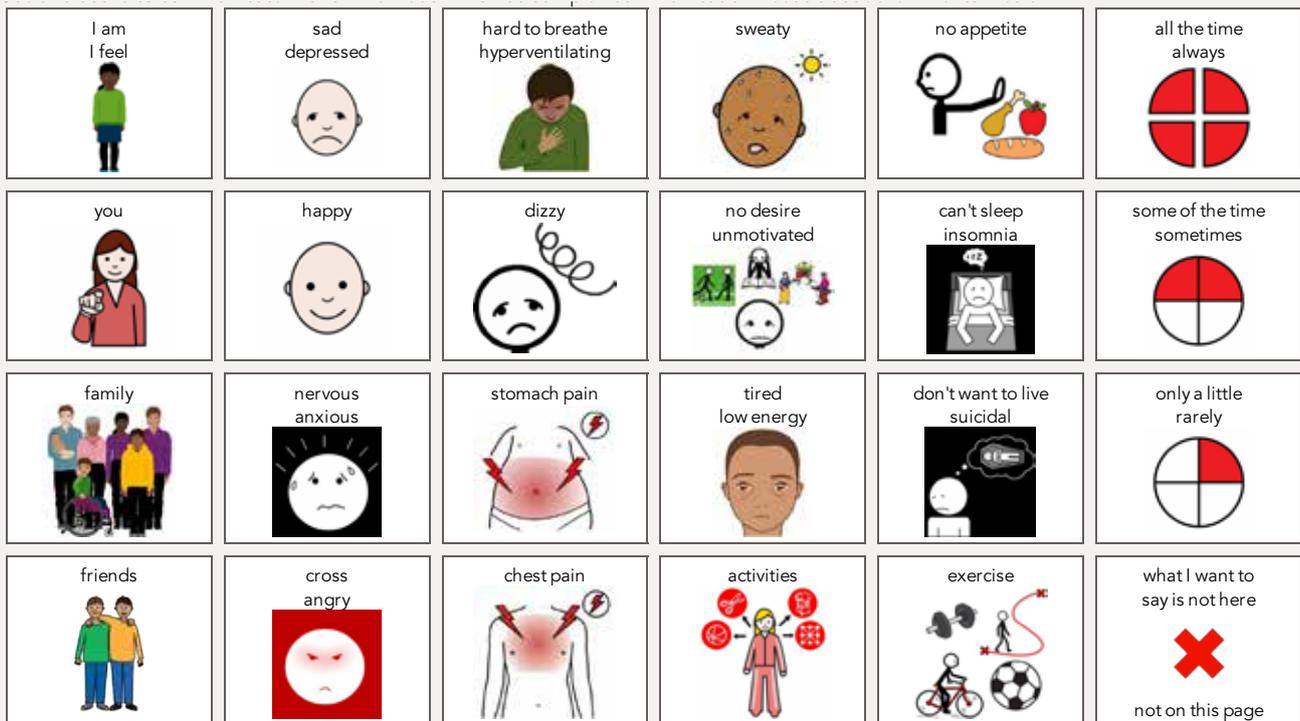
While physical access to services that support mental health is a right to be afforded to all people,⁵⁷ persons with disabilities – and specifically persons with complex communication needs – are less likely to utilise these services. Persons with complex communication needs are defined as “having limited or no access to functional verbal speech and are unable to use speech to meet their daily communication needs”.⁵⁸ This may lead to mainstream mental health services not being fully aware of their needs,⁵⁹ yet this group faces various risk factors for mental health problems, including experiences of discrimination and stigma, physical health challenges, and difficulties in establishing and maintaining relationships.⁶⁰

Individuals with complex communication needs would benefit from Augmentative and Alternative Communication (AAC). AAC encompasses any form of communication used to supplement or replace oral speech and plays a critical role in supporting communication and promoting the participation and inclusion of persons with complex communication needs.⁶¹ It is often challenging for persons

with complex communication needs to take care of their health, and the COVID-19 pandemic exacerbated the situation. Health information is often couched in confusing and inaccessible language and provided in formats and modalities that do not support comprehension. The Centre for Augmentative and Alternative Communication and Future Africa (at the University of Pretoria) and UNICEF embarked on a project entitled ‘Co-designing health communication and education materials’ during the COVID-19 pandemic. The health education materials were developed in collaboration with youth with disabilities, caregivers of children and youth with communication disabilities, and professionals who work in the health and education sector.⁶² A variety of resources, in various South African languages, is available for download, including a series of animated stories specifically focused on maintaining mental health.¹

In addition, an example of a communication board that can be used to communicate about mental health was specifically prepared to accompany this chapter.

Figure 31: A communication board to discuss aspects of mental health



i <https://www.up.ac.za/centre-for-augmentative-alternative-communication/article/2938080/co-designing-health-education-materials->

Enabling policies

Given the close connection between mental health and participation, enabling policies should support not only access but also meaningful engagement. The White Paper 6 on Inclusive Education⁶³ aims to create an inclusive and supportive learning environment that would facilitate mental health and well-being in schools, if effectively implemented. Similarly, health policies emphasise equal access and reasonable accommodation for children and adolescents with disabilities and their families and could help to address some of the environmental barriers that influence mental well-being. The Framework and Strategy on Disability and Rehabilitation has also done well in highlighting the need to improve access to services, however, this policy has been critiqued for excluding learning or intellectual disabilities,⁶⁴ and does not address psychosocial disabilities. The draft National Disability Background Paper⁶⁵ also acknowledges barriers to participation – a call which requires enacting changes in national policies, laws and environments. The recent Strategic Policy Framework on Disability for the Post-School Education and Training System⁶⁶ signified one such positive step towards change and includes measures to provide financial support and upgrade infrastructure and services to improve participation of those with disabilities. The policy also advocates for institutions to report on initiatives for all disability types.

The more recent National Strategic Framework on Reasonable Accommodations for Persons with Disabilities is important as it focuses on environmental as well as technological supports to accommodate persons with disabilities.⁶⁷ This framework supports the independence of persons with disabilities through advocating for provision of assistive devices, reasonable accommodation measures and support services to enhance the well-being and participation of persons with disabilities as fully as possible in activities such as education and later employment. It specifically notes that service providers and sectors implementing this policy must integrate psychosocial services and interventions within reasonable accommodation measures.

Policies also need to prioritise getting services to both children and their families, to effectively nurture the development of children with disabilities. To ensure that both long-term and short-term needs are addressed, policy solutions must expand home-visiting programmes as these bring services close to home and benefit both the child and caregivers. The programmes should be complemented with investments in telehealth services for those who can access virtual platforms. Policymakers, therefore, need to enhance both these support services by allocating public funding

for community-based services and ensuring that families and service providers have the digital access and training needed to make telehealth a possibility. We have recently witnessed how limited funds disrupt services for children with disabilities in South Africa. For example, TimesLive reported in December 2021 that workers who care for 84 persons with profound disabilities at Durban and Coastal Mental Health's Jona Vaughan residential facility did not arrive at work because they had not been paid since September 2021, and amid this funding crisis, children were left without care.

Additional costs incurred to provide for the disability-related needs of their children can be a significant source of stress for both families living in poverty, and low-income earners for whom the cost of assistive devices and other supports add a taxing burden on their limited financial resources. Policy makers can help alleviate the additional costs of caring for a child with a disability by increasing the value of the CDG, while policy implementers can take steps to enable greater access to this support. This targeted support is in line with other calls to increase the value of social grants for children and their caregivers and would respond decisively to persistent inequity in South Africa.

Alongside this, government services should support the multidimensional – and therefore multisectoral – needs of children with disabilities. For example, if the Department of Health enhanced the provision of services and access to assistive technologies and the Department of Basic Education provided fully inclusive quality educational services to children with disabilities, then this would enhance the impact of the CDG, as families would be able to use this limited resource to meet the home care needs of their children, instead of using to cover the costs of other services.

Conclusion

Meaningful participation is central to the mental health of children with disabilities and is an area where children with disabilities are most likely to encounter significant barriers, including stigma and inaccessible environments. To address this problem, mainstream environments and communities need to become more inclusive and welcoming, while at the same time, more specific (and possibly more individualised) supports should be provided to enable the participation of children with disabilities.⁶ It is critical that supportive services adopt a family focus and a developmental, life-course perspective in a way that is congruent with African contexts and aspirations. Given that exclusion and isolation undermine the mental health of all children, adolescents

and their caregivers, efforts to support the meaningful participation of children with disabilities have the potential to prevent and mitigate the mental health impacts of exclusion and disability – including psychosocial disabilities.

This includes putting in place reasonable accommodation and child-friendly measures to support the participation of children, adolescents and their caregivers in the design and implementation of policies and programmes.

References

1. United Nations. *Convention on the Rights of Persons with Disabilities*: 2006. Accessed: 2 September. Available from: <http://www.un.org/disabilities/>.
2. World Health Organisation, World Bank. *World Report on Disability*. Geneva: WHO, World Bank. 2011.
3. Olusanya BO, Davis AC, Wertlieb D, Boo N-Y, Nair M, Halpern R, Gladstone M. Developmental disabilities among children younger than 5 years in 195 countries and territories, 1990–2016: A systematic analysis for the Global Burden of Disease Study 2016. *The Lancet Global Health*. 2018;6(10):e1100–e1121.
4. Visser M, Nel M, Bronkhorst C, Brown L, Ezendam Z, Mackenzie K, Venter M. Childhood disability population-based surveillance: Assessment of the Ages and Stages Questionnaire Third Edition and Washington Group on Disability Statistics/UNICEF module on child functioning in a rural setting in South Africa. *African Journal of Disability*. 2016;5(1).
5. Statistics South Africa. *Profile of persons with disabilities in South Africa*. Pretoria: Statistics South Africa. 2014.
6. Philpott S, McKenzie J. Welcoming all children: The inclusion imperative. *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town; 2017. p. 84–90.
7. World Health Organization. *Mental disorders*. Geneva: WHO. 2019. [Accessed 15 November 2021: [<https://www.who.int/news-room/fact-sheets/detail/mental-disorders>]
8. Hunt X, Skeen S, Honikman S, Bantjes J, Mabaso K, Docrat S, Tomlinson M. *Maternal, child and adolescent mental health: An ecological life course perspective*. 2021.
9. Anaby D, Law M, Coster W, Bedell G, Khetani M, Avery L, Teplicky R. The mediating role of the environment in explaining participation of children and youth with and without disabilities across home, school, and community. *Archives of Physical Medicine and Rehabilitation*. 2014;95(5):908–917.
10. Power R, King C, Muhiit M, Heanoy E, Galea C, Jones C, Khandaker G. Health-related quality of life of children and adolescents with cerebral palsy in low-and middle-income countries: a systematic review. *Developmental Medicine & Child Neurology*. 2018;60(5):469–479.
11. Downs J, Blackmore AM, Epstein A, Skoss R, Langdon K, Jacoby P, Glasson EJ. The prevalence of mental health disorders and symptoms in children and adolescents with cerebral palsy: A systematic review and meta-analysis. *Developmental Medicine & Child Neurology*. 2018;60(1):30–38.
12. Emerson E, Hatton, C. Applying a health inequalities perspective. *Health Inequalities and People with Intellectual Disabilities*. Cambridge: Cambridge University Press; 2013.
13. Augustad LB. Mental health among children and young adults with visual impairments: A systematic review. *Journal of Visual Impairment & Blindness*. 2017;111(5):411–425.
14. World Health Organization. *Promoting mental health: Concepts, emerging evidence, practice: Summary report*: WHO; 2004.
15. Lebrun-Harris LA, McManus MA, Ilango SM, Cyr M, McLellan SB, Mann MY, White PH. Transition planning among US youth with and without special health care needs. *Pediatrics*. 2018;142(4).
16. Watermeyer B, McKenzie J. Mothers of disabled children: In mourning or on the march? *Journal of Social Work Practice*. 2014;28(4):405–416.
17. Ned L, McKinney ELM, McKinney V, Swartz L. COVID-19 pandemic and disability: Essential considerations. *Social and Health Sciences*. 2020;18(2):136–148.
18. Santini ZI, Koyanagi A, Tyrovolas S, Mason C, Haro JM. The association between social relationships and depression: A systematic review. *Journal of Affective Disorders*. 2015;175:53–65.
19. Ned L, Lorenzo T. Enhancing the public sector's capacity for inclusive economic participation of disabled youth in rural communities. *African Journal of Disability*. 2016;5(1):1–9.
20. Hillier S, Inglis-Jassiem G. Rehabilitation for community-dwelling people with stroke: Home or centre-based? A systematic review. *International Journal of Stroke*. 2010;5(3):178–186.
21. Maleka D, Kusambiza-Kiingi A, Ntsiea V. Stroke survivors' levels of community reintegration, quality of life, satisfaction with the physiotherapy services and the level of caregiver strain at community health centres within the Johannesburg area. *African Journal of Disability*. 2017;6(1):1–8.
22. Watermeyer B. *Towards a contextual psychology of disability*. London: Routledge; 2013.
23. Fleisch B, Shindler J, Perry H. Who is out of school? Evidence from the Statistics South Africa Community Survey. *International Journal of Educational Development*. 2012;32(4):529–536.
24. Scheffler E, Swartz L, Vergunst R, Braathen SH, Kritzing J, Mannan H, Mji G. Exploring the interaction of activity limitations with context, systems, community and personal factors in accessing public health care services: A presentation of South African case studies. *African Journal of Primary Health Care and Family Medicine*. 2017;9(1):1–9.
25. Statistics South Africa. *Poverty on the rise in South Africa*. Statistics South Africa. 2017. [Accessed 6 June 2020: [<http://www.statssa.gov.za/?p=10334>]
26. Yeo R. Disability, poverty and the new development agenda. *Disability Knowledge and Research Programme* 2005. p. 1–33.
27. Thomas C. *Female forms: Experiencing and understanding disability*: McGraw-Hill Education (UK); 1999.
28. Imms C, Adair B, Keen D, Ullenhag A, Rosenbaum P, Granlund M. 'Participation': A systematic review of language, definitions, and constructs used in intervention research with children with disabilities. *Developmental Medicine & Child Neurology*. 2016;58(1):29–38.
29. Arvidsson P, Granlund M, Thyberg I, Thyberg M. Important aspects of participation and participation restrictions in people with a mild intellectual disability. *Disability and Rehabilitation*. 2014;36(15):1264–1272.
30. Augustine L, Lyngegård F, Granlund M. Trajectories of participation, mental health, and mental health problems in adolescents with self-reported neurodevelopmental disorders. *Disability and Rehabilitation*. 2021:1–14.
31. Arvidsson P, Dada S, Granlund M, Imms C, Bornman J, Elliott C, Huus K. Content validity and usefulness of Picture My Participation for measuring participation in children with and without intellectual disability in South Africa and Sweden. *Scandinavian Journal of Occupational Therapy*. 2020;27(5):336–348.
32. Samuels A, Dada S, Van Niekerk K, Arvidsson, P HK. Children in South Africa with and without Intellectual Disabilities' rating of their frequency of participation in every day activities. *International Journal of Environmental Research and Public Health*. 2020;17:6702.
33. Schlebush L, Huus K, Samuels A, Granlund M, Dada S. Participation of young people with disabilities and/or chronic conditions in low-and middle-income countries: A scoping review. *Developmental Medicine & Child Neurology*. 2020;62(11):1259–1265.
34. King GA, Law M, King S, Hurley P, Hanna S, Kertoy M, Young N. *Children's assessment of participation and enjoyment (CAPE) and preferences for activities of children (PAC)*: PsychCorp; 2000.
35. Dada S, Bastable K, Schlebush L, Halder S. The participation of children with intellectual disabilities: Including the voices of children and their caregivers in India and South Africa. *International Journal of Environmental Research and Public Health*. 2020;17(18):6706.
36. Dada S, Bastable K, Halder S. The role of social support in participation perspectives of caregivers of children with intellectual disabilities in India and South Africa. *International Journal of Environmental Research and Public Health*. 2020;17(18):6644.
37. World Health Organization. *Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential*. Report No.: 924151406X. WHO. 2018.
38. Department of Social Development. *White Paper on the Rights of Persons with Disabilities*. Pretoria: Republic of South Africa. 2015.
39. Watermeyer B, Lourens H, Botha M, Khumalo B, Kelly J, Shanda N. Emotional and embodied aspects in the education of learners with visual impairment: The use of standpoint 'panel chats' in teacher training. *International Journal of Disability, Development and Education*. 2021:1–17.
40. CBM. *Disability Inclusive Development Toolkit*. Germany CBM; 2017.
41. Clark H, Coll-Seck AM, Banerjee A, Peterson S, Dalglis SL, Ameratunga S, Costello A. A future for the world's children? A WHO–UNICEF–Lancet Commission. *The Lancet*. 2020;395(10224):605–658.
42. United Nations. *Convention on the Rights of the Child*. New York: United Nations. 1990.
43. Connors C, Stalker K. Children's experiences of disability: Pointers to a social model of childhood disability. *Disability & Society*. 2007;22(1):19–33.
44. Curran T. Disabled children's childhood studies: Alternative relations and forms of authority? In: Curran T, Runswick-Cole K, editors. *Disabled Children's Childhood Studies: Critical approaches in a global context*.

- London: Palgrave Macmillan UK; 2013. p. 121-135.
45. Piškur B, Beurskens AJ, Jongmans MJ, Ketelaar M, Norton M, Frings CA, Smeets RJ. Parents' actions, challenges, and needs while enabling participation of children with a physical disability: A scoping review. *BMC Pediatrics*. 2012;12(1):177.
 46. Heah T, Case T, McGuire B, Law M. Successful participation: The lived experience among children with disabilities. *Canadian Journal of Occupational Therapy*. 2007;74(1):38-47.
 47. Oono IP, Honey EJ, McConachie H. Parent-mediated early intervention for young children with autism spectrum disorders (ASD). *Evidence-Based Child Health: A Cochrane Review Journal*. 2013;8(6):2380-2479.
 48. Organization WH. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental health Gap Action Programme (mhGAP)*: World Health Organization; 2016.
 49. Salomone E, Pacione L, Shire S, Brown FL, Reichow B, Servili C. Development of the WHO Caregiver Skills Training Program for Developmental Disorders or Delays. *Front Psychiatry*. 2019;10:769.
 50. King G, Curran C, McPherson A. A four-part ecological model of community-focused therapeutic recreation and life skills services for children and youth with disabilities. *Child: care, health and development*. 2013;39(3):325-336.
 51. McKenzie JA, Kahonde C, Mostert K, Aldersey HM. Community participation of families of children with profound intellectual and multiple disabilities in South Africa. *Journal of Applied Research in Intellectual Disabilities*. 2020.
 52. Lorenzo T, van Pletzen E, Booyens M. Determining the competences of community based workers for disability-inclusive development in rural areas of South Africa, Botswana and Malawi. *Rural and remote health*. 2015;15(2):[62]-[75].
 53. Kambowe H. *A qualitative study into the advocacy and activism of carers of adolescents with Down Syndrome in Oshana, Namibia*: Faculty of Health Sciences; 2019.
 54. Hohlfeld ASJ, Harty M, Engel ME. Parents of children with disabilities: A systematic review of parenting interventions and self-efficacy. *African Journal of Disability (Online)*. 2018;7:1-12.
 55. Mulibana M. Lack of consultation led to persons with disabilities being neglected in the COVID-19 response. *AfricLaw*. 2020.
 56. Grut L, Braathen SH, Mji G, Ingstad B. Accessing community health services: Challenges faced by poor people with disabilities in a rural community in South Africa. *African Journal of Disability*. 2012;1(1):1-7.
 57. World Health Organization. *World health statistics 2016: Monitoring health for the SDGs sustainable development goals*: WHO; 2016.
 58. Biggs EE, Carter EW, Gilson CB. Systematic review of interventions involving aided AAC modeling for children with complex communication needs. *American Journal on Intellectual and Developmental Disabilities*. 2018;123(5):443-473.
 59. Hagiliassis N, DiMarco M, Gulbenkoglou H, Iacono T, Larkin H, Watson J, Watson J. The Bridging Project: Physical disability and mental health. *Inpsych: the bulletin of the Australian Psychological Society*. 2005;27(4):22-24.
 60. Di Marco M, Iacono T. Mental health assessment and intervention for people with complex communication needs associated with developmental disabilities. *Journal of Policy and Practice in Intellectual Disabilities*. 2007;4(1):40-59.
 61. Beukelman D, Light J. *Augmentative and alternative communication for children and adults*. Baltimore, MD: Paul H Brookes Publishing Co; 2020.
 62. Dada S, Flores C, Bastable K, Schlosser RW. The effects of augmentative and alternative communication interventions on the receptive language skills of children with developmental disabilities: A scoping review. *International Journal of Speech-Language Pathology*. 2021;23(3):247-257.
 63. Department of Education. *Education White Paper 6. Special needs education: Building an inclusive education and training system*. Pretoria: Government Printer. 2001.
 64. National Department of Health (SA). *Framework and strategy for disability and rehabilitation service in South Africa*. Pretoria: Government printer. 2015.
 65. National Planning Commission. *Disability Background Paper: The status of disability in South Africa - Draft 2, July 2020*. Pretoria: Government Printer. 2020.
 66. Department of Higher Education and Training. *Strategic policy framework on disability for the post-school education & training system*. Pretoria: Government printer. 2018.
 67. Republic of South Africa. *National Strategic Framework on reasonable accommodations for persons with disabilities*. Government Gazette. 2021.

Conclusion: Putting children at the centre

Mark Tomlinson,ⁱ Lori Lakeⁱⁱ and Sharon Kleintjesⁱⁱⁱ

Children and adolescents are growing up in a world that is increasingly on fire. The COVID-19 pandemic has revealed the deep fissures in our country and in our world – fissures of deep and unsustainable exploitation of our resources, the moral bankruptcy of a world where a handful of individuals own more wealth than 25% of the world's population. A world, using Naomi Klein's phrase, where we are confronted with an increasing number of 'sacrifice zones' – places destroyed by climate breakdown; usually poor, out of the way places where people lack political power.¹ Places where the dying and suffering of children are simply not reported anymore.

Amidst the existential threat of climate change, coupled with the devastating social, educational and economic impacts of the COVID-19 pandemic, it is not surprising that children are grappling with feelings of fear, anger, distress and hopelessness. Add in the challenges of social media and an upsurge of violence and global conflict, and it is clear that we are in a crisis. Andri Snær Magnason is an Icelandic documentary film maker, one-time candidate for President of Iceland and the writer of *On Time and Water*. In his poignant and majestic book, he states that 'because of climate chaos, an entire generation is being asked not what they want to become but what they need to become'.² We are living too fast, pushing the boundaries of nature beyond what they can tolerate, and he makes a strident plea for us to all slow down. He argues that our education systems have become fixated on creating human resources for business and industry rather than on preparing the next generation with the knowledge to live in harmony with nature, the ethics to envision a new way of living and being, and the values to engage with the moral quandaries our children and grandchildren are going to have to deal with.

On Time and Water evokes a new sense of urgency – the time to act is now. So how can we as a society create an enabling environment that better protects our children from harm, builds their ability to cope with adversity and enables them to realise their potential? In this 16th issue of the *South*

African Child Gauge, we have made the case for a whole-of-society, life-course approach that places children at the centre of all policies and programmes, coupled with a shift from short-term political expediency to making decisions today that will enable both our children and the planet to thrive in the future. The Nurturing Care Framework (NCF) has highlighted the key concepts of responsive care, of relationships and environments characterised by early learning opportunities.³ Recently, the NCF has been extended across the life course (not just until the age of three) in a Lancet series that outlines approaches to optimising child and adolescent health.^{4,5}

In addition, what is required is a renewed focus on enabling environments that reach beyond the sphere of the individual child, and that tackle the determinants of health and well-being.⁶ Investments need to extend beyond the strengthening of essential child and adolescent mental health services, and we must put children's health and best interests at the centre of all our policy-making and programming. The intergenerational impact of trauma, poverty and mental ill health forces us to take an incredibly long view of well-being – much like how in the Middle Ages it took seven generations of a family to build a cathedral.

When we fail an individual child, the lifetime and intergenerational impact is felt at a societal level.⁷ The costs of not intervening and of not strengthening support systems for vulnerable children and families are huge.⁷ Investing early is a moral imperative but investing early is also perhaps the best investment that can be made in the generational health of our society. Ensuring that children thrive now will yield benefits in later generations as thriving children become parents themselves⁸.

What is thriving?

Thriving has multiple dimensions, including growth, learning, and the development of healthy interpersonal relationships, creativity, empathy, the capacity for moral reasoning, and social development.³ Crucially, thriving is not an event or

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life stage but rather a process that unfolds across the life course. Young people need support throughout their lives – with additional supports at key transitions such as starting school, moving to high school – and at times of stress – such as hospitalisation, or natural disaster. Neuroscience has also shown that the brain continues maturing until at least 24 years of age,⁴ pointing to the need for additional support as young people navigate the transition from school to further education and employment (as outlined in Case 33).

A thriving child, adolescent, or youth is better able to study and gains more from education or training, resulting in a young adult who has higher earning potential and is better equipped to make a positive contribution to society, both

economically and socially.¹⁵ A successful ‘thrive’ agenda will also yield substantial benefits in future generations, as many children will later become parents and all will have a role in supporting the next generation.

Yet Martha Nussbaum’s work illustrates how thriving and the development of individual capabilities is dependent on the creation of societies that provide children with the freedom, opportunities and resources to realise their dreams and potential.⁹ Her list of 10 human capabilities (in Box 4) looks beyond a narrow utilitarian approach to development and foregrounds the importance of human dignity, respect for others, and freedom of speech and association. In doing so, she encourages us to foster children’s agency and active

Figure 32: Building an ecosystem of support



Adapted from: Partnership for Maternal Newborn and Child Health UHL. *Multistakeholder Consultations on Programming to Promote Adolescent Well-Being: Summary Report*. Geneva: World Health Organization; 2022.

Case 32: COVID-19 and child and adolescent mental health

Mark Tomlinsonⁱ

The impacts of the COVID-19 pandemic on child and adolescent mental health are direct and indirect, as well as immediate and delayed. In the early months of 2020, there were few data on child and adolescent mental health. Lessons from previous health crises such as HIV and Ebola were strongly suggestive that there would be traumatic impacts on young people's mental health, including post-traumatic stress disorder, higher levels of depression and aggression, poorer social outcomes and impacts on stigma and discrimination.^{22, 23}

Towards the end of 2020, as the first data began to emerge, the worst-case scenario of a massive spike in mental health difficulties had not materialised. In one study, 43% of children stated that their lives had got worse, yet at least a quarter stated that in fact their lives had got better.²⁴ Some of this may be explained by families and communities coming together to support each other in the immediate aftermath of a scary and unknown virus, and before the full effects of lockdown, school closures and job losses were felt.

In the medium and long term, a different picture has emerged. A 2021 meta-analysis²⁵ found that the prevalence of depression and anxiety for children and adolescents had increased two-fold. A more recent systematic review of global studies on child and adolescent mental health found a high prevalence of COVID-19-related fear, as well as increases in the symptoms of depression and anxiety.²⁶ Worryingly, children and adolescents living with neuro-diversities and/or chronic physical conditions had higher negative mental health outcomes.²⁶ In a UNICEF report focusing only on studies from Africa, rates of mental health burden (elevation of anxiety and depression levels) ranged from 5% to 74%. Unfortunately, many of these studies were of low quality with strong risks of bias, and therefore need to be interpreted with caution. However, they do suggest a complex picture with children and adolescents in some areas struggling considerably more than in others. Another finding from the same study was how vulnerability tended to cluster during the pandemic and in its aftermath, exacerbating existing vulnerabilities.²³ As is so often the case, the most negative impacts are

worst in families facing multiple onslaughts (violence, trauma, job losses, mental health difficulties).

In terms of the more delayed impacts, we have already seen – and continue to see – a 'hunger pandemic' (exacerbated by the Russian invasion of Ukraine), where tens of millions of children are falling into extreme poverty,²⁷ with concomitant severe food insecurity. Hundreds of millions of children have missed significant amounts of schooling, many have not returned to school, and a significant proportion will never return. Increased levels of stunting due to food insecurity will affect school performance and increase the likelihood of later school dropout. When children drop out of school, they are more likely to become involved with gangsterism, violence and be vulnerable to substance abuse. In households living in poverty and food insecurity, parental stress may become severe with implications for violence against, and violence by, children.

COVID-19 and its ongoing ramifications are of significant concern for child and adolescent mental health in the short and long term. There is, however, a positive (perhaps the only positive from the pandemic) and that is the new openness to conversations about mental health globally. Mental health is now a priority for governments, donor agencies and international agencies such as the World Health Organization and UNICEF. It has enabled a fresh awareness of psychosocial well-being and has, in many communities, resulted in a new ethics of care for one another. We have recently seen this in South Africa when, at the beginning of May 2022, the Ministerial Advisory Committee (MAC) on COVID-19 within the Department of Health released an advisory entitled, 'The Mental Health Impact of COVID-19 on South African Society: How to Build Back Better'²⁸. The advisory makes specific mention of children, adolescents and youth, as well as economically disadvantaged people. This high-level focus and attention is a key achievement of many years of advocacy. We must harness this moment to ensure that we place children and adolescents and their well-being at the centre of our build back plans and ensure that mental health is never ignored.

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Box 4: 10 central human capabilities

1. **Life.** Being able to live a complete and satisfying life into old age. Not having life cut short or being made such that it hardly seems worth living.
2. **Bodily health.** Being able to have good health, nourishment and shelter.
3. **Bodily integrity.** Being able to move freely from place to place; protected from violence and abuse; and having choice in matters of sex and reproduction.
4. **Senses, imagination, and thought.** Being free to use the senses to imagine, think, and reason; having the freedom to express political, artistic and religious views; being able to experience pleasure and avoid unnecessary pain.
5. **Emotions.** Being able to experience love, grief, longing, gratitude, and justified anger, without having one's development blighted by fear and anxiety.
6. **Practical reason.** Being able to engage in critical reflection and plan one's life.
7. **Affiliation.** Being able to live with and show concern for other human beings; and being treated as a dignified being whose worth is equal to that of others – without discrimination.
8. **Other species.** Being able to live with concern for and in relation to animals, plants, and the world of nature.
9. **Play.** Being able to laugh, to play, to enjoy recreational activities.
10. **Control over one's environment.** Being able to participate in the political choices that govern one's life; having the right to free speech and association; and being able to hold property and seek employment on an equal basis with others.

Adapted from: Nussbaum M. Human rights and human capabilities. *Harvard Human Rights Journal*, 20: 21-24.

citizenship and to challenge and transform the social and material conditions that continue to prevent the majority of South Africa's children from realising their potential.

Recommendations

Our recommendations strive to create enabling environments that promote children's mental health and ability to act with agency, reach their potential, engage in meaningful relationships, cope with adversity and contribute to their communities.⁶ Ensuring that children are thriving is not an event, an early intervention, a late intervention, a cash transfer or a behavioural programme. These interventions must be embedded in a long-term multidimensional approach, rooted in addressing poverty and inequality, providing opportunities for learning and for family, peer and social relationships, safe communities, quality education and the development of creativity, empathy and resilience.⁸ In the context of climate breakdown, it will require a long-term strategy, instead of short-term thinking informed by the dictates of election cycles.

1. Put children at the centre

Children and adolescents are at the forefront of experiencing the negative mental health impacts of the COVID-19 pandemic, and they and their children are the ones who are going to experience the real impacts of climate breakdown. A global movement with children at the heart of it is key. The

WHO/UNICEF/Lancet Commission 'A future for the world's children?'²¹ as well as Children in All Policies (CAP2030) (<https://cap-2030.org/>) are recent initiatives to ensure we place children at the centre of all policies. Children must be engaged with as the active citizens they are. Internationally, young people are urging country leaders, government and civil society to take action to preserve their future by acting decisively to curb the impact of climate change on the planet's dwindling capacity to sustain future generations. Their insights into the mental health challenges they face, and the solutions that are needed, are critical. They must be engaged with meaningfully, and we must ensure they are key stakeholders in decision-making and policymaking. In South Africa, efforts to actualise this are in their infancy. For example, the expert committees that monitor the implementation of the United Nation Convention on the Rights of the Child and the United Nations Convention of Persons with Disabilities have urged states and civil society not only to report on progress towards the realisation of children's rights, but to also include direct representation from children and adolescents. The appointment of a Children's Commissioner and Child Government Monitors in all provinces offers another important mechanism for increasing the direct participation of children in the design and implementation of policies and programmes (see Case 3 on p38), as is the involvement of Media Monitoring Africa's Web Rangers in the development of information and communication technology policies (see Case 22 on p109).

2. Strengthen child and adolescent mental health services

Calls to address the high levels of adversity experienced by children and adolescents date back several decades,¹⁰ yet the South African Human Rights Commission report¹¹ still points to systemic neglect and lack of resourcing of the South African mental health care system, identifying children and adolescents as a priority group for service resourcing and provision.

