South African Child Gauge 2025

Intersections of violence against women and children: Disrupting intergenerational harm

Lucy Jamieson, Shanaaz Mathews, Mercilene Machisa & Lori Lake

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CHILDREN'S INSTITUTE

Broad overview of the *South African Child Gauge 2025*

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 the intersections of violence against women and children and how early exposure to violence can spark an intergenerational cycle of violence that has huge human, social and economic costs.

PART ONE: Children and Law Reform

Part one outlines recent policy and legislative developments affecting South Africa's children. This includes the South African Council of Educators' Sanctioning Policy, regulations on Minimum Uniform Norms and Standards for Public School Infrastructure, draft regulations on School Capacity and Admissions, the Tobacco Products and Electronic Delivery Systems Control Bill, Cannabis for Private Purposes Act and draft National Strategy to Accelerate Action for Children.

See pages 14 – 29.

PART TWO: Intersections of violence against women and children: Disrupting intergenerational harm

Part two starts by examining the intersections of violence against women and violence against children, defining a common language and explaining how social norms, patriarchy and historical inequalities drive an intergenerational cycle of violence. The following chapters present critical opportunities to disrupt harm through an integrated approach in different contexts. Drawing on Bronfenbrenner's socio-ecological model, the chapters highlight how violence prevention must begin early – within the first 1,000 days of life – and extend across homes, schools, communities and the whole of society. A further five chapters focus on creating an enabling ecosystem. Securing a continuum of care to prevent and respond to violence against women and children requires systemic change supported by an enabling policy environment, strong leadership and coordination, adequate financial and human resources, and multisectoral data and information systems to guide service delivery.

See pages 30 – 173.

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 which is a permanent data project of the Children's Institute.

See pages 174 – 218.

Front cover photograph:
Imagine a world where men, women and children are free from violence in their homes, schools and communities, where they are nurtured with care, and feel confident to meet life's challenges. Breaking the intergenerational cycle of violence starts up close and personal in the relationships we build – and we all have a role to play in nurturing this change.

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The 'Garden of Hope' mural, designed by Lovell Freidman, helps breathe life and colour into Mitchell's Plain hospital. © *Children's Institute, UCT*

Abbreviations

BELA	Basic Education Laws Amendment
CBO	Community-Based Organisations
CDG	Care Dependency Grant
CDR	Child Death Review
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHWs	Community Health Workers
CSG	Child Support Grant
DBE	Department of Basic Education
DHA	Department of Home Affairs
DHIS	District Health Information System
DoH	Department of Health
DOJCD	Department of Justice and Constitutional Development
DPME	Department of Planning, Monitoring and Evaluation
DSD	Department of Social Development
DVA	Domestic Violence Act
DVAA	Domestic Violence Amendment Act
DWYPD	Department of Women, Youth and Persons with Disabilities
ECD	Early Childhood Development
ELP	Early Learning Programmes
FCG	Foster Child Grant
FCS	Family Violence, Child Protection and Sexual Offences Units
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GHS	General Household Survey
HCWs	Healthcare Workers
HIV	Human Immunodeficiency Virus
IMC	Inter-Ministerial Committee
IMR	Infant Mortality Rate
IPV	Intimate Partner Violence
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, or Otherwise Gender Non-Conforming
MTBPS	Medium-Term Budget Policy Statement
MTEF	Medium-Term Expenditure Framework
NDP	National Development Plan
NGO	Non-Governmental Organisation
NIECD Policy	National Integrated Early Childhood Development Policy
NPA	National Prosecuting Authority
NPOs	Non-Profit Organisations
NPR	National Population Register
NSP-GBVF	National Strategic Plan on Gender-Based Violence and Femicide
POPIA	Protection of Private Information Act
SAPS	South African Police Service
SASSA	South African Social Security Agency
SDGs	Sustainable Development Goals
SFP	Sector Funding Policy
SOC	Sexual Offences Courts
SRH	Sexual and Reproductive Health
Stats SA	Statistics South Africa
TCCs	Thuthuzela Care Centres
TFV	Technology-Facilitated Violence
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
VAC	Violence Against Children
VAW	Violence Against Women
VEP	Victim Empowerment Programme
WHO	World Health Organization

Foreword

Dr Najat Maalla M'jid
Special Representative of the Secretary-General on Violence Against Children, United Nations

Violence against children is a global crisis that spares no country, no community and no family. Each year, more than one billion children experience violence, yet so many cases remain unreported and under-prosecuted.

Violence against children (VAC) and violence against women (VAW) are duly interconnected. The intersections between violence against women (VAW) and violence against children (VAC) run deep. Children and women often experience violence in the same environments – such as homes, communities and online spaces. Both forms of violence are driven by shared risk factors such as poverty, inequality, conflicts, humanitarian crisis, displacement and harmful social norms. They also have common and compounding consequences and are characterised by intergenerational transmission.

These overlapping vulnerabilities mean that interventions should be holistic and inclusive, but often a lack of access to services increases vulnerability to violence for both women and children. Addressing both forms of violence together through coordinated, integrated programmes can lead to more effective prevention and response.

The human and economic costs of violence are staggering. Beyond the immediate physical and psychological harm, the effects of violence can last a lifetime and even extend across generations. Children who witness intimate partner violence often develop both immediate and long-term behavioural, emotional and cognitive difficulties that hinder their health, learning and social development.

The consequences for health and wellbeing are profound, undermining human potential and social cohesion. There is, therefore, a compelling economic as well as moral case for prevention and early intervention.

The case for investment should be integral to every government's economic and development strategy. Investing in violence prevention has a high return: it enhances human capital, which in turn increases productivity and overall gross domestic product (GDP); and the reduction of violence eliminates many of the costs currently borne by governments in health care, social welfare and the justice system. Many proven interventions are low-cost and scalable, meaning that even modest increases in spending can generate significant and sustained returns for societies and economies alike.

With less than five years left to achieve the Sustainable Development Goals, ending violence against children and violence against women are not just targets – they are a prerequisite for progress across every goal, whether in health, education, gender equality or freedom from all forms of violence. If we fail to stop this violence, we jeopardise the entire 2030 Agenda and risk leaving too many women and children behind.

We cannot afford to wait. With the clock ticking toward 2030, we need a paradigm shift – moving away from fragmented, siloed plans and toward integrated, evidence-based strategies that tackle the root causes of violence. Preventing violence requires a chain of strong, accessible services that support families and communities early and across every life stage.

Child participation is essential to strengthen our efforts to both prevent and respond to violence. It includes providing children with age-appropriate information so that they know their rights and can access support services. It is also about creating safe spaces for children to raise concerns and share their views so that we can create services that are better attuned to their needs, as they did at Mitchell's Plain Hospital when developing this series of murals.

Minister of Women, Youth and Persons with Disabilities

The Honourable Sindisiwe Chikunga

South Africa stands at a defining moment in its journey towards building a society where every woman and child can live free from fear, harm, and deprivation. As we collectively reflect through the lens of the *South African Child Gauge*, we are reminded that the protection and empowerment of our youngest citizens is not merely a moral obligation, but more of a national imperative that defines the future of our democracy.

In line with Pillar 2 of the National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF), preventing violence against women and children requires more than reactive interventions. The pillar focuses on Prevention and Rebuilding Social Cohesion. It demands a shift in mindset, from response to prevention, from silence to action, from fragmented efforts to coordinated partnerships. As government, we have embraced an evidence-based, whole-of-society approach that prioritises prevention as the foundation of sustainable social transformation. This approach recognises that violence is not inevitable. It is learned, and therefore, it can be unlearned.

At the heart of our vision is the belief that every child deserves to grow up in a nurturing environment where they are valued, protected, and given the opportunity to thrive. Early childhood development, access to education, food security, and safe communities are not standalone priorities. These are the very conditions that shield children from vulnerability and build resilience against violence.

Our work is further guided by the NSP-GBVF, which sets out a bold and coordinated roadmap to end violence in our lifetime. Central to this plan is Pillar 1: Accountability, Coordination and Leadership, which calls for strengthened institutional frameworks and shared accountability across all sectors of society. We recognise that government cannot do this work alone. Families, communities, civil society, faith-based organisations, and the private sector all have a critical role to play in shaping safer and more inclusive environments.

To this end, the Department of Women, Youth and Persons with Disabilities is leading the development of an Integrated Prevention Strategy, one that seeks to address the structural drivers of violence, including poverty, inequality, harmful social norms, and intergenerational trauma. Our focus is on breaking the cycle of violence before it begins, through targeted interventions that support positive parenting, promote gender equality, and ensure that children grow up witnessing respect and empathy in their homes and communities.

We are also investing in the social and economic empowerment of women and young people, because empowerment is prevention. A woman who is economically independent and a young person with hope for the future are far less vulnerable to exploitation, abuse, and neglect. Through the District Development Model, we are ensuring that these priorities are implemented at local level, where impact is most needed and most felt.

Ultimately, preventing violence against women and children is about nurturing a culture of care and accountability. Above all, a culture that restores dignity, builds trust, and reaffirms our shared humanity. The vision that government holds is one of a South Africa where every child can play without fear, where every woman can walk freely, and where every community becomes a safe haven of opportunity, equality, and love.

This issue of the Child Gauge is both a mirror and a map in terms of a reflection of where we stand, and a guide to where we must go. Let us move forward together, with courage, compassion, and conviction, to build a nation that truly protects and cherishes its women and children.

Minister of Social Development

The Honourable Nokuzola Sisisi Tolashe

I welcome the opportunity to contribute to the *South African Child Gauge's* 18th publication, which focuses on violence against women and children in South Africa. While government has made giant strides in improving outcomes for all children over the last thirty years through implementing various pieces of legislation and programmes, the unacceptably high levels of violence against women and children remain a major challenge. The urgency to address this challenge is underlined by the last quarterly crime statistics released by the South African Police Service, which paint a bleak picture about the safety of women and children.

Given the multidimensional nature of violence, we must also implement multidimensional partnerships. Such partnerships require the involvement of all sectors of our society. This was the principal motivator for the Department to develop the National Child Care and Protection Policy, a national road map for the provision of a continuum of childcare and protection programmes and services that are necessary to advance the National Development Plan and discharge our national and international obligations to children in South Africa.

Guided by this policy, the Department has developed and is currently rolling out RISIHA, a community-based prevention and early intervention programme across the country, focusing on areas with high levels of violence. The programme provides direct, day-to-day prevention, early intervention, care and support services within the life spaces of children.

The Department is also guided by the National Strategic Plan of Gender-Based Violence and Femicide (NSP-GBVF), an overarching national policy framework that guides national efforts towards preventing and responding to violence against women and children. The NSP-GBVF centres around six pillars, with the Department responsible for Pillar 4: Response, care, support and healing. In line with this mandate, work is already underway to expand shelter services for survivors of gender-based violence.

On the legislative front, we will table the Victim Support Services Bill before the Cabinet during this year. The Bill provides a framework within which victim support services may be provided to victims of violent crimes. The Bill further clarifies the roles and responsibilities of different service providers in the provision of victim empowerment services and mitigating secondary victimisation.

Over the coming months and years, prevention of violence against women and children will remain a central focus of our work. We will build and scale up on the successes of community-led prevention initiatives such as RISIHA. However, government's contribution is only part of the story. Vital contributors to improved outcomes for all children are families, the foundation on which we rely to nurture our children and young people and instill a culture of non-violence and equality.

We welcome this timely publication, which I have no doubt will go a long way towards strengthening our prevention and response programmes and the services of this Department that I am privileged to lead. I hope that this publication will also encourage reflection by all partners on the critical actions required to advance and uphold the rights of women and children in South Africa.

These beautiful mosaics at Mitchell's Plain Hospital were developed by Lovell Freidman in collaboration with local children. The mosaics convey care, hope and healing and are a feature throughout the inside and exterior spaces of the hospital.
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Part 1

Children and Law Reform

Part one summarises and comments on new law and policy that affects children, including the:

- South African Council of Educators Sanctioning Policy
- Regulations in terms of the South African Schools Act: Minimum Uniform Norms and Standards for Public School Infrastructure
- Cannabis for Private Purposes Act

It also comments on draft policy and law, including the:

- draft regulations in terms of the South African Schools Act: School Capacity and Admissions
- Tobacco Products and Electronic Delivery Systems Control Bill
- draft National Strategy to Accelerate Action for Children

Realising children's rights to health and education requires not only law and policy reform, but also a transformation in the way in which we deliver services to children. The Children's Hospital Trust has been working in collaboration with the Red Cross War Memorial Children's Hospital to create a warm and welcoming environment in which children feel at home. Artist: Lovell Freidman.

Law reform and case law affecting children 2024/25

Paula Proudlock,[i] Lori Lake,[i] Zeenat Sujee,[ii] Demichelle Petheridge,[ii] Anthony Westwood,[iii] Nadine Harker,[iv] Nancy Horsnby,[iv] Tara Carney,[iv] Lucy Jamieson,[i] Amanda Mpedi,[i] and Angela Stewart-Buchanan[v]

In this chapter, we summarise and comment on recent law reform and court cases that affect children, with a focus on key developments in the areas of education and child health, followed by a summary of the draft National Strategy for Accelerated Action for Children.

Education

The South African Council of Educators (SACE) published a revised policy on sanctions for educators found guilty of misconduct. Educators found by SACE to have used corporal punishment in schools can now be required to attend programmes aimed at equipping them to manage conflict in the classroom in non-violent ways. In the context of overcrowded classrooms and corporal punishment still being prevalent in many schools, capacitating educators on non-violent methods to manage classroom dynamics will contribute to making schools safer for learners.

Many schools continue to lack the basic infrastructure needed for a conducive and safe learning environment: water, sanitation, electricity, perimeter security, safe building materials and enough classrooms, and libraries and laboratories. Regulations that set norms and standards, and timeframes for meeting these standards, were first promulgated in 2013. These have helped to hold government accountable for providing the infrastructure required but the deadlines have not been met for all schools. Revised regulations promulgated in June 2025 incorporate a public planning and reporting process aimed at promoting accountability, but do not include any deadlines; raising concerns about governments ability and commitment to meet the norms and standards for all schools.

Draft regulations on school capacity and admissions have been published for public comment. If drafted appropriately, they could contribute to the realisation of the transformative intent of the Basic Education Laws Amendment Act – greater equity across the education system. The consultation period has been extended twice, in recognition of the significant public interest.

SACE's Sanctioning Policy for educators guilty of misconduct

In September 2024, the South African Council of Educators (SACE) published a revised version of its *Sanctioning Policy: For the contravention of the code of professional ethics.* The revisions were ordered by the High Court, after hearing a case where inadequate sanctions were imposed on two teachers who had assaulted learners.[1]

Centre for Child Law v SACE

The first incident involved a seven-year-old child who was hospitalised after a teacher hit him with a PVC pipe, the second incident involved a ten-year-old learner who was slapped across the face by a teacher and sustained head injuries that left her bleeding from the ears and with long-term medical complications. In accordance with the 2016 SACE sanctions policy, both teachers were fined R15,000 and it was decided that they should be removed from the register of educators. However, their removal from the register of educators was suspended for 10 years on condition that they were not found guilty of similar misconduct. The SACE sanctions policy did not include the option of requiring educators to attend rehabilitative programmes to equip them with knowledge and skills to restore discipline using non-violent measures. As a result, the educators were allowed to return to the classroom without acquiring the tools to change their behaviour, putting learners at continued risk.[vi]

In 2019, just over one million children aged 5 – 17 years reported experiencing some form of violence, including corporal punishment, at school.[2] Corporal punishment not only results

i Children's Institute, University of Cape Town
ii SECTION27
iii Department of Paediatrics and Child Health, University of Cape Town
iv Alcohol, Tobacco and other Drug Research Unit, South African Medical Research Council
v DG Murray Trust
vi The Supreme Court of Appeal (SCA) ordered SACE to review the sanctions imposed on the two educators at the centre of the case. Consequently, SACE later added rehabilitative sanctions to the fines and suspended sentences they had initially received.

in physical injury but is also associated with adverse mental health and behavioural outcomes that can have long-lasting effects. For many children, schools become spaces where they constantly fear being harmed. This environment contributes to school avoidance, difficulty concentrating, impaired learning, poor academic performance, and, in some cases, school dropout which culminate in significantly reduced lifetime earnings.

Corporal punishment must be understood as a structural problem, perpetuated by a broader system that has historically endorsed the use of violence as a legitimate means of disciplining learners. It is often a symptom of inadequate teacher training in classroom management, making it an accessible – albeit harmful – fallback strategy. In contexts where schools are under-resourced, learner-to-teacher ratios are high, and in-class support for educators is limited – the likelihood of resorting to harsh disciplinary practices increases. Addressing this deeply entrenched issue is critical.