Investment is urgently needed to enable a progressive shift from a solely hospital-based, highly-specialist child and adolescent mental health (CAMH) service to a more integrated CAMH system that spans all three levels of care and is more widely accessible to children and adolescents in South Africa. This process should commence with a commitment to equip each province with a CAMH team in the medium term, and health districts with appropriate resources for child-friendly primary mental health care.

CAMH services should be offered across multiple services, systems and levels of care, recognising that specialist CAMH services will be most fully effective when embedded in a well-coordinated, intersectoral system that supports the mental health and well-being of children and adolescents. A Strategic Mental Health Service Plan for the country must therefore ensure that these services are available across the care pathway. At community level, child and adolescent mental health can be promoted by ensuring that the public and non-governmental workforce are equipped with knowledge and skills to promote mental health and well-being, identify signs of mental ill health and offer psychological first aid in response to crises and trauma¹² and, when necessary, knowledge of how and where to refer the child and family to CAMH specialists for more intensive care. Following these specialist health interventions, children and adolescents with serious episodic or ongoing mental health problems or disorders should continue to receive care from their families, and from a well-capacitated mental health team which is easily accessible through local clinics, district hospitals and/or school health services. These services should be complemented by community-based mental health and well-being programmes.

In addition, the scarcity of dedicated specialist health care teams needs to be urgently addressed so that it does not limit their crucial role in reaching out and capacitating district-based health and community services to provide care and support to children, adolescents and their families. It is therefore essential that the proposed package of CAMH services is incorporated into the proposed baskets of care offered by accredited public and private providers under the

National Health Insurance system.¹³ In addition, financing mechanisms must enable formal collaboration between key sectors addressing child and adolescent health, to ensure that the mental health needs of children and adolescents are adequately addressed and resourced in the Health Benefits Package.

3. Address the social determinants of mental ill health

A consideration of enabling environments is key, one that delivers for the individual in the context of community, but one that goes further and tackles the social determinants of well-being, such as inequality. Young people and families experiencing mental health problems or mental disorders are particularly at risk for drifting into or remaining in poverty as a result of reduced productivity, loss of employment, and increased health expenditure. Poverty eradication programmes that enable families to meet their own needs and foster trade and community security can have a direct impact on mental health and well-being and on families' abilities to thrive and contribute to their own and others' health and well-being. Economic and social development is crucial to create the predictable, enriched and nurturing environments needed to meet the physical, emotional and social needs of children of all abilities, including those with special health care needs, and enable them to flourish.¹⁴ At the same time, we need to address the commercial determinants of health that are fuelling overconsumption and challenge the marketing machinery that makes us think that our happiness and self-worth can be found in the latest fashion or the purchase of material things.

4. Strengthen intersectoral collaboration

Any agenda that has child and adolescent thriving at its core must be ambitious and multisectoral. A comprehensive approach to the systemic disablers of mental health requires a multisectoral approach that extends beyond the departments of health, social development and education to develop an ecosystem of support as outlined in Figure 32. Sectors such as labour, energy, agriculture, water and sanitation, roads, community safety and the built environment can make a tangible difference in promoting mental health by addressing spatial inequalities, improving living conditions, and easing the daily life tasks of children, adolescents and their families. Finally, tackling the commercial determinants of ill-health is vital. From the earliest years across the first two decades of life, children and adolescents are exposed to a tsunami of marketing and advertising for junk food, alcohol and gambling.¹⁵

Case 33: An ecosystem of support for youth and pathways to education and employment

Mario Meyer and Anwar Parker

YearBeyond was established in 2014 as a Youth Service partnership between the Western Cape Government, the Community Chest of the Western Cape, the Michael and Susan Dell Foundation, and numerous non-governmental organisations (NGOs). The programme offers 18–25-year-olds who are not in employment, education or training (NEET) a meaningful work experience and a pathway to further studies and work, while encouraging a culture of active citizenship and volunteerism.

The programme is designed to develop participants' professionalism, emotional intelligence, and agency. Which have been identified as core competencies for first-time employees, based on feedback from alumni and corporates.

During their time on the programme, participants engage in a work experience opportunity, for which they receive a stipend, in an organisation that provides public benefit in the local community. Participants develop their competencies through curated personal and professional development training. At the end of the programme, they are supported to identify and action their 'next step' – the objective being a minimum of 75% of participants progressing to further study or work opportunities.

Participants come from communities that face multiple and complex challenges that undermine their ability to self-actualise. This learning is not unique to YearBeyond. The Presidential Youth Initiative has piloted a Basic Package of Support that targets 18–24-year-olds who are NEET and offers them holistic support and refers them to existing support services so that they are able to find pathways (back) into education, training and work.

YearBeyond's solution for this dilemma was to provide young people with an ecosystem of support that caters for their social, emotional, mental, physical, intellectual, spiritual, financial, and occupational well-being. This is offered through a curated youth development curriculum, mentors, and pathway and progression support.

But this core offering is not always sufficient to unlock the potential of all youth. The programme therefore also offers referrals to specialised or crisis services, leveraging a network of NGOs and state providers.

Eighty percent of requests for support have been focused on trauma support, including trauma debriefing, crisis counselling, social work intermediation, life coaching, as well as depression and anxiety management.

After a year and a half of offering this broader service, approximately 10% of participants have requested access to support. However, based on mentor feedback and surveys, the pool of young people needing support is higher, at closer to 20%. But there are a number of barriers that need to be addressed to improve uptake of support:

- There is often stigma attached to reaching out for help. Consequently, many who need support opt not to seek it out. YearBeyond has found that providing young people with information about available support services at the start of the programme and encouraging discussions about well-being within a safe network of relationships results in a higher take up of support.
- Another reason why young people do not access support services is because they do not know where to find support or how to locate the right service. This calls for better information on what kinds of services are available.
- Many resources and services are available online or telephonically, where the associated communication and connectivity challenges of virtual engagements create additional barriers in accessing support. Those who do have mixed responses to the services received.
- Accessing face-to-face services presents additional challenges related to capacity, location, cultural fit, and opening hours of services. Often this requires going beyond public sector services and reaching out to a broader network of organisations.

Strengthening the focus on trauma and mental health

The demand for trauma-related support points to three areas for action. Firstly, there is a need for a multi-disciplinary, collaborative, trauma-informed approach to working with youth. Organisations that work with young people should consciously include trauma education and interventions in their programmatic work and staff training.

Secondly, building a continuum of support is important. Youth who require medical support for mental well-being are often failed by a system which does not adequately cater for outpatients. Notwithstanding the need to address public health system failures, the responsibility for providing support services to young people cannot rest with the public health system alone. Finally, every youth programme should provide information and navigational skills so that young people are able to access services.

5. Adopt a life-course approach

Interventions to prevent mental health problems and enhance mental health and well-being must start as early as possible and continue as needed across the life course. As children transition to adolescence, continued access to supportive parenting, psychosocial support, and the prevention of injuries, violence, harmful practices and substance abuse; and access to sexual and reproductive health information and services can enhance their mental health and well-being. Preventing negative events early in life must be coupled with targeted interventions further on in the life course that bolster early promotion and prevention efforts to ensure that these early gains are not eroded. What is needed is not only prevention and early intervention, but also sustained investment in child and adolescent mental health.

6. Take an intergenerational approach

A life-course approach should be expanded to account for the ways in which children and their family's mental health and well-being are interdependent and have an intergenerational impact on the mental health and well-being status of future generations. Supporting children and their families living under physically and psychologically adverse conditions provides the potential for improvements in mental health and well-being of both current and future generations.¹⁴ Key here is recognising the intersections between violence against children and violence against women, and how violence may beget violence across generations.

7. Proactively address discrimination and exclusion

Policy development, implementation and resourcing to promote the mental health and well-being of children and adolescents must mainstream responses to the mental health of marginalised young people, including those discriminated against on the grounds of race, class, sex, gender and ability. Actions should prioritise the transformation of our institutions and society to create more tolerant, welcoming, inclusive and enabling environments – where all children are treated with dignity and respect and given equal opportunity. For example, explicit attention to gender discrimination requires actions which break down harmful beliefs and practices that give rise to violent and toxic forms of masculinity. A gendered lens must also consider children's sexual orientation and gender identity and challenge the ways in which the mental and physical health of children, adolescents and adults self-identifying as LGBTQIA+ are threatened by discrimination, social ostracization and threat of incarceration.

8. Close the gap between policy and implementation

Laws and policies must actively address the deep-rooted structural inequalities that continue to compromise children's survival, health and optimal development. South Africa has some of the most progressive and powerful policies and laws in this regard, but all too often, implementation is compromised by a lack of resources and political will. Laws and policies are passed nationally but implemented locally. Therefore, efforts to build the capacity and commitment of local authorities, coupled with community demand and civil society advocacy, are essential to strengthen accountability and enhance the quality of services.

9. Strengthen the evidence base

Given the paucity of research into child and adolescent mental health in South Africa, a number of research avenues need to be explored. South Africa should invest in a national prevalence study to provide accurate information on the extent of child and adolescent mental disorders in the country. Such a study would provide accurate data that can be used to advocate for greater investment in CAMH, guide the planning of services, and assess their impact. Secondly, we need to invest in innovative studies using child participatory methods, human-centred design and programme evaluation. Thirdly, we urgently require research to enhance the design and delivery of state services. Finally, there is a paucity of data focusing on mechanisms linking economic conditions and mental health, related outcomes for children's mental health, and cost-effectiveness of interventions to prevent or treat childhood mental disorders.^{16, 17}

10. Be open, agile, responsive and resilient

Looking back at the COVID-19 pandemic and looking forward to a world undergoing rapid and unprecedented change, it is essential that we develop systems and services that are able to adapt and respond in agile ways to emerging shocks and crises. This focus on building resilient systems needs to extend beyond disaster preparedness to include efforts to build 'everyday resilience', and the leadership practices, organisational culture and social networks that enable people and systems to adapt well to acute shocks and more chronic forms of stress and adversity.¹⁸ To build resilient systems, we must recognise the role of the transformed, multidimensional, cross-sectoral approach we emphasise in this volume in preparing and enabling our children and adolescents to be able to lead their own and the next generations, responses to current and future crises. Ringfencing resources for children's services in times of crisis is an essential first step.

Case 34: Addressing the mental health impacts of climate change

Hanna-Andrea Rotherⁱ and Linda Theronⁱⁱ

Impacts of climate change for South Africa

South Africa faces many challenges linked to climate change. A major concern is the global increase of extreme weather events (EWEs) or natural disasters such as storms, droughts, flooding, heatwaves, high winds and wildfires. Figure 33 illustrates the EWEs' impact on physical, mental and community health. This includes direct impacts on health (e.g., extreme heat stress, malnutrition, mental health strain, violence, injury and disease), as well as indirect impacts (e.g., on water scarcity, agriculture, infrastructure such as schools and health facilities).²⁹

Climate change also intensifies social and economic inequalities,³⁰ and poor children and adolescents are predicted to carry the bulk of the negative climate change impacts³¹. For example, flooding of urban townships will destroy informal housing and increase children's exposure to mould and vector-borne diseases, while drought and water scarcity is likely to increase rural to urban migration. UNICEF describes the climate crisis as a child rights crisis, and South Africa is ranked as a medium- to high-risk country on the Children's Climate Risk Index which

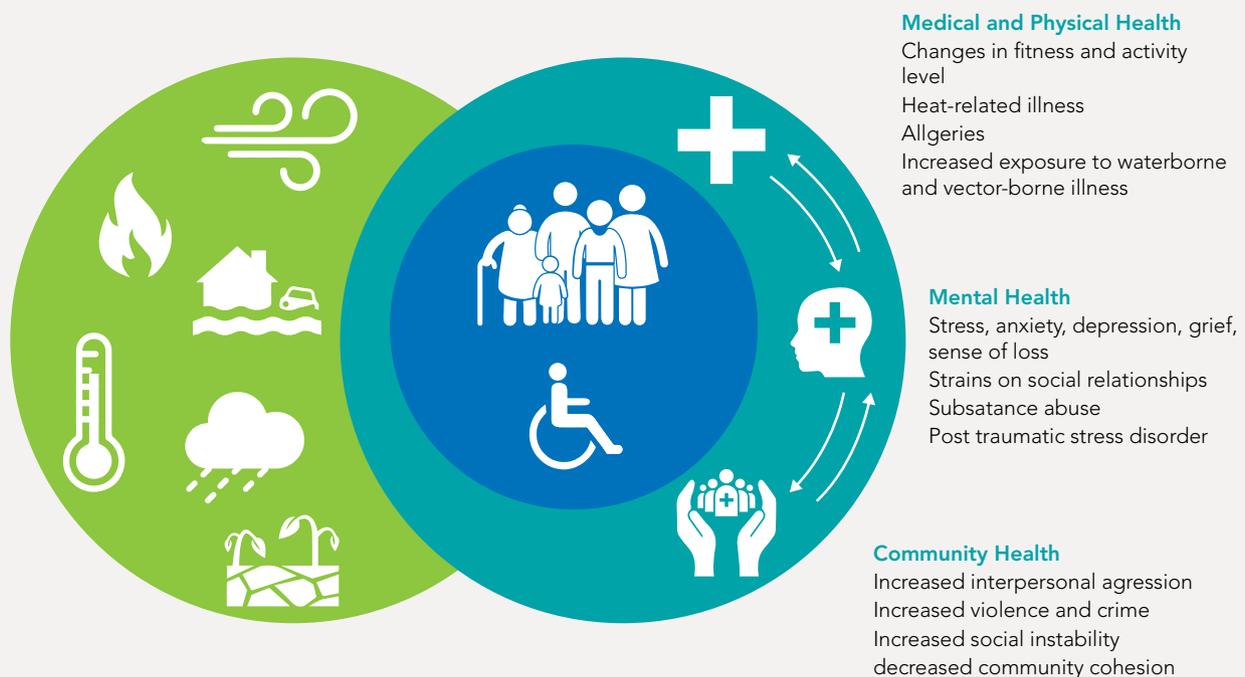
measures children's vulnerability to environmental and climate stresses, hazards and shocks.³²

Climate change impacts on mental health

Relatively few studies have investigated the effects of climate change on child and adolescent mental health,^{31,33} and more especially in African settings where children and adolescents constitute the majority of the population³⁴. These oversights are problematic as most mental health difficulties commence in childhood and adolescence, and young people living in these settings are least likely to have access to mental health services. The studies that have considered child and adolescent mental health in relation to climate change underscore how climate change effects put young people at high risk for psychological distress and mental illness.^{31,33,35-37} This includes risk for first onset, relapse, or aggravated mental health problems.

Direct impacts. Children and adolescents who are exposed to climate change effects, such as floods, droughts and other EWEs and hotter temperatures, are vulnerable to developing mental disorders including anxiety, depression, substance abuse, and post-traumatic

Figure 33: Impacts of climate change on physical, mental and community health



<https://www.psychiatry.org/patients-families/climate-change-and-mental-health-connections>

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stress disorder.³⁸ Heat exposure is typically associated with increased aggression and violence. There are also concerns about young people's capacity to concentrate and make academic progress when poorly insulated and ventilated classrooms expose them to heat stress, as is typically the case in many South African schools.³⁹ Further, girls appear to be more prone to experience negative mental health impacts from exposure to EWEs.⁴⁰

Child and adolescent awareness of climate change threats often translates into psychological distress referred to as 'climate-anxiety' or 'eco-anxiety' – not to be confused with a 'pathological condition'.⁴¹ Eco-anxious young people report anger, fear, despair, and grief⁴² linked to perceptions of no hope for a future and being failed by governments and adults.⁴³ These emotions are more pronounced for young people exposed to high climate risk (e.g., the Philippines).⁴⁴ There is an indication that the enduring impacts on child and adolescent mental health will be felt for years to come as a result stress of climate change and the 'moral injury'⁴³ of governments' failure to put in place effective responses.

Indirect impacts. Often, child and adolescent mental health is indirectly affected by the negative impact of EWEs and rising temperatures on children's social and physical ecologies. For example, weather shocks can diminish caregivers' capacity for quality parenting, disrupt services and social networks, jeopardise livelihoods, and prompt displacement. Similarly, heat-exposed adults may struggle to regulate their emotion and behaviour thereby increasing the risk of domestic and other forms of violence.⁴⁵

Indirect effects can start in utero when the stress of EWEs or heat can compromise healthy prenatal development in ways that then give rise to mental health challenges in childhood and adolescence.³³

Mitigating harm and promoting resilience

Key is to put mechanisms in place to buffer children from climate impacts – this includes mitigating and adapting to the effects of climate change and building the resilience of children, families, and communities.

Resilience is the capacity to adjust well to significant stress (e.g., to sustain or regain mental health following exposure to severe floods). Youth climate justice activists take the responsibility on themselves to facilitate such adjustment. Their activism can have positive personal effects too, building mental health resilience³⁷ and helping young people experience mastery and feel less hopeless

about the future. Yet children's capacity for resilience is only partly shaped by their personal resources (e.g., agency; problem-solving skills). In addition, the capacity for resilience is shaped by resources that are distributed across the multiple systems that young people are connected to.^{46, 47} Examples include resources within young people's social and physical ecologies. For instance, caring, competent parents; functional, enabling schools and child-care facilities; opportunities to play with friends; well-insulated classrooms and homes; and disaster-ready built environments. Together, these multiple resources promote a sense of safety, calm, self- and collective efficacy, connectedness, and hope.^{37, 48} In short, child and adolescent resilience to heat or severe weather events depends on how well their social and physical ecologies respond to climate change threats or events.

In South Africa, not only should every child be educated on climate change and the impacts on their health, but they should also be provided with interpersonal support to develop the skills to seek help, solve problems and soothe themselves to strengthen their resilience. However, the onus for resilience to climate change threats is not only on young people. Instead, resilience is a shared responsibility. Social ecologies that young people interact with daily (such as their immediate families or school communities) as well as more distant ecologies (such as government departments and policy makers) are key partners in building young people's resilience to climate change threats.⁴⁹ For example, caregivers, teachers and schools are typically the first to respond to young people impacted by EWEs. Because EWEs typically disrupt family and school functioning, a first step is to support families and schools to restore everyday routines.⁴⁹ In this regard, schools have a special responsibility to be disaster ready,⁵⁰ and practitioners have a special responsibility to prepare parents and teachers to support child and adolescent mental health in the face and aftermath of climate stress,⁴⁹ as well as to support parents and teachers to maintain their own well-being,⁵¹ while communities have a responsibility to safeguard and restore basic resources (such as electricity) that underpin family and school routines.

While it is important to activate resilience measures across multiple systems to protect children and adolescents' mental health, we should not lose sight of the root of the problem. Efforts to mitigate climate change and reduce CO₂ emissions in South Africa must be equally

prioritised through a just and rapid transition to clean energy sources, clean transportation and sustainable infrastructure and agricultural practices.

Adaptation plans in South Africa should provide guidance on how communities and health systems infrastructure can prevent EWEs effects⁵² and buffer potential mental health impacts. Building on current research, these plans should incorporate child and adolescence appropriate resilience and adaptation benchmarks that need to be achieved.⁴¹ This includes a commitment to improving mental health services in South Africa to ensure timely and adequate treatment to prevent the mental health effects of climate change persisting into adulthood. Adaptation strategies need to be guided not only by the extent of EWEs but should also recognise children and adolescents' particular vulnerability to mental health stressors. It is therefore vital

that South Africa's climate adaptation strategy makes specific reference to safeguarding child and adolescent mental health from the direct and indirect impacts of climate change, which is currently not the case.

Preventing and responding to climate stressors impact on children and adolescent's mental health requires a multidimensional approach that addresses young people's particular developmental vulnerabilities to the multiple impacts on physical, mental and community health. While these responses need to occur at the international, national, sub-national and community level, it is ultimately those in power who wield the means to make a significant impact. Youth climate activism – and the inclusion of youth in developing the policies that will impact their future – provide validating and empowering channels to advance youth resilience and climate justice. In South Africa, this has yet to become a reality.

But in these extraordinary times, Ann Masten's work reminds us that the secret to building resilience is rooted in 'ordinary magic', including 'close relationships with competent caring adults, committed families, effective schools and communities, opportunities to succeed, where belief in the self is nurtured by positive interactions in the world (p14).'¹⁹

Conclusion

The foundations of healthy adulthood are laid in childhood and adolescence, and the core of our humanity lies in our mental well-being and our capacity for healthy engagement with others. The COVID-19 pandemic has shone a harsh spotlight on our existing societal fissures and nowhere is this truer than in how we have treated children and adolescents. Despite being at considerably lower risk of infection and severe illness, children and adolescents have paid a massive cost in terms of schooling lost and missed opportunities for peer interaction. Crucially, decisions about school closures were made for children by adults without any consultation or engagement. No one would suggest children and adolescents would have sacrificed the lives of their parents and grandparents for a few extra days of school. But from time immemorial, we have failed to engage with children and

adolescents meaningfully about their lives, and in the decisions we have made for them and in their name.

We have failed to recognise their drive and creativity, and we have underestimated their resilience, creativity and capacity to persevere in times of challenge. Most profoundly, we have failed to fully grasp the clarity of thought of children and adolescents. This clarity, coupled with their curiosity and a willingness to take risks, is perhaps a function of their not having a vested interest in the status quo.²⁰ Increasingly, however, they are looking around their world and noting our failure as adults, leaders and policymakers to act in their best interests.

The pandemic is a minor dress rehearsal for what climate breakdown portends. The children and adolescents of today are going to have to live with the consequences of our actions – and our failures. We have a brief window of opportunity to act and put children at the centre of all that we do, to harness their energy, curiosity and clarity of thought, and to build resilient communities better able to withstand the challenges to come. Placing the well-being of children and adolescents at the centre of all our policies and actions, and providing opportunities for them to learn, grow and participate in decision-making, will ensure that our 'societies' soul' is one that Mandela – and our children – would be proud of.

Case 35: The global cost of inaction

Donela Besadaⁱ, Sumaiyah Docratⁱⁱ, Crick Lundⁱⁱⁱ

“Economists have estimated that mental, neurological and substance use (MNS) conditions will cost the global economy USD 16.3 trillion (USD 7.3 trillion from LMICs) in the period 2010–30 – more than cancer, diabetes, and respiratory diseases combined.”⁵³

Global estimates reveal that approximately half of mental health conditions have their onset in the mid-teens, rising to nearly three quarters by the mid-twenties.⁵⁴ Amongst those between 10 – 24 years, MNS conditions represent the largest cause of disability, and among the five leading contributors to the global disease burden.⁵⁶ Countries reporting the largest proportion of children and adolescent populations are amongst those most likely to lack the inclusion of child and adolescent health services within mental health policy.⁵⁷ Furthermore, child and adolescent mental health (CAMH) receives approximately 0.1% of overseas development health financing, intensifying the continued neglect of mental health care, in particular, amongst this population.⁵⁸

Low-and middle-income countries face a myriad of challenges in tackling their MNS, including the CAMH burden, particularly in the context of high levels of public debt and additional pressures imposed by the COVID-19 pandemic on all major sources of development finance, inefficiency of public health spending, and competing disease priorities. The synergies that exist between CAMH and other health and development priorities call for an integrated response by governments to address the common risk factors and systems barriers that exist.

What is the role of investment cases?

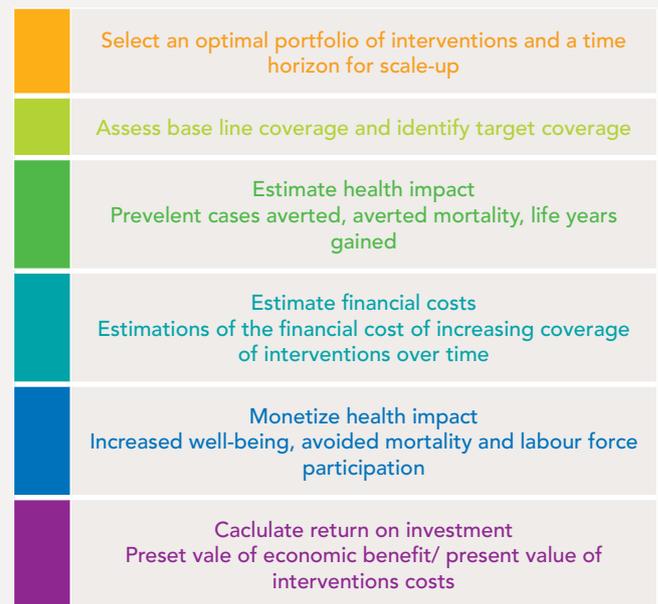
“An investment case provides a compelling argument to potential investors on the desired impact, benefits and/or returns accruing from targeted allocation, release and utilization of resources for key priorities in a given context.”^{59(p. 13)}

Commitments to accelerate global progress towards the Sustainable Development Goals have spurred a series of collaborative efforts between the World Health Organization (WHO), the United Nations Development Programme (UNDP) and national ministries of health to

develop economic arguments to motivate for investment action to address the burden of non-communicable disease. At best, the generation of locally relevant evidence may prompt national governments to increase expanded access to effective clinical interventions for CAMH through enacting bold fiscal, regulatory and policy measures.

The investment case involves a series of six steps as illustrated in Figure 34.

Figure 34: Steps for developing a mental health investment case



Adapted from: World Health Organization, United Nations Development Programme. *Mental health investment case: A guidance note*. Report No.: 9240019383. 2021.

Economic benefits hold instrumental value (through improved educational attainment and an available productive workforce later in life) because of avoided mortality, whilst broader social benefits carry intrinsic value (through increased well-being). The return on investment, presented as the benefit-to-cost ratio, accounts for both, with a ratio greater than 1 indicative of a valuable investment.

$$\text{Benefit – cost ratio} = \frac{(\text{value of increased well-being} + \text{value of increased productivity})}{\text{intervention costs}}$$

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Adapting interventions to local needs

A South African mental health investment case was undertaken to adapt global treatment recommendations to the national context.⁶⁰ The investment case included a number of important additional innovations, including: (1) strong collaboration with provincial departments of health to contextualize the analysis within implementation realities, (2) a broad consultation with a panel of experts through a Delphi study to obtain consensus across intervention priorities, (3) increased focus on primary health care and redistribution of resources towards the development of community mental health services, and (4) consideration of programmatic enablers, including governance arrangements in the health system and broad sectoral responsibilities, amongst others.

Results of the South African mental health investment case for children and adolescents

The investment case included the following interventions targeted at children and adolescents:

- universal and indicated social-emotional learning programmes for learners;
- psychosocial support and treatment for anxiety and depressive disorders;
- diagnosis and management of behavioural disorders, including conduct disorder and ADHD through family psychoeducation; and
- diagnosis and management of intellectual disabilities, including through the provision of community-based services.

The analysis demonstrates returns on investment of R2.30 and R3.60 for every R1.00 invested, for universally provided socio-emotional learning programmes, and intensive psychosocial interventions and medication for

children with moderate-severe depression, respectively. Modelled returns on investment for child and adolescent populations are likely to be much larger than current methodologies allow for, as immediate productivity gains from this population group could not be included. This is mainly because there is not yet an established methodology for translating educational improvements to increased job and earning potential later in life. This has likely contributed to an underestimate of the returns on investment modelled for interventions for childhood behavioural and conduct disorders, anxiety, and intellectual disability. Estimated returns are further limited by extremely high rates of unemployment, exacerbated by the COVID-19 pandemic. Despite these limitations, investments in CAMH are recognised as key to global development and economic recovery.

Making an economic case for investment is a strong advocacy tool but has been criticised for its narrow focus on productivity as the primary outcome, and its failure to consider additional benefits (including improvements in inequality, discrimination and human dignity).⁶¹ Consequently, these economic arguments should be considered in tandem with broader public health and health system goals and a nation's human rights obligations. The principles underlying the South African Mental Health Investment Case were therefore not only guided by cost-containment objectives, but also by the moral imperatives for rights-based, quality care.

In summary, both global^{62, 63} and local adolescent investment cases focusing on the risk factors associated with CAMH and early interventions to address these conditions, provide a strong, quantifiable justification for child and adolescent health to be made an explicit priority in national and international policy.

References

1. Klein N. *This Changes Everything: Capitalism vs the climate*. New York: Simon & Shuster; 2014.
2. Andri Snaer Magnason. *On Time and Water: A History of Our Future*. London: Serpents Tail. 2020
3. World Health Organization. *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential*. Geneva: WHO; 2018.
4. Black RE, Liu L, Hartwig FP, Villavicencio F, Rodriguez-Martinez A, Vaidetti LP, et al. Health and development from preconception to 20 years of age and human capital. *Lancet*. 2022;399(10336):1730-40. 10.1016/S0140-6736(21)02533-2.
5. Bhutta ZA, Boerma T, Black MM, Victora CG, Kruk ME, Black RE. Optimising child and adolescent health and development in the post-pandemic world. *Lancet*. 2022. 10.1016/S0140-6736(21)02789-6.
6. Tomlinson M, Hunt X, Daelmans B, Rollins N, Ross D, Oberklaid F. Optimising child and adolescent health and development through an integrated ecological life course approach. *BMJ*. 2021;372:m4784. 10.1136/bmj.m4784.
7. Desmond C, Watt K, Tomlinson M, Williamson J, Sherr L, Sullivan M, et al. Other people's children and the critical role of the social service workforce. *Vulnerable Children and Youth Studies*. 2022:1-13.
8. Tomlinson M, Ross DA, Bahl R, Rollins N, Daelmans B, Simon J, et al. What will it take for children and adolescents to thrive? The Global Strategy for Women's, Children's, and Adolescents' Health. *The Lancet Child & Adolescent Health*. 2019;3(4):208-9. 10.1016/S2352-4642(19)30004-5.
9. Nussbaum MC. *Creating Capabilities: The human development approach*. Cambridge, MA: Harvard University Press; 2011.
10. Reynolds P, Dawes A. *Truth and Reconciliation Commission: Focus on children and youth*. May 1997. *Truth and Youth: Pain and blame*. 1997.
11. South African Human Rights Commission. *Report of the National Investigative Hearing into the Status of Mental Health Care in South Africa*. 14 and 15th November 2017. Pretoria: SAHRC; 2017.
12. Kriel E, Rademeyer M. *Psychological trauma for children, adolescents and their families*. A guide for first responders. 2021. <https://www.unicef.org/southafrica/media/5731/file/ZAF-psychological-first-aid-children-adolescents-families-experiencing-trauma-2021.pdf>.
13. Department of Health. *Government Gazette no. 42598, National Health Insurance Bill, 2019*, 26 July 2019. 2019.
14. United Nations. *Every Woman, every Child: The global strategy for women's, children's and adolescents' health (2016-2030)*. 2015. <https://www.who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf>.
15. Clark H, Coll-Seck AM, Banerjee A, Peterson S, Dalgligh SL, Ameratunga S, et al. A future for the world's children? A WHO-UNICEF-Lancet Commission. *Lancet*. 2020;395(10224):605-58. 10.1016/S0140-6736(19)32540-1.
16. Golberstein E, Gonzales G, Meara E. How do economic downturns affect the mental health of children? Evidence from the National Health Interview Survey. *Health Economics*. 2019;28(8):955-70.
17. Schmidt M, Werbrouck A, Verhaeghe N, Putman K, Simoens S, Annemans L. Universal mental health interventions for children and adolescents: A systematic review of health economic evaluations. *Applied Health Economics and Health Policy*. 2020;18(2):155-75.
18. Barasa E, Mbau R, Gilson L. What is resilience and how can it be nurtured? A systematic review of empirical literature on organizational resilience. *International Journal of Health Policy and Management*. 2018;7(6):491-503.
19. Masten AS. *Ordinary Magic: Resilience in development*. New York The Guilford Press 2014.
20. Hershovitz S. *Nasty, Brutish, and Short: Adventures in Philosophy with my Kids*. London: Penguin Press; 2022.
21. Clark H, Coll-Seck AM, Banerjee A, Peterson S, Dalgligh SL, Ameratunga S, et al. A future for the world's children? A WHO-UNICEF-Lancet Commission. *Lancet*. 2020;395(10224):605-58.
22. Sherr L, Cluver L, Tomlinson M, Idele P, Banati P, Anthony D, . . . Hunt X. *Mind Matters: Lessons from past crises for child and adolescent mental health during COVID-19*. . Innocenti, Florence: UNICEF Office of Research. 2021.
23. Sherr L, Cluver L, Tomlinson M, Laurenzi C, Roberts K. *Everybody Knows: COVID-19 Mental health and Psychosocial support needs for adolescents and young adults in the ESAR region*. Nairobi: UNICEF ESARO. 2022.
24. Vizard T, Sadler K, Ford T, Newlove-Delgado T, McManus S, Marcheselli F, Cartwright C. *Mental Health of Children and Young People in England, 2020*. London: NHS: Health and Social Care Information Centre. 2020. [mhryp_2020_rep.pdf (digital.nhs.uk)]
25. Racine N, McArthur BA, Cooke JE, Eirich R, Zhu J, Madigan S. Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: A meta-analysis. *JAMA Pediatrics*. 2021;175(11):1142-1150.
26. Samji H, Wu J, Ladak A, Vossen C, Stewart E, Dove N, . . . Snell G. Review: Mental health impacts of the COVID-19 pandemic on children and youth - a systematic review. *Child and Adolescent Mental Health*. 2022;27(2):173-189.
27. Tomlinson M, Richter L, Slemming W. What the science of child and adolescent development contributes to understanding the impacts of COVID-19. *South African Journal of Science*. 2021;117:1-2.
28. Ministerial Advisory Committee. *The Mental Health Impact of COVID-19 on South African Society: How to Build Back Better*. Pretoria: Department of Health: Ministerial Advisory Committee (MAC) on COVID-19. 2022. [https://sacoronavirus.b-cdn.net/wp-content/uploads/2022/05/MAC-Advisory_Mental-Health_04-May-2022_final.pdf]
29. Rother H-A, Wijesekere S, Ward F. The impact of the environment on South Africa's child and adolescent health: An overlooked health risk. In: Shung-King M, Lake L, Sanders D, M H, editors. *Child and adolescent health - Leave no one behind South African Child Gauge 2019*. Cape Town: Children's Institute, University of Cape Town; 2019. p. 161.
30. Hoffman JS, Shandas V, Pendleton N. The effects of historical housing policies on resident exposure to intra-urban heat: A study of 108 US urban areas. *Climate*. 2020;8(1):12.
31. Burke SE, Sanson AV, Van Hoorn J. The psychological effects of climate change on children. *Current Psychiatry Reports*. 2018;20(5):1-8.
32. Rees N. *The climate crisis is a child rights crisis: Introducing the Children's Climate Risk Index*. New York: United Nations Children's Fund (UNICEF); 2021.
33. Vergunst F, Berry HL. Climate Change and Children's Mental Health: A Developmental Perspective. *Clinical Psychological Science*. 2021:21677026211040787.
34. Rother H-A, Hayward RA, Paulson JA, Etzel RA, Shelton M, Theron LC. Impact of extreme weather events on Sub-Saharan African child and adolescent mental health: The implications of a systematic review of sparse research findings. *The Journal of Climate Change and Health*. 2021:100087.
35. Clemens V, von Hirschhausen E, Fegert JM. Report of the intergovernmental panel on climate change: Implications for the mental health policy of children and adolescents in Europe—a scoping review. *European Child & Adolescent Psychiatry*. 2020:1-13.
36. Rataj E, Kunzweiler K, Garthus-Niegel S. Extreme weather events in developing countries and related injuries and mental health disorders: A systematic review. *BMC Public Health*. 2016;16(1):1-12.
37. van Nieuwenhuizen A, Hudson K, Chen X, Hwong AR. The effects of climate change on child and adolescent mental health: Clinical considerations. *Current Psychiatry Reports*. 2021;23(12):1-9.
38. Clayton S, Manning C, Speiser M, Hill A. *Mental health and our changing climate: Impacts, inequities, responses*. Washington DC. 2021.
39. Chersich MF, Scorgie F, Wright C, Mullick S, Mathee A, Hess J, Rees H. Climate change and adolescents in South Africa: The role of youth activism and the health sector in safeguarding adolescents' health and education. *South African Medical Journal*. 2019;109(9):615-619.
40. Taukeni S, Chitiyo G, Chitiyo M, Asino I, Shipena G. Post-traumatic stress disorder amongst children aged 8-18 affected by the 2011 northern-Namibia floods. *Jambá: Journal of Disaster Risk Studies*. 2016;8(2):1-6.
41. Hurley EA, Dalgligh SL, Sacks E. Supporting young people with climate anxiety: Mitigation, adaptation, and resilience. *The Lancet Planetary Health*. 2022;6(3):e190.
42. Lee K, Gjersoe N, O'Neill S, Barnett J. Youth perceptions of climate change: A narrative synthesis. *Wiley Interdisciplinary Reviews: Climate Change*. 2020;11(3):e641.
43. Hickman C, Marks E, Pihkala P, Clayton S, Lewandowski RE, Mayall EE, van Susteren L. Climate anxiety in children and young people and their beliefs about government responses to climate change: A global survey. *The Lancet Planetary Health*. 2021;5(12):e863-e873.
44. Aruta JJBR, Simon PD. Addressing climate anxiety among young people in the Philippines. *The Lancet Planetary Health*. 2022;6(2):e81-e82.
45. Sanz-Barbero B, Linares C, Vives-Cases C, González JL, López-Ossorio JJ, Diaz J. Heat wave and the risk of intimate partner violence. *Science of the Total Environment*. 2018;644:413-419.
46. Masten AS, Motti-Stefanidi F. Multisystem resilience for children and youth in disaster: Reflections in the context of COVID-19. *Adversity and resilience science*. 2020;1(2):95-106.
47. Ungar M, Theron L. Resilience and mental health: How multisystemic processes contribute to positive outcomes. *The Lancet Psychiatry*. 2020;7(5):441-448.
48. Masten AS, Narayan AJ. Child development in the context of disaster, war, and terrorism: Pathways of risk and resilience. *Annual review of psychology*. 2012;63:227-257.
49. Masten AS. Resilience of children in disasters: A multisystem perspective. *International journal of psychology*. 2021;56(1):1-11.