Expecting individual teachers to change their behaviour when they work in a school culture where violence is normalised and corporal punishment is rife, is unrealistic if we do not give them the tools. To promote real change within the school environment, the Centre for Child Law (an applicant) and Children's Institute (a friend of the court) argued in front of the court for the inclusion of rehabilitative sanctions in the policy. The Children's Institute's submissions included an expert affidavit that demonstrated that rehabilitative programmes can empower teachers to effectively manage learners' behaviour, making their jobs less stressful and more rewarding, and that these programmes are relatively short in duration, readily available and cost effective, or free in many instances.[3]

SACE's 2024 Sanctioning Policy

SACE's new 2024 Sanctioning Policy outlines the overarching rationale for imposing sanctions on educators found guilty of professional misconduct, including the use of corporal punishment. It details guiding principles (including the best interests of the child), applicable sanctions, procedural steps and a structured decision-making framework to ensure consistency and fairness in disciplinary processes and outcomes.

The policy includes corrective and rehabilitative sanctions such as anger management and training on non-violent child discipline techniques, and allows for an educator's mandatory removal from the educators register in the case of serious assaults of learners. It also establishes procedures to ensure that the views of children and parents are considered when sanctions are set.

Equipping educators to manage difficult classroom behaviour

Retraining teachers after a guilty verdict helps to protect individual children and change the culture in our schools and society. On a broader level, there is an urgent need to invest in training all teachers to enable them to manage difficult classroom behaviour as this has the potential to shift the experience of millions of children across South Africa. Ideally this should be incorporated into teacher training and continual professional development.

South African Schools Act: Minimum Uniform Norms and Standards for Public School Infrastructure

The 2013 Regulations

On 29 November 2013, the Minister of Basic Education published *Regulations Relating to Minimum Uniform Norms and Standards for Public School Infrastructure*.[4] These Regulations established legally binding minimum infrastructure norms and standards that needed to be met at each public school to ensure that proper teaching and learning could take place.

The Regulations described norms and standards related to electricity and water supply, sanitation, libraries, sports and recreation facilities and universal design[vii] that must be implemented in each school. Importantly, the Regulations included timeframes within which these norms and standards were meant to be implemented and clarified the norms and standards that had to be prioritised. More specifically, all schools built from mud and materials such as asbestos, metal and wood; and all schools that did not have access to any form of power supply, water supply or sanitation; had to be assisted by 29 November 2016.

Norms and standards relating to the availability of classrooms, electricity, water, sanitation, electronic connectivity and perimeter security had to be implemented by 29 November 2020, while norms and standards relating to libraries and laboratories for science, technology and life sciences had to be implemented by 29 November 2023.

All remaining norms and standards, such as those relating to sports and recreation facilities and universal design had to be implemented before 31 December 2030.

Unfortunately, the Department of Basic Education (DBE) has not met all the 2013 Regulation's deadlines and infrastructure needs at many public schools remain unaddressed today. Notwithstanding, the Regulations' timeframes remained legally binding and meant that civil society could continue to hold the

vii The 2013 Regulations defines "universal design" as "the design of products, environments, programmes and services to be usable by all people, to address the diversity of learners and teachers with functional limitations."

DBE accountable for missing these deadlines and thereby violating learners' rights to basic education.[viii]

The May 2024 Regulations

Following a court order handed down in 2018, the DBE was obliged to amend the 2013 Regulations to, amongst other things, revise vague language and strengthen provisions that ensured accountability and transparency.[ix]

After much delay, new Regulations replacing the 2013 regulations were published on 28 May 2024.[5] Unfortunately, only three timeframes concerning the implementation of norms and standards were included in these – namely, that schools with no water or power supply or sanitation had to be assisted by 28 November 2025[6] and schools without perimeter fencing had to be assisted by 28 May 2025.[7] The implementation of norms and standards to assist schools with insufficient classrooms also had to be addressed and reviewed annually.[x,8]

The June 2024 Regulations

Without any warning or justification, the May 2024 Regulations were withdrawn and on 27 June 2024, new Regulations were published[9] which removed all timeframes within which norms and standards had to be implemented, except those pertaining to overcrowded classrooms.[10] In terms of these, all that is now required is that specific norms and standards be included in provincial infrastructure plans by 27 June 2025, and that progress on the implementation of these be reported on annually.[xi,11]

Notably, the June 2024 Regulations do include stricter, and more detailed, reporting obligations for provincial education departments (PEDs).[xii] In particular, PEDs must submit a detailed infrastructure plan to the DBE on the implementation of the infrastructure programme ninety days after the beginning of each financial year.[xiii,12] In addition, PEDs must submit an End of Year Evaluation Report to the DBE sixty days after the end of the financial year, indicating progress made in implementing the infrastructure programme.[xiv,13] The plans and reports must also be published on the DBE and PED's websites.[14]

In terms of the 2013 Regulations, Members of the Executive Council for Education (MECs) were also obliged to provide the Minister of Basic Education with a detailed plan on the manner in which the norms and standards were to be implemented by 29 November 2014 and thereafter on an annual basis.[xv,15] MEC's were also obliged to report annually on the implementation of the afore-mentioned plans[16] However, fewer aspects had to be reported on, the submission of annual reports were not subject to express timelines in the regulations, and there was no requirement to make the reports public.[xvi]

The stricter and public planning and reporting obligations are an improvement. However, without prescribed timeframes, the June 2024 Regulations remain problematic as the prioritisation of norms and standards and the timeframes within which these will be met, will be determined soley by PEDs.

Commitment to review the June 2024 Regulations

The promulgation of regulations in 2013, which included prescribed timeframes, was the result of persistent activism and eventual litigation.[xvii] The June 2024 Regulations have diluted this hard-won victory and the obligations resting on the

viii For example, in *D.M. Mahuda and Another v Minister of Basic Education and Others* case no. 21/16034, SECTION27 intervened as amicus curiae (friend of the court) and, amongst other things, submitted that the Gauteng Department of Education (GDE) failed to meet the 29 November 2020 deadline in the 2013 Regulations obliging it to provide fencing to schools in the province and ensure security. The matter was unopposed and the High Court of South Africa, Gauteng Division, Johannesburg, granted the applicant's order which included an obligation on the respondents (including, amongst others, the DBE and GDE) to improve security at the affected school to prevent the theft of circuit breakers and earth leakage equipment.

ix See *Equal Education and Another v Minister of Basic Education and Others* 2019 (1) SA 421 (ECB). In this case, the applicants challenged specific subregulations of the 2013 Regulations for their inconsistency with the Constitution, the South African Schools Act 84 of 1996 and a court-order granted in 2013 obliging the Minister to promulgate the regulations. The High Court of South Africa, Eastern Cape Division, Bisho, found in favour of the applicants and declared certain of the impugned subregulations unlawful and invalid, clarified the meaning of other impugned subregulations and ordered the Minister to make specific amendments.

x Notably, the norms and standards contained in subregulations 4(2)(b) and (e) relating to schools built entirely or substantially of inappropriate materials and schools without relevant minimum education areas respectively, merely had to be included in provincial infrastructure plans by 28 May 2025, and reported on annually. Unfortunately, norms and standards related to aspects such as universal design and electronic connectivity were not provided with either an implementation date or a date within which these should be included in provincial infrastructure plans.

xi Notably, again, norms and standards related to aspects such as universal design and electronic connectivity are not provided with either an implementation date or a date within which these should be included in provincial infrastructure plans.

xii Notably, the May 2024 Regulations contained similar requirements.

xiii In terms of subregulation 4(11)(a)-(h) of the June 2024 Regulations, this plan must contain information on the need for school infrastructure, the current status of school infrastructure, the prioritisation of school infrastructure backlogs, the scope of, allocated budget and source of funding for planned projects in the Medium-Term Expenditure Framework, the status of each project and human resources capacity.

xiv In terms of subregulation 4(13)(a)-(f) of the June 2024 Regulations, this report must indicate the overall performance regarding the achievement of practical completion targets, the overall performance regarding the utilisation of budgets, the overall performance according to the nature of investment and commitments, the original budget allocation, revised budget allocation and expenditure to date per project, the status of each project and the projects planned for the new financial year.

xv Subregulation 4(6)(b)(i)-(iv) of the 2013 Regulations indicate that these plans are to make provision for, but not be limited to, the backlogs at district level that each province experiences, costed short, medium and long-term plans with targets, information on how new schools should be planned and maintained and how existing schools are to be upgraded and maintained, and lastly, proposals in respect of procurement, implementation and monitoring.

xvi After requests by civil society organisations, these plans were eventually made available on the DBE's website.

xvii See *Equal Education and Others v Minister of Basic Education and Others case* no 81/2012, which resulted in a settlement agreement wherein the Minster of Basic Education undertook, among other things, to promulgate regulations by 15 May 2013. However, after the Minister failed to do so, Equal Education returned to court and another settlement agreement was entered into wherein the Minister undertook to promulgate regulations by 30 November 2013.

DBE to ensure the implementation of the norms and standards in all schools.

The new Minister of Basic Education, Siviwe Gwarube, has publicly undertaken to review the Regulations,[xviii] which should be followed by the publication of draft regulations for public comment. Civil society is urged to participate in this process and highlight its concerns, so that the Regulations can result in all schools providing a safe, healthy and conducive learning environment.

According to the DBE's 2025 Education Facilities Management Systems (EFMS) Report,[17] only 32% of all public schools have laboratories, while only 57% have libraries and only 49% have computers, with the Limpopo province experiencing the most shortages. Unfortunately, the EFMS report does not indicate the status of overcrowded classrooms in public schools, how many schools are still built entirely or partially from inappropriate materials and, up until recently, does not reflect how many schools still rely solely on plain pit toilets.[xix]

The severe infrastructure challenges many schools continue to face cannot be denied and the lack of official, consolidated data on critical infrastructure issues underscores the importance of greater accountability. It is therefore crucial that the reviewing of the Regulations commences urgently so that the Regulations are amended to serve as the meaningful and transformative mechanisms they were meant to be.

South African Schools Act: Draft Regulations on School Capacity and Admissions

Despite 31 years of democracy, the education system still faces apartheid-era racial and economic disparities that negatively affect the quality of education for the majority of learners. The Basic Education Law Amendment Act of 2024 (BELA),[18] incorporating the jurisprudential developments in education law over the years, is aimed at addressing discriminatory and unfair practices at schools. Whether its aim can be achieved depends on how it is implemented

The Act came into operation on 24 December 2024, [19] putting a range of amendments to the Schools Act into effect. Regulations still need to be finalised to guide the implementation of the various amendments. The regulations play a central role in implementation of the law because they clarify for education managers, administrators, principals, educators, parents and learners; exactly what the law means and what their roles and responsibilities are in practical terms. A central rule in law is that the regulations cannot go beyond or conflict with the principal Act. Their role is to enable the implementation of the Act as it was intended.

The Minister of Basic Education announced that she would be releasing at least ten sets of regulations on the following areas:

- Minimum Uniform Norms and Standards for Capacity of an Ordinary Public School
- Admission of Learners to Public Schools
- Management of Learner Pregnancy
- Registration and Administration of Home Education
- National Education Information System
- Election of Members of Governing Bodies
- Prohibition of the Payment of Unauthorised Remuneration or the Giving of other Benefits to certain Employees
- Minimum Norms and Standards for Provincial Education Development Institutes and District Educator Development Centres
- Organisation Roles and Responsibilities of Education Districts
- Guidelines on the Adoption of Code of Conduct for Learners by the Governing Bodies.

On 6 August 2025, the DBE released draft regulations on Capacity[20] and Admissions[21] for public comment. These two sets of draft regulations should be read together with the 2024 Infrastructure Regulations discussed above.

Capacity Regulations

The draft Capacity Regulations limit class sizes to 30 learners in Grade R and 40 learners from Grades 1 to 12. These limits are also stated in the 2024 Infrastructure Regulations. Realisation will require additional budget to be allocated by National and Provincial Treasuries for more classrooms, educators and school resources and improved management of infrastructure spending by provincial departments of education. Realising the equity intent of BELA with regards to the transformation of school admission decisions and policies will also contribute to the realisation of the class size limits.

Admission Regulations

Admission policies

Individual school admission policies, drafted and approved by School Governint Bodies (SGBs), have been used as a

xviii See, for example, the Basic Education Budget Vote Speech for the 2024/2025 financial year delivered by Minister Gwarube before the National Assembly on 15 July. Minister Gwarube also undertook to review the Regulations on 11 March 2025 in a ministerial briefing session on school infrastructure and equipment before the National Council of Provinces. The DBE also undertook to review the June 2024 Infrastructure Regulations in its 2025 – 2030 Strategic Plan and its Revised Annual Performance Plan for 2025/26 presented to the Portfolio Committee on Basic Education on 17 June 2025.

xix The DBE's 2023 and 2024 EFMS reports as well as their predecessors, the National Education Infrastructure Management reports, included national and provincial data on how many schools still operate with plain pit toilets only. The DBE's 2025 EFMS does indicate how many schools operate with plain pit toilets, but these numbers include schools provided with appropriate sanitation and are operating with undemolished pit toilets.

mechanism to prevent Black and underprivileged learners from accessing schools in affluent areas. In particular, the use of feeder zones, language, and proximity have been found to perpetuate apartheid era spatial inequalities by excluding learners in disadvantaged areas from accessing former Model C and elite schools. The result is that schools in disadvantaged areas are overcrowded and under-resourced, while schools in wealthier areas have acceptable class sizes and more resources.[22]

Admissions was one of the most contested sections in BELA.[23] Some stakeholders argued that the provisions in the tabled bill diminished the powers of SGBs by including the provision for provincial Heads of Department (HODs) to approve school admission policies.[24] In response to these arguments, the National Council of Provinces proposed amendments which removed the requirement of HOD approval of school admission policies.[25] Public interest organisations contested this removal, arguing that the watered-down provisions did not give full effect to the High Court judgments that require the HOD to have greater decision-making powers over admissions.[26] In the end, the watered down provisions were passed by Parliament: SGBs do not need to submit their admission policies to the HOD for approval, but should consider transformative and rights-based criteria when drafting or amending their admission policies. These include the best interests of the child, whether other schools in the area can accommodate a learner, the availability of resources and the space available at the school. The draft regulations expand on this list of factors that should be considered.

The draft regulations outline the HOD's authority to request an SGB to review and amend their admission policy if the HOD believes that the policy does not comply with the Act or the Regulations. Upon receiving such a request, the governing body must review and revise their admission policy within a reasonable period not exceeding ninety days.

Feeder zones

The draft regulations provide that the HOD has the discretion to determine feeder zones in consultation with SGBs, and define the factors that the HOD should consider when determining zoning. These include the capacity, language and curricula offered at the school and other schools in the vicinity; information and projections regarding area population density; learner population density and learner enrolment; the need for geographical and spatial transformation; and whether the school has boarding facilities and, if so, the need to ensure the school is accessible to learners requiring placement in such facilities.

Feeder zones must also be established in a transformative manner so that the radius covers learners living in disadvantaged areas.

Admission management plans

The draft regulations require the HOD to furnish an admission management plan with timelines and guidance on periods of applications for admissions, and strategies to encourage early applications. The draft regulations neglect however to require HODs to plan for the inevitability of late applications caused by unexpected events in families' lives; such as the death of a parent or caregiver, or a need to move to secure income.[27]

Undocumented learners

Another contested issue in BELA has been the incorporation of the Eastern Cape High Court's decision in the case of *Centre for Child Law v Minister of Basic Education 2020.*[28] The court held that preventing undocumented learners from enrolment at schools was unconstitutional, as it infringed on their rights to basic education, equality, dignity and the best interests of the child. The court held that an affidavit including the learner's details is sufficient for enrolment at school.

BELA amends section 5 of South African Schools Act (SASA), making it clear in the law that a learner who is undocumented must be allowed to access school. It states that principals must advise learners and their parents to obtain the necessary documentation. These provisions were inserted to bring SASA in line with the *Centre for Child Law* judgment.

The National Admission Policy[29] that used to govern this area, but is now overruled since BELA came into effect, specified that a parent must present a birth certificate, and non-national parents must produce a study permit for their child. Without these documents, admission was conditional and the parent was expected to submit the documents within three months to finalise the admission. This resulted in parents and learners who did not submit the documents within three months being threatened with exclusion from school and various education activities such as sport, the school feeding programme or writing matric. Many school admission policies still contain these provisions despite this not being in line with BELA.

In alignment with BELA, the draft regulations emphasise that an undocumented learner should be admitted and there is no longer any reference to such admission being conditional. However, the draft regulations add that the school should refer the matter to the HOD and that the HOD, or a person duly authorised by the HOD, should hold the learner's parents accountable for not having the relevant documentation.[30] This addition goes beyond what BELA intended and should be removed for that reason alone. A further concern is that there

is no definition of what holding a parent accountable entails. This could range from warning letters, to reporting the family to immigration authorities.

Proof of immunisation

Requiring immunisation records for admission into Grade 1 has been a provision in the National Admission Policy and School Admission Policies for many years and is therefore standard practice in most schools. The immunisation record must include polio, tetanus, measles, diphtheria, TB and Hepatitis B. The draft regulations retain immunisation records as an admission requirement. What is new is that specifying this in the regulations as opposed to in the admissions policy, elevates the requirement to a legal requirement, and the draft regulations also oblige school principals to inform parents that learners without immunisation records will not be permitted to attend school. This change in the legal status of the requirement could cause schools to enforce the immunisation requirement more strictly, resulting in children being refused access to school at both the application stage and on the first day of school, particularly in Grades R, 1 and 7.