50. Theron L. Learning about systemic resilience from studies of student resilience. *Multisystemic resilience*. 2021;232-252.
51. Matsopoulos A, Luthar SS. Parents, caregivers and educators: The forgotten stakeholders in the discussion of resilience—An international perspective. *International Journal of School & Educational Psychology*. 2020;8(2):75-77.
52. Chersich MF, Wright CY. Climate change adaptation in South Africa: A case study on the role of the health sector. *Globalization and Health*. 2019;15(1):1-16.
53. Bloom DE, Cafiero E, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, Mowafi M. *The Global Economic Burden of Noncommunicable Diseases*. Program on the Global Demography of Aging. 2012.
54. Ryan G, Lemmi V, Hanna F, Loryman H, Eaton J. *Mental Health for Sustainable Development: A topic guide for development professionals*. 2020. [<https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/14908>]
55. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry*. 2007;20(4):359.
56. Erskine H, Moffitt TE, Copeland W, Costello E, Ferrari A, Patton G, Scott J. A heavy burden on young minds: The global burden of mental and substance use disorders in children and youth. *Psychological Medicine*. 2015;45(7):1551-1563.
57. World Health Organization. *Atlas: Child and adolescent mental health resources. Global concerns: implications for the future*: WHO; 2005.
58. Lu C, Li Z, Patel V. Global child and adolescent mental health: The orphan of development assistance for health. *PLoS Medicine*. 2018;15(3):e1002524.
59. Carvalho N MA, Rasmussen B, Stover J Dieleman J L, Weiberger M, Sanders R, Chou V, Winfrey W. *Developing Investment Cases For Transformative Results: Toolkit* New York, U.S.A: United Nations Population Fund (UNFPA). 2021 [https://www.unfpa.org/sites/default/files/pub-pdf/Developing_Investment_Cases_for_Transformative_Results_Toolkit.pdf]
60. Besada D, Docrat S, Lund C. *Mental Health Investment Case for South Africa. Final report of the Mental Health Investment Case Task Team*. Pretoria: Department of Health. 2021.
61. Cosgrove L, Mills C, Karter JM, Mehta A, Kalathil J. A critical review of the Lancet Commission on global mental health and sustainable development: Time for a paradigm change. *Critical Public Health*. 2020;30(5):624-631.
62. Sweeny K, Friedman HS, Sheehan P, Fridman M, Shi H. A health system-based investment case for adolescent health. *Journal of Adolescent Health*. 2019;65(1, Supplement):S8-S15.
63. Watkins D, Hale J, Hutchinson B, Kataria I, Kontis V, Nugent R. Investing in non-communicable disease risk factor control among adolescents worldwide: A modelling study. *BMJ Global Health*. 2019;4(2):e001335.





PART THREE

Children Count – the numbers

Part three presents a set of key indicators highlighting drivers of child and adolescent morbidity and mortality and disaggregates data to make visible inequalities in children's health, nutrition, living conditions and access to services. A set of key indicators tracks progress in the following domains:

- Demography of South Africa's children
- Income poverty, unemployment and social grants
- Child health
- Nutrition
- Education
- Housing
- Basic services

A full set of indicators and detailed commentaries are available on www.childrencount.uct.ac.za.

Good nutrition and household food security are essential building blocks for physical and mental health, and the food gardens of the Bulungula Incubator Project in the Eastern Cape provide young children with a daily meal that is rich in nutrients
© Annette Champion, Bulungula Incubator

Introducing Children Count

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

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

A rights-based approach

Children Count was established in 2005 to monitor progress for children and is an ongoing data and advocacy project of the Children's Institute, updated every year. It provides statistical information that can be used to inform the design and targeting of policies, programmes and interventions, and as a tool for tracking progress in the realisation of children's rights.

Child-centred data

Any monitoring project needs regular and reliable data, and South Africa is fortunate to have a reasonably good supply. There is an array of administrative data sets, and the national statistics body, Statistics South Africa (Stats SA), undertakes regular national population surveys that provide useful information on a range of measures. Most reports about the social and economic situation of people living in South Africa do not focus on children, but rather count all individuals or households. This is of limited use for those interested in understanding the situation of children.

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

Counting South Africa's children

Children Count presents child-centred data on many of the areas covered under socio-economic rights. As new data become available with the release of national surveys and other data sources, it is possible to track changes in the conditions of children and their access to services over time. This year, national survey data are presented the period 2002 to 2020, and many of

the indicators in this issue compare the situation of children over this 19-year period.

The main household survey used as a data source for *Children Count* is the General Household Survey (GHS), a large nationally representative survey that Stats SA runs every year. We analyse the raw data to derive statistical estimates for the *Children Count* indicators. Usually, the survey is undertaken through face-to-face interviews at people's homes and fieldwork runs throughout the year. In 2020, data collection was stopped abruptly in March due to COVID-19 and lockdown. Stats SA revised the questionnaire so that interviews could be conducted telephonically and conducted the survey between September and December 2020. There were two important consequences of this change.

First, the survey only included households in the sample that were contactable by telephone, limiting the sample to those who had previously provided phone numbers in 2019 and whose numbers still worked in 2020. The response rate was unusually low (39.4% in 2020, compared with 87.2% in 2019). Although Stats SA adjusted the population weights to control for bias, the profile of people who have phones is different from those who do not (or those whose numbers change), and bias adjustment is unlikely to be able to correct adequately for the skewed sample. Stats SA acknowledges that because the GHS estimates are not based on a full sample, comparisons with previous years should be made with caution, especially when interpreting results at low levels of disaggregation.

Second, because the survey was adjusted to allow for telephonic interviews, it needed to be shortened. Some of the questions usually analysed for *Children Count* were excluded – notably the time taken to get to school and to health facilities, and the questions on pregnancy and birth. For these indicators we have used 2019 data.

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

The indicators in this *South African Child Gauge* are a sub-set of the *Children Count* indicators. The project's website contains the full range of indicators and more detailed interactive data, as well as links to websites and useful documents. It can be accessed at www.childrencount.uct.ac.za.

Confidence intervals

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

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

Data sources and citations

Children Count uses a few data sources. Most of the indicators are analysed by our team using data from the General Household Survey while some draw on administrative databases used by government departments (Health, Education, and Social Development) to record and monitor the services they deliver.

Most of the indicators presented were developed specifically for this project. Data sources are carefully considered before inclusion, and the technical notes and strengths and limitations of each are outlined on the project website.

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

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

Hall K (2020) Demography of South Africa's children. In: Tomlinson M, Kleintjes S & Lake L (eds) *South African Child Gauge 2021*. Cape Town: Children's Institute, University of Cape Town.

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

Hall K (2022) Housing and Services – Access to adequate water. Children Count website, Children's Institute, University of Cape Town. Accessed on 20 May 2022: www.childrencount.uct.ac.za

Each domain is introduced below, and key findings are highlighted.

Demography of South Africa's children

(pages 164 – 168)

This section provides child population figures and gives a profile of South Africa's children and their care arrangements, including children's co-residence with biological parents. There were 20 million children in South Africa in 2020 and 20% of children do not live with either of their biological parents.

Income poverty, unemployment and social grants

(pages 169 – 176)

Job loss due to lockdown had a direct effect on children. Unemployment increased and in the latter part of 2020, 36% of children lived in households where nobody was earning income through employment or self-employment (up from 30% in 2019). Alongside the rise in unemployment, income poverty rates increased. Income poverty rates are calculated in two ways: with

and without disaster relief grants and top-ups. In the absence of disaster relief, the child poverty rate at the upper bound poverty line was 63%, while 39% of children (8 million) were below the food poverty line. In a scenario for the months where the full disaster relief programme was in place, strong protective effects are evident, with the upper bound poverty rate among children reduced to 60% and the food poverty rate to 34%. Social assistance grants are therefore an important source of income for caregivers to meet children's basic needs and to protect children and their households from income shocks. In March 2022, 12.9 million children received the Child Support Grant (a slight drop from the previous year); 252,000 children received the Foster Child Grant (a substantial and consistent decline in numbers over the past decade). The Care Dependency Grant has remained stable, with about 150,000 child beneficiaries in 2022.

Child health

(pages 177 – 183)

This domain monitors child health through a range of indicators. Over 2 million children (11%) live in households where children are reported to experience hunger. Under-five mortality has decreased from 39 deaths per 1,000 live births in 2015 to 28 deaths per 1,000 live births in 2020. The infant mortality rate has also declined and is estimated at 21 deaths per 1,000 live births in 2020. The neonatal mortality rate, however, has remained stable at 12 per 1,000 live births over the six-year period. A fifth (19%) of children travel far to reach their primary health care facility and 83.5% of children are fully immunised in their first year.

Children's access to education

(pages 184 – 191)

South Africa has made significant strides in improving access to education with a reported attendance rate of 97% in 2020. Access is also increasing in the preschool years, with 93% of 5 – 6-year-olds attending some kind of educational institution or care facility. However, this does not necessarily translate into improved educational outcomes or progress through school. A third of young people aged 15 – 24 (35%) are not in employment, education or training, and there has been no improvement in this measure since 2002.

Children's access to housing

(pages 192 – 195)

This domain presents data on children living in rural or urban areas, and in adequate housing. The latest available data show that, in 2020, 57% of children were living in urban areas, and 85% of children lived in formal housing. Nearly one in ten children (1.6 million) lived in backyard dwellings and shacks in informal settlements, and one in five children (21%) lived in overcrowded households.

Children's access to basic services

(pages 196 – 198)

Without water and sanitation, children face substantial health risks that also compromise their nutritional status. In 2020, 70% of children had piped drinking water at home, and 78% have an adequate toilet on site – an improvement from 47% in 2002.

Demography of South Africa's children

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

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

The child population in South Africa

In mid-2018, South Africa's total population was estimated at 60 million people,² of whom 20 million were children under 18 years. Children therefore make up 34% of the total population.

The distribution of children across provinces is slightly different to that of adults, with a greater share of children living in provinces with large rural populations. Together, KwaZulu-Natal, the Eastern Cape and Limpopo accommodate almost half of all children in South Africa. Gauteng, the smallest province in terms of physical size, has overtaken KwaZulu-Natal to become the province with the largest child population: 22% of all children in the country live in Gauteng. Gauteng also has the largest share of the adult population (28%) and the largest share of households. The child population of Gauteng has grown by 50% since 2002, making it the fastest growing province.

There have also been striking changes in other provincial child populations since 2002. The number of children living in the Eastern Cape has decreased substantially (by 13%), while the number of children living in the Western Cape has risen by 30%. The North West has also seen a substantial increase of 24% in the child population since 2002. A rise in the child population is partly the result of population movement (for example, when children are part of migrant households or move to join existing

urban households), and partly the result of natural population growth (new births within the province).

We can look at inequality by dividing all households into five equal groups or income quintiles, based on total income to the household (including earnings and social grants) and dividing that by the number of household members, with quintile 1 being the poorest 20% of households, quintile 2 being the next poorest and so on. Quintile 5 consists of the least-poor 20%. Children are concentrated in poorer households, with 58% of children living in the poorest 40% of households (the poorest two quintiles), compared with 42% of adults.

The gender split is equal for children: 50% male and 50% female. In terms of the apartheid-era racial categories, 86% of children are African, 8% are Coloured, 4% White and 2% Indian.

These population estimates are based on the General Household Survey (GHS), which is conducted annually by Statistics South Africa. The GHS usually collects data on about 20,000 households and over 70,000 individuals, though in 2020 the survey was conducted telephonically with a smaller sample of just under 30,000 individuals in 9,000 households. The population numbers derived from the survey are weighted to the mid-year population estimates using weights provided by Statistics South Africa. Using previously weighted data (the

Table 1a: Distribution of households, adults and children in South Africa, by province, 2020

PROVINCE	HOUSEHOLDS		ADULTS		CHILDREN		
	N	%	N	%	N	%	% change 2002 - 2020
Eastern Cape	1,709,000	10%	3,970,000	10%	2,554,000	12%	-13%
Free State	931,000	5%	1,891,000	5%	1,057,000	5%	6%
Gauteng	5,174,000	30%	11,091,000	28%	4,417,000	22%	50%
KwaZulu-Natal	3,026,000	17%	7,345,000	19%	4,302,000	21%	4%
Limpopo	1,641,000	9%	3,566,000	9%	2,472,000	12%	2%
Mpumalanga	1,354,000	8%	2,978,000	8%	1,722,000	8%	13%
North West	1,267,000	7%	2,630,000	7%	1,439,000	7%	24%
Northern Cape	354,000	2%	821,000	2%	440,000	2%	11%
Western Cape	1,962,000	11%	4,844,000	12%	2,092,000	10%	30%
South Africa	17,418,000	100%	39,136,000	100%	20,496,000	100%	13%

Source: Statistics South Africa (2021) *General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

2013 population model), it appeared that the child population had remained fairly stable, with a marginal reduction of 0.2% in the population size between 2002 and 2015. However, there was considerable uncertainty around the official population estimates, particularly in the younger age groups.³ In 2017, Statistics South Africa updated the model and recalibrated

the mid-year population estimates all the way back to 2002,⁴ and subsequently released the data with new weights from 2018. Based on the revised weights it appears that the child population has grown by 13%, increasing from 18.1 million in 2002 to 20.5 million in 2020.

Children living with their biological parents

Many children in South Africa do not live consistently in the same household as their biological parents. This is an established feature of childhoods in South Africa, and international studies have shown that the country is unique in the extent that parents are absent from children's daily lives.^{5, 6} Parental absence is related to many factors, including apartheid-era controls on population movement, labour migration, poverty, housing and educational opportunities, low marriage and cohabitation rates, as well as customary care arrangements.⁷⁻¹¹ It is common for relatives to play a substantial role in child-rearing. Many children experience a sequence of different caregivers, are raised without fathers, or live in different households to their biological siblings.

Parental absence does not necessarily mean parental abandonment. Many parents continue to support and see their children regularly even if they have to live elsewhere.¹²⁻¹⁴

Virtually all children live with at least one adult, and 91% of children live in households where there are two or more co-resident adults. This indicator examines co-residence between children and their biological parents specifically. Although many children live with just one of their biological parents (usually the mother), this does not mean that the mother is a "single parent" as she is not necessarily the only adult caregiver in the household. In most cases, there are other adult household members such as aunts, uncles and grandparents who may

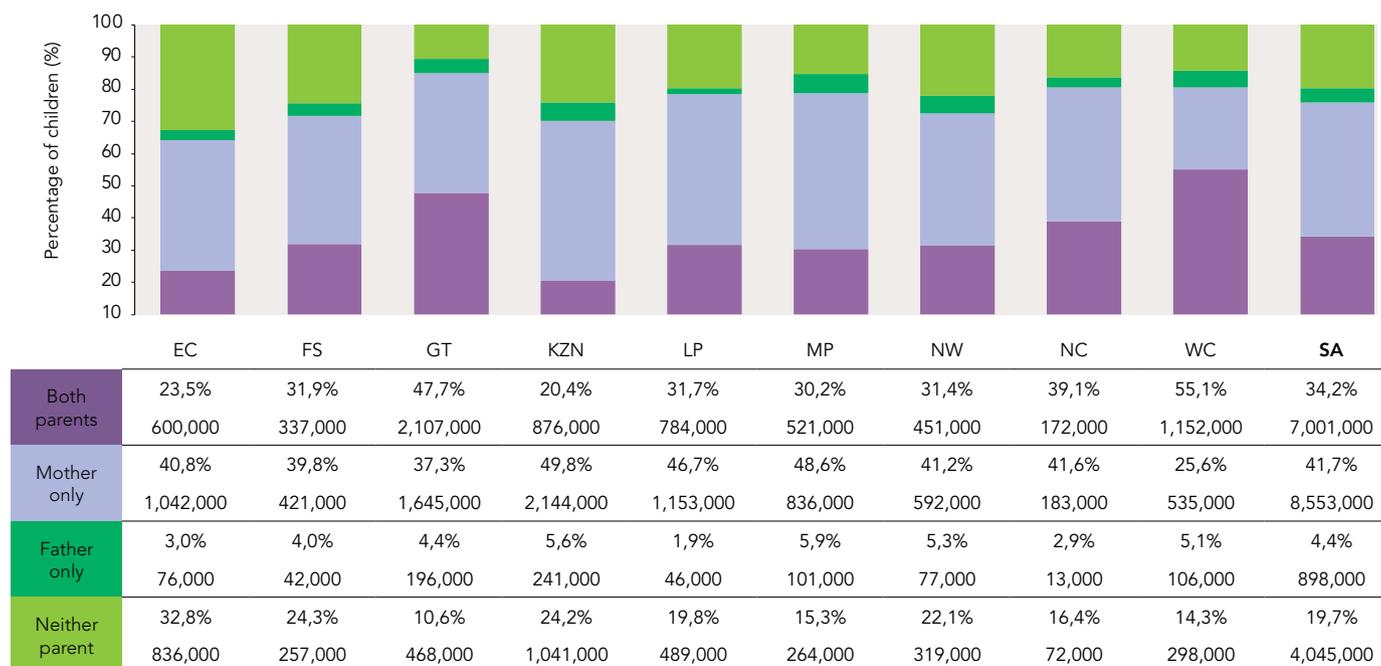
contribute to the care of children.

The share of children living with both parents decreased gradually from 39% in 2002 to 34% in 2010, and remained stable at around 34% for the next 10 years. Forty-two percent of all children (8.6 million children) live with their mothers but not with their fathers. Only 4% of children live in households where their fathers are present and their mothers absent. Twenty percent do not have either of their biological parents living with them. This does not necessarily mean that they are orphaned: 85% of children without any co-resident parents have at least one parent who is alive but living elsewhere.

There is substantial provincial variation within these patterns. In the Western Cape and Gauteng, the share of children living with both parents is significantly higher than the national average, with around half of children resident with both parents (55% and 48%, respectively). Similarly, the number of children living with neither parent is relatively low in these two provinces (14% and 11%, respectively). In contrast, a third of children (33%) in the Eastern Cape live with neither parent. These patterns have been fairly consistent from 2002 to 2020.

Children in the poorest 20% of households are least likely to live with both parents: only 21% have both parents living with them, compared with 51% of children in the wealthiest 20% of households.

Figure 1a: Children living with their biological parents, by province, 2020



Source: Statistics South Africa (2021) *General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Less than one-third (30%) of African children live with both their parents, while the vast majority of Indian and White children (86% and 79%, respectively) reside with both biological parents. More than one in five of all African children do not live with either parent and a further 45% live with their mothers but not their fathers. These figures are striking for the way in which they suggest the

limited presence of biological fathers in the home lives of large numbers of children. Younger children are more likely than older children to have co-resident mothers, while older children are more likely to be living with neither parent. While 14% of children aged 0 – 5 years (965,000) live with neither parent, this increases to 25% (1.6 million) of children aged 12 – 17 years.

Orphaned children

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

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

The total number of orphans is the sum of maternal, paternal and double orphans.

In 2020, there were 2.9 million orphans in South Africa. This includes children without a living biological mother, father or both parents, and is equivalent to 14% of all children in South Africa. The majority (61%) of all orphans in South Africa are paternal orphans (with living mothers).

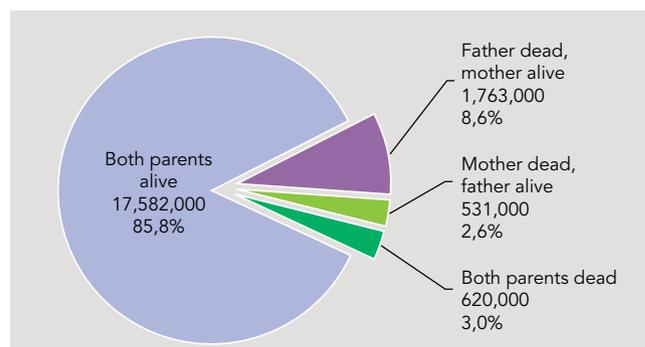
The total number of orphans increased by over a million between 2002 and 2009, after which the trend was reversed. By 2017, orphan numbers had fallen to below 2002 levels. This was largely the result of improved access to antiretrovirals. Since 2018, the number of orphaned children has increased by 230,000.

Orphan status is not necessarily an indicator of the quality of care that children receive. It is important to disaggregate the total orphan figures because the death of one parent may have different implications for children than the death of both parents. In particular, it seems that children who are maternally orphaned are at risk of poorer outcomes than paternal orphans – for example, in relation to education.¹⁵

In 2020, 3% of all children in South Africa were maternal orphans with living fathers, 9% were paternal orphans with living mothers, and a further 3% were recorded as double orphans. This means that 6% of children in South Africa (1,15 million children) did not have a living biological mother and twice that number did not have a living biological father. The numbers of paternal orphans are high because of the higher mortality rates of men in South Africa, as well as the frequent absence of fathers from their children's lives (2.1% or 429,000 children have fathers whose vital status is reported to be 'unknown', compared with 0.2% or 44,000 children whose mothers' status is unknown).

The number and share of children who are double orphans more than doubled between 2002 and 2009, from 361,000 to 886,000 after which the rates fell again.¹⁶ In 2018, 471,000 children had lost both their parents, but the numbers rose again through 2019 and 2020, to 620,000. Orphaning rates are particularly high in the Eastern Cape, where households carry a large burden

Figure 1b: Children living in South Africa, by orphanhood status, 2020



Source: Statistics South Africa (2021) *General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

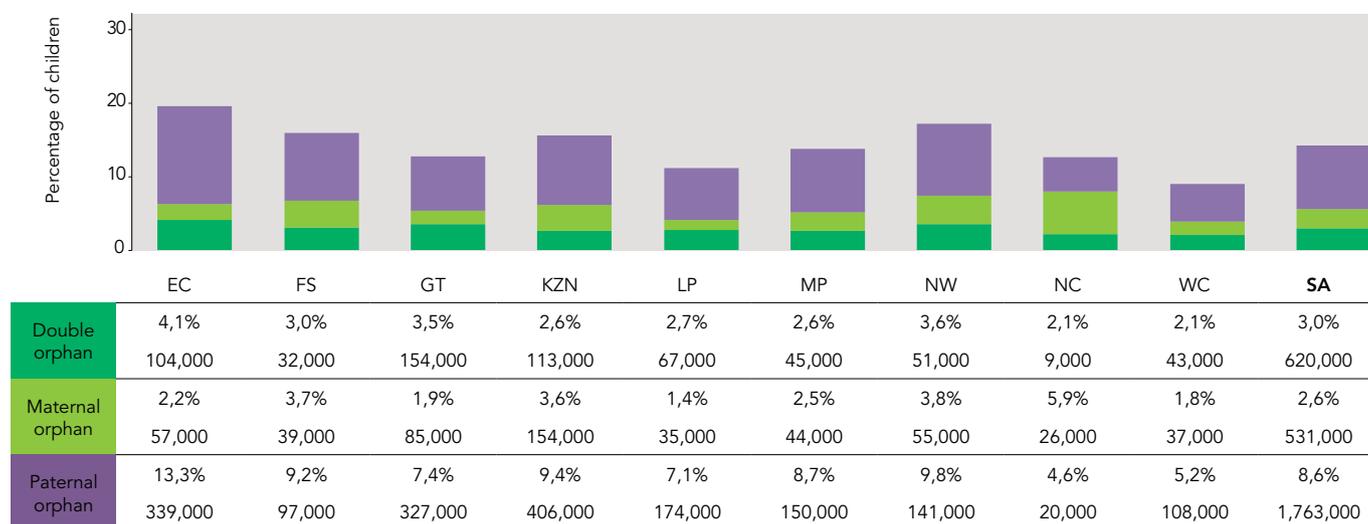
of care for orphaned children and 4% of children are double orphans. In terms of orphan numbers, double orphans are concentrated mostly in three provinces: KwaZulu-Natal (23% of double orphans), Gauteng (19%) and the Eastern Cape (19%). Together these three provinces are home to 61% of all double orphans.

KwaZulu-Natal has the largest child population and the highest orphan numbers, with 673,000 children (16% of children in that province) recorded as orphans who have lost a mother, a father or both parents. Orphaning rates in the Eastern Cape (20%) are even higher, although the number of children orphaned is lower (500,000 because the child population is smaller). In 2020, Gauteng emerged as the province with the second highest and quickest growing orphaning numbers, where 13% of children (566,000) were single or double orphans. North West also appears to have experienced an increase in orphaning rates over the past three years, in particular maternal and double orphaning. The lowest orphaning rates are in the Western Cape (9% of children) and Limpopo (11%).

The poorest households carry the greatest burden of care for orphans. More than a third (36%) of all orphans are resident in the poorest 20% of households. Seventeen percent of children in the poorest 20% of households are orphans, compared with the richest 20% where total orphaning rates are around 11% – lower than the poorer quintiles but an increase from 2018 when orphaning rates in the wealthiest quintile were 4%.

The likelihood of orphaning increases with age. Across all age groups, the main form of orphaning is paternal orphaning, which increases from 5% among children under six years of age, to 13% among children aged 12 – 17 years. While less than 1% of children under six years are maternal orphans, this increases to 5% in children aged 12 – 17 years.

Figure 1c: Number and percentage of orphans, by province, 2020



Source: Statistics South Africa (2021) *General Household Survey 2020*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Child-only households

A child-only household is defined as a household in which all members are younger than 18 years. These households are also commonly referred to as 'child-headed households', although this definition differs from the one contained in the Children's Act. The Children's Act definition of a child-headed household includes households where there are adults who may be too sick or too old to effectively head the household and a child over 16 years bears this responsibility.

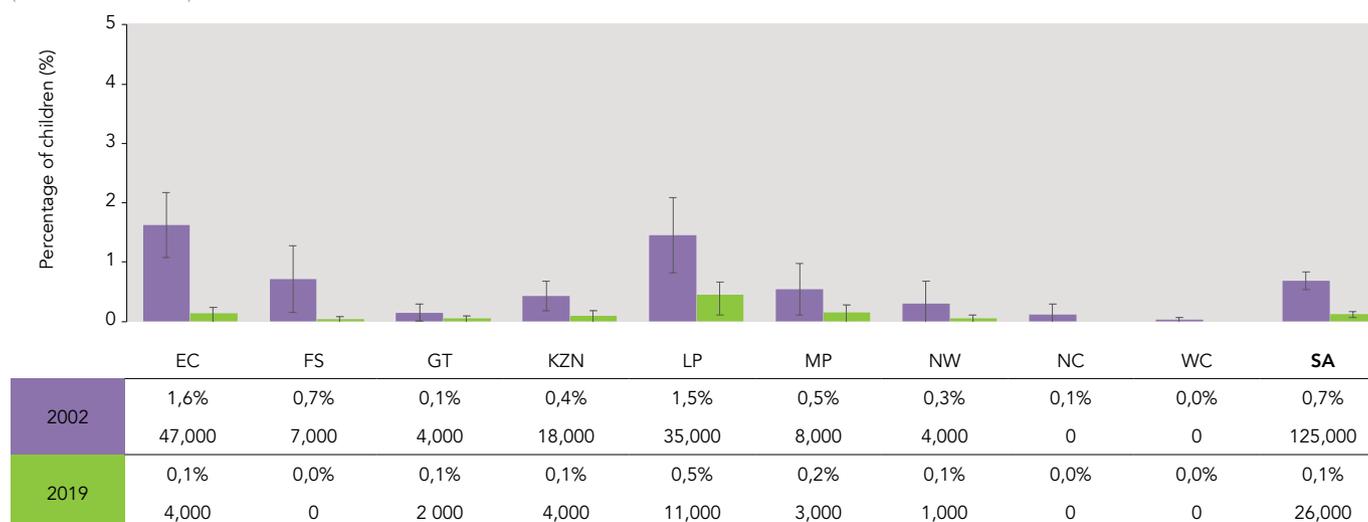
While orphaning undoubtedly places a large burden on families, there is little evidence to suggest that their capacity to care for orphans has been saturated, as commentators feared in the past. Rather than seeing increasing numbers of orphaned children living on their own, the vast majority of orphans live with adult family members.