Parents who wish to be exempted from this requirement will need to obtain an exemption from the HOD. Exemption is possible on medical grounds if accompanied by a letter from a medical professional or on cultural/religious grounds if accompanied by proof of previous observances of that religion or culture, such as a letter from a religious or cultural leader.

In a case where the learner has not been immunised, or does not have proof of immunisation and does not have an exemption from the HOD, the principal "must" inform the learner's parents that the learner cannot be allowed into the school until they have been immunised or obtained an exemption, and that they can approach a public health care facility to access immunisation for free.

Immunisation coverage in South Africa remains suboptimal: Only 83.3% of infants under one year were fully immunised in 2023/24, well below the national target of 90% needed to achieve herd immunity – and there are striking inequalities in coverage across provinces and districts. For example, only 74.8% of infants were fully immunised in the Western Cape.[31]

While it is in children's best interests and in the public's health interests to use school admissions as an opportunity to identify and address gaps in immunisation coverage, any such intervention should recognise that the majority of unvaccinated children are not as a result of vaccine hesitancy or neglect but are more likely the result of system failures such as vaccine stock-outs or socio-economic factors. A retrospective analysis of data collected in a national immunisation coverage survey, found that health facility obstacles accounted for 68% of missed vaccinations. These included vaccine stockouts, lack of access to vaccination services (because the clinic was not open after working hours, or was closed on the day of visit, or there was no vaccinator on duty, or no clinic nearby); or caregivers were not told that they needed to return for catch-up doses.[32]

The Department of Health's (DoH) immunisation catch-up plan of 2024[33] provides for when – and if – children can receive a catch-up dose. For example, the plan stipulates that the BCG vaccine for TB cannot be given to children older than 12 months. The remaining vaccines can be given, but the doses should be staggered over a few months to avoid complications. Yet, the draft Regulations prescribe that children who do not have immunisation records should not be allowed into school and that their parents have 30 days to return with their child's completed immunisation records.

There is currently no recognition in the regulations that there will be cases of learners who may have lost their immunisation records due to being separated from their parents, migration from another country or province, or whose immunisation record has been destroyed in a fire or flood.

Immunisation coverage was extremely low during the first year of COVID (79.5% in 2020/21),[31] and these children will be turning 5 and 6 years old in 2026. The Grade R and Grade 1 intake in 2026 may therefore be faced with a large number of children who are not fully immunised.

The catch-up plan for children who are not fully immunised should begin long before children are ready to start school, through concerted catch-up campaigns run through the health care system and early childhood development programmes. If a child is still not immunised when they apply for school admission, a supportive approach should be activated to put a catch-up plan in place – in a way that enables the child to access education while completing their vaccine catch-ups, rather than excluding the child from admission to school.

Next steps

Public comments on the draft regulations are due by 5 December. Once public comment has been considered by the Department, the regulations will be finalised. When this will happen will depend on the number of submissions received and the concerns they raise.

Child health

Tobacco, nicotine and cannabis carry higher physical and mental health risks for children than for adults. Any law reform affecting these substances therefore needs to build in adequate provisions

to prevent the use of these substances by children. The Cannabis for Private Purposes Act decriminalises the use of cannabis by adults for private purposes and measures to protect children still need to be put in place. Companies that make profits from products including these substances are increasingly adopting marketing strategies targeted at children, adolescents and young adults to entice them to use their products.[34] The state is obliged to regulate business practices such as these that are harmful to children's health.[35]

The *Tobacco Products and Electronic Delivery Systems Control Bill*[36] is aimed at introducing stricter controls on the sale and marketing of tobacco products. It is also aimed at extending the controls to vaping. The National Assembly held public hearings on the bill in 2025 – with big industry and small businesses arguing for less control; while public health advocates and organisations representing the youth motivated for stricter control and enforcement.

Cannabis for Private Purposes Act

The Cannabis for Private Purposes Act [Cannabis Act] was signed by the President in May 2024 but is not yet in effect as regulations still need to be finalised.[37] It was passed in response to a 2018 Constitutional Court judgment. The Act decriminalises the use of cannabis for private purposes by adults, while retaining the prohibition on use by children and making it a criminal offence for an adult to use cannabis in the presence of a child. When a drug is legalised for adult use, it becomes more accessible and visible to children. To prevent children from accidently ingesting cannabis or using cannabis – a range of measures still need to be put in place.

The Prince judgement

In September 2018, the Constitutional Court declared it unconstitutional to criminalise adults' private use and cultivation of cannabis.[38] Sections of the Drugs and Drug Trafficking Act[xx] and the Medicines and Related Substances Act,[xxi] were declared to be inconsistent with the constitutional right to privacy[39] because they criminalised the use or possession in private, or cultivation in a private place, of cannabis by an adult for their own personal consumption.[40] The Court suspended its order until September 2020, giving Parliament two years to amend the Acts to align with the judgment.[41] The Court also granted interim relief while Parliament passed the amendments.[xxii] The effect of the interim relief was that as of September 2018; the use, possession or cultivation of cannabis by an adult for private purposes were no longer criminal offences.

Implications for children

While making cannabis use and cultivation for private purposes legal for adults, the *Prince* judgment explicitly prohibited cannabis use by children, or by an adult in the presence of a child. However, decriminalisation for adults may have made the use of cannabis more socially acceptable, and therefore more visible and accessible for children in their homes and in communities.

Children who accidently ingest cannabis or adolescents who use cannabis are more at risk than adults to negative health outcomes because of their lower body weight, and the fact that their brains are still developing. Public health experts monitoring the effects of cannabis on children and adolescents are therefore calling for measures to be put in place to protect children from the risk of accidental ingestion of edible cannabis products and to prevent increased use by adolescents.

Accidental or intentional ingestion of cannabis edible products containing THC (trans delta-9-tetrahydrocannabinol), the main psychoactive component of cannabis, can lead to serious health effects among children, including lethargy, impaired concentration, muscle weakness, rapid heartbeat, hypoventilation and psychosis lasting several days.[42-44] Scientific evidence also shows that regular cannabis use (in any form) during adolescence may be associated with persistent neurological changes, cognitive deficits and mental health conditions.[45, 46] Compared to adults, the adolescent brain is especially vulnerable to the neurotoxic effects of CBD (cannabidiol) – the non-psychoactive component of cannabis – due to incomplete neuromaturation of certain brain structures.[47] Adolescents are also at increased risk of diagnosable substance use disorders, psychosis, depression, anxiety and suicidal behaviour.[48, 49]

The prevalence of adolescent annual cannabis use in Southern Africa among those aged 15 – 16 is estimated at 7.5%, which is much higher than the rest of the continent (between 3.6 and 4.3%).[50] In South Africa, national surveys show an increase in cannabis use by individuals over the age of 15 years from 1.5% in 2002 to 7.8% in 2017.[51] Treatment admission data from the South African Community Epidemiology Network on Drug Use (SACENDU) revealed that from 2021 to 2023, just under 20% of total admissions were for those under 18, with the mean age of initiation just under 16 years, and over

xx Drugs and Drug Trafficking Act 140 of 1992. Sections declared unconstitutional were sections 4(b) and 5(b) and the definition of "deal in" in section 1, read together with Part III of Schedule 2

xxi Medicines and Related Substances Act 101 of 1965. The section declared unconstitutional is section 22A(9)(a)(1)

xxii By a 'reading-in' remedy which means the court adds words into the sections to cure the constitutional defect and see Cannabis for Private Purposes Bill, 2020 Memorandum on the Objects of the Cannabis for Private Purposes Bill at para 1.2; Minister of Justice and Constitutional Development and Others v Prince at paras 104 – 108.

half reporting cannabis as their primary substance.[52] Given these risks for children and adolescents, any shift in drug law should be carefully assessed and monitored for its impact on children and adolescents, enabling mitigation adaptations to be designed and put in place timeously.

Cannabis for Private Purposes Act

In May 2024, the President signed the Cannabis for Private Purposes Act [Cannabis Act], making South Africa the first country in Africa to pass a law that decriminalises recreational cannabis use for adults.[37] The Cannabis Act aligns South Africa with global trends to legalise and regulate adult usage of cannabis, while retaining the prohibition on usage by children, with due regard for the best interest of the child.[53]

The Act will only come into operation when regulations are finalised – which is planned for the beginning of 2026.[54] A range of regulations are required, including on the amount of cannabis that an adult can have in their possession for private purposes.[55] Draft regulations have been prepared by the Department of Justice and sent to a number of other Ministers[xxiii] and the Presidency for comments before they will be gazetted for public comment.

Key terms and provisions

'Use' of cannabis is defined in the Act[56] as the consumption of cannabis; including eating, drinking and smoking. 'Cannabis' is defined as the fruiting or flowering part of the cannabis plant, excluding the seeds; and any products made from these parts. The Act therefore covers smoked cannabis products including joints, pipes and vapes; oils; concentrates; and edible products made from cannabis dried product or from concentrates.

The Act retains the legal prohibition on the use of cannabis by a child (anyone under 18) and makes it a criminal offence for an adult to knowingly allow a child to use cannabis or to supply a child with cannabis (unless prescribed by a medical practitioner).[57]

Adults using cannabis are prohibited from using cannabis in the presence of a child,[58] and if found guilty are liable on conviction to a fine or imprisonment.[59] Similarly, adults in possession of cannabis must ensure that the cannabis is not accessible to a child and can be fined R2000 if a child manages to access the cannabis.[60]

Commercial sale and purchase prohibited

The commercial sale and purchase of cannabis remains prohibited. However, in reality, private members' clubs (or lounges) exist where cannabis can be acquired by adults for private use, as well as kiosk dispensaries and online purchases for cannabis-based products. The model of clubs exist due to the *Prince* Judgement, where it was held that the permitted use of cannabis for recreational reasons is not confined to a home or private dwelling.[61] Certain clubs are also dispensaries of cannabis as a medicinal product, provided that they have a s21 permit in terms of the Medicines Act and they are licenced to dispense unregistered medicines. While clubs and dispensaries are not supposed to sell products to children, the existence of these and online outlets may make cannabis more accessible and visible to children and adolescents.

Amount of cannabis allowed for private use not yet specified

The tabled bill specified a maximum allowed amount of 600 grams per adult and 1.2 kilograms of dried flower or cannabis equivalent per household with two adults. One gram of dried cannabis is equal to 5 grams of fresh cannabis and 0,25 grams of cannabis concentrates (solids & liquids).[62]

However, Parliament decided not to specify the amounts in the Act and instead delegated the authority to the Minister of Justice to decide the amounts in regulations.[xxiv] These regulations are now in development and will soon by gazetted for public comment.

Cannabis infused foods

Food containing cannabis, including edibles such as gummies, baked goods and chocolates is allowed in terms of the Act for adult private use. The specific amount of edibles or grams of cannabis per edible allowed per adult is likely to be prescribed in the regulations, and should adhere to scientific standard units of what is considered safe per portion.

Sale, manufacture and import of cannabis infused foods

Food infused with cannabis can contain unknown or high levels of THC and pose a higher risk of adverse outcomes for both adults and children. This risk is compounded when edibles are presented in forms that are especially appealing to children, such as cupcakes, chocolates, lollies and sweets.

Food products containing cannabis have often been classified simply as food, which allows them to bypass the usual regulatory systems intended to manage the risks linked to cannabis. South Africa does not yet have any regulations governing imported cannabis-containing foodstuffs, making it difficult to ensure their safety. The Department of Health (DOH) recognised this gap and aimed to align South Africa with global standards, which require that all food products containing cannabis undergo evaluation and approval before

xxiii Police; Health; Agriculture; Trade, Industry and Competition; Social Development; and Small Business Development.
xxiv See Cannabis Bill [B19B – 2020] and Section 6 (1) (a) and (b) of the Act.

being allowed to be sold or imported. To achieve this, DOH sought to create a single regulatory framework for cannabis-containing foods, rather than treating them as ordinary food products. In March 2025, the Minister of Health promulgated regulations in terms of the Foodstuffs, Cosmetics, and Disinfectants Act. However, instead of regulating cannabis infused food, the regulations imposed a wholescale ban on the sale, manufacture or import of any food or drinks containing ingredients derived from the genus cannabis sativa L plant, including hemp seeds, hemp seed oil, hemp seed flour and cannabis-infused beverages.[63]

These regulations were withdrawn in April 2025 following a backlash over their negative impact on hemp and cannabinoid CBD products that do not contain psychoactive compounds such as THC (for example hemp seeds) and lack of stakeholder consultation.[64] The government is currently reviewing the legal framework on the manufacture, sale and import of all cannabis-infused food products to regulate the industry and protect adults and children from dangerous levels of CBD and THC.

The National Cannabis Master Plan

Cabinet took a decision in July 2019 that the country needs a national strategy to commercialise cannabis in order to increase economic growth, create jobs and alleviate poverty, hence the development of the National Cannabis Master Plan.[65] More recently, President Ramaphosa noted in his 2025 State of the Nation Address that government wants South Africa to be leading in the commercial production of hemp and cannabis.[66]

As these developments unfold, it is likely that cannabis will become increasingly available to children and adolescents.

Are current protections for children adequate?

The Cannabis Act and future law reform to commercialise the cannabis industry is expected to have a significant impact on the lives and health of children and adolescents, making strong protective measures essential. Considering the physical and mental health risks, it is imperative for policy and law makers, supported by public health advocates and the public, to continue limiting children and adolescent's access to cannabis.

Enforcement of the Act

The Act prohibits adults from using cannabis around children and bans its possession and use by children. Effective enforcement of these prohibitions is critical to ensure their success. However, policing what happens in private households is not an easy task.

Educating about the risks

As cannabis becomes more available in homes, public awareness campaigns by government departments, in particular Education and Health, are needed to educate adults, educators, health workers, adolescents and children about the shift in the law and the health risks associated with cannabis use, especially products that contain THC. In particular, education is required on the standard THC unit that is considered 'safe' (ie 5mg for all cannabis products)[67] and the risks of accidental ingestion by children.

School- and community-based prevention programmes and adolescent-friendly treatment programmes will also need to be developed.

Additional regulatory measures required

Additional regulatory measures should also be introduced and enforced, including:

- prohibiting the sale of cannabis and cannabis-infused foods to children
- regulating the marketing and advertising of cannabis and cannabis infused foods (including by private clubs and dispensaries). In particular, the marketing of cannabis (including edibles) through mechanisms that appeal to children and youth, such as attractive packaging, giveaways and social media promotions should be prohibited
- regulating the labelling of cannabis-infused foods to ensure the amount of THC is clear
- setting limits on the amount of THC allowed per serving, and defining what constitutes a serving.

Improved public health monitoring

Improved public health monitoring will also be necessary to quickly identify and respond to changes in children's use of cannabis.[46, 68] The state should therefore invest in nationally representative surveys and surveillance systems to monitor youth cannabis use and related harms, assess the impact of legalisation and guide future policy reform.

Tobacco Products and Electronic Delivery Systems Control Bill

The Bill[36] aims to reduce tobacco and nicotine related harm in the adult population and to prevent the use of tobacco and nicotine by children. Besides strengthening tobacco control, the Bill aims to fill the regulatory void on the contents, sale and use of nicotine- and non-nicotine-containing electronic delivery devices (commonly called 'e-cigarettes' and 'vapes') and other 'novel' nicotine products such as nicotine pouches and 'heat don't burn' tobacco products; given significant health concerns about their use and the addictiveness of nicotine and its harmful effects on brain development in adolescents and young adults.

Key provisions of the Bill

- 'Smoking' includes both tobacco-based and electronic systems.
- Restrictions on where smoking may take place. Restricted places have been set out in more detail than in the 1993 Act and include motor vehicle transport. The Bill empowers owners of buildings, public spaces and conveyances to prohibit smoking and vaping in these places.[69]
- Stricter prohibitions of advertising, promotion, sponsorship, distribution and display of products. Notably, products may not be visible where they are sold to the public. Online advertising and the associated 'influencing' that takes place online are prohibited.[70]
- Standardised packaging (uniform colour package with simple name of product only) of all products with designated health-related messages.[71]
- Broad ministerial powers are given in relation to the manufacturing and other standards in the production and testing of products.[72] The Minister is also enabled to acquire any product-related information from the manufacturers of products.[73]
- The sale of any tobacco or nicotine products to children is prohibited and none of these products may be sold online.[74]

Public hearings in the provinces

The Portfolio Committee on Health called for public submissions which elicited considerable interest from those concerned about the health and social effects of tobacco and nicotine as well as from the tobacco and nicotine industries. There have subsequently been public hearings in all provinces. A report on the first seven provinces was presented to the Committee in early 2024. Membership of the Committee then changed after the National Elections, meaning that most of the Members of Parliament (MPs) now responsible for approving and amending the Bill did not participate in the extensive provincial hearings. They are however able to consider the written report.