Stats SA's sample in 2020 was too small to yield reliable data on child-headed households: only four children were identified in child-headed households. We therefore report the figures for 2019. There were about 26,000 children living in child-only households across South Africa in 2019. This equates to 0.1% of all children. While children living in child-only households are rare relative to those residing in other household forms, the number of children living in this extreme situation is of concern as the children may be particularly vulnerable.

Importantly, however, there has been no increase in the share of children living in child-only households in the period 2002 – 2019. If anything, the number has dropped. Predictions of rapidly increasing numbers of child-headed households as a result of HIV are unrealised, though the 2020 sample was too small to show

Figure 1d: Children living in child-only households, 2002 & 2019

(Y-axis reduced to 5%)



Source: Statistics South Africa (2003; 2020) *General Household Survey 2002; General Household Survey 2019*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

whether there was any growth in the number of child-headed households due to COVID-19 related orphaning. An analysis of national household surveys to examine the circumstances of children in child-headed households in South Africa revealed that most children in child-only households are not orphans¹⁷ and 84% have a living mother. These findings suggest that social processes other than mortality are factors in the formation of these households. For example, leaving teenage boys to look after a rural homestead while parents migrate to work may be a livelihood strategy for the household.

While it is not ideal for any child to live without an adult resident, it is positive that three quarters of all children living in child-only households are aged 15 years and above and 41% are 17 years old. Children can work legally from the age of 15, and from 16 they can obtain an identity document and receive grants on behalf of younger children. Only 9% of children in child-headed households are under 10 years of age.

Research suggests that child-only households may be temporary arrangements, and often exist just for a short period, for example while adult migrant workers are away, or for easy access to school during term time, or after the death of an adult

and prior to other arrangements being made to care for the children (such as other adults moving in or the children moving to live with other relatives).¹⁸

Over 70% of all children in child-only households live in three provinces: the Eastern Cape, Limpopo and KwaZulu-Natal. From 2002 to 2019, these provinces have consistently been home to the majority of children living in child-only households.

Relative to children in mixed-generation households, child-only households are vulnerable in a number of ways. Child-only households are predominantly clustered in the poorest households; 90% of children living in child-only households are in the poorest 20% of households. In addition to the absence of adult members who may provide care and security, they are at risk of living in poorer conditions, with poor access to services, less (and less reliable) income, and low levels of access to social grants. There has been very little robust data on child-headed households in South Africa to date. The figures should be treated with caution as the number of child-only households forms just a very small sub-sample of the General Household Survey. In 2019, only 49 children (unweighted) were identified as being in child-headed households, out of a sample of nearly 25,000 children.

References

1. United Nations Children's Fund. *First Call for Children. World Declaration and Plan of Action from the World Summit for Children*. New York: UNICEF; 1990.
2. Statistics South Africa. *Mid-year Population Estimates 2020*. Pretoria: Statistics South Africa. 2020.
3. Dorrington R. *Alternative South African Mid-year Estimates 2013*. Monograph 13. University of Cape Town. 2013.
4. Statistics South Africa. *Mid-year Population Estimates 2017*. Pretoria. 2017.
5. Social Trends Institute. *World Family Map 2017: Mapping family change and child well-being outcomes*. New York, Barcelona. 2017.
6. Martin F. Who cares for children? A descriptive study of care-related data available through global household surveys and how these could be better mined to inform policies and services to strengthen family care. *Global Social Welfare*. 2016;3(2):51-74.
7. Hall K, Mokomane Z. The shape of children's families and households: A demographic overview. In: Hall K, Richter L, Mokomane Z, Lake L, editors. *Children, Families and the State: Collaboration and Contestation South African Child Gauge 2018*. Cape Town: Children's Institute, UCT; 2018.
8. Hall K, Posel D. Fragmenting the family? The complexity of household migration strategies in post-apartheid South Africa. *IZA Journal of Development and Migration*. 2019;10(4).
9. Hall K. *Children's Spatial Mobility and Household Transitions: A study of child mobility and care arrangements in the context of maternal migration* [Unpublished PhD thesis]: University of the Witwatersrand; 2017.
10. Makiwane M, Nduna M, Khalema E. *Children in South African Families: Lives and Times*. Newcastle upon Tyne: Cambridge Scholars; 2016.
11. Amoateng A, Heaton T, editors. *Families and Households in Post-Apartheid South Africa: Socio-demographic perspectives*. Cape Town: HSRC Press; 2007.
12. Hatch M, Posel D. Who cares for children? A quantitative study of childcare in South Africa. *Development Southern Africa*. 2018;35(2):267-282.
13. Van den Berg W, Makusha T. *State of South Africa's Fathers 2018*. Cape Town. 2018.
14. Madhavan S, Townsend N, Garey A. Absent breadwinners: Father-child connections and paternal support in rural South Africa. *Journal of Southern African Studies*. 2008;34(3):647-663.
15. Ardington C, Leibbrandt M. Orphanhood and schooling in South Africa: Trends in the vulnerability of orphans between 1993 and 2005. *Economic Development and Cultural Change*. 2010;58(3):507-536.
16. Hall K. *Demography - Orphaning*. Children Count website: Children's Institute, UCT; 2019. Accessed: 2 October. Available from: www.childrencount.uct.ac.za.
17. Meintjes H, Hall K, Marera D, Boule A. Orphans of the AIDS epidemic? The extent, nature and circumstances of child-headed households in South Africa. *AIDS Care*. 2010;22(1):40-49.
18. Hill C, Hosegood V, Newel M. Children's care and living arrangements in a high HIV prevalence area in rural South Africa. *Vulnerable Children and Youth Studies*. 2008;3(1):65-77.

Income poverty, unemployment and social grants

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

The Constitution of South Africa, section 27(1)(c), says that “everyone has the right to have access to ... social security, including, if they are unable to support themselves and their dependants, appropriate social assistance”.¹

The UN Convention on the Rights of the Child, article 27, states that every child has the right “to a standard of living adequate for his or her development” and obliges the state “in case of need” to “provide material assistance”. Article 26 guarantees “every child the right to benefit from social security”.²

Children living in income poverty

This indicator shows the number and share of children living in households that are income-poor. Because money is needed to access a range of goods and services, income poverty is often closely related to poor health and nutrition, reduced access to education and Early Childhood Development (ECD) facilities, and physical living environments that compromise health and personal safety.

International law and the Constitution recognise the link between income and the realisation of basic human rights and acknowledge that children have the right to social assistance (social grants) when families cannot meet children's basic needs. Income poverty measures are therefore important for determining how many people need social assistance, and for evaluating the state's progress in realising the right to social assistance.

No poverty line is perfect. Using a single income measure tells us nothing about how resources are distributed between family members, or how money is spent. But this measure does give some indication of how many children are living in households with severely constrained resources.

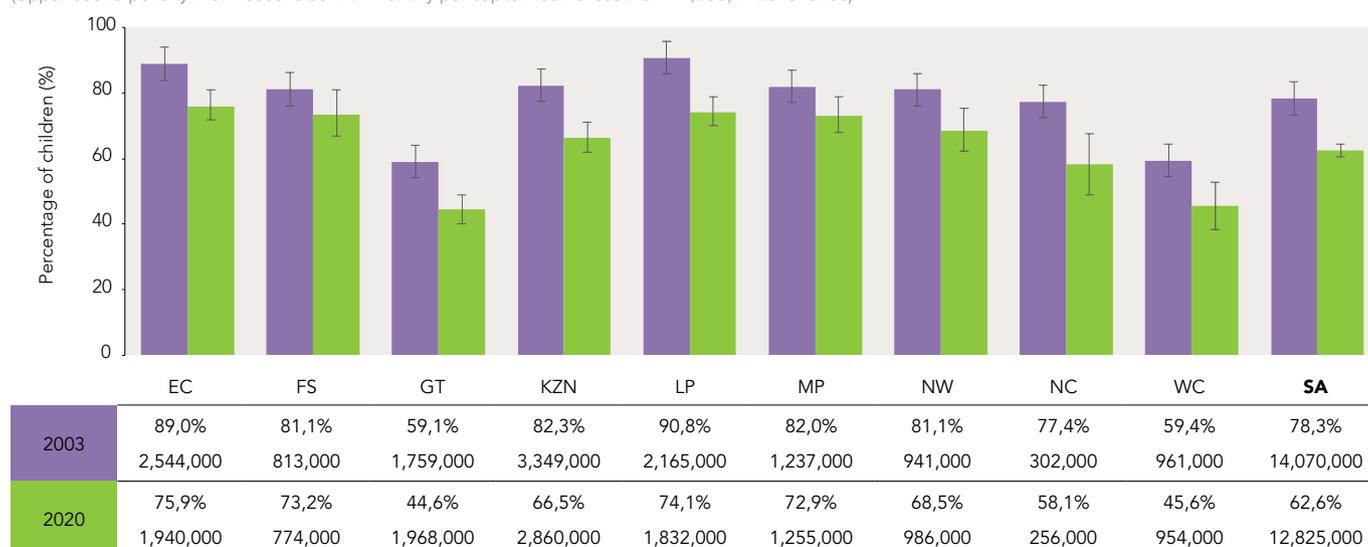
The measure used is the Statistics South Africa (Stats SA) 'upper bound' poverty line that was set at R779 per person per month in 2011 prices. Poverty lines increase with inflation and in 2020 the real value of the upper bound line was R1,268.³ Per capita income is calculated by adding all reported earnings for household members older than 15 years, adding the value of social grants received by anyone in the household, and dividing the total household income by the number of household members.

Stats SA proposed two other poverty lines:

- A 'lower bound' poverty line is calculated by adding to the food poverty line the average expenditure on essential non-food items by households whose food expenditure is below but close to the food poverty line. The value of the lower bound poverty line in 2011 prices was R501 per person per month (R840 in 2020 prices). Those living below this line would not be able to pay for the minimum non-food expenses or would be sacrificing their basic nutrition to pay for non-food expenses.

Figure 2a: Children living in income poverty, by province, 2003 & 2020

(Upper-bound poverty line: Households with monthly per capita income less than R1,268, in 2018 rands)



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

- A 'food' poverty line is based on the cost of the minimum nutritional requirement of 2,100 kilocalories per person per day, without any allowance for non-food basic necessities. The value of the food poverty line in 2011 prices was R335 per person per month (R585 in 2020). Anyone living below this line will be malnourished and their health and survival may be at risk.

We use the upper bound poverty line as our main indicator for tracking child poverty, as this is linked to the minimum requirement for basic nutrition as well as other basic needs such as clothing and shelter. In other words, the upper bound line is the only poverty line that meets the minimum requirement for children's basic needs.

South Africa has very high rates of child poverty and, although poverty rates have reduced substantially over the last two decades, a large number of children remain in poverty. In 2019, 56% of children (11.2 million) lived below the upper bound poverty line and 33% were below the food poverty line. Income poverty rates have fallen substantially since 2003, when 78% (14.1 million) children were defined as 'poor' at the upper bound threshold. The reduction in the child poverty headcount is partly the result of a massive expansion in the reach of the Child Support Grant (CSG) over the same period.

The 2020 child poverty rate (upper bound) is estimated at 63%, based on reported income from earnings and grants. This is an increase of seven percentage points from 2019, the year before COVID-19. In terms of population numbers, this translates as an additional 1.7 million children below the poverty line, compared with the previous year.

There are substantial differences in poverty rates across the provinces. Using the upper bound poverty line, around three-quarters of children in the Eastern Cape, Limpopo, Free State and Mpumalanga are poor. Gauteng and the Western Cape have

the lowest child poverty rates, although there was a substantial increase in poverty in both these provinces – from 35% in 2019 to 45% in 2020 in Gauteng, and from 27% to 46% in the Western Cape. Child poverty remains most prominent in the rural areas of the former homelands, where 81% of children were below the poverty line in 2020. The urban child poverty rate, by contrast, was 51%.

There are also glaring racial disparities in income poverty: while 68% of African children lived in poor households in 2020, and 47% of Coloured children were defined as poor, only 3% of White children lived below this poverty line. There are no significant differences in child poverty levels across gender or between different age groups in the child population.

Using Stats SA's lower bound poverty line (which does not provide enough for basic essentials), 51% of children (10.5 million) were poor in 2020 (up from 43% in 2019), and 39% (8 million children) were below the food poverty line, meaning that they were not getting enough nutrition. Food poverty had increased from 33% in 2019, with an additional 1.5 million children in food poverty in 2020.

The Sustainable Development Goals (SDGs) replaced the Millennium Development Goals in 2015 and set a global agenda for development by 2030. Target 1.1 is to eradicate extreme poverty using the international poverty line of \$1.90 per person per day (equivalent to R401 per person per month in 2020, using the IMF purchasing power parity conversion). This poverty line is extremely low – below survival level – and is not appropriate for South Africa. No child should be below it. In 2003, 52% of children (9.3 million) lived below the equivalent of the SDG poverty line. By 2019, this had decreased to 22% (4.3 million), but in 2020 the ultra-low 'SDG' poverty rate had increased again to 28% (5.7 million children).

Impact of disaster relief grants and grant top-ups on child poverty

The poverty rates presented above are based on reported income and the normal grant amounts – in other words, the graph reflects poverty rates in the absence of disaster relief.

There was a sharp rise in unemployment in the lockdown of 2020. Three million jobs were lost between February and April 2020. Two million of those who lost employment were women.⁴ This had a direct effect on child poverty, especially as children in South Africa are more likely to be co-resident with women than with men.

The South African government introduced disaster relief grants and top-ups to existing grants, starting in May 2020 and ending in October. Only the newly introduced R350 COVID-19 Social Relief of Distress grant for unemployed adults (SRD) continued into 2021 and beyond.

The General Household Survey, on which the analysis for this indicator is based, took place telephonically between September and December 2020. The survey therefore spans two months when grant top-ups were in place, and two months after they had been terminated. For this reason, the child poverty rates for 2020 have been estimated in two ways:

- First, the poverty rates are calculated in a scenario without the disaster relief grants and top-ups (i.e., including existing

grants but excluding disaster relief) as presented above; and

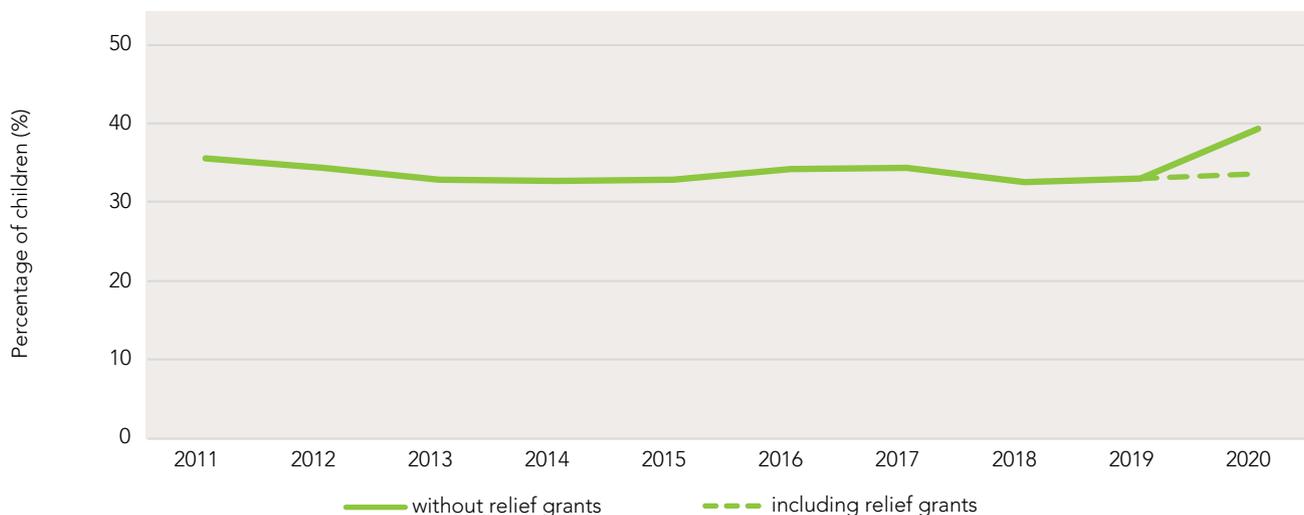
- Second, the poverty rates are calculated in a scenario that includes the R250 top-ups to existing grants, the temporary caregiver grant (R500 per month per caregiver who receives a child support grant for one or more children) and the R350 COVID-19 SRD. The CSG received a top-up for only one month, in May 2020, and this has not been included in the poverty calculations as it was a once-off top-up that preceded the survey.

The disaster relief grants and top-ups had a small impact on child poverty at the upper bound poverty line, reducing the poverty rate from 63% (without disaster relief) to 60% (including disaster relief). The impact of disaster relief was more pronounced at the food poverty line: during the months where grant top-ups and the caregiver grant were active, the food poverty rate for children would have decreased from 39% (8 million children) to 34% (6.9 million children).

As shown in the trend graph below, the disaster relief grants and top-ups had a strong protective effect, counteracting rising poverty in the context of lockdown. This protective effect would have ended when the top-ups and caregiver grant were withdrawn.

Figure 2b: Child food poverty and impact of COVID-19 disaster relief, 2011 – 2020

(Food poverty line: Households with monthly per capita income less than R585, in 2020 rands)



Source: Statistics South Africa (2012–2021) *General Household Survey 2011 – 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

Children living in households without an employed adult

This indicator measures unemployment from a children’s perspective and gives the number and proportion of children who live in households where no adults are employed in either the formal or informal sector. It therefore shows the proportion of children living in ‘unemployed’ households where it is unlikely that any household members derive income from labour or income-generating activities.

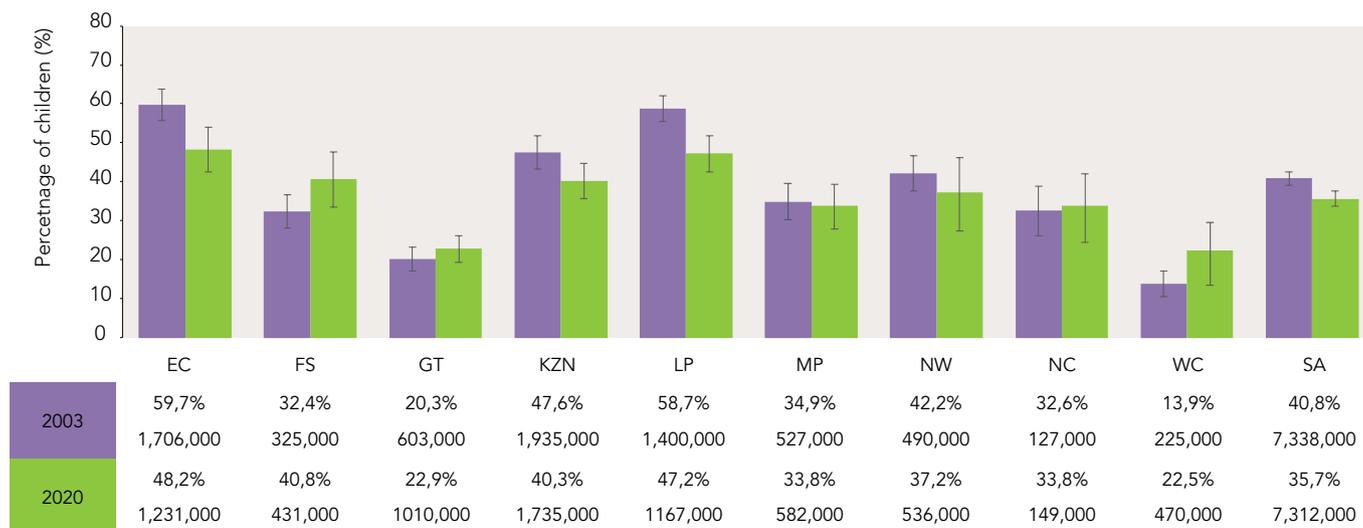
Unemployment in South Africa continues to be a serious problem, and the situation worsened during lockdown. In the 2nd quarter of 2020, the expanded unemployment rate breached the 40% mark for the first time since the Quarterly Labour Force Survey was introduced in 2008, and it remained above 40% for the rest of the year.⁵

Although there was some clawback of jobs, in the last quarter of 2020 Stats SA still recorded a net decrease of 1.4 million (8.5%)

in total employment numbers, compared with the same period the previous year. By the end of 2020, 39% of men and 46.3% of women in the labour force were unemployed.⁶

The official national unemployment rate was 29.1% in the fourth quarter of 2019 and 32.5% in the fourth quarter of 2020.⁷ This official rate is based on a narrow definition of unemployment that includes only those adults who are defined as economically active (i.e. they are not studying or retired or voluntarily staying at home) and who had actively looked but failed to find work in the four weeks preceding the survey. An expanded definition of unemployment, which includes ‘discouraged work-seekers’ who were unemployed but not actively looking for work in the month preceding the survey, gives a higher, and more accurate, indication of unemployment. The expanded unemployment rate (which includes those who are not actively looking for work) was

Figure 2c: Children living in households without an employed adult, by province, 2003 & 2020



Source: Statistics South Africa (2004; 2021) *General Household Survey 2003; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

38.7% in the fourth quarter of 2019 and 42.6% a year later at the end of 2020. Gender differences in employment rates are relevant for children, as it is mainly women who provide for children's care and material needs. Unemployment rates are consistently higher for women than for men. At the end of 2019, 42.4% of women were unemployed by the expanded definition (compared with 35.5% of men) and this increased to 46.3% for women at the end of 2020 (compared with 39.4% of men).⁷

Apart from providing regular income, an employed adult may bring other benefits to the household, including health insurance, unemployment insurance and parental leave that can contribute to children's health, development and education. The definition of 'employment' is derived from the Quarterly Labour Force Survey and includes regular or irregular work for wages or salary, as well as various forms of self-employment, including unpaid work in a family business.

In 2019, 70% of children in South Africa lived in households with at least one working adult. The other 30% (5.9 million children) lived in households where no adults were working. The number of children living in workless households had decreased by 1.4 million since 2003, when 41% of children lived in households where there was no employment. By late 2020, the share of children in workless households had increased again to 36% (7.3 million) – effectively back to the 2007 rate in percentage terms, though substantially higher in terms of numbers due to a growing population.

Children receiving the Child Support Grant

This indicator shows the number of children receiving the Child Support Grant (CSG), as reported by the South African Social Security Agency (SASSA) which disburses social grants on behalf of the Department of Social Development.

The right to social assistance is designed to ensure that people living in poverty can meet basic subsistence needs. Government is obliged to support children directly when their parents or caregivers are too poor to do so. Income support is provided through social assistance programmes such as the CSG, which is an unconditional cash grant paid to the caregivers of eligible children.

Introduced in 1998 with an initial value of R100, the CSG has become the single biggest programme for alleviating child poverty in South Africa. Take-up of the CSG has increased dramatically over the years and the grant amount is increased slightly each year, more or less keeping pace with overall inflation. At the end of March 2022, a monthly CSG of R460 was paid to 13 million children aged 0 – 17 years. The value of the CSG increased to R480 per month from the beginning of April 2022.

There have been two important changes in eligibility criteria over the years. The first concerns age eligibility. Initially the CSG was only available for children younger than seven years. From 2003 it was gradually extended to older children up to the age of 14. Since January 2012, following a second phased extension, eligible children can receive the grant until they turn 18.

The second change concerns the income threshold for the means test. The income threshold remained static for 10 years until a formula was introduced – set at 10 times the amount of the grant. This means that every time the grant is increased, the

This indicator is very closely related to the income poverty indicator in that provinces with relatively high proportions of children living in unemployed households also have high rates of child poverty. At the end of 2020, nearly 50% of children in the Eastern Cape and Limpopo lived in households without any employed adults, and 40% of those in KwaZulu-Natal were in workless households. These provinces are home to large numbers of children and also have relatively high rates of child poverty. In contrast, Gauteng and the Western Cape have the lowest poverty rates, and the lowest unemployment rates, although the effects of job loss were also evident in these provinces in 2020. In the Western Cape, 22% of children lived in households where nobody was working (up from 12% in 2019), and in Gauteng the rate was 23% in 2020 (up from 14% in 2019).

Racial inequalities are striking: 39% of African children had no working adult at home in 2020 (up from 33% in 2019), while 25% of Coloured children and less than 5% of Indian and White children lived in these circumstances. There are no significant differences in child-centred unemployment measures when comparing girls and boys or between age groups. In the rural former homelands, 53% of children lived in workless households in 2020, an increase from 47% in 2019.

Income inequality is clearly associated with unemployment. Nearly 80% of children in the poorest income quintile live in households where no adults are employed.

means test also increases. From April 2022, the income threshold was R4,800 per month for a single caregiver and R9,600 per month for the joint income of the caregiver and spouse, if the caregiver is married.

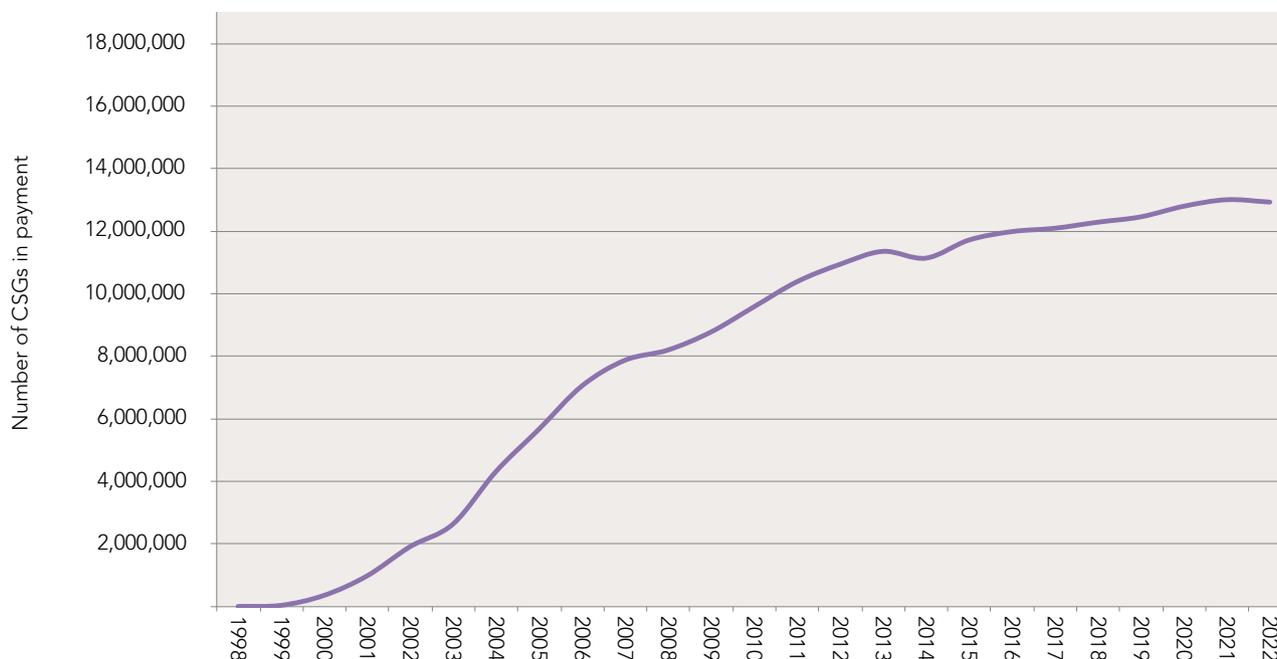
A slight dip in grant access in 2014 was probably the result of the introduction of a biometric system which led to the

Table 2a: Children receiving the Child Support Grant, by province and age group, 2022

Province	Number of child beneficiaries at end March 2022			
	0 – 5 years	6 – 11 years	12 – 17 years	TOTAL
Eastern Cape	604,759	670,077	651,350	1,926,186
Free State	222,178	245,974	238,712	706,864
Gauteng	637,190	707,032	636,780	1,981,002
KwaZulu-Natal	950,709	1,029,300	981,543	2,961,552
Limpopo	695,844	675,668	578,911	1,950,423
Mpumalanga	405,844	396,380	362,219	1,164,443
North West	299,752	311,591	282,815	894,158
Northern Cape	110,030	116,029	103,141	329,200
Western Cape	294,186	366,821	340,905	1,001,912
South Africa	4,220,492	4,518,872	4,176,376	12,915,740

Source: South African Social Security Agency (2020) SOCPEN database – special request. Pretoria: SASSA.

Figure 2d: Children receiving the Child Support Grant, 1998 – 2022



Sources: 1998 – 2007: National Treasury Intergovernmental Fiscal Reviews. 2008 – 2022: South African Social Security Agency SOCPEN monthly reports, by special request.

identification and removal of beneficiaries who were not verified biometrically or were found to be fraudulent. From 2014, the numbers have increased again gradually, only tapering off in 2021 and 2022. In March 2022, fewer CSGs were in payment than in March the previous year – the number of CSGs had decreased by nearly 80,000, from 13 million in 2021. This was the first overall decline in the number of CSGs since 2014, with the decrease being most pronounced in the Western Cape and Eastern Cape. The year-on-year decrease is spread across all age groups and the reasons for it are not clear. However, in the previous period (2020 – 2021), there was a clear decrease (of over 100,000) in the number of CSGs paid to infants under a year. This was almost certainly the result of delays in birth registration and grant applications in the context of lockdown.

There is substantial evidence that grants, including the CSG, are being spent on food, education and basic goods and services. The grant not only helps to alleviate income poverty and realise

children’s right to social assistance, it is also associated with improved nutritional, health and education outcomes.⁸⁻¹⁷

Given the positive and cumulative effects of the grant, it is important that caregivers can access it for their children as early as possible. One of the main concerns is the slow take-up for young children. An analysis of exclusions from the CSG found that exclusion rates for eligible infants under a year were as high as 43% in 2014, up only three percentage points from 47% in 2008. Exclusion rates were found to be highest in the Western Cape and Gauteng. The total rate of exclusion for all ages was estimated at 17.5% (more than 1.8 million children).¹⁸ Barriers to take-up include confusion about eligibility requirements and the means test in particular; lack of documentation (mainly identity books or birth certificates, and proof of school enrolment, although the latter is not an eligibility requirement) and problems of institutional access (including the time and cost of reaching SASSA offices, long queues and lack of baby-friendly facilities).

CSG and grant top-ups in the context of COVID-19 and lockdown

The disaster relief package announced by the President in late April 2020 included a R300 top-up to the CSG for just one month (in May). This reached 13 million children on the CSG. From June, the CSG top-up was discontinued and a temporary caregiver allowance of R500 was introduced, reaching just over 7.1 million caregivers who received CSGs for children in their care. The caregiver allowance was paid for five months (from June to October), after which it was discontinued. Until April 2021, caregivers who received CSGs were excluded from applying for the R350 COVID-19 SRD grant for unemployed working age adults. The one-month additional amount to the CSG used the most efficient available mechanism to transfer much-needed cash into millions of highly vulnerable

households. The CSG is the most pro-poor of all the grants and reaches 74% of all households in the poorest income decile.¹⁹ The CSG also reaches around 80% of households that rely on income from informal employment and would therefore not receive assistance through the Unemployment Insurance Fund (UIF) or the Temporary Employer-Employee Relief Scheme (TERS).²⁰

When the caregiver allowance was introduced in June 2020, the CSG reverted to its previous value of R440. The CSG already had the lowest value of all the social grants, was the only grant below the food poverty line (R585 per month in 2020 Rands), and whereas all other grants received R250 top-ups for six months (May to October 2020), the CSG remained at its base value.

Children receiving the Foster Child Grant

This indicator shows the number of children who are accessing the Foster Child Grant (FCG) in South Africa, as recorded in the SOCPEN administrative data system of the SASSA.

The FCG is available to foster parents who have a child placed in their care by an order of the court. It is a non-contributory cash grant valued at R1,070 per month from April 2022.

The relatively large value of the grant, compared to the CSG, is justified on the basis that the child is technically a ward of the state, and the state is therefore directly responsible for ensuring that all the child's needs are provided for. The grant was initially intended as financial support for children removed from their families and placed in foster care for protection in situations of abuse or neglect.

However, the FCG has increasingly been used to provide financial support to caregivers of children who are orphaned and has effectively been used as a poverty alleviation grant for orphans in kinship care. The appropriateness and effectiveness of this approach was questioned as far back as 2003, particularly because many children live with grandparents, aunts or other relatives, whether or not their parents are alive.²¹

The number of FCGs remained stable for many years when foster care applied mainly to children who were in need of care and protection because of abuse or neglect, or because they were awaiting adoption. Its rapid expansion since 2003 coincided with the rise in HIV-related orphaning and an implied policy change by the Department of Social Development, which from 2003 started encouraging family members (particularly grandmothers) caring for orphaned children to apply for foster care and the FCG. During the subsequent five years, the number of FCGs increased by over 50,000 per year as orphans were brought into

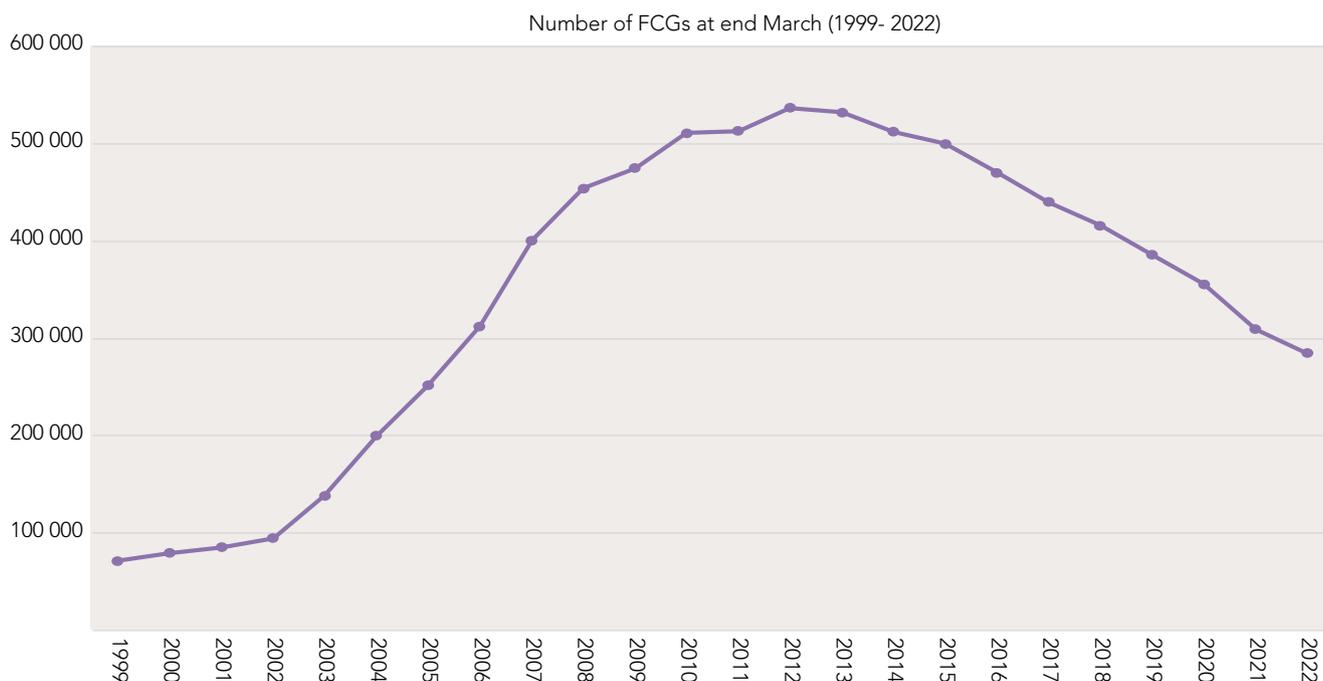
the foster care system. The increases were greatest in provinces with large numbers of orphaned children: the Eastern Cape, KwaZulu-Natal, Limpopo and Mpumalanga.

By 2010, more than 500,000 FCGs were in payment and the foster care system was struggling to keep pace with the numbers due to the legally required initial investigations and reports by social workers, court-ordered placements, and additional two-yearly social worker reviews and court-ordered extensions. SASSA is not allowed to pay the FCG without a valid court order or extension order, and more than 110,000 FCGs lapsed between April 2009 and March 2011 because of backlogs in the extensions of court orders.²²⁻²⁴

In 2011, a court-ordered settlement stipulated that the foster care court orders that had expired – or that were going to expire in the following two years – must be deemed to have been extended until 8 June 2013. This effectively placed a moratorium on the lapsing of these FCGs. As a temporary solution, social workers could extend orders administratively (without having to go to court) until December 2014, by which date a comprehensive legal solution should have been found to prevent qualifying families from losing their grants in future.²⁵ Yet, no policy solution had been developed by the 2014 cut-off date. Instead, the Department of Social Development sought (and received) an urgent court order extending the date to the end of 2017, which was then extended until the end of November 2019, then to the end of November 2020 and again to the end of November 2022.

After a decade during which the Department has failed to meet the terms of the court order, the High Court is now closely supervising the Department's compliance by requiring and engaging with regular progress reports. Two laws need to be

Figure 2e: Children receiving the Foster Child Grant, 1999 – 2022



Sources: 1999 – 2007: National Treasury Intergovernmental Fiscal Reviews. 2008 – 2022: South African Social Security Agency SOCPEN monthly reports, by special request.

amended to enable a sustainable solution. The Social Assistance Act was passed by Parliament in 2020 to provide for a CSG top-up; but the Children's Amendment Bill is still with Parliament and will also require regulations before it can be implemented. The Bill needs to clarify that the majority of orphaned children in the care of relatives should be referred to the CSG top-up, and only those who are in need of care and protection should be placed in foster care.

Since its height in 2012, when nearly 540,000 FCGs were paid each month, the number of FCGs has declined year-on-year. At the end of 2014, 300,000 court orders had expired, representing more than 60% of all foster care placements.²⁶ The grants remained in payment only because the High Court order mentioned above prevented them from lapsing. In March 2022, 285,000 FCGs were paid to caregivers of children in foster care, effectively back to below 2006 levels. The most dramatic drop has been in KwaZulu-Natal, where the number of FCGs fell by 64%, from 142,000 to 51,000.

The declining numbers are partly due to lower rates of foster care placement and enrolment onto the grant, and partly because of an increase in the numbers of grants terminating at the end of each year when children turn 18. This in turn is because the beneficiaries of the FCG are mainly orphaned children, who are typically older children as orphaning rates increase with age. In 2020, only 14% of FCGs went to children who were not orphaned, while 6% went to paternal orphans, 8% to maternal orphans and 72% to double orphans.²⁷ The Western Cape is the only province that has not experienced a drop in the number of FCGs, probably because it is also the only province where foster care is used mainly for its original purpose, rather than to supplement the income of orphans living with relatives. Rural provinces tend to bear the main burden of caring for orphans.

It is not possible to calculate a take-up rate for the FCG as there is no accurate record of how many children are eligible for placement in foster care because they are abused or neglected and in need of care and protection. Currently, orphans in the care of relatives are still legally eligible to be placed in foster care and receive the CSG,ⁱ but only a small portion of these children are being supported to access it. The declining numbers are therefore regressive in terms of the current law.

If all double orphans were to be placed in foster care, this would require around 620,000 foster care placements, excluding those who need to be placed in foster care because they are awaiting adoption or have been removed from their families for reasons of abuse or neglect. This would once again send the number of children in foster care well above half a million – which the system has not previously been able to support.

Children receiving the Care Dependency Grant

This indicator shows the number of children who are accessing the Care Dependency Grant (CDG) in South Africa, as recorded in the SOCPEN administrative data system of the SASSA.

The CDG is a non-contributory monthly cash transfer to caregivers of children with disabilities who require permanent care or support services. It excludes those children who are cared for in state institutions because the purpose of the grant is to

i In terms of section 150(1)(a) of the Children's Act No 38 of 2005.

Table 2b: Children receiving the Foster Child Grant, by province, 2012 & 2022

Province	2012	2022	Difference	% difference
Eastern Cape	116,826	63,046	-53,780	-46%
Free State	43,311	20,230	-23,081	-53%
Gauteng	56,451	35,415	-21,036	-37%
KwaZulu-Natal	142,114	51,241	-90,873	-64%
Limpopo	56,066	34,728	-21,338	-38%
Mpumalanga	32,886	18,612	-14,274	-43%
North West	45,634	22,493	-23,141	-51%
Northern Cape	14,456	9,342	-5,114	-35%
Western Cape	29,003	29,999	996	3%
South Africa	536,747	285,106	-251,641	-47%
FCG amount	R 770	R 1,070		

Source: South African Social Security Agency (2012; 2022) SOCPEN database, by special request. Pretoria: SASSA.

The systemic problems that caused FCGs to lapse and reduced social worker capacity to respond to children and others in need of protection and welfare services need to be addressed through a legislative amendment to clarify the eligibility criteria for foster care and provide an adequate grant for orphans in the care of relatives.

An amendment to the Social Assistance Act has been passed by Parliament and signed by the President, providing for a CSG top-up (instead of the FCG) for orphaned children living with kin. The 2022 budget provided for a CSG top-up for orphans, and the plan is that implementation should start in mid-2022. Certain sections of the Children's Act also need to be amended to clarify the revised eligibility criteria for foster care.

The Children's Amendment Bill is currently before Parliament and is scheduled to be passed by the end of 2022. The CSG top-up approach would give orphaned children living with relatives access to a larger child support grant, around half-way between the value of the CSG and the FCG, without first having to go through a foster care placement. If implemented effectively, the reforms could improve access to social grants for orphans and responsive child protection services for children in need of state care and protection, irrespective of who their caregivers are and whether or not they are orphans.

cover the additional costs (including opportunity costs) that the parent or caregiver might incur as a result of the child's disability. The child needs to undergo a medical assessment to determine eligibility and the parent must pass an income or 'means' test.

Although the CDG targets children with disabilities, children with chronic illnesses are eligible for the grant once the illness becomes disabling, for example, children who are very sick with

AIDS-related illnesses. Children with disabilities and chronic illnesses need substantial care and attention, and parents may need to stay at home or employ a caregiver to tend to the child. Children with health conditions may need medication, equipment or to attend hospital often. These extra costs can put strain on families that are already struggling to make ends meet. Poverty and chronic health conditions are therefore strongly related.

It is not possible to calculate a take-up rate for the CDG because there are no reliable data on the number of children with disabilities or who are chronically ill, and in need of permanent care or support services. At the end of March 2022, 151,000 children were receiving the CDG, and from the beginning of April 2022, the grant was valued at R1,980 per month.

The provincial distribution of CDGs is fairly consistent with the distribution of children. The provinces with the largest numbers of children – KwaZulu-Natal, the Eastern Cape and Gauteng – receive the largest share of CDGs, though the number of CDG recipients has also increased in the Western Cape. There has been a gradual but consistent increase in access to the CDG each year since 1998, when only 8,000 CDGs were disbursed.

Table 2c: Children receiving the Care Dependency Grant, by province, 2012 & 2022

Province	2012	2022	Difference	% difference
Eastern Cape	18,235	22,775	4,540	25%
Free State	5,419	8,831	3,412	63%
Gauteng	14,170	21,163	6,993	49%
KwaZulu-Natal	34,969	39,044	4,075	12%
Limpopo	11,318	16,668	5,350	47%
Mpumalanga	7,950	11,408	3,458	43%
North West	8,736	9,528	,792	9%
Northern Cape	4,236	5,725	1,489	35%
Western Cape	9,960	16,054	6,094	61%
South Africa	114,993	151,196	36,203	31%
	R 1 200	R 1 980		

Source: South African Social Security Agency (2012; 2022) SOCPEN database, by special request. Pretoria: SASSA.

References

1. Constitution of the Republic of South Africa, Act 108 of 1996.
2. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Geneva: United Nations. 1989.
3. Statistics South Africa. *National Poverty Lines. Statistical Release No. P0310.1*. Pretoria: Stats SA. 2018.
4. Spaull N et al. *NIDS-CRAM survey, Wave 1. Overview and findings*. [https://cramsurvey.org/wp-content/uploads/2020/07/Spaull-et-al.-NIDS-CRAM-Wave-1-Synthesis-Report-Overview-and-Findings-1.pdf]
5. Statistics South Africa. *QLFS Trends 2008-2020Q4 (Historical tables)*. Pretoria: Stats SA. [http://www.statssa.gov.za/?page_id=1854&PPN=P0211&SCH=72942]
6. Statistics South Africa. *Quarterly Labour Force Survey, 4th quarter 2020*. Pretoria: Stats SA. 2021. [http://www.statssa.gov.za/publications/P0211/P02114thQuarter2020.pdf]
7. Statistics South Africa. *Quarterly Labour Force Survey: Quarter 3, 2018. Statistical Release No. P0211*. Pretoria. 2018.
8. Grinspun A. No small change: The multiple impacts of the Child Support Grant on child and adolescent well-being. In: Delany A, Jehoma S, Lake L, editors. *South African Child Gauge 2016*. Cape Town: Children's Institute, UCT; 2016.
9. Coetzee M. *Do Poor Children Really Benefit from the Child Support Grant?* 2014 10 July 2014. [Accessed 14 July 2018: [www.econ3x3.org/article/do-poor-children-really-benefit-child-support-grant]
10. Coetzee M. Finding the benefits: Estimating the impact of the South African Child Support Grant. *South African Journal of Economics*. 2013;81(3):427-450.
11. Department of Social Development, South African Social Security Agency, UNICEF. *The South African Child Support Grant Impact Assessment: Evidence from a survey of children, adolescents and their households*. Pretoria: UNICEF South Africa. 2012.
12. Woolard I, Leibbrandt M. *The Evolution and Impact of Unconditional Cash Transfers in South Africa*. Cape Town: SALDRU, UCT. 2010.
13. Agüero J, Carter M, Woolard I. *The Impact of Unconditional Cash Transfers on Nutrition: The South African Child Support Grant*. Working Paper 39. Brasilia: International Policy Centre for Inclusive Growth. 2007.
14. Samson M, Heinrich C, Williams M, Kaniki S, Muzondo T, Mac Quene K, van Niekerk I. *Quantitative Analysis of the Impact of the Child Support Grant*. Pretoria: Economic Policy Research Institute. 2008.
15. Budlender D, Woolard I. *The Impact of the South African Child Support and Old Age Grants on Children's Schooling and Work*. Geneva: International Labour Office. 2006.
16. Case A, Hosegood V, Lund F. The reach and impact of Child Support Grants: Evidence from KwaZulu-Natal. *Development Southern Africa*. 2005;22(4):467-482.
17. M Samson, U Lee, A Ndlebe, Mac Quene K, Van Niekerk I, V Ghandi, . . . C Abrahams. *The Social and Economic Impact of South Africa's Social Security System*. Cape Town: Department of Social Development. 2004.
18. Department of Social Development, South African Social Security Agency, UNICEF. *Removing Barriers to Accessing Child Grants: Progress in reducing exclusion from South Africa's Child Support Grant*. Pretoria: UNICEF South Africa. 2016.
19. Independent Panel of Experts for the Review of Zero Rating in South Africa. *Recommendations on Zero Ratings in the Value-Added Tax System, p.71*. 2018. [https://static.pmg.org.za/180806VAT_Panel_Final_Report_for_public_comment.pdf]
20. Bassier I, Budlender J, Zizzamia R, Leibbrandt M, Ranchhod V. Locked down and locked out: Repurposing social assistance as emergency relief to informal workers. *World Development*. 2021;139:105271.
21. Meintjes H, Budlender D, Giese S, Johnson L. *Children 'in Need of Care' or in Need of Cash? Questioning social security provisions for orphans in the context of the South African AIDS pandemic*. Cape Town. 2003.
22. Hall K, Proudlock P. *Orphaning and the Foster Child Grant: A return to the 'care or cash' debate*. Children Count brief. Cape Town: Children's Institute, University of Cape Town. 2011.
23. Proudlock P. The Case of Child SS and 1.1 Million Others like Him - Orphan children in need of social assistance. Towards Carnegie3: Strategies to overcome poverty & inequality conference; 3-7 September 2012; University of Cape Town.
24. Skelton A. The Story of 110,000 Foster Child Grants that Stopped Being Paid in 2010/2011. Towards Carnegie3: Strategies to overcome poverty & inequality; 3-7 September 2012; University of Cape Town.
25. Centre for Child Law v Minister of Social Development and Others. North Gauteng High Court; 2011.
26. Department of Social Development. *Annexure to urgent application to the High Court In: Centre for Child Law v Minister of Social Development and Others. Unreported case 21726/110. December 2014*. 2014.
27. Statistics South Africa. *General Household Survey 2020*. Analysed by K Hall. 2021.

Child health

Katharine Hall and Nadine Nannan

Section 27 of the Constitution of South Africa provides that everyone has the right to have access to health care services. In addition, section 28(1)(c) gives children “the right to basic nutrition and basic health care services”.¹

Article 14(1) of the African Charter on the Rights and Welfare of the Child states that “every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health”, and article 14(2)(c) states that State Parties shall take measures “to ensure the provision of adequate nutrition...”.²

Article 24 of the UN Convention on the Rights of a Child says that state parties should recognise “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. It obliges the state to take measures “to diminish infant and child mortality” and “to combat disease and malnutrition”.³

The infant and under-five mortality rate

Nadine Nannan (Burden of Disease Research Unit, Medical Research Council)

The infant and under-five mortality rates are key indicators of health and development. They are associated with a broad range of bio-demographic, health and environmental factors which are not only important determinants of child health but are also informative about the health status of the broader population.

The infant mortality rate (IMR) is defined as the probability of dying within the first year of life and refers to the number of babies under 12 months who die in a year per 1,000 live births during the same year. Similarly, the under-five mortality rate (U5MR) is defined as the probability of a child dying between birth and their fifth birthday. The U5MR refers to the number of children under five years old who die in a year per 1,000 live births in the same year.

This information is ideally obtained from vital registration systems. However, like in many middle- and lower-income countries, the under-reporting of births and deaths renders the South African system inadequate for monitoring purposes. South Africa is therefore reliant on alternative methods, such as survey and census data, to measure child mortality. Despite several surveys which should have provided information to monitor progress, the lack of reliable data since 2000 led to considerable uncertainty around the level of childhood mortality for a prolonged period. However, the second South Africa National Burden of Disease Study has produced national and provincial infant and under-five mortality trends from 1997 up until 2012.⁴

An alternative approach to monitoring age-specific mortality nationally since 2009 is the rapid mortality surveillance system (RMS) based on the deaths recorded on the population register by the Department of Home Affairs.⁵ The RMS data have been recommended by the Health Data Advisory and Co-ordinating Committee because corrections have been made for known biases. In other words, the indicators shown in Table 3a are nationally representative. The RMS reports vital registration data adjusted for under-reporting which allows for the evaluation of annual trends. They suggest the IMR peaked in 2003 when it was 53 per 1,000 and decreased to 27 per 1,000 in 2019 with a

further decrease to 21 in 2020. During the same period the U5MR decreased from 81 per 1,000 in 2003 to 36 per 1,000 in 2019 and 28 in 2020.⁶

With reference to the substantial decrease in infant and under-5 mortality in 2020, the authors of the Rapid Mortality Surveillance Report note that “the lack of seasonal increases in the numbers of registered deaths suggest that the winter increases in respiratory syncytial virus (RSV) and other pneumonias as well as seasonal outbreaks of diarrhoea were absent in 2020.”⁷ This was possibly due to the effects of lockdown with “unusually low” monthly deaths in April and May 2020, and “no seasonal trend in the following [winter] months”.⁸

The neonatal mortality rate (NMR) is the probability of dying within the first 28 days of life per 1,000 live births. The NMR has remained stable, at around 12 deaths per 1,000 live births. Estimates of the NMR are derived directly from vital registration data (i.e., registered deaths and births without adjustment for incompleteness) up to 2013, and from 2013 onwards the estimates were derived directly from neonatal deaths and live births recorded in the District Health Information System. The South African Demographic and Health Survey (SADHS) also reports

Table 3a: Child mortality indicators, rapid mortality surveillance, 2012 – 2020

INDICATOR	2015	2016	2017	2018	2019	2020
Under-five mortality rate per 1,000 live births	39	36	33	35	36	28
Infant mortality rate per 1,000 live births	28	26	23	26	27	21
Neonatal mortality	12	12	12	11	12	12

Source: Dorrington RE, Bradshaw D, Laubscher R & Nannan, N (2021) *Rapid Mortality Surveillance Report 2019-2020*. Cape Town: South African Medical Research Council.

child mortality rates. After a long gap (since 2003), the SADHS was conducted again in 2016. For the period 2012 – 2016, the RMS estimated a slightly higher overall under-five mortality rate than the SADHS – 42 versus 39 per 1,000 live births. However, the

SADHS infant mortality rate (IMR) for recent years is much higher than the IMR from the RMS (35 versus 27 per 1,000 live births for the period 2012 – 2016). The SADHS estimates are likely to be too high because its neonatal mortality rate is too high.

Children living in households where there is reported child hunger

This indicator shows the number and proportion of children living in households where children are reported to go hungry ‘sometimes’, ‘often’ or ‘always’ because there isn’t enough food.

Child hunger is emotive and subjective, and this is likely to undermine the reliability of estimates on the extent and frequency of reported hunger, but it is assumed that variation and reporting error will be reasonably consistent so that it is possible to monitor trends from year to year.

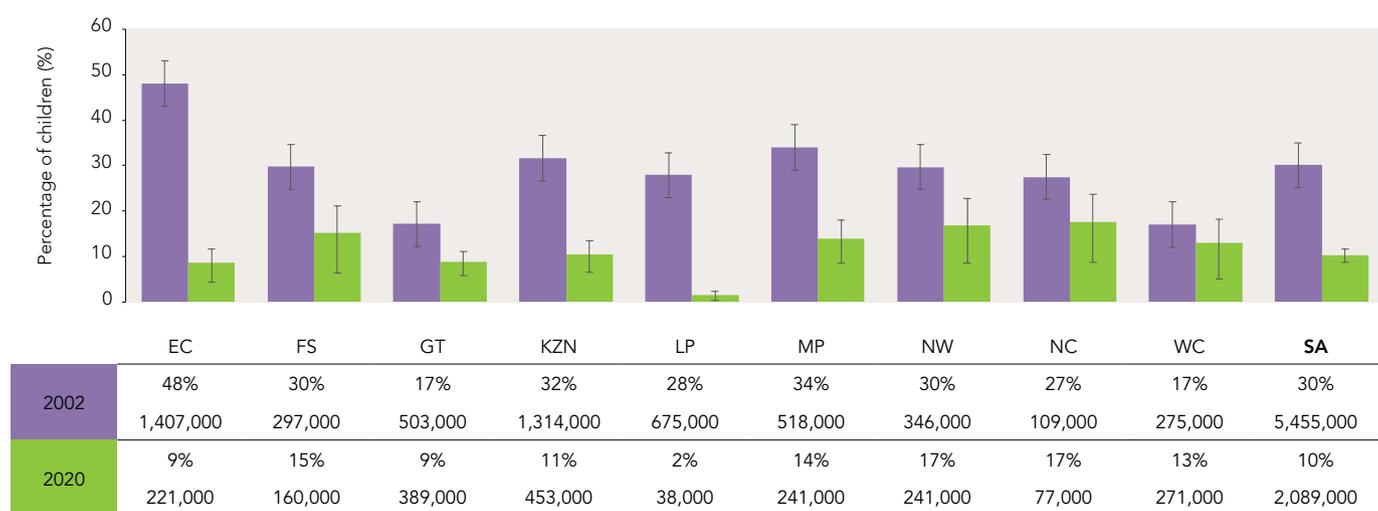
In 2020, 10% of children in South Africa (nearly 2.1 million) lived in households that reported child hunger. More than a fifth of these children (22%) were from KwaZulu-Natal, while 19% were from Gauteng. Child hunger rates in 2020 were 20 percentage points lower than they were in 2002 when 30% of children (5.5 million) lived in households that reported child hunger. The largest declines have been in the Eastern Cape, KwaZulu-Natal and Limpopo. One of the main contributors to this decline is the expansion of the Child Support Grant which has steadily increased its coverage, reaching nearly 13 million children in 2020.⁹ Another is the National School Nutrition Programme (NSNP), which by 2019 reached over 9 million learners in approximately 20,000 schools.¹⁰ However, the NSNP only operates during term-time and does not include children who are too young to attend school. When schools were closed at the beginning of lockdown in March 2020, the NSNP ceased to operate altogether until the matter was taken to court by civil society organisations in July and the Gauteng High Court ordered the Department of Basic Education to resume the NSNP even if learners were not attending school due to the COVID-19 pandemic.¹¹

Analysis of child hunger rates within provinces shows that child hunger rates in 2020 are highest in the Northern Cape and

North West (in each of these provinces, 17% of children were in households that reported child hunger), followed by the Free State (15%) and Mpumalanga (14%). The lowest reported hunger rates were in Limpopo (2%). Despite high poverty rates, Limpopo has always reported child hunger rates below the national average, perhaps because of its highly fertile and productive land in rural areas where most of the population lives. However, there is no clear explanation for the dramatic decline in reported hunger in the Eastern Cape. Over the period 2002 – 2019, reported child hunger rates in that province fell from 48% (higher than any other province) to 5% (the second lowest), despite the fact that the Eastern Cape has the highest poverty rates in the country, with 44% of children living below the food poverty line. There was a small but statistically significant increase in reported child hunger in the Eastern Cape from 5% in 2019 to 9% in 2020.

There are no differences in reported child hunger across gender or age groups. However, there are significant differences across race: 11% of African children and 9% of Coloured children live in households that reported child hunger, compared to less than 1% of Indian and White children. Differences are even more pronounced across income quintiles. While 19% of children living in the poorest 20% of households experienced hunger, only 4% of children in quintile 5 (the richest 20%) lived in households where child hunger was reported. Of all those who did report child hunger, over half were in the poorest income quintile. While reported children hunger rates are slightly higher in the rural former homelands (11%) than in urban areas (10% of children), the difference is not great. Food insecurity is prevalent in both urban and rural areas.

Figure 3a: Children living in households with reported child hunger, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA.
 Analysis by Katharine Hall, Children’s Institute, UCT.

The NIDS-CRAM study recorded increased rates of reported child hunger during 2020, almost certainly due to rising poverty and unemployment during lockdown.¹² Although the overall child hunger rates in the General Household Survey (GHS) did not increase significantly, there were slight increases in reported child hunger in the two poorest income quintiles between 2019 and 2020. In the poorest income quintile, child hunger rates increased from 17.6% in 2019 to 18.7% in 2020, while the reported child hunger rate in quintile 2 increased from 8.4% to 9.8%.

Children who suffer from hunger are at risk of various forms of malnutrition, including wasting, stunting, overweight and micronutrient deficiencies. The 2016 Demographic and Health Survey recorded the stunting rate among children under 5 years at 27% – a figure that has remained persistently high since the

1990s and indicates high rates of chronic undernutrition. It must be recognised that child hunger is a subjective indicator and does not capture other important aspects of food security such as dietary diversity and consumption of nutrient-rich foods, both of which are important for children’s healthy growth especially in early childhood. Children may live in households that do not report hunger but may still not have access to sufficient nutritious food and are therefore at risk of malnutrition. In 2019, for example, approximately 30% of children who lived in households that did not report child hunger were classified as living below the food poverty line, an indicator that their households lacked the financial resources needed to meet minimum dietary requirements for children and other household members.¹³

Children living far from their health facility

This indicator reflects the distance from a child’s household to the health facility they normally attend. Distance is measured as the length of time travelled to reach the health facility, by whatever form of transport is usually used. The health facility is regarded as ‘far’ if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport.

A review of international evidence suggests that universal access to key preventive and treatment interventions could avert up to two-thirds of under-five deaths in developing countries.¹⁴ Preventative measures include the promotion of breast and complementary feeding, micronutrient supplements (vitamin A and zinc), immunisation, and the prevention of mother-to-child transmission of HIV, amongst others. Curative interventions provided through the government’s Integrated Management of Childhood Illness strategy include oral rehydration, infant resuscitation and the dispensing of medication.

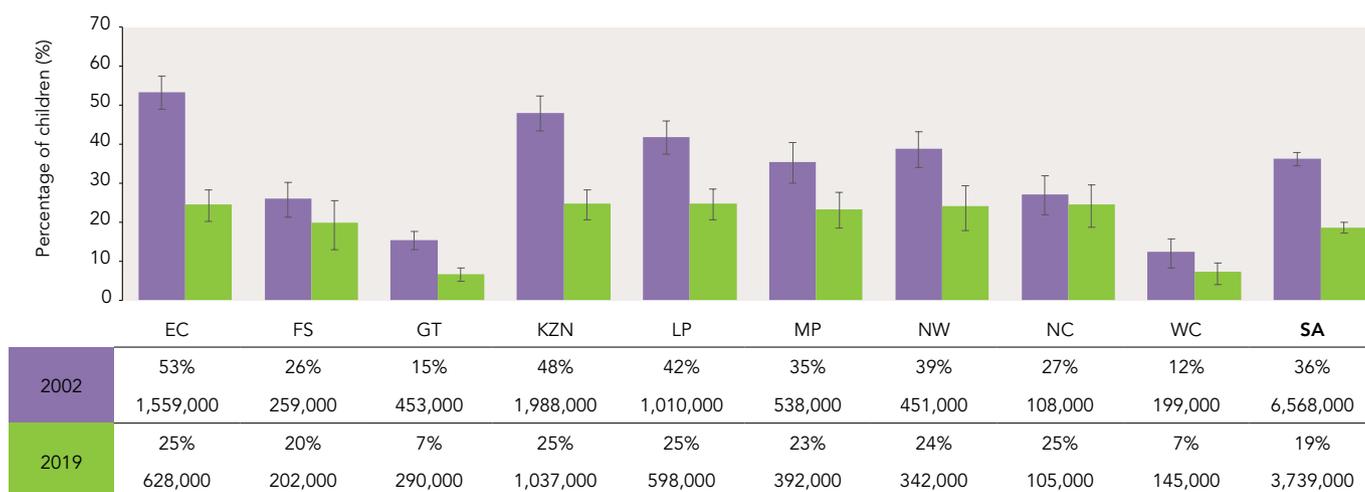
According to the UN Committee on Economic, Social and Cultural Rights, primary health care should be available (in sufficient supply), accessible (easily reached and affordable), acceptable and of good quality.¹⁵ In 1996, primary level care was

made free to everyone in South Africa, but the availability and physical accessibility of health care services remain a problem, particularly for people living in remote areas.

Physical inaccessibility poses particular challenges when it comes to health services because the people who need these services are often unwell or injured or need to be carried because they are too young, too old or too weak to walk. Physical inaccessibility can be related to distance, transport options and costs, or road infrastructure. Physical distance and poor roads also make it difficult for mobile clinics and emergency services to reach outlying areas. Within South Africa, the extent to which patients use health care services is influenced by the distance to the health service provider: those who live further from their nearest health facility are less likely to use the facility. This ‘distance decay’ is found even in the uptake of services that are required for all children, including immunisation and maintaining the Road-to-Health Book.¹⁶

The GHS 2020 did not ask questions about the distance or mode of travel to health facilities. In 2019, a fifth (19%) of South Africa’s children lived far from the primary health care facility they normally use. Most children (93.5%) lived in

Figure 3b: Children living far from their health facility, by province, 2002 & 2019



Source: Statistics South Africa (2003; 2020) *General Household Survey 2002; General Household Survey 2019*. Pretoria: Stats SA.

Analysis by Katharine Hall, Children’s Institute, UCT.

households where members attended the health facility closest to their home. Within the poorest 20% of households, only 3% do not use their nearest facility. The main reasons for attending a remote health service relate to perceptions of service quality; a preference for private health services (36%), and other specific quality complaints including long waiting times (19%); the unavailability of medication (8%) and rude or uncaring staff (4%). Cost considerations also inform choices, and 12% of households that did not use their nearest facility chose to travel further in order to access cheaper medical care or free government health services.¹⁷

In total, 3.7 million children would travel more than 30 minutes to reach their usual health care service provider. This is a significant improvement since 2002, when 36% (or 6.6 million children) lived far from their nearest health facility.

It is encouraging that the greatest improvements in access have been made in provinces which performed worst in 2002: the Eastern Cape (where the share of children with poor access to health facilities dropped from 53% in 2002 to 25% in 2019), KwaZulu-Natal (down from 48% to 25%), Limpopo (from 42% to 25%) and North West (from 39% to 24%). Provinces with the

highest rates of access are the largely metropolitan provinces of the Western Cape and Gauteng, where only 7% of children live more than 30 minutes from their usual health care service.

There are also significant differences between population groups. Twenty percent of African children and 11% of Coloured children travel far to reach their usual health care facility, compared with 6% and 4% of Indian and White children respectively. Racial inequalities are amplified by access to transport: if in need of medical attention, 95% of White children would be transported to their health facility in a private car, compared with only 12% of African children. Only 3% of the poorest children (quintile 1) travel to their health facility in a private car, while 61% walk.

Poor children bear the greatest burden of disease, due to undernutrition and poorer living conditions and access to services (water and sanitation). Yet health facilities are least accessible to the poor. More than a quarter of children (26%) in the poorest 20% of households travel far to access health care, compared with 10% of children in the richest quintile.

There are no significant differences in patterns of access to health facilities when comparing children of different sex and age groups.

Teenage pregnancy

This indicator shows the number and proportion of young women aged 15 – 24 who are reported to have given birth to a live child in the past year.