National public hearings

Further meetings took place in 2024 in which the MPs were orientated to the provisions of the Bill and there was general support for the provisions of the Bill. After some procedural questions were addressed, the Committee held national public hearings from March to August in 2025. Many people and organisations who had sent in written submissions were invited to present. Oral submissions were heard from many quarters, including the local and international tobacco and nicotine industries;[75, 76] small business organisations;[77] 'harm reduction' advocates;[78] public, child and adolescent health advocacy groups;[79] organisations representing youth;[80] and health practitioners and experts on the economic, social and health impacts of tobacco and nicotine.[81, 82]

Those representing the tobacco and nicotine industries challenged the constitutionality of the Bill in terms of the right to trade and the individual rights of people who use these products. They emphasised the potential for the Bill to increase the illicit trade in cigarettes and drive 'vaping' underground. Many argued that combining 'combustible' products such as cigarettes with electronic and other non-combustible products was incorrect since non-combustible products carry lower health risks (though not as much lower as the statistics that they quoted suggested). They argued that the Bill had one view on harm ('harm is harm') that did not allow for harm reduction approaches. Those individuals and organisations (a majority from outside of South Africa) that spoke to 'harm reduction' expressed similar arguments.

Those representing small businesses were concerned about loss of trade, and their members' likely inability to abide by aspects of the law (e.g. curbing the display of these products and smoking in public spaces). This would make them primary targets for enforcement which they believed to be unfair.

The Congress of South African Trade Unions (COSATU) was fully in support of the Bill, emphasising the need to protect South Africans, especially the young, from the harms of these products. They also called for more vigorous measures to limit the illicit trade in tobacco (such as track and trace systems) to be included in the Bill.

All health, academic and youth presenters were strongly in favour of the tight controls on tobacco and nicotine in the Bill. Specifically, the Bill's potential to further protect children and young people from harm was highlighted, and to prevent nicotine addiction amongst adolescents and young adults. They pointed to evidence of the marked addictiveness of nicotine and its potential impact on brain development in younger people. Evidence of high levels of use of these products and addictive behaviours among school-age children was also presented. Evidence was also presented on aerosols from electronic systems revealing that they are not as harmless as the industry claims. Apart from nicotine, they contain many chemicals known to be toxic and others for which there is minimal knowledge of what would happen with long term use. These groups also alerted the Committee to the self-serving and underhand ways of the tobacco and nicotine industries. The industry's approach of promoting 'harm reduction' rather than preventing harm was one of these strategies. Yet the role of electronic devices and pouches in reducing smokers' use of tobacco (let alone helping them to give up tobacco and nicotine altogether) is far from clear,

and other countries such as Uganda have succeeded in reducing tobacco use through control legislation without allowing other nicotine products to be used as a 'harm reduction' strategy.
In summary, these groups all strongly asserted that stringent regulations were necessary to curb the tobacco and nicotine industries deliberate targeting of young people through their advertising strategies and the flavouring of their products.

Children's right to a safe environment was highlighted to the Committee. Evidence was presented that, even before they are born, infants can be affected by tobacco and nicotine in ways that can have lifelong negative effects on lung and other organ function. Ensuring clean and safe air in all public spaces and modes of transport are essential to realising this right. South Africa also has an obligation to protect children from harmful business practices and uphold their right to be protected from harmful drugs. The Bill is well placed to promote all these aims.

The children, youth and public health submissions reminded parliament that the Bill and its regulations must be worded such that they control all forms of commercial nicotine products. This would include those designed for oral or nasal use such as nicotine pouches and 'snus'. These groups noted their support for bans on advertising, the use of standardised packaging, greater controls on smoking in public places, and restrictions on sales and youth-oriented formulations of all products covered by the Bill, noting the urgent need to use this opportunity to regulate all nicotine products. Protecting youth and preventing harm from tobacco and nicotine exposure must be prioritised, above the interests of tobacco and vaping companies.

Next steps

With the public hearings over, the Portfolio Committee will soon begin its deliberations on the clauses of the Bill. Once passed by the National Assembly, the Bill will be referred to the National Council of Provinces where public hearings will again be held and further deliberations.

National Strategy to Accelerate Action for Children

The draft National Strategy to Accelerate Action for Children (NSAAC) is the outcome of a consultative process initiated in the Presidency in 2023 to fast-track change for children by working with and galvanising the whole of society around ten key priorities to advance the rights and well-being of children. This process was prompted by the general observation that greater political prioritisation is critical for proper resourcing and scaling of programmes for children[83] and the specific realisation that while child outcomes for children in South Africa have improved over the past thirty years, there are concerning signs that some of those gains may be starting to reverse.[84]

The implication is that government should move fast to prevent the further erosion of progress for children and intensify its existing efforts to improve child outcomes, and it should also identify and implement catalytic strategies to accelerate changes in the lived experience of children in South Africa.

International experience shows that accelerated action for children and adolescents requires strong central leadership in convening a national programme of action across all sectors of society. In his capacity as Chairperson of the Global Leaders Network for Women's, Children's and Adolescents' Health, President Cyril Ramaphosa has challenged global leaders to agree on bold steps to accelerate the actions needed to achieve the Sustainable Development Goals (SDGs) related to their health and well-being worldwide.[85]

The General Measures of Implementation of the Convention on the Rights of the Child outline the need for a "unifying, comprehensive and rights-based national strategy, rooted in the Convention".(para 28)[86] The Department of Social Development is responsible for the development of a National Plan of Action for Children (NPAC) which sets targets and consolidates the sectoral implementation plans of various government departments, but there was a need for an overarching strategy led by the Presidency to coordinate policy and establish national priorities for children and give direction to the next NPAC-5 which will detail the operational commitments of the different government departments. The Medium Term Development Plan 2024 – l 2029 notes that the NSAAC "will fast-track essential child rights delivery through strengthening institutional mechanisms and intersectoral collaboration" (p.87)[87] together with the Department of Planning, Monitoring and Evaluation. Guided by the global frameworks of Nurturing Care and Adolescent Well-Being, the National Strategy to Accelerate Action for Children aims to:

- build a common understanding of the national priorities for children and adolescents;
- establish effective interfaces with civil society and the private sector to enable participation in child rights governance and to support the implementation of national priorities that do not fit neatly into single departmental mandates, and which require a high degree of intersectoral collaboration; and
- strengthen institutional mechanisms and accountability, responding in part to the concluding observations and recommendations of the United Nations Committee on the Rights of the Child and the African Committee of Experts on the Rights and Welfare of the Child.

The Presidency led a national process of consultation, involving all relevant government departments, representatives from non-

Box 1: Ten priorities to accelerate action for children and adolescents

1. Strengthen families and enable parents & caregivers to care for their children.
2. Reduce infant and child deaths.
3. Eliminate HIV transmission to babies.
4. Improve child nutrition.
5. Grow children's brain power through early learning and language development.
6. Prevent disability in children and give those with disabilities the same opportunities as others.
7. Protect children and adolescents from all forms of abuse, violence, injuries and harmful substances.
8. Give adolescents good access to health care, including sexual and reproductive health.
9. Increase participation in quality education and training and link school-leavers to work.
10. Build adolescents' sense of identity, agency and connectedness.

government organisations and coalitions, as well as children and adolescents themselves through learner representative councils and other organised groups. This culminated in a national meeting of stakeholders in October 2024 which considered the draft document, and the ten priorities identified through consultation.

For each domain of child and adolescent well-being, the NSAAC outlines both the existing programmes which need to be strengthened, as well as catalytic strategies that could accelerate improvements in child outcomes. It goes further to list ten interventions that would make the biggest impact for children and adolescents – some of which are not yet government policy – which the relevant government departments should consider for implementation along with collaboration with other departments.

In his State of the Nation Address on 6 February 2025, the President announced that Cabinet would soon approve the National Strategy to Accelerate Action for Children.[66]

Unfortunately, the NSAAC has, as of September 2025, yet to be presented by the Minister of Social Development to National Cabinet for approval due to delays in the finalisation

Figure 1: Ten interventions that would make the most difference to children and adolescents

	Intervention	Responsible department
1	Restore the Child Support Grant to the Food Poverty Line	DSD National Treasury
2	Provide matching subsidy for a basket of protein-rich food staples, discounted through industry collaboration	DTIC/DoA National Treasury
3	Ensure the Nutrition Therapeutic Programme (NTP) is adequately funded and implemented in all provinces	NDoH
4	Strengthen childcare and protection systems	DSD (lead)/DBE/DOJ&CD/SAPS
5	Drive a responsive care campaign, incl. early language development and cognitive stimulation for children <3 yrs	NDoH DBE
6	Ensure access for every child (3 – 5 yrs) to a quality early learning programme	DBE
7	Ensure universal neonatal hearing screening and visual screening for Grade R learners	NDoH (lead)/DBE
8	Ban alcohol advertising (except at point of sale), introduce a minimum unit price for alcohol and restrict on-site liquor hours to midnight	DTIC (lead) / DSD / SAPS
9	Expand prevention and early intervention of basket of services including sexual & reproductive health services for adolescents, including community-based supply of contraceptives	NDoH DSD/DBE
10	Build a national network of support promoting a sense of meaningful participation, agency and Identity among adolescents	NDoH

Critical interventions to prevent erosion of gains in poverty reduction, nutrition and child protection

Other key interventions to accelerate gains

Source: Republic of South Africa. The National Strategy to Accelerate Action for Children [Draft 2025].

of the decision about the future position of the Office of the Rights of the Child (ORC). Established in 1998, the ORC is the institutional mechanism responsible for overseeing South Africa's child rights governance framework and monitoring of its implementation obligations. Originally located in the Presidency, the ORC was moved to the Department of Social Development in 2014, against the advice of the children's sector. The National Plan of Action (4) 2019 to 2024 recommended that the ORC be relocated back in the Presidency.[88] The configuration of government and the state departments, and hence the ORC is at the prerogative of the President. This matter was escalated to the Forum of Directors-General in 2023.[89] However, to date, there has been no progress in moving the ORC to the Presidency.