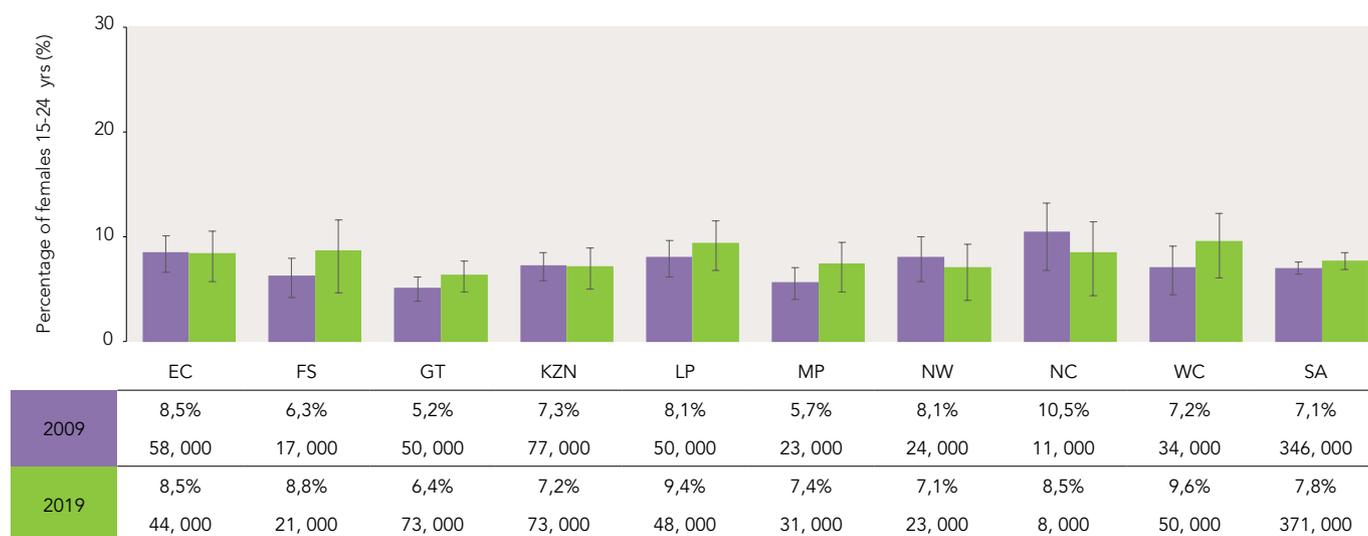
Teenage pregnancy rates are difficult to calculate directly because it is hard to determine how many pregnancies end in miscarriage, still-birth or abortion: these are not necessarily known to the respondent, or accurately reported. In the absence of reliable data on pregnancy, researchers tend to rely on childbearing data (i.e., the percentage of women in an age group who have given birth to a live child).

Despite widespread assumptions that teen pregnancy in South Africa is an escalating problem, the available data suggest that the percentage of teenage mothers is not increasing. A

number of studies have suggested a levelling off and even a decrease in fertility rates among teenagers in South Africa.¹⁸⁻²⁰ Teenage fertility rates declined after the 1996 census from 78 births per 1,000 women aged 15 – 19 years, to 65 births per 1,000 adolescents in 2001. The adolescent birth rate recorded in the 2011 population census suggested an increase to 72 per 1,000, and the 2016 SA Demographic and Health Survey recorded a similar (slightly lower) rate of 71. These patterns (the decline, increase and stability over the past two decades) are not exclusive to adolescents but follow the overall fertility trends for the country.²¹

Statistics South Africa regularly reports the number of 'recorded live births', using vital statistics data. The pattern over the past

Figure 3c: Annual childbearing rates among young women aged 15 – 24 years, by province, 2009 & 2019



Source: Statistics South Africa (2010; 2020) *General Household Survey 2009; General Household Survey 2019*. Pretoria: Stats SA.

Analysis by Katharine Hall, Children's Institute, UCT.

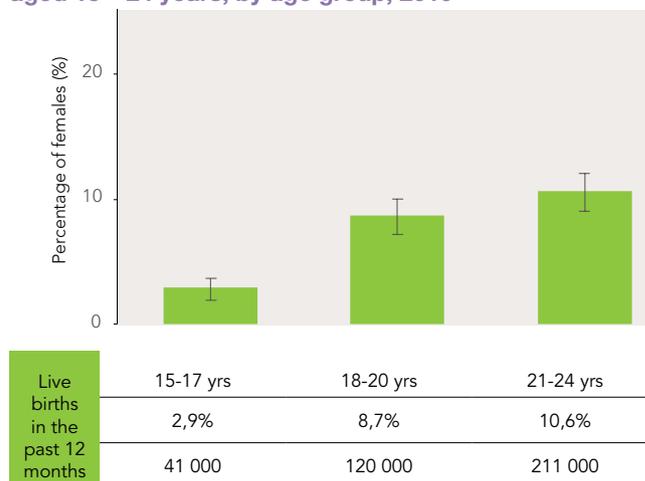
decade (from 2011) has been a decrease in adolescent births, this decrease being reflected in both the rate of current year birth registrations and late birth registrations. In 2020, out of over a million births registered, 112,127 births were registered to the mothers of adolescents aged 19 or younger.²² Of these, just over 94,000 were registrations of babies born in the past year, while just under 18,000 were late birth registrations. This was the second lowest number of births registered to adolescent mothers since the current birth registration record system was developed in 1998, with the exception of 2014 when the number was slightly lower. It is possible that the closure of Home Affairs offices during the lockdown of 2020 caused a drop in the number of registered births to child and adolescent mothers, but this will only be known once late registration of births in 2021 and 2022 has been completed and those numbers are published.

Department of Health data between 2004 and 2017 showed a consistent decline in the share of teenagers aged 15 – 19 who attended antenatal clinics and participated in the national HIV sero-prevalence survey.²³ A further decline was recorded in 2019, both in real numbers and as a percentage of the total sample (teens aged 15 – 19 represented 13.1% of participants in the 2019 ante-natal survey, down from 17.5% in 2013). All of these data sources suggest that pregnancy and fertility rates among teenagers did not increase in the two decades leading up to 2020.

Fertility rates are, of course, an indicator of possible exposure to HIV. HIV prevalence rates are higher among women in their late twenties and thirties, and lower among teenagers, and the prevalence rate in the 15 – 24 age group has decreased over the past 10 years. However, prevalence rates are still worryingly high: of the young pregnant women surveyed in antenatal clinics in 2019, 10.3% of those aged 15 – 19 and 19.4% of those aged 20 – 24 were HIV positive.²⁴ For many years the majority of deaths in young mothers were caused by HIV.²⁵ Much of the overall decline in maternal deaths since 2011 is attributed to implementation of policies to manage and prevent HIV,²⁶ but it is still important that safe sexual behaviour is encouraged and practised.

Studies have found that early childbearing – particularly by teenagers and young women who have not completed school – has a significant impact on the education outcomes of both the mother and child, and is also associated with poorer child health and nutritional outcomes.^{19, 25, 27} For this reason, it is important to delay childbearing, and to ensure that teenagers who do become pregnant are appropriately supported. This includes ensuring that young mothers can complete their education, and that they have access to parenting support programmes and health services. Although pregnancy is a major cause of school drop-out, some research has also suggested that teenage girls who are already falling behind at school are more likely to become pregnant than those who are progressing through school at the expected rate.²⁸ So efforts to provide educational support for girls who are not coping at school may also help to reduce teenage pregnancies.

Figure 3d: Childbearing rates among young women aged 15 – 24 years, by age group, 2019



Source: Statistics South Africa (2020) *General Household Survey 2019*. Pretoria: Stats SA.

Analysis by Katharine Hall, Children's Institute, UCT.

Poverty alleviation is important for both the mother and child, but take-up of the Child Support Grant (CSG) among teenage mothers is low compared with older mothers.^{20, 29, 30} This suggests that greater effort should be made to assist young mothers to obtain identity documents for themselves and birth certificates for their babies so that they can apply for CSGs. Ideally, home affairs and social security services should form part of a comprehensive maternal support service at all maternity facilities.

Since 2009 the nationally representative GHS conducted by Statistics South Africa has included questions on pregnancy and fertility. The pregnancy question asks the household respondent: “Has any female household member [between 12 – 50 years] been pregnant during the past 12 months?” For those reported to have been pregnant, a follow-up question asks about the current status of the pregnancy. This indicator calculates the number and percentage of young women who have given birth in the past year.

According to the GHS, the national childbearing rate for young women aged 15 – 24 was 7.8% in 2019 (the question was not asked in 2020). This is equivalent to 371,000 births to young women in this age group, out of over 1.1 million births per year. There has been no significant change in this rate since 2009 when the question was first asked in the survey.

As would be expected, childbearing rates increase with age. Only 3% of girls aged 15 – 17 were reported to have given birth in the previous 12 months (representing 41,000 teenagers in this age group). Childbearing rates rose to 9% among 18 – 20-year-olds (120,000 when weighted), and 11% in the 21 – 24 age group (211,000). These rates have also been fairly stable over the past decade, and in the teen group (under 18) the childbearing rate has never risen above 3.2% (its peak in 2013).

Immunisation coverage of children

This indicator shows the percentage of children younger than one year who are fully immunised. ‘Full immunisation’ refers to children having received all the required doses of vaccines given in the first year of life.

Immunisation is one of the most effective preventative health care interventions to prevent serious illnesses and death in young children. It entails giving injections or drops to young children that protect them against potentially life-threatening illnesses such as tuberculosis, polio, hepatitis and measles. South Africa has an up-to-date immunisation programme, in keeping with world standards.

The Expanded Programme on Immunisation (EPI) in South Africa was last updated in 2015.

The revised EPI schedule for public health facilities providing services to children in the first year of life includes immunisation at birth, and then at 6 weeks, 10 weeks, 14 weeks and 9 months.³¹ Thus, by the time of their first birthday, all babies should have visited a health facility at least four times after birth for immunisation services, and these immunisations should be recorded in the child’s Road-to-Health booklet.

Immunisation coverage serves as a good indicator of the extent to which young children access primary health care services. Immunisation coverage is also a proxy for the extent to which children access other health services, as the immunisation schedule provides a point of contact for identifying other health problems and for scheduling preventative child health interventions. Examples of these are the vitamin A supplementation programme, developmental screening, and prophylaxis for babies born to HIV-positive mothers.

Immunisation rates are tracked in the District Health Information System and are calculated as the number of children who have received complete immunisation divided by the child population within that district. The percentages obtained in this way will be influenced by population movement in health seeking behaviour – for example, if children from one district are taken to a health facility in a neighbouring district. This has sometimes resulted in some districts, and even provinces,

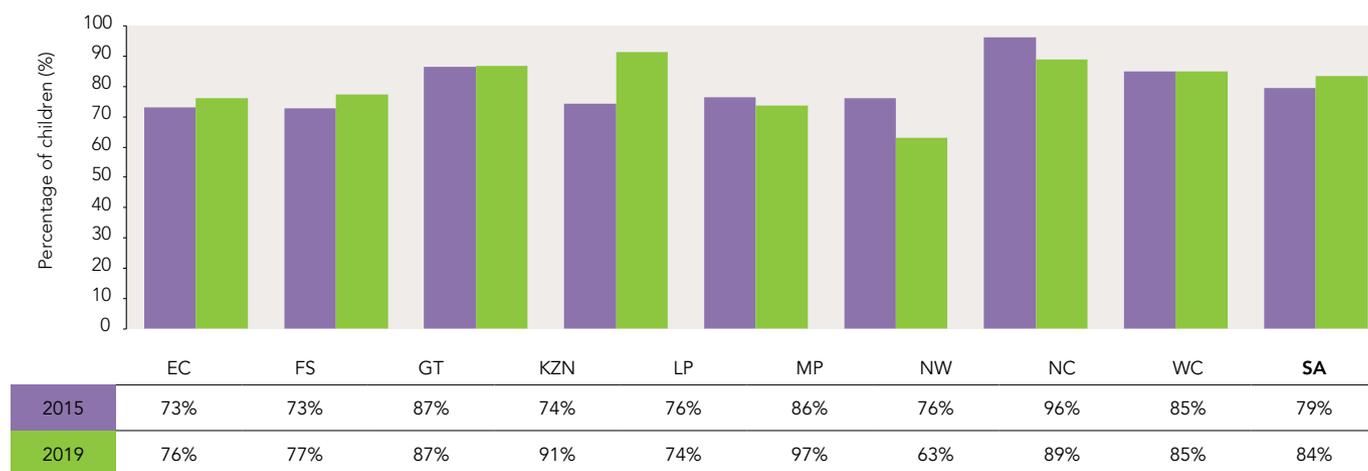
reporting immunisation rates of over 100%. The immunisation rates are also affected by national (and district-level) estimates of population size.

The 2015/16 immunisation rate, as reported in the 2016/17 District Health Barometer, reflected high levels of immunisation for infants under a year, at 89.2%.³² Since then, Statistics South Africa revised its model to derive the mid-year population estimates, and it was found that the number of children in the country had previously been underestimated.³³ The 2015/16 immunisation rate was revised downwards to 79.5%. The 2016 rate had dropped even before the new population estimates were released and, after retrospective adjustment to the revised population estimates, the rate for that year was calculated at 71%. The lower immunisation rate for that year was attributed to a global shortage of Hexavalent vaccine.³¹ In 2017/18 the immunisation rate was estimated at 77%, increasing to 82% in 2018/19 and 83.5% in 2019/20. The immunisation rates in the District Health Barometer have not been adjusted retrospectively before 2015, and so it is not possible to determine long-term trends in immunisation uptake.

The highest immunisation rates for 2019/20 were in Mpumalanga (97%), KwaZulu-Natal (91%) and the Northern Cape (89%). North West had the lowest immunisation rate (63%) with the rate having fallen from 76% in 2015. Other provinces with immunisation rates below the national average were the Free State (77%), Eastern Cape (76%) and Limpopo (74%).

The challenge of national and provincial aggregates is that they can mask differences between districts and hide areas with low coverage. The District Health Barometer provides detail on immunisation at district level and shows substantial inter-district inequities in service access for young children – ranging from coverage rates in the low 60 percentages in three out of the four districts in North West, to over 100% in three districts (Ehlanzeni in Mpumalanga, John Taolo Gaetsewe in the Northern Cape and iLembe in KwaZulu-Natal).³⁴ Low coverage rates are concentrated mainly in poor districts, where health needs may be greatest.

Figure 3e: Immunisation coverage of babies younger than one year, by province, 2015 & 2019



Source: Health Systems Trust (2020) “District Health Barometer” data file (derived from Department of Health’s District Health Information System – DHIS). Available at www.hst.org.za.

Effective immunisation requires high levels of coverage to achieve a certain level of immunity within the broader community. This is known as 'herd immunity' and it means that, if immunisation coverage has reached a high enough level, even the most vulnerable who have not been immunised in that community will be protected – including young children and those with low immunity.

Even though immunisation is freely available, and the goal is for it to be universal, it is voluntary and there is growing evidence that some parents choose not to immunise their children. A 'worldwide increase in vaccine hesitancy and refusal' has been described as a threat to the public health achievements in controlling and preventing infectious diseases.³⁵ At a country level, vaccine sentiment and voluntary compliance is inversely

correlated with socio-economic status (i.e. compliance is lower in wealthy countries than in poorer ones).³⁵

The completion rates for 'basic immunisation' (BCG, three doses of STaP-IPV-Hib, and one dose of measles vaccine) in the South African Demographic and Health Survey of 2016 were substantially lower than those recorded in the District Health Information System for the same year (at 61%, compared with 77%). The reason for this discrepancy is not clear, but it is important to note that compliance was highest in the poorest wealth quintile (66%) while the richest quintile was lower, at 60%.³⁶ This suggests an inverse correlation between socio-economic status and immunisation in South Africa, a highly unequal country.

References

1. Constitution of the Republic of South Africa Act 108 of 1996.
2. Organisation of the African Union. *African Charter on the Rights and Welfare of the Child, 11 July 1990*. OAU Doc 24.9/49. Addis Ababa: OAU. 1990.
3. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child. UN General Assembly Resolution 44/25*. Geneva: United Nations. 1989.
4. Nannan N, Groenewald P, Pillay-van Wyk V, Msemburi W, Dorrington R, Bradshaw D. Child mortality trends and causes of death in South Africa, 1997-2012, and the importance of a national burden of disease study. *South African Medical Journal*. 2019;209(7):480-485.
5. Bradshaw D, Dorrington R, Nannan N, Laubscher R. *Rapid Mortality Surveillance Report 2013*. Cape Town: South African Medical Research Council. 2014.
6. Dorrington R, Bradshaw D, Laubscher R, Nannan N. *Rapid Mortality Surveillance Report 2019 & 2020*. Cape Town: South African Medical Research Council. 2021.
7. Ibid, p11
8. Ibid, p14
9. Hall K. Income poverty and grants - *Child Support Grants Cape Town*: Children's Institute, University of Cape Town; 2019. Accessed: April 2022. Available from: www.childrencount.uct.ac.za.
10. National Treasury. *Estimates of National Expenditure, Vote 14 Basic Education*. Pretoria: National Treasury. 2019.
11. Equal Education and others v Minister of Basic Education and others. Case number 22588/2020.
12. Van der Berg S, Patel L, Bridgman G. *Hunger in South Africa during 2020: Results from Wave 3 of NIDS-CRAM*. 2021.
13. Statistics South Africa. *General Household Survey 2018*. Analysis by K Hall, Children's Institute.
14. Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, Belagio Child Survival Study Group. How many deaths can we prevent this year? *The Lancet*. 2003;362(9977):65-71.
15. United Nations Economic and Social Council. *International Covenant on Economic, Social and Cultural Rights, Article 12: The Right to the Highest Attainable Standard of Health: General Comment No. 14*. Geneva: Committee on Economic, Social and Cultural Rights. 2000.
16. McLaren Z, Ardington C, Leibbrandt M. *Distance as a Barrier to Health Care Access in South Africa*. Cape Town: Southern Africa Labour and Development Research Unit, UCT. 2013.
17. Statistics South Africa. *General Household Survey 2018*. Pretoria: Stats SA. 2019.
18. Jonas K, Crutzen R, van den Borne B, Sewpaul R, Reddy P. Teenage pregnancy rates and associations with other health risk behaviours: A three-wave cross-sectional study among South African school-going adolescents. *Reproductive Health*. 2016;13(1):50.
19. Ardington C, Branson N, Leibbrandt M. *Trends in Teenage Childbearing and Schooling Outcomes for Children Born to Teens in South Africa*. Cape Town: Southern African Labour & Development Research Unit, University of Cape Town. 2011.
20. Makiwane M, Desmond C, Richter L, Udjo E. *Is the Child Support Grant Associated with an Increase in Teenage Fertility in South Africa? Evidence from national surveys and administrative data*. Pretoria: Human Sciences Research Council. 2006.
21. Statistics South Africa. *Demographic profile of adolescents in South Africa. Report no. 03-00-10*. Pretoria: Stats SA. 2018.
22. Statistics South Africa. *Recorded Live Births 2011 - 2020*. Pretoria: Stats SA. (2012 - 2021).
23. Department of Health. *National Antenatal Sentinel HIV and Syphilis Prevalence Surveys 2004 - 2017*. Pretoria: DoH. 2004 - 2019.
24. Department of Health. *National Antenatal Sentinel HIV and Syphilis Prevalence Surveys 2017*. Pretoria: DoH. 2019.
25. Ardington C, Menendez A, Mutevedzi T. Early childbearing, human capital attainment and mortality risk. *Economic Development and Cultural Change*. 2015;62(2):281-317.
26. Department of Health. *Saving Mothers 2014 - 2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa: Short report*. Pretoria: DoH. 2018.
27. Branson N, Ardington C, Leibbrandt M. Health outcomes of children born to teen mothers in Cape Town, South Africa. *Economic Development and Cultural Change*. 2015;63(3):589-616.
28. Timæus I, Moultrie T. Trends in childbearing and educational attainment in South Africa. *Studies in Family Planning*. 2015;46(2):143-160.
29. Makiwane M. The Child Support Grant and teenage childbearing in South Africa. *Development Southern Africa*. 2010;27(2):193-204.
30. Kesho Consulting and Business Solutions. *Report on Incentive Structures of Social Assistance Grants in South Africa*. Pretoria. 2006.
31. Dlamini N. Immunisation. In: Massyn N, Pillay Y, Padarath A, editors. *District Health Barometer*. Durban: Health Systems Trust; 2019.
32. Massyn N, Padarath A, Peer N, Day C. *District Health Barometer 2016/17*. Durban: Health Systems Trust. 2018.
33. Hall K, Sambu W, Almeleh C, Mabaso K, Giese S, Proudlock P. *South African Early Childhood Review 2019*. Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana. 2019.
34. Massyn N, Day C, Ndlovu N, Padayachee T. *District Health Barometer 2019/20*. Westville: Health Systems Trust. 2020.
35. Verelst F, Kessels R, Delva W, Beutels P, Willem L. Drivers of vaccine decision-making in South Africa: A discrete choice experiment. *Vaccine*. 2019;37(15):2079-2089.
36. Department of Health, Statistics South Africa, South African Medical Research Council, ICF. *South African Demographic & Health Survey 2016: Key Indicators*. Pretoria and Rockville, Maryland: NDOH, Stats SA, SAMRC & ICF. 2017.

Children's access to education

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Section 29(1)(a) of the South African Constitution states that "everyone has the right to a basic education", and section 29(1)(b) says that "everyone has the right to further education", and that the state must make such education "progressively available and accessible".¹

Article 11(3)(a) of the African Charter on the Rights and Welfare of the Child says "States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realization of this right and shall in particular ... provide free and compulsory basic education".²

Article 28 of the UN Convention on the Rights of the Child recognises "the right of the child to education" and also obliges the state to "make primary education compulsory and available free to all".³

Children attending an educational institution

This indicator shows the number and percentage of children aged 7 – 17 who are reported to be attending a school or educational facility. It is different from 'enrolment rate', which reflects the number of children enrolled in educational institutions, as reported by schools to the national Department of Basic Education (DBE) early in the school year.

Education is a central socio-economic right that provides the foundation for lifelong learning and economic opportunity. Children have a right to basic education and are admitted into Grade 1 in the year they turn seven. Basic education is compulsory in Grades 1 – 9 or for children aged 7 – 15. Children who have completed basic education also have a right to further education (Grades 10 – 12), which the government must take reasonable measures to make available.

South Africa has high levels of school enrolment and attendance. Among children of school-going age (7 – 17 years), the vast majority are reported to attend some form of educational facility. There was a small but significant increase from 2002, when the reported attendance rate was 95%, to 2018,

when reported attendance rates were 98%. The overall increase was mainly due to the growth in reported attendance rates for African and Coloured children, and in 2018, for the first time since this indicator was tracked, there were no significant differences in attendance rates across race groups.

School attendance in 2020 is expected to be different to previous years because of COVID-19 and lockdown. All schools were closed from 18 March 2020. From June, there was some partial reopening of schools, but only for specific grades. Schools re-opened for all grades from late August 2020, but even then they ran at reduced capacity, with rotational timetabling of classes.

Stats SA ran its General Household Survey from September to December 2020. The survey included the usual question about whether household members were attending an educational institution, but did not ask whether they were attending every day. Thus, reported attendance rates do not reflect the regularity of attendance, even at a time when it is known that learners were unlikely to be attending every day. Reported attendance rates in the last quarter of 2020 were at a similarly high level as

Figure 4a: School-age children (7 – 17-year-olds) attending an educational institution, by province, 2002 & 2020



Source: Statistics South Africa (2003, 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

previous years, with just a small decrease of one percentage point from 2019, to 97%. Of a total of 12.3 million children aged 7 – 17 years, 370,000 were reported as not attending school between September and December 2020. The lowest attendance rates were reported in the Western Cape, at 95%.

Wave 3 of the NIDS-CRAM survey, conducted in November 2020, asked whether children had attended school at any time in the last seven days. The overall estimate was 98%, a similar attendance rate to that reported in GHS. Attendance rates earlier in the year had been much lower, and varied substantially by grade, ranging from 88% for Grade 12 learners to as low as 11% for Grade 9 learners.⁴ This was due to the staggered re-opening of grades and prioritisation of those approaching the end of the primary or secondary phase.

Overall attendance rates tend to mask drop-out among older children. Analysis of attendance among discrete age groups shows that although there is a slight drop in reported attendance among children beyond the compulsory schooling phase, attendance still remains in the high-90s for children aged 16 and 17. It is only at age 18 that there is a substantial drop: to around 90% for males and 80% for females who have not completed Grade 12. Differences in reported school attendance rates between boys and girls in the compulsory education phase are not statistically significant.

The 2020 General Household Survey included additional questions to gauge levels of access to education through remote learning (when children were not able to attend school in person due to lockdown and restrictions on school capacity). The responses to these questions suggest that South Africa was not well-prepared for remote schooling. For children aged 7 – 17 years, the following information was recorded:

- 10% were in schools that offered remote learning opportunities
- 6% participated in online learning
- 3% had access to a smartphone in the household that they could use for remote learning
- 1% had access to a computer (desktop or laptop) that they could use for remote learning during lockdown.

Thus, although, by the last quarter of 2020 when schools had reopened, school attendance rates had almost returned to 'normal' levels, this attendance rate overstates daily attendance or access to learning.

Usually, the General Household Survey asks about reasons for non-attendance for those who are not attending an educational institution. This question was not asked in 2020, as the

Access to early childhood learning programmes

This indicator shows the number and percentage of children aged 5 – 6 who are reported to be attending an early childhood development (ECD) programme or educational institution – in other words, those attending out-of-home group care and learning centres including ECD centres, pre-Grade R, Grade R or Grade 1 in ordinary schools. While all these facilities provide care and stimulation for early learning for young children, the emphasis on providing learning opportunities through structured learning programmes differs by facility type.

Educational inequalities are strongly associated with structural socio-economic (and therefore also racial) inequalities in South Africa.^{10, 15} These inequalities are evident from the early years,

questionnaire had to be amended and shortened. In 2019, as in previous years, the main set of reasons for non-attendance related to the quality of education or the learners ability to progress: 'Education is useless or not interesting' was the main reason given for 9% of children aged 7 – 17 who were not attending school. Another 9% were 'unable to perform at school' while 4% dropped out because they failed the exams and 6% were not accepted for enrolment, despite being in the age range 7 – 17 years. These signals of failures in the education system account for nearly 30% of all reported non-attendance.

The second main barrier to education is financial constraints. These include the cost of schooling (the reason given for 13% of children not attending schools in 2019) – which would also include related costs such as uniform and transport – and the opportunity costs of education where children have family commitments such as child minding (4%) or are needed to work in a family business or elsewhere to support household income (4%).

Disability is also an important reason, accounting for 10% of non-attendance in 2019, while illness accounted for an additional 6% of the non-attendance rate.

The main reasons for non-attendance can therefore be divided into three main categories: system failures (including exclusions and quality problems); financial barriers; and illness or disability. Together, these account for nearly 70% of non-attendance.

Pregnancy accounts for around 8% of drop-out amongst teenage girls not attending school, and only 3% of all non-attendance.⁵⁻⁷

Although the costs of education are cited as a barrier to attendance, the overall attendance rate for children in the lower income quintiles is not significantly lower than those in the wealthier quintiles.

Attendance rates alone do not capture the regularity of children's school attendance or their progress through school. Research has shown that children from more disadvantaged backgrounds – with limited economic resources, lower levels of parental education, or who have lost their mother – are more prone to dropping out or progressing more slowly than their more advantaged peers. Racial inequalities in school advancement remain strong.⁸⁻¹⁰ Similarly, school attendance rates tell us nothing about the quality of teaching and learning.¹¹ Inequalities in learning outcomes are explored through standardised tests such as those used in the international SAQMEC,¹² TIMMS and PIRLS¹³ studies. The DBE's Annual National Assessments¹⁴ have been discontinued.

even before entry into primary school.¹⁶ They are exacerbated by an unequal schooling system,^{17, 18} and are difficult to reverse. But early inequalities can be reduced through pre-school exposure to developmentally appropriate activities and programmes that stimulate cognitive development.^{19, 20} Provided that they are of good quality, early learning programmes are an important mechanism to interrupt the cycle of inequality by reducing socio-economic differences in learning potential between children before they enter the foundation phase of schooling.

The Five-year Strategic Plan²¹ of the DBE included a broad goal to improve the quality of ECD provisioning and specifically to improve access to grade R through the supply of learning

materials and improving the quality of Grade R educators. Evidence suggests that quality group learning programmes are beneficial for cognitive development from about three years of age²² and the National Development Plan (NDP) priorities, cited in the DBE's strategic plan, include universal access to two years of early childhood development programmes. The DBE funds and monitors thousands of community-based Grade R centres in addition to the school-based Grade R classes. The NDP proposes the introduction of a second year of pre-school education, and that both years be made universally accessible to children.²³ It therefore makes sense to monitor enrolment in early learning programmes of children in the 5 – 6-year pre-school age group.

Preliminary numbers from the Department of Basic Education, show that, in addition to children in ECD centres, 822,000 learners were attending Grade R or pre-Grade R at ordinary primary schools in early 2020. Just over half (54%) of pre-Grade R learners were enrolled in independent schools, while 95% of Grade R learners were at public (government schools).²⁴

In 2019, 93% of children (nearly 2.2 million) in the pre-school age group (5 – 6-year-olds) were reported to be attending some kind of educational facility, mostly in Grade R or Grade 1. This was double the 2002 level, when slightly fewer than 1.1 million children in the same age group were reported to be attending an educational institution. Around 170,000 children in this age group were not attending any kind of educational facility in 2019.

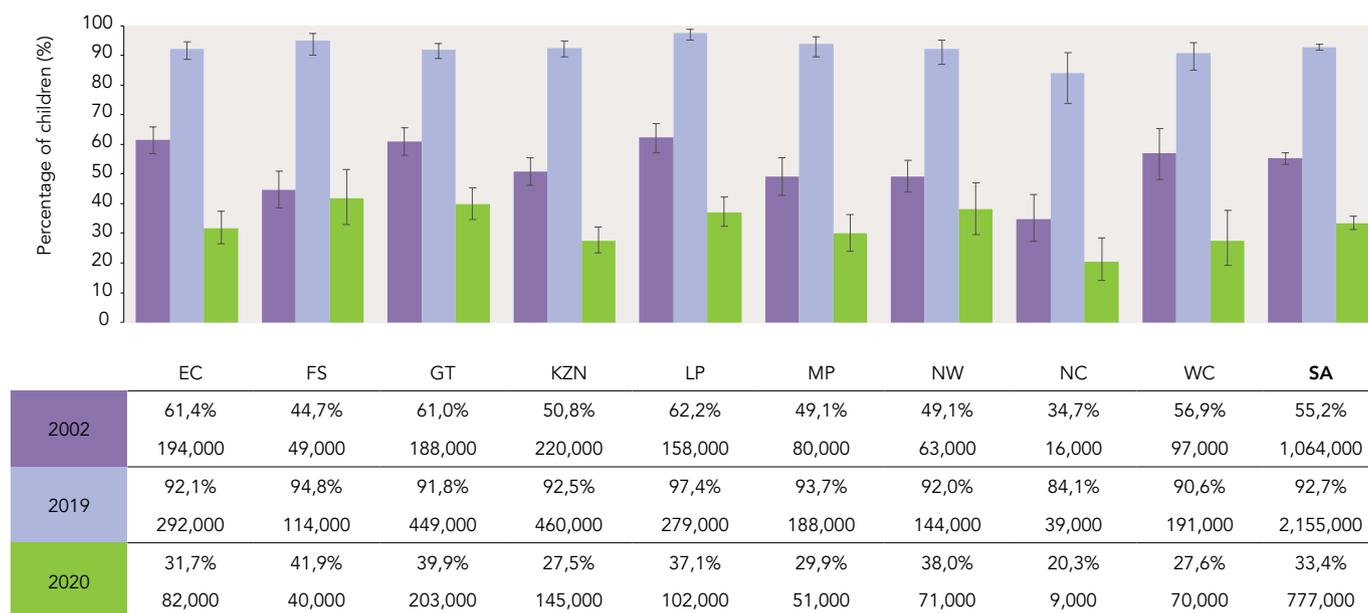
Attendance rates were above 90% in all provinces except the Northern Cape (84%). This pattern differed from many other indicators, where the Western Cape often out-performs poorer and more rural provinces like the Eastern Cape and Limpopo. Similar patterns were found in analyses of the 2007 Community Survey and the 2008 National Income Dynamics Study, which also did not find strong provincial disparities.²⁵ Given the inequalities in South Africa, it was also pleasing to see that as access

to education increased among 5 – 6 year-olds so too did the disparities narrow across races and income quintiles. There were also no significant gender differences in access to pre-school.

The effect of COVID-19 and lockdown on early learning was dramatic. In late 2020, when the General Household Survey was conducted, only 33% of children aged 5 – 6 were attending any kind of educational centre. Of the 2.3 million children in this age group, 780,000 were reported to attend while 1.5 million were not attending. The highest reported attendance rates were in the Free State (42%). The Eastern Cape, KwaZulu-Natal, Mpumalanga, Northern Cape and Western Cape all had attendance rates below the national average of 33%. Alongside the sharp fall in attendance was an apparent increase in racial inequality (60% of White children aged 5 – 6 years were reported to be accessing some kind of learning facility by late 2020, compared with 33% of African and 26% of Coloured children). Similarly, income inequalities became more pronounced, with attendance rates ranging from 28% in the poorest income quintile to 43% in the wealthiest quintile.

As with the indicator that monitors school attendance, it should be remembered that this indicator tells us nothing about the quality of care and education that young children receive at educational facilities or the resources available at those facilities. Attendance provides a unique opportunity because almost all children in an age cohort can be reached at a particularly important developmental stage; but this is a lost opportunity if the service is of poor quality. The year 2020 saw a rapid reversal of the gains made over nearly two decades in early learning access for 5 – 6 year olds. In 2020 there was further loss because of the closure of early learning programmes, difficulties in the registration procedures for re-opening, and delays and administrative obstacles in funding flows to early learning centres.

Figure 4b: Children aged 5 – 6 years attending school or ECD facility, by province, 2002, 2019 & 2020



Source: Statistics South Africa (2002; 2020, 2021) *General Household Survey 2002, 2019, 2020*; Pretoria: StatsSA. Analysis by Katharine Hall, Children's Institute, UCT. Note: Prior to 2009, enrolment in crèches, playgroups and ECD centres would have been under-reported as the survey only asked about attendance at "educational institutions". More specific questions about ECD facilities were introduced from the 2009 survey onwards and are likely to have resulted in higher attendance rates (for a more detailed technical explanation, see www.childrencount.uct.ac.za).

Children living far from school

This indicator monitors the share of school-going children who have to travel far to get to school. Distance is measured as the length of time travelled to reach school. The school the child attends is defined as 'far' if a child has to travel more than 30 minutes to reach it, irrespective of mode of transport. Children aged 7 – 13 are defined as primary school age, and children aged 14 – 17 are defined as secondary school age.

Access to schools and other educational facilities is a necessary condition for achieving the right to education. A school's location and distance from home can pose a barrier to education. Access to schools is also hampered by poor roads, transport that is unavailable or unaffordable, and danger along the way. Risks may be different for young children, for girls and boys, and are likely to be greater when children travel alone.

For children who do not have schools near to their homes, the cost, risk and effort of getting to school can influence decisions about regular attendance, as well as participation in extramural activities and after-school events. Those who travel long distances to reach school may wake very early and risk arriving late or physically exhausted, which may affect their ability to learn. Walking long distances to school may also lead to learners being excluded from class or make it difficult to attend school regularly.

Questions about distance and means of travel to school were not asked in the 2020 General Household Survey. Of the 11.6 million children who were attending school in 2019, over 7 million (63%) walked to school, while 13% travelled in vehicles hired by a group of parents, 9% travelled in private cars and 9% used public transport (bus, minibus, taxi or train). Only 2% report using school buses or school transport provided by the government. The vast majority (81%) of White children were driven to school in private or hired cars, compared with only 17% of African children.⁵ These figures illustrate pronounced disparity in child mobility and means of access to school.

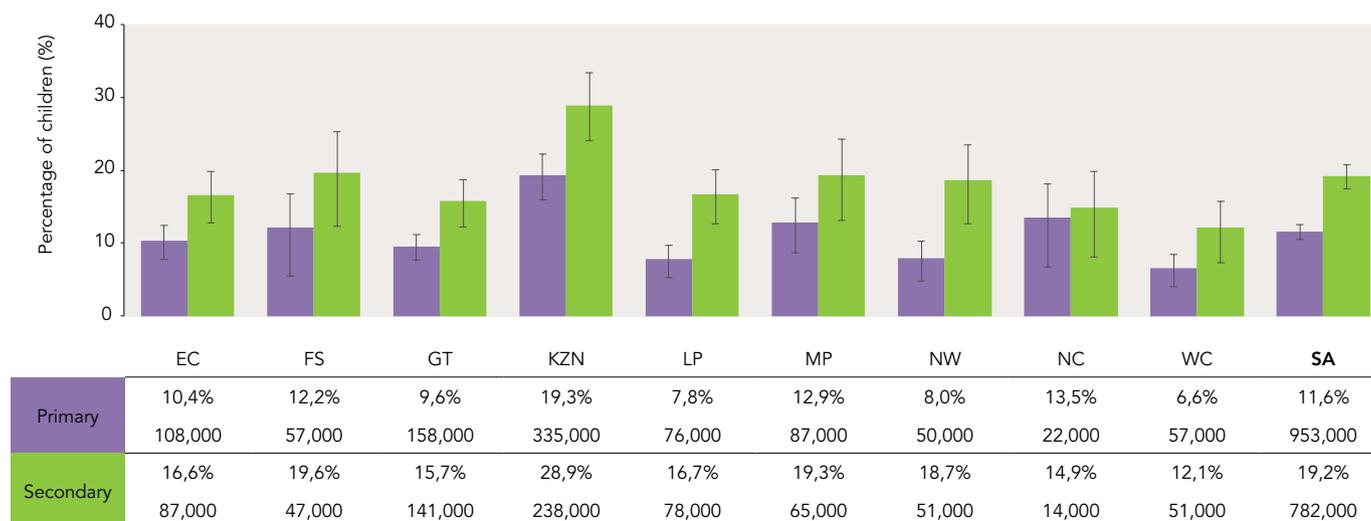
Assuming that schools primarily serve the children living in communities around them, the ideal indicator to measure physical access to school would be the distance from the child's household to the nearest school. This analysis is no longer possible due to

question changes in the General Household Survey. Instead, the indicator shows the number and percentage of children who travel far (more than 30 minutes) to reach the actual school that they attend, even if it is not the closest school. Eighty percent of school-going children attend their nearest school.

Overall, the vast majority (86%) of the 11.6 million children who attended school in 2019 travelled less than 30 minutes to reach school. Children of secondary school age are more likely than primary school learners to travel far to reach school. In 2019 there were 8.2 million children of primary school age (7 – 13 years) in South Africa. Nearly a million of these children (12%) travel more than 30 minutes to and from school every day. In KwaZulu-Natal, this percentage is significantly higher than the national average, at 19%. Of the 4 million children of secondary school age (14 – 17 years), 19% travel more than 30 minutes to reach school, and again it is children in KwaZulu-Natal who are most likely to travel far (29%). The majority of these children live in rural areas: 24% of secondary school age children in the former homelands travel far to school, compared to 15% of children living in urban areas.

Physical access to school remains a problem for many children in South Africa, particularly those living in more remote areas where public transport to schools is lacking or inadequate and where households are unable to afford private transport for children to get to school. There are 25,000 schools in South Africa, of which just over 23,000 are public and 2,000 are independent.²⁴ Over 3,000 government schools have closed since 2002 as the Department consolidates smaller schools and closes state-funded farm schools. The Eastern Cape has lost nearly a thousand public schools, while the Free State has lost over a thousand. Other provinces with substantial reductions in the number of schools are the North West and Limpopo. While the concentration of more children into fewer schools may be an advantage from a school management perspective, it may mean that children in remote areas have more difficulty in accessing school. Over the same period, the number of independent schools in the country has increased by 61% (an increase of over 700 schools).²⁶

Figure 4c: School-aged children living far from school, by province, 2019



Source: Statistics South Africa (2020) *General Household Survey 2019*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Children's progress through school

We have already seen that school attendance rates are very high during the compulsory schooling phase (Grades 1 – 9). However, attendance tells us little about the quality of education that children receive, or their progress through the education system.

Systemic evaluations by the Department of Education have recorded very low pass rates in numeracy and literacy among both Grade 3 and Grade 6 learners,²⁷ and internationally comparative studies have repeatedly found South Africa's performance to be poor even when compared with other countries in the region. In the international PIRLS study, which assessed literacy amongst Grade 4 learners, South Africa was placed last out of 50 participating countries. Four out of five Grade 4 children in South Africa could not read for meaning in any language.²⁸ In the International TIMMS study, which assessed numeracy among Grade 5 learners, South Africa was placed second last out of 49 countries. Three out of five learners could not do basic arithmetic calculations like addition and subtraction.²⁹ Despite measures to address the inherited inequities in the education system through revisions to the legislative and policy frameworks and the school funding norms, continued disparities in the quality of education offered by schools reinforce existing socio-economic inequalities, limiting the future work opportunities and life chances of children who are born into poor households.^{18, 30, 31}

High rates of grade repetition have been recorded in numerous studies. For example, a study of children's progress at school found that only about 44% of young adults (aged 21 – 29) had matriculated, and of these less than half had matriculated 'on time'.³² This was based on 2008 data from the National Income Dynamics Study. In 2016, only 51% of young people aged 20 – 24 had completed a matric or matric equivalent.³³ In South Africa, the labour market returns to education only start kicking in on successful completion of matric, not before. However, it is important to monitor progress and grade repetition in the earlier grades as slow progress at school is a strong determinant of school drop-out.⁶

Assuming that children are enrolled in primary school at the prescribed age (by the year in which they turn seven) and assuming that they do not repeat a grade or drop out of school, they would be expected to have completed the foundation phase (Grade 3) by the year that they turn nine, and the general education phase (Grade 9) by the year they turn 15.

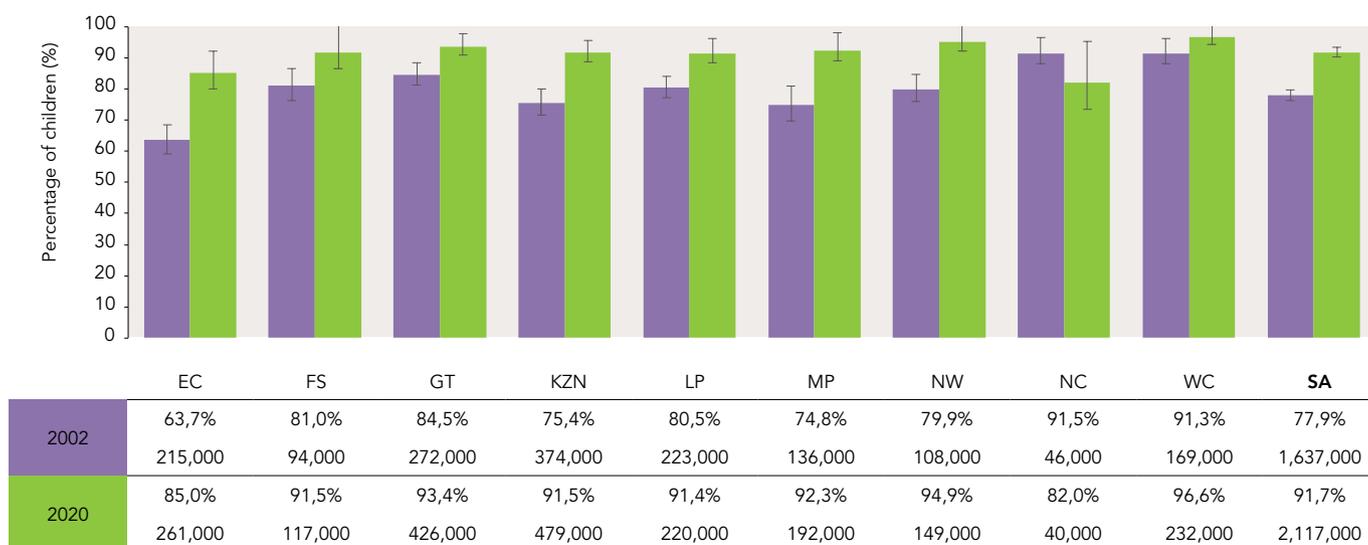
This indicator allows a little more leeway: it measures the number and percentage of children aged 10 and 11 who have completed a minimum of Grade 3, and the percentage of those aged 16 and 17 who have completed a minimum of Grade 9. In other words, it allows for the older cohort in each group to have repeated one grade.

In 2020, 92% of all children aged 10 and 11 were reported to have completed Grade 3. This was up from 78% in 2002. An improvement in progress through the foundation phase was evident across most of the provinces, with significant advances in the Eastern Cape (from 64% in 2002 to 85% in 2020), North West (from 80% to 95%), Mpumalanga (75% to 92%), Limpopo (80% to 91%) and KwaZulu-Natal (75% to 92%). These improvements have narrowed the gap between provinces.

As would be expected, the rate of progression through the entire general education and training band (Grades 1 – 9) is lower, as there is more time for children to have repeated or dropped out by Grade 9. Nearly seventy percent of children aged 16 – 17 years had completed Grade 9 in 2020. This represents an overall improvement of almost 20 percentage points over the 16-year period, from 50% in 2002. Provincial variation is slightly more pronounced than for progress through the foundation phase: Gauteng and Mpumalanga had the highest rate of grade 9 progression (75%), followed by the Western Cape (74%). Progress was poorest in the North West and Eastern Cape, where less than 60% (57% and 58% respectively) of children had completed Grade 9 by the expected age.

As found in other analyses of transitions through school,^{10, 15, 34} educational attainment (measured by progress through school)

Figure 4d: Children aged 10 – 11 years who passed Grade 3, by province, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

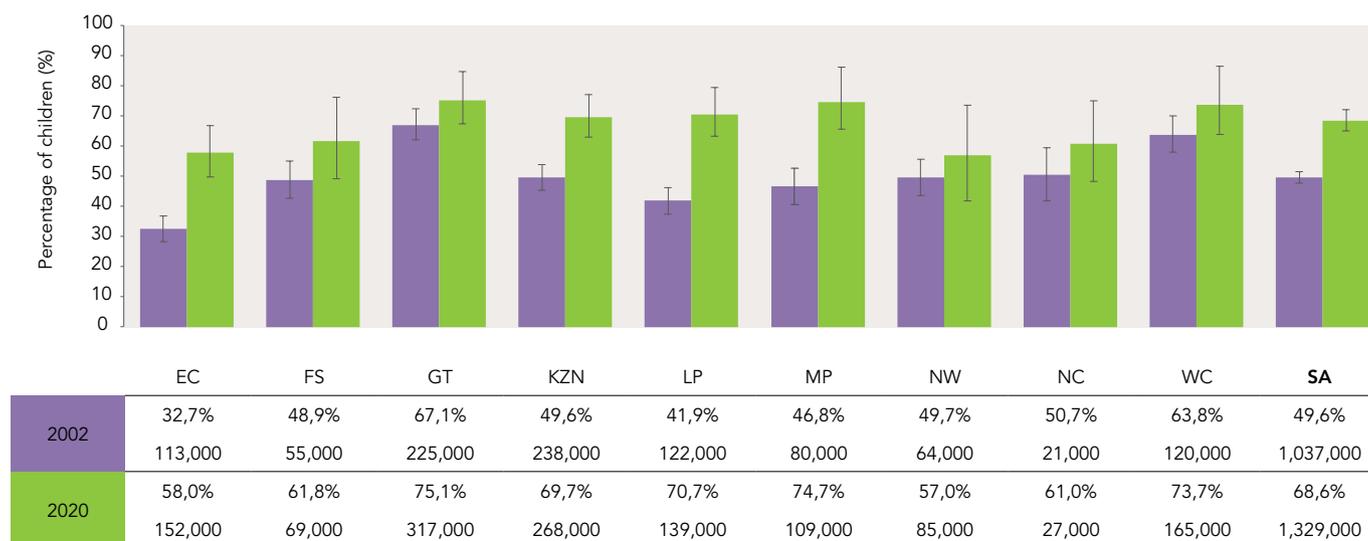
varies along socio-economic and racial lines. These differences become more pronounced as children advance through the grades. Gender differences in school progression, on the other hand, have remained consistent and even widened over the years: girls are more likely than boys to progress through school at the expected rate and the difference becomes more pronounced in the higher grades. In 2020, 94% of girls aged 10 – 11 had completed Grade 3, compared with 90% of boys; in the same year, 79% of 16 – 17-year-old girls had completed Grade 9, compared with only 59% of boys in the same age cohort. This finding is consistent with analyses elsewhere.^{6, 35}

There are significant differences in grade completion across income quintiles, especially amongst children who have completed Grade 9: in 2020, 66% of 16 – 17-year-olds in the poorest 20% of households had completed Grade 9, compared to 79% in the richest 20% of households.

The most striking improvements in grade progression, at both Grade 3 and Grade 9 level, occurred through the years between 2002 and 2010. The rate of improvement has slowed and in some years remained stable since then.

Of course, grade progression and grade repetition are not easy to interpret. Prior to Grade 12, the promotion of a child to the next grade is based mainly on assessment by teachers, and the measure may be confounded by the teacher's competence to assess the performance of the child, as well as pressure on teachers and/or schools to promote children through the system. Analyses of the determinants of school progress and drop-out point to a range of factors, many of which are interrelated: there is huge variation in the quality of education offered by schools. These differences largely reflect the historic organisation of schools into racially defined and inequitably resourced education departments. Household-level characteristics and family background also account for some of the variation in grade progression. For example, the level of education achieved by a child's mother explains some of the difference in whether children are enrolled at an appropriate age and whether they go on to complete matric successfully.³² This in turn suggests that improved educational outcomes for children will have a cumulative positive effect for each subsequent generation.

Figure 4e: Children aged 16 – 17 who passed grade 9, by province, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Youth not in employment, education or training (NEETs)

'NEET' is a term used to describe young people who are not in employment, education or training. The definition used here includes youth aged 15 – 24 who are not attending any educational institution and who are not employed or self-employed.³⁶

Widespread concerns about the large numbers of youth in this situation centre on two main issues: the perpetuation of poverty and inequality, including intergenerational poverty; and the possible implications of a large 'idle' youth population for risk behaviour, social cohesion and the safety of communities.

Little is known about what NEETs actually do with their time. Young people who are neither learning nor engaged in income-generating activities may nevertheless be "productive" within

their households, for example by helping to maintain the home or looking after children and others in need of care. However, in the absence of income, NEETs remain dependent on the earnings of other household members, and on grants that are directed to children and the elderly. The Old Age Pension in particular has been found to support job-seeking activities for young people³⁷ and it has been argued that this unenvisioned expenditure of the grant could be addressed by extending social security to unemployed youth.³⁸

The large number of NEETs in South Africa is linked to underlying problems in the education system and the labour market. Young people in South Africa have very high participation rates in education, including at secondary level. Enrolment rates

for Grades 11 and 12 have increased in recent years and more young people attain Grade 12 (and at an earlier age).³⁹ But there is still a sharp drop-off in enrolment numbers after Grade 10 and only about half of young people in their early twenties have successfully completed Grade 12.^{33, 39} This reduces prospects for further study or employment.⁴⁰ Low quality and incomplete education represent what are termed the 'supply-side' drivers of youth unemployment, where young people do not have the appropriate skills or work-related capabilities to be employable or to set up successful enterprises of their own, and so struggle to make the transition from education to work.^{41, 42} The 'demand-side' driver relates to a shortage of jobs or self-employment opportunities for those who are available to work.

In 2020, there were 9.6 million young people aged 15 – 24 in South Africa. Of these, 35% (3.4 million) were neither working nor enrolled in any education institution such as a school, university or college. The number of young people nationally who are not in education, training or employment has remained remarkably consistent over the last decade, but has increased over the two decades since 1996 when only two million NEETs were recorded.⁴³ South Africa has made no progress towards what is now an explicit target of the Sustainable Development Goals, namely to substantially reduce the proportion of youth

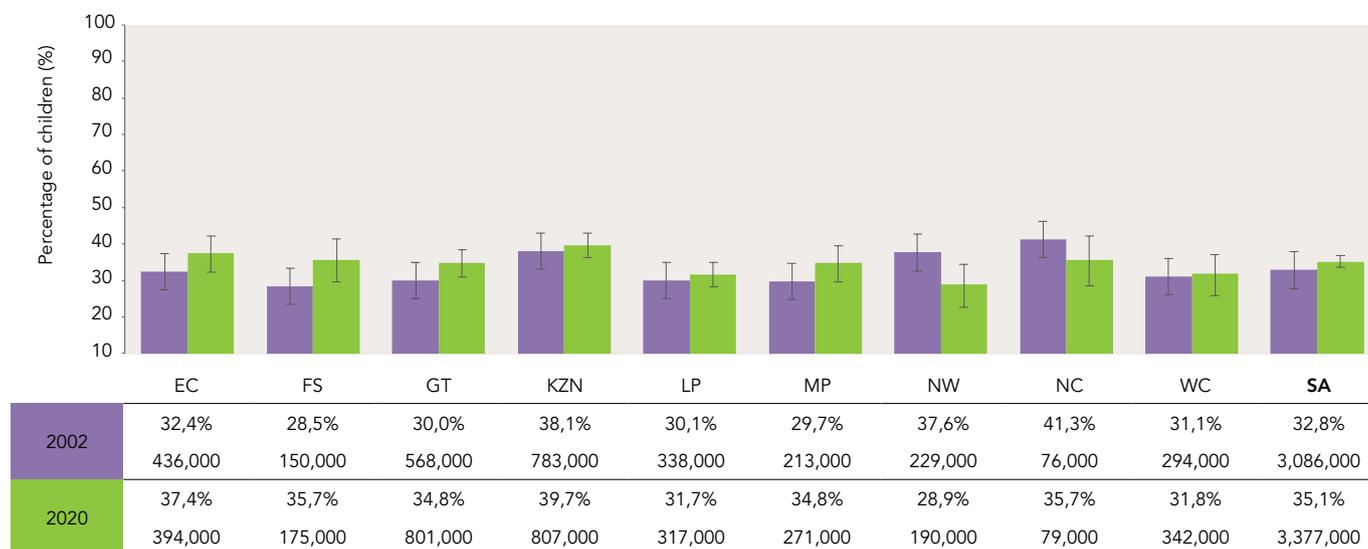
not in employment, education or training by 2020.⁴⁴ If anything, the number of NEETs has increased marginally.

The NEET rates are fairly even across the provinces. This is hard to interpret without further analysis. Limpopo, for example, is a very poor and largely rural province. It is possible that the slightly lower-than-average percentage of NEETs in that province is partly the result of many young people migrating to cities in search of work and they are therefore counted among the NEETs in more urban provinces. It is possible that young people who are not employed in the labour market may nevertheless be employed in small-scale agriculture if their household has access to land, and this could also help to smooth the provincial inequalities that are characteristic of many other indicators.

There is enormous variation within the broad youth group of 15 – 24 years. Only 4% of children aged 15 – 17 are classified as NEET because the majority are attending school. Within the 18 – 20 age band, 32% are NEETs, and nearly two thirds (63%) of those in the 21 – 24 age band are neither working nor in education or training.

While education attendance rates are fairly even for males and females, the gender disparity among NEETs is more pronounced. Thirty-seven percent of young women are not in employment, education or training – compared with 33% of young men.

Figure 4f: Youth (15 – 24 years) not in employment, education or training (NEETs), by province, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

References

1. Constitution of the Republic of South Africa, Act 108 of 1996.
2. Secretary General of the Organisation of the African Union. *African Charter on the Rights and Welfare of the Child, OAU Resolution 21.8/49*. Addis Ababa: OAU. 1990.
3. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Geneva: United Nations. 1989.
4. Nohohlwane N, Taylor S, Shepherd D. *Schooling during the COVID-19 pandemic: An update from Wave 3 of the NIDS-CRAM data*. [https://cramsury.org/wp-content/uploads/2021/02/7.-Nohohlwane-N.-Taylor-S.-Shepherd-S.-2021-Schooling-during-the-COVID-19-pandemic-An-update-from-Wave-3-of-the-NIDS-CRAM-data.pdf]
5. Statistics South Africa. *General Household Survey 2018*. Pretoria: Stats SA. 2019.
6. Branson N, Hofmeyer C, Lam D. Progress through school and the determinants of school dropout in South Africa. *Development Southern Africa*. 2014;31(1):106-126.
7. Gustafsson M. *The When and How of Leaving School: The Policy Implications of New Evidence on Secondary School in South Africa*. Stellenbosch Economic Working Papers 09/11. Stellenbosch: Stellenbosch University. 2011.
8. Crouch L. *Disappearing Schoolchildren or Data Misunderstanding? Dropout Phenomena in South Africa*. North Carolina: RTI International. 2005.
9. Lam D, Seekings J. Transitions to Adulthood in Urban South Africa: Evidence from a Panel Survey. The International Union for the Scientific Study of Population (IUSSP) general conference; 18-23 July 2005; Tours, France.2005.

10. Lam D, Ardington A, Leibbrandt M. Schooling as a lottery: Racial differences in school advancement in urban South Africa. *Journal of Development Economics*. 2011;95:133-136.
11. Spaull N, Taylor S. Access to what? Creating a composite measure of educational quantity and educational quality for 11 African countries. *Comparative Education Review*. 2015;59(1):133-165.
12. The Southern and Eastern Africa Consortium for Monitoring Education Quality. *SACMEQ Reports*. 2020. [<http://www.sacmeq.org/?q=sacmeq-members/south-africa/sacmeq-reports>]
13. International Association for the Evaluation of Educational Achievement: Trends in International Mathematics and Science study & Progress in International Reading Literacy Study. *Data to Improve Education Worldwide*. 2020. [<http://www.pirls.org/>]
14. National Department of Basic Education. *Annual National Assessments*. 2018. [<https://www.education.gov.za/Curriculum/AnnualNationalAssessments.aspx>]
15. S Van der Berg, C Burger, R Burger, M de Vos, M Gustafsson, E Moses, D von Fintel. *Low Quality Education as a Poverty Trap*. Stellenbosch: Stellenbosch University. 2011.
16. Hall K, Sambu W, Almeleh C, Mabaso K, Giese S, Proudlock P. *South African Early Childhood Review 2019*. Cape Town: Children's Institute, UCT and Ilifa Labantwana. 2019.
17. Spaull N. Poverty & privilege: Primary school inequality in South Africa. *International Journal of Educational Development*. 2013;33(5):436-477.
18. South African Human Rights Commission, UNICEF. *Poverty Traps and Social Exclusion among Children in South Africa 2014*. Pretoria: SAHRC and UNICEF. 2014.
19. Heckman J. Skill formation and the economics of investing in disadvantaged children. *Science*. 2006;312:1900-1902.
20. Southern and Eastern Africa Consortium for Monitoring Education Quality. *Learner Preschool Exposure and Achievement in South Africa*. SACMEQ Policy Brief No. 4, April 2011. Pretoria: Ministry of Education. 2011.
21. Department of Basic Education. *Five-year Strategic Plan (2015/16 - 2019/20)*. Pretoria: DBE. 2016.
22. Engel P, Black M, Behrman J, Mello Md, Gerler P, Kapiriri L, International Child Development Steering Group I. Strategies to avoid the loss of developmental potential in more than 200 million children in the development world. *The Lancet*. 2007;369(9557):2229-2242.
23. National Planning Commission. *National Development Plan - Vision for 2030*. Pretoria: The Presidency. 2012.
24. Department of Basic Education. *School Realities 2018*. Pretoria: DBE. 2019.
25. Gustafsson M. *Policy Note on Pre-primary Schooling: An Empirical Contribution to the 2009 Medium Term Strategic Framework*. Stellenbosch Economic Working Papers 05/10. Stellenbosch: Stellenbosch University. 2010.
26. Department of Basic Education. *Education Statistics series, and School Realities series*. Pretoria: DBE. 2004-2019.
27. Department of Basic Education. *Report on the Annual National Assessments of 2014*. Pretoria: DBE. 2014.
28. Howie S, Combrinck C, Tshele M, Roux K, Palane NM, Mokoena G. *PIRLS 2016 Progress in International Reading Literacy study 2016 Grade 5 Benchmark Participation: South African Children's Reading Literacy Achievement*. Pretoria: Centre for Evaluation and Assessment. 2017.
29. Reddy V, Visser M, Winnaar L, Arends F, Juan A, Prinsloo C, Isdale K. *TIMSS 2015: Highlights of Mathematics and Science Achievement of Grade 9 South African Learners*. Human Sciences Research Council. 2016.
30. Zoch A. *Life Chances and Class: Estimating inequality of opportunity in South Africa over various life stages*. Stellenbosch Economic Working Papers 08/13. Stellenbosch University. 2013.
31. Spaull N. Schooling in South Africa: How low quality education becomes a poverty trap. In: Lannoy AD, Swartz S, Lake L, Smith C, editors. *South African Child Gauge 2015: Children's Institute, University of Cape Town*; 2015.
32. Timæus I, Simelane S, Letsoalo T. Poverty, race and children's progress at school in South Africa. *The Journal of Development Studies*. 2013;49(2):270-284.
33. Youth Explorer. *Youth Explorer*. 2018. Accessed: 20 September. Available from: <https://youthexplorer.org.za/profiles/country-ZA-south-africa/#education>.
34. Branson N, Lam D. Educational inequality in South Africa: Evidence from the National Income Dynamics Study. *Studies in Economics and Econometrics*. 2010;34(3):85-105.
35. Fleisch B, Shindler J. Gender repetition: School access, transitions and equity in the 'Birth-to-Twenty' cohort panel study in urban South Africa. *Comparative Education*. 2009;45(2):265-279.
36. Organisation for Economic Co-operation and Development. *Youth Not in Employment, Education or Training (NEET)*. 6 June 2017.
37. Ardington C, Bärninghausen A, Case A, Menendez A. *Social Protection and Labour Market Outcomes of Youth in South Africa*. Working Paper 96. Cape Town: Southern Africa Labour & Development Research Unit, UCT. 2013.
38. Altman M, Mokomane Z, Wright G. Social security for young people amidst high poverty and unemployment: Some policy options for South Africa. *Development Southern Africa*. 2014;31(2):347-362.
39. Department of Basic Education. *Report on Progress in the Schooling Sector against Key Learner Performance and Attainment Indicators*. Pretoria: DBE. 2016.
40. Timæus I, Moultrie T. Teenage childbearing and educational attainment in South Africa. *Studies in Family Planning*. 2015;46(2):143-160.
41. Smith J. *Connecting Young South Africans to Opportunity: Literature Review and Strategy*. Cape Town: DG Murray Trust. 2011.
42. Lam D, Leibbrandt M, Mlatsheni C. *Education and Youth Unemployment in South Africa*. Working Paper 22. Cape Town: Southern Africa Labour and Development Research Unit, UCT. 2008.
43. Department of Higher Education and Training. *Fact Sheet on NEETs: An Analysis of the 2011 South African Census*. Pretoria: DHET. 2013.
44. United Nations Development Programme. *Sustainable Development Goals*. 2017. [www.undp.org/content/undp/en/home/sustainable-development-goals.html]

Children's access to housing

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

Section 26 of the Constitution of South Africa provides that "everyone has the right to have access to adequate housing", and section 28(1)(c) gives children "the right to ... shelter".¹

Article 27 of the UN Convention on the Rights of the Child states that "every child has the right to a standard of living adequate for his/her development" and obliges the state "in cases of need" to "provide material assistance and support programmes, particularly with regard to ... housing".²

Children living in urban and rural areas

This indicator describes the number and share of children living in urban and rural areas in South Africa.

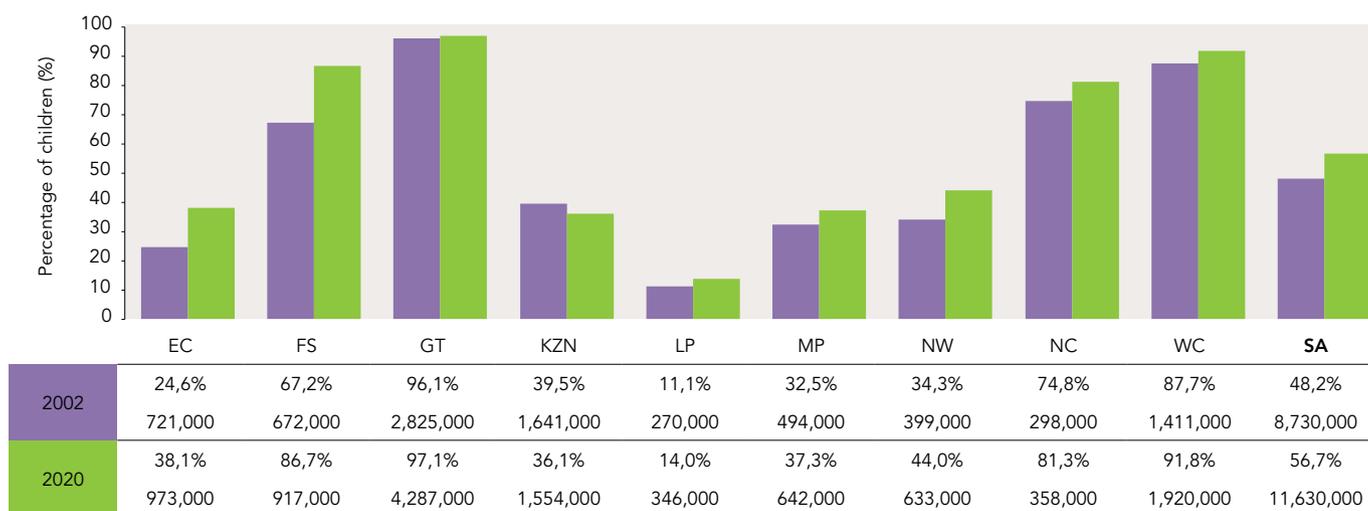
Location is one of the seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights.³ Residential areas should ideally be situated close to work opportunities, clinics, police stations, schools and child-care facilities. In a country with a large rural population, this means that services and facilities need to be well distributed, even in areas that are not densely populated. In South Africa, service provision and resources in rural areas lag far behind urban areas.

The General Household Survey captures information on all household members, making it possible to look at the distribution of children in urban and non-urban households and compare this to the adult distribution. Nearly half of South Africa's children (43%) lived in rural households in 2020 – equivalent to 8.9 million children. Looking back over a decade, there is a clear shift in the distribution of children towards urban areas: in 2002, 48% of children were found in urban households, and this increased gradually to 57% by 2017, after which it has remained stable. Given estimated population growth, the urban child population has grown by nearly 3 million, from 8.7 million children in 2002 to 11.6 million in 2020. Children are consistently less urbanised than adults: In 2020, 67% of the adult population was urban, compared with 57% of children.

There are marked provincial differences in the rural and urban distribution of the child population. This is related to the distribution of cities in South Africa, and the legacy of apartheid's spatial arrangements where women, children and older people in particular were relegated to the former homelands. The Eastern Cape, KwaZulu-Natal and Limpopo provinces alone are home to about three-quarters (73%) of all rural children in South Africa. KwaZulu-Natal has the largest child population in numeric terms, with 2.7 million (64%) of its child population being classified as rural. The least urbanised province is Limpopo, where only 14% of children live in urban areas. Proportionately more children (39%) live in the former homelands, compared with adults (29%). Almost all of children living in the former homeland areas are African (99.8%).

In 2020, children living in the Gauteng and Western Cape were almost entirely urban based (97% and 92% respectively). These provinces historically have large urban populations. The urban child population in Gauteng alone has grown by 1.5 million since 2002 and the urban child population in the Western Cape has grown by just over 500,000. These increases would be partly the result of urban births, but also partly the result of within-province movement and migration from other provinces. Other provinces that have experienced a marked growth in the urban share of the child population are the Eastern Cape, Free State and North

Figure 5a: Children living in urban areas, by province, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002*; *General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

West. KwaZulu-Natal, in contrast, has seen a slight reduction in its urban child population, both in percentage and numeric terms.

Rural areas, and particularly the former homelands, have much poorer populations. In 2018, nearly two-thirds of children in the poorest income quintile lived in rural areas compared with 10% in the richest quintile, and this had been a consistent trend over the previous decade. In other words, within the poorest part of the population, it is mainly rural households that care for children – even though many of these children may have parents

who live and work in urban areas. The 2019 and 2020 data suggest the possibility of a shift in this pattern, with a decline in the rural share of children in the poorest quintile (from 70% to 58%), and an increase in the rural share of the child population in the wealthiest quintile (from around 10% to over 20%).

The inequalities also remain strongly racialised. Around 90% of White, Coloured and Indian children are urban, compared with 51% of African children.

There are no statistically significant differences in the child population in urban and rural areas across age groups.

Children living in formal, informal and traditional housing

This indicator shows the number and share of children living in formal, informal and traditional housing. For the purposes of the indicator, 'formal' housing is considered a proxy for adequate housing and consists of: dwellings or brick structures on separate stands; flats or apartments; town/cluster/semi-detached houses; units in retirement villages; rooms or flatlets on larger properties provided they are built with sturdy materials. 'Informal' housing consists of: informal dwellings or shacks in backyards or informal settlements; dwellings or houses/flats/rooms in backyards built of iron, wood or other non-durable materials; and caravans or tents. 'Traditional' housing is defined as a 'traditional dwelling/hut/structure made of traditional materials' situated in a rural area.

Children's right to adequate housing means that they should not have to live in informal dwellings. One of the seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights is that it must be 'habitable'.³ To be habitable, houses should have enough space to prevent overcrowding, and should be built in a way that ensures physical safety and protection from the weather.

Formal brick houses that meet the state's standards for quality housing could be considered 'habitable housing', whereas

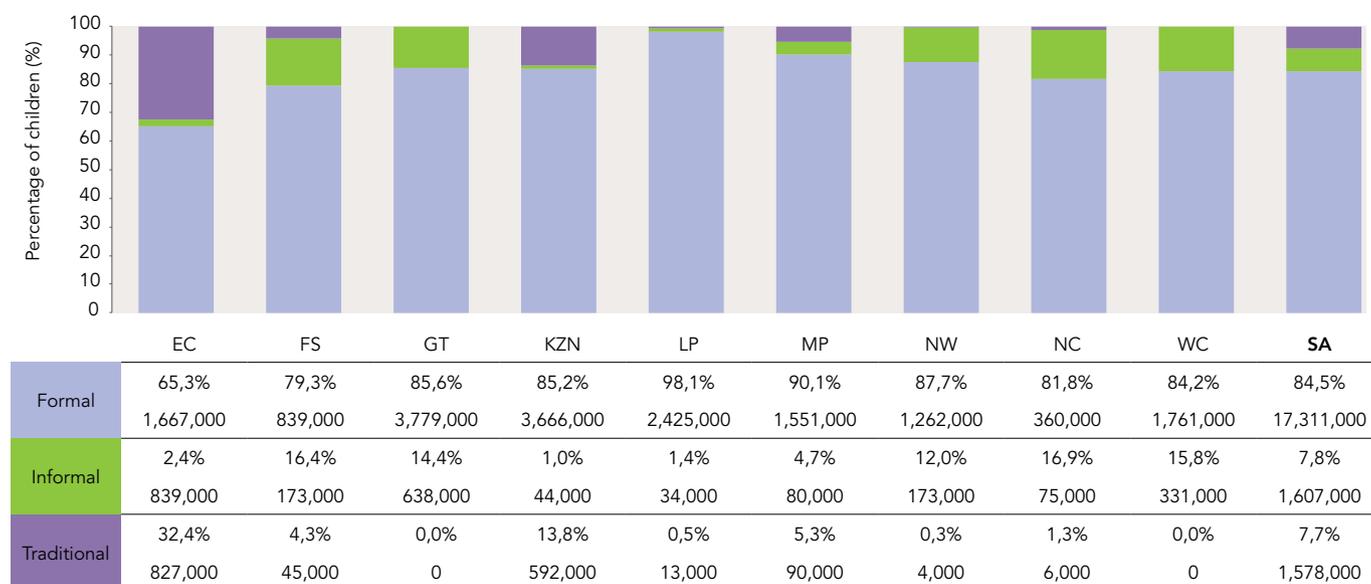
informal dwellings such as shacks in informal settlements and backyards would not be considered habitable or adequate. Informal housing in backyards and informal settlements make up the bulk of the housing backlog in South Africa. 'Traditional' housing in rural areas cannot necessarily be assumed to be inadequate. Some traditional dwellings are more habitable than new subsidy houses – they can be more spacious and better insulated, for example.

Access to services is another element of "adequate housing". Children living in formal areas are more likely to have services on site than those living in informal or traditional dwellings. They are also more likely to live closer to facilities like schools, libraries, clinics and hospitals than those living in informal settlements or rural areas. Children living in informal settlements are more exposed to hazards such as shack fires and paraffin poisoning.

The environmental hazards associated with informal housing are exacerbated for very young children. The distribution of children in informal dwellings is slightly skewed towards younger children and babies: 36% of children in informal housing are in the 0 – 5-year age group, whereas 29% are aged 12–17 years.

In 2020, 1.6 million children (8%) in South Africa lived in backyard dwellings or shacks in informal settlements. The number

Figure 5b: Children living in formal, informal and traditional housing, by province, 2020



Source: Statistics South Africa (2021) *General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

of children in informal housing has declined gradually from 2.3 million (13%) in 2002. The provinces with the highest shares of informally-housed children are the Western Cape, Northern Cape and Free State (each with around 16% of their child populations informally housed), and Gauteng (14%). The Eastern Cape, KwaZulu-Natal and Limpopo have by far the lowest shares of children in informal housing. The vast majority of children in Limpopo are recorded as living in formal housing, while Eastern Cape has a relatively large share of its child population living in

traditional dwellings (32%). The distribution of children in formal, informal and traditional housing has remained fairly constant since 2002. But racial inequalities persist. All White children in the 2020 survey lived in formal housing, compared with only 83% of African children. Access to formal housing increases with income. Ninety percent of children in the wealthiest 20% of households live in formal dwellings, compared with 78% of children in the poorest quintile.

Children living in overcrowded households

Children are defined as living in overcrowded dwellings when there is a ratio of more than two people per room (excluding bathrooms but including kitchen and living room). Thus, a dwelling with two bedrooms, a kitchen and sitting-room would be counted as overcrowded if there were more than eight household members.

The UN Committee on Economic, Social and Cultural Rights defines 'habitability' as one of the criteria for adequate housing.³ Overcrowding is a problem because it can undermine children's needs and rights. For instance, it is difficult for school children to do homework if other household members want to sleep or watch television. Children's right to privacy can be infringed if they do not have space to wash or change in private. The right to health can be infringed as communicable diseases spread more easily in overcrowded conditions, and young children are particularly susceptible to the spread of disease. Overcrowding also places children at greater risk of sexual abuse, especially where boys and girls have to share beds, or children have to share beds with adults.

Overcrowding makes it difficult to target services and programmes to households effectively – for instance, urban households are entitled to six kilolitres of free water, but this household-level allocation discriminates against overcrowded households because it does not take account of household size.

In 2020, 4.3 million children lived in overcrowded households. This represents 21% of the child population – much higher

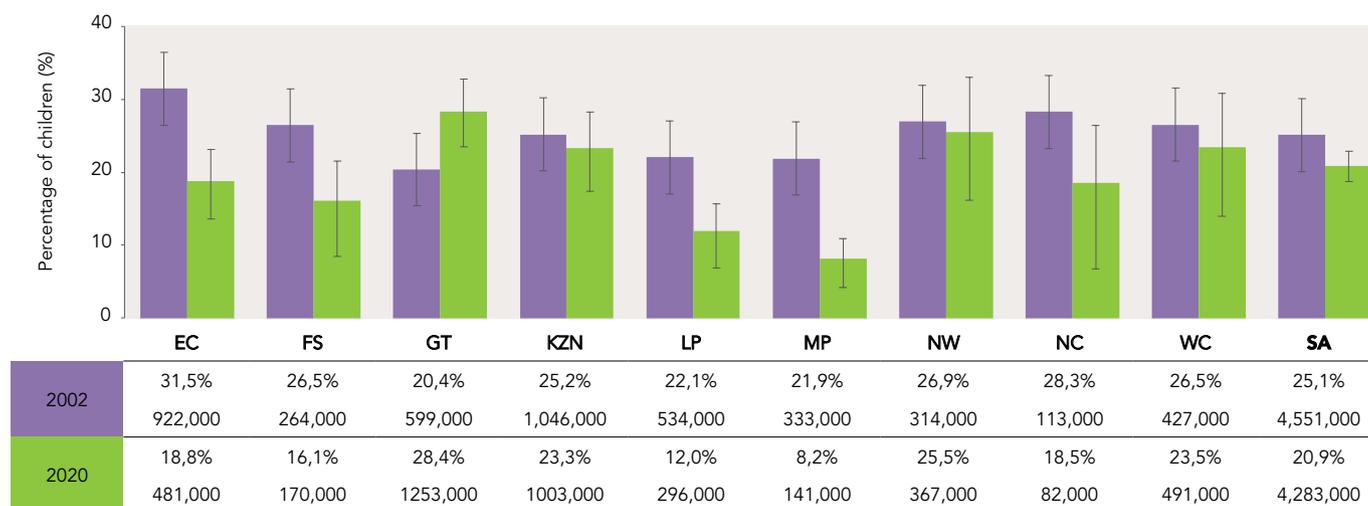
than the share of adults living in crowded conditions (12%). Overcrowding is associated with housing type: 46% of children who stay in informal dwellings also live in overcrowded conditions, compared with 25% of children in traditional dwellings and 18% of children in formal housing.

Young children are slightly more likely than older children to live in overcrowded conditions. Twenty-three percent of children below six years live in crowded households, compared to 18% of children over 12 years.

There is a strong racial bias in children's housing conditions. While 22% of African and 18% of Coloured children live in crowded conditions, less than 3% of White children live in overcrowded households. Children in the poorest 20% of households are more likely to be living in overcrowded conditions (30%) than children in the richest 20% of households (15%).

The average household size has gradually decreased from 4.5 at the time of the 1996 population census, to around 3.5 in 2020, indicating a trend towards smaller households. This is related to the rapid growth in single-person households where adults live alone: In 2020 there were 17.4 million households in South Africa, of which 19% (around 3.4 million) were households where one adult lived alone.⁴ The reduction in average household size during the 1990s and early 2000s was linked to the rapid provision of small subsidy houses that could not accommodate extended families.^{5, 6} It has also been linked to adult urban migration coupled with continuing constraints on family co-migration and

Figure 5c: Children living in overcrowded households, by province, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

declining marriage and cohabitation rates between men and women.⁷ Households in which children live are larger than the national average, although they have also declined in size over

time. The mean household size for adult-only households in 2020 was 1.9 while the mean household size for households with children was 4.8.⁸

References

1. Constitution of the Republic of South Africa, Act 108 of 1996.
2. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Geneva: United Nations. 1989.
3. Office of the United Nations High Commissioner for Human Rights. *The Right to Adequate Housing (art. 11 (1)): 13/12/91. CESCR General Comment 4*. Geneva: United Nations. 1991.
4. Hall K, Mokomane Z. The shape of children's families and households. In: Hall K, Richter L, Mokomane Z, Lake L, editors. *Children, Families and the State: Collaboration and Contestation South African Child Gauge 2018*. Cape Town: Children's Institute, UCT; 2018.
5. Hall K. Accommodating the poor? A review of the Housing Subsidy Scheme and its implications for children. In: Leatt A, Rosa S, editors. *Towards a Means to Live: Targeted poverty alleviation to make children's rights real*. Cape Town: Children's Institute, UCT; 2005.
6. Public Service Commission. *Report on the Evaluation of the National Housing Subsidy Scheme*. Pretoria: Public Service Commission. 2003.
7. Posel D, Hall K. The economics of households in South Africa. In: Oqubay A, Tregenna F, I V, editors. *The Oxford Handbook of the South African Economy*. Oxford: Oxford University Press; 2021.
8. Statistics South Africa. *General Household Survey 2018*. Pretoria: Stats SA. 2019.

Children’s access to services

Katharine Hall (Children’s Institute)

Section 27(1)(b) of the Constitution of South Africa provides that “everyone has the right to have access to ... sufficient ... water” and section 24(a) states that “everyone has the right to an environment that is not harmful to their health or well-being”.¹

Article 14(2)(c) of the African Charter on the Rights and Welfare of the Child obliges the state to “ensure the provision of ... safe drinking water”.²

Article 24(1)(c) of the UN Convention on the Rights of the Child says that states parties should “recognise the right of the child to the enjoyment of the highest attainable standard of health” and to this end should “take appropriate measures to combat disease and malnutrition ..., including the provision of clean drinking-water”.³

Children’s access to basic water

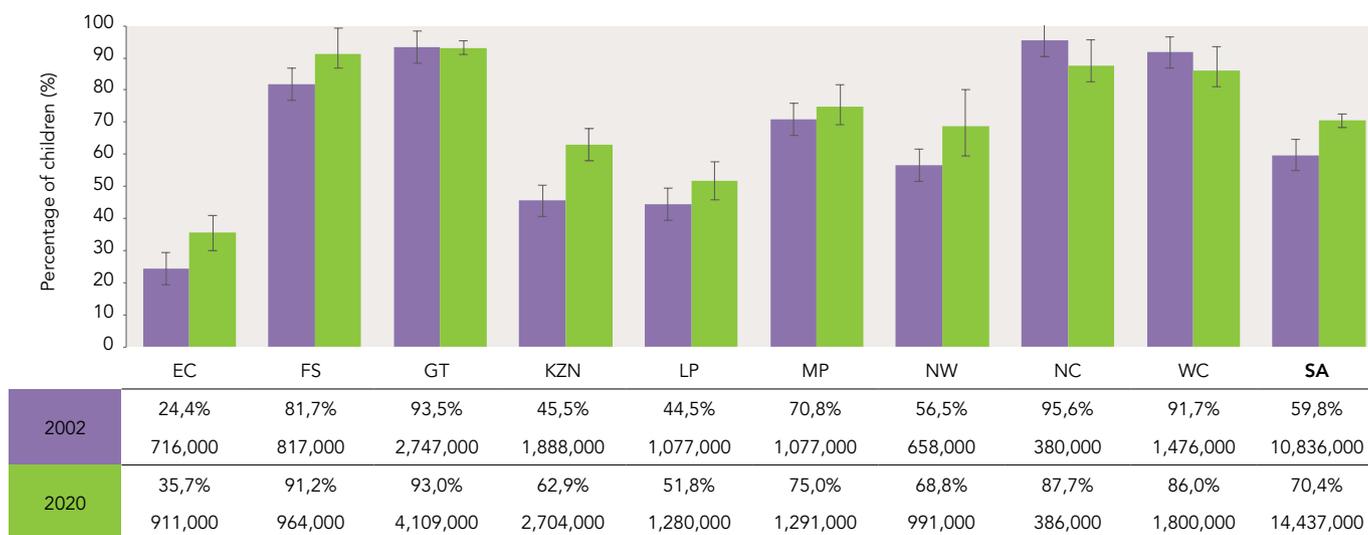
This indicator shows the number and percentage of children who have access to piped drinking water at home – either inside the dwelling or on site. This is used as a proxy for access to adequate water. All other water sources, including public taps, water tankers, dams and rivers, are considered inadequate because of their distance from the dwelling or the possibility that the water is of poor quality. The indicator does not show whether the water supply is reliable or if households have broken facilities or are unable to pay for services.

Clean water is essential for human survival. The World Health Organisation defined ‘reasonable access’ to water as being a minimum of 20 litres per person per day.⁴ The 20-litre minimum is linked to the estimated average consumption when people rely on communal facilities and need to carry their own water for drinking, cooking and the most basic personal hygiene. It does not allow for bathing, showering, washing clothes or any domestic cleaning.⁵ The water needs to be supplied close to home, as households that travel long distances to collect water often struggle to meet their basic daily quota. This can

compromise children’s health and hygiene. More recently, the Sustainable Development Goals (target 6.1) call for universal and equitable access to safe and affordable drinking water, and this is defined as a safely managed drinking water service from an improved water source that is located on premises.

Young children are particularly vulnerable to diseases associated with poor water quality. Gastro-intestinal infections with associated diarrhoea and dehydration are a significant contributor to the high child mortality rate in South Africa,⁶ and intermittent outbreaks of cholera in some provinces pose a serious threat to children. Lack of access to adequate water is closely related to poor sanitation and hygiene. In addition, children may be responsible for fetching and carrying water to their homes from communal taps, or rivers and streams. Carrying water is a physical burden that can lead to back problems or injury from falls. It can also reduce time spent on education and other activities and can place children at personal risk.⁷ This child-centred indicator of adequate water is therefore limited to a safe water source on site.

Figure 6a: Children living in households with water on site, by province, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002*; *General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

There has been some improvement in children's access to water over the past 18 years. The share of children with piped water at home has increased by 10 percentage points, from 60% in 2002 to 70% in 2020. This represents an increase of 3.6 million children with a water connection at home. However, six million children still live in households that do not have piped drinking water on site. In 2020, more than three-quarters (79%) of adults lived in households with adequate water access – compared with only 70% of children. This is because, compared with the adult population, children are over-represented in rural households located in areas without bulk service infrastructure.

Provincial differences are striking. Around nine out of ten children in Gauteng (93%), the Free State (91%), the Northern Cape (88%) and Western Cape (86%) have piped water at their home. All of these provinces started from a high base in terms of water access, and there has not been significant change over the past 18 years. The provinces that have experienced substantial improvements in water provision are those which had the lowest levels of access to start with: KwaZulu-Natal (a significant improvement in the provincial share of children with water on site, from 46% in 2002 to 63% in 2020); Limpopo (a more modest improvement from 45% to 52%) and the Eastern Cape (from 24%

to 36%). The Eastern Cape, with its large under-served former homeland areas, remains the only province in which more than half of all children do not have piped water to their home.

Children living in formal areas are more likely to have services on site than those living in informal settlements or in the rural former homelands. While the majority (76%) of children in formal dwellings have access, it decreases to 55% for children living in informal dwellings. Only 22% of children living in traditional housing have water available on the property.

The vast majority of children living in traditional dwellings are African, so there is also a pronounced racial inequality in access to water. In 2020, two thirds (67%) of African children had water on site, while the vast majority (more than 90%) of all other population groups had piped drinking water at home. There are no significant differences in access to water across age groups.

Inequality in access to safe water is also pronounced when the data are disaggregated by income group. Only 53% of children in the poorest 20% of households have access to water on site, while 91% of those in the richest 20% of households have this level of service. In this way, inequalities are reinforced: the poorest children are most at risk of diseases associated with poor water quality and the associated setbacks in their development.

Children's access to basic sanitation

This indicator shows the number and percentage of children living in households with basic sanitation. Adequate toilet facilities are used as proxy for basic sanitation. This includes flush toilets and ventilated pit latrines that dispose of waste safely and that are within or near a house. Inadequate toilet facilities include pit latrines that are not ventilated, chemical toilets, bucket toilets, or no toilet facility at all.

A basic sanitation facility was defined in the government's *Strategic Framework for Water Services* as the infrastructure necessary to provide a sanitation facility that is "safe, reliable, private, protected from the weather and ventilated, keeps smells to a minimum, is easy to keep clean, minimises the risk of the spread of sanitation-related diseases by facilitating the appropriate control of disease carrying flies and pests, and enables safe and appropriate treatment and/or removal of human waste and wastewater in an environmentally sound manner".⁸

Adequate sanitation prevents the spread of disease and promotes health through safe and hygienic waste disposal. To do this, sanitation systems must break the cycle of disease. For example, the toilet lid and fly screen in a ventilated pit latrine stop flies reaching human faeces and spreading disease. Good sanitation is not simply about access to a particular type of toilet. It is equally dependent on the safe use and maintenance of that technology; otherwise toilets break down, smell bad, attract insects and spread germs.

Good sanitation is essential for safe and healthy childhoods and for reducing inequalities for children.⁹ It is very difficult to maintain good hygiene without water and toilets. Poor sanitation is associated with diarrhoea, cholera, malaria, bilharzia, worm infestations, eye infections and skin disease. These illnesses compromise children's health and nutritional status. Using public toilets and the open veld (fields) can also put children in physical

danger. The use of the open veld and bucket toilets is also likely to compromise water quality in the area and to contribute to the spread of disease. Poor sanitation undermines children's health, safety and dignity.

The data show a gradual and significant improvement in children's access to sanitation since 2002, although the number of children without adequate toilet facilities remains worryingly high. In 2002, less than half of all children (46%) had access to adequate sanitation. By 2020, the share of children with adequate toilets had risen to 78%. But 4.4 million children still use unventilated pit latrines, buckets or other inadequate forms of sanitation, despite the state's reiterated goals to provide adequate sanitation to all and to eradicate the bucket system. Around 270,000 children have no sanitation facilities at all (open defecation or buckets). Children (22%) are slightly more likely than adults (18%) to live in households without adequate sanitation facilities.

As with other indicators of living environments, there are great provincial disparities. In provinces with large metropolitan populations, like Gauteng and the Western Cape, around 90% of children have access to adequate sanitation (mostly in the form of flush toilets), while provinces with large rural populations tend to have the poorest sanitation. Provinces with the greatest sanitation improvements in numeric terms are the Eastern Cape (where the number of children with access to adequate sanitation more than tripled from 626,000 to over 2.2 million, resulting in an increase in access for 1.7 million children), KwaZulu-Natal (an increase of 1.9 million children) and Gauteng (an increase of 1.4 million children with adequate sanitation facilities on site). In the Free State, the share of children with sanitation improved from 53% in 2002 to 84% in 2020).

The dramatic improvement in access to sanitation from 21% in 2002 to 89% in 2020 in the Eastern Cape is due to increased

provisioning of ventilated pit latrines, which may be provided by the state or built by households themselves. In other words, the achievements in sanitation access have not necessarily been accompanied by improved or more extensive bulk infrastructure. Of the nearly 90% of children in this province who are defined as having adequate sanitation, nearly two thirds have pit latrines while only 37% have flush toilets. Similarly, the substantial improvements in KwaZulu-Natal and Limpopo have been achieved without corresponding expansion of bulk infrastructure to rural households. Sanitation infrastructure needs to be maintained to be safe and hygienic, but the available data do not enable us to determine whether flush toilets are working properly or provide any indication about the quality and maintenance of pit latrines.

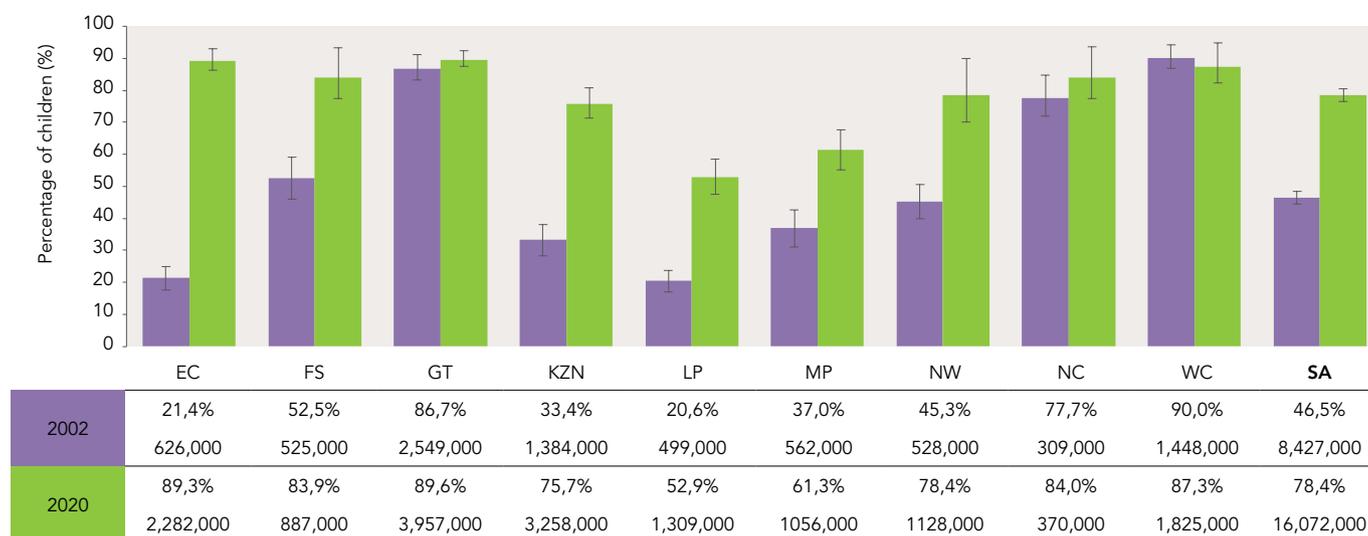
Although there have also been significant improvements in sanitation provision in Limpopo, this province still lags behind, with only 53% of children living in households with adequate sanitation. It is unclear why the vast majority of children in

Limpopo are reported to live in formal houses, yet access to basic sanitation is the poorest of all the provinces. Definitions of adequate housing such as those in the UN-HABITAT and South Africa's National Housing Code include a minimum quality for basic services, including sanitation.

The statistics on basic sanitation provide yet another example of persistent racial inequality: almost 100% of Indian and White children had access to adequate toilets in 2020 and 95% of Coloured children had adequate sanitation, while only 75% of African children had access to adequate basic sanitation. This is, however, a marked improvement from 37% of African children in 2002.

Children in relatively well-off households have better levels of access to sanitation than poorer children. Among the richest 20% of households, around 90% of children have adequate sanitation, while 70% of children in the poorest 20% of households have this level of service.

Figure 6b: Children living in households with basic sanitation, by province, 2002 & 2020



Source: Statistics South Africa (2003; 2021) *General Household Survey 2002; General Household Survey 2020*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

References

1. *Constitution of the Republic of South Africa Act 108 of 1996*.
2. Secretary General of the Organisation of African Unity. *African Charter on the Rights and Welfare of the Child*. OAU Resolution 21.8/49. Addis Ababa: OAU; 1990.
3. Office of the High Commissioner of Human Rights. *Convention on the Rights of the Child, UN General Assembly Resolution 44/25*. Geneva: United Nations; 1989.
4. Ki-moon B. *Children and the Millennium Development Goals: Progress towards a world fit for children*. New York: UNICEF; 2007.
5. Howard G, Bartram J. *Domestic water quantity, service level and health*. Geneva: World Health Organisation; 2003.
6. A W. Diarrhoeal disease. In: Stephen C BL, Patrick W & the MRC Unit for Maternal and Infant Health Care Strategies, editor. *Saving Children 2009: Five Years of Data A Sixth Survey of Child Healthcare in South Africa*. Pretoria: Tshepesa Press, Medical Research Council & Centre for Disease Control and Prevention; 2011.
7. COHRE, AAAS, SDC, UN-Habitat. *Manual on the right to water and sanitation*. Geneva: Centre on Housing Rights and Evictions; 2007.
8. Department of Water Affairs and Forestry. *Strategic framework for water services*. Pretoria: DWAF; 2003.
9. Chopra M, Hall K, Westwood A. Poverty, social inequity and child health. In: Westwood A, Saloojee H, Shung-King M, editors. *Child health for all*. 6th Edition. Cape Town: Oxford University Press; 2021.

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Advocate Bongani Majola is the Chairperson of the South African Human Rights Commission. The Commission was established under section 181(3) of the Constitution to promote and protect human rights and to monitor and assess their observance in the country. He is the former Assistant Secretary-General of the United Nations and Registrar of the UN International Criminal Tribunal of Rwanda (UNICTR). He is the former Dean of the Faculty of Law at the University of Limpopo and former National Director of the Legal Resources Centre.

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Joan van Niekerk is an independent consultant in the field of child rights and child protection. She has a PhD in Social Work. Joan has a lengthy history in social work services to children and families and presently offers consultation and training opportunities to NGOs involved in child protection. She was involved in the SA Law Reform processes in child protection and sexual offences, most recently in the expert committee on law reform relating to child pornography and child safety on the internet.

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About the South African Child Gauge

The *South African Child Gauge* is an annual publication of the Children's Institute, University of Cape Town, that monitors progress in the realisation of children's rights. Key features include an in-depth analysis of a particular dimension of children's lives; a summary of new legislative and policy developments affecting children; and child-centred statistics which track the demographic and socio-economic status of South Africa's children.



Previous issues of the South African Child Gauge:

- 2020: The slow violence of malnutrition
- 2019: Child and adolescent health: Leave no one behind
- 2018: Children, Families and the State: Collaboration and contestation
- 2017: Survive – Thrive – Transform
- 2016: Children and social assistance
- 2015: Youth and the intergenerational transmission of poverty
- 2014: Preventing violence against children
- 2013: Essential services for young children
- 2012: Children and inequality: Closing the gap
- 2010/2011: Children as citizens: Participating in social dialogue
- 2009/2010: Healthy children: From survival to optimal development
- 2008/2009: Meaningful access to basic education
- 2007/2008: Children's constitutional right to social services
- 2006: Children and poverty
- 2005: Children and HIV/AIDS

All issues of the *South African Child Gauge* are available for download at www.ci.uct.ac.za

The Children's Institute, University of Cape Town, has been publishing the *South African Child Gauge*® every year since 2005 to track progress towards the realisation of children's rights.

This sixteenth issue of the *South African Child Gauge* focuses attention on child and adolescent mental health and how early experiences of adversity ripple out across the life course and generations at great cost to individuals and society. It calls on South African society to put children at the centre of everything we do. This starts with early intervention, and the proactive support of families, schools, health care services and government to protect children from harm, build their capacity to cope with stress and adversity, and provide them with opportunities to thrive.

The *Child Gauge* collates and interrogates the latest research evidence from a child-centred and policy perspective. In the process of seeking to make research relevant and accessible to policymakers and practitioners, it helps to identify blind spots, knowledge gaps and areas for further enquiry.

Linda Richter, Distinguished Professor – DSI-NRF Centre of Excellence in Human Development, University of the Witwatersrand

The annual *South African Child Gauge* is without question the pre-eminent national publication on the subject of children, and society owes a debt of gratitude to the Children's Institute for this evidence-led investment in the future.

Jonathan Jansen, Distinguished Professor, Faculty of Education, University of Stellenbosch

Within the South African context, the *Child Gauge* fulfils a three-fold purpose. First it mobilises the resources of the university to promote engaged scholarship that seeks to better understand and address the challenges faced by South Africa's children. Second, it makes this evidence accessible to those in government who are responsible for the design and delivery of services for children. Last, but not least, it supports the efforts of civil society and an informed citizenry who can then challenge rights violations and hold government accountable.

Benyam Mezmur, Special Rapporteur on children and armed conflict in Africa – African Committee of Experts on the Rights and Welfare of the Child, and member of United Nations Committee on the Rights of the Child

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