Key takeaways

- Educators need to be equipped to use non-violent strategies to manage difficult classroom behaviour, especially in the context of overcrowded classrooms.
- The Infrastructure Regulations should be reviewed and revised to include timeframes to ensure that all schools are able to meet the minimum norms and standards.
- The draft School Admission regulations should promote equity across the education system and provide support to children who do not have all the necessary documents, with clear prohibitions on excluding any child from education based on a missing document.
- Parents and children need to be provided with information on the harmful effects of cannabis for children; and the commercial sale and marketing of cannabis, cannabis products and cannabis infused food urgently needs to be regulated.
- The Tobacco Products and Electronic Devices Control Bill needs to be prioritised by Parliament as the long delays have left children and youth exposed to an unregulated and growing vaping industry.
- The National Strategy for Accelerated Action for Children needs to be submitted to Cabinet for approval by the Minister of Social Development as promised by the President.
- The Office on the Rights of the Child needs to be moved to the Presidency to ensure that services for children are prioritised by all government departments.

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Part 2

Intersections of Violence against Women and Children

A series of six chapters explore opportunities to prevent and respond to violence against women and children:

- Understanding the intersections of violence against women and children
- Intervening early in the first 1,000 days
- Adopting an integrated response to violence in the home
- Using schools as a catalyst for change
- Engaging communities
- Creating an enabling environment

A further five chapters outline key building blocks of an effective system:

- Law and policy
- Leadership and coordination
- Finance
- Human resources
- Data systems

The Violence Prevention through Urban Upgrading (VPUU) project works in collaboration with communities to upgrade public spaces in informal settlements in order to reduce crime and create a safe place for children to play. This beautiful mosaic was developed by local residents in collaboration with artist, Lovell Friedman, and it forms the focal point of the Harare Urban Park in Khayelitsha.

Glossary

Child abuse – any form of harm or ill-treatment deliberately inflicted on a child – including bullying, exploitation, physical or sexual abuse, or exposing a child to behaviour that may harm the child psychologically or emotionally.[1]

Child maltreatment – includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation which result in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power – most often in the home but also in settings such as schools.[2]

Domestic violence – occurs between people living together. It includes physical abuse; sexual abuse; emotional, verbal and psychological abuse; economic abuse; controlling or coercive behaviour; intimidation; harassment; sexual harassment; related person abuse; spiritual abuse; stalking; exposing a child to domestic violence; entry into the complainants' residence without her consent or any other controlling or abusive behaviour taking place in domestic relationships.[3]

Early intervention – see secondary prevention.

Femicide – involves the intentional murder of women because they are women. *Intimate femicide* is defined as the killing of female by an intimate partner (ie her current or ex-husband or boyfriend, same sex partner or a rejected would-be lover).[4]

Gender – refers to an individual's personal and social identity as a man, woman or non-binary person (a person who is not exclusively a man or a woman). *Gender identity* refers to how a person feels internally; and *gender expression* is how a person expresses their gender through body language, aesthetic choices or accessories. A person's gender may differ from their sex at birth and may change over time.[5]

Gender-based violence (GBV) – the general term used to capture violence that occurs as a result of the normative role expectations associated with a person's gender, as well as the unequal power relations between the genders, within the context of a specific society. GBV includes physical, sexual, verbal, emotional and psychological abuse or threats of such acts or abuse, coercion, and economic or educational deprivation, whether occurring in public or private life.[6] While GBV can affect everyone, women and girls are disproportionally affected, and some women and girls are at higher risk, including those with disabilities and those from the LGBTQI+ community.

Gender norms – are deeply entrenched and widely held beliefs and expectations about gender roles that govern human behaviours and practices within a particular social context and at a particular point in time.[7] They are embedded in formal and informal institutions, nested in the mind, and produced and reproduced through social interaction. They play a role in shaping women and men's (often unequal) access to resources and freedoms, thus affecting their voice, power and sense of self.[8]

Gender transformative approaches – advancing gender equality by: promoting critical examination of inequalities and gender roles, norms and dynamics; recognising and strengthening positive norms that support equality; creating an enabling environment that promotes the relative position of women, girls and marginalised groups; and transforming the underlying social structures, policies, systems and broadly held social norms that perpetuate and legitimise gender inequalities.[9]

Intersections – this term is used to describe the points at which violence against children and violence against women intersect or overlap.[10]

Intersectionality – how power, privilege, discrimination and oppression interact to increase the risk of violence against women and children. Although all women face discrimination some women face multiple forms of oppression because of their race, ethnicity, religion, socio-economic background, abilities and sexual orientation, which in turn shape their experiences of violence. (See Figure 1 on p. 36).

Intersectoral – working collaboratively across different sectors eg health, social services, education, police and justice.

Intergenerational cycle of violence – violence that occurs across generations and that is passed from one generation to another.

Intimate partner violence (IPV) – includes behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, controlling behaviours[11] and economic abuse.

Life course approach – this is a theory used in the social sciences that looks at how a person grows and changes over time. It helps us to understand how experiences and events throughout a person's life, including in utero and early childhood, can influence their health and well-being later in life.[12]

Patriarchy – patriarchy is a social system in which men hold primary power and dominate in leadership roles, establishing moral authority, acquiring social privilege, and control of property.

Prevention – Violence prevention is the whole of society working deliberately and sustainably to remove sources of harm and inequality, and heal woundedness, by intentionally growing an ethic of mutual care, respect and inclusion to build peace.[13] It includes a continuum of care from prevention to response (see Figure 6 on p. 44):

- *Primary prevention* aims to target interventions before an individual has experienced an incident of violence and can be either universal or targeted. Universal primary prevention programmes are aimed at an entire population or group. For example, community mobilisation or activism to change harmful social norms. In contrast, targeted or selective prevention programmes are targeted at specific groups or individuals considered to be at higher risk.
- *Secondary prevention* (early intervention) aims to detect violence early and directs programmes at high-risk groups. This includes, for example, support for vulnerable teenage parents and substance abuse programmes targeting individuals or families already experiencing violence.
- *Tertiary prevention* (response) aims to meet the immediate and long-term needs of survivors of violence to promote recovery and to limit the impacts of violence. Such programmes can also focus on strengthening institutional capacities to provide more accessible and quality services to women and children.[14]

Social norms – are rules of action shared by people in a given society or group; they define what is considered acceptable and unacceptable behaviour for the members of that group.[15] Social norms are distinct from individual attitudes and personal beliefs and may even be in direct conflict.

Trauma-informed – interventions that not only address the immediate psychological and social wounds inflicted by violence but also facilitate long-term community healing (see Box 6 on p. 64).

Violence against children (VAC) – a deliberate, unwanted and nonessential act, threatened or actual, against a child or against a group of children that either results in, or has a high likelihood of resulting in, death, injury or other forms of physical and psychological suffering.[16]

Violence against women (VAW) – any act of violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[17]

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Why we need to address the intersections of violence against women and children

Shanaaz Mathews[i]

Violence against women (VAW) and violence against children (VAC) are global public health burdens and human rights violations.[1, 2] Globally, one in three women (35%) experience physical and/or sexual intimate partner violence (IPV),[1] while one billion children or over half of all children aged 2 to 17 years experience violence at some point in their lifetime[3]. One in four children live with a mother or caregiver experiencing IPV,[4] and nearly one in four adolescent girls have been in a relationship where they experienced violence from their intimate partner.[5]

Since democracy, South Africa has introduced a comprehensive statutory framework aimed at upholding and protecting the rights of women and children. The Constitution ensures substantive equality – prioritising the rights of those who are the most marginalised, in particular women and children.[6] Section 12 of the Constitution states that *everyone has the right to freedom and security of the person, which includes the right to be free from all forms of violence from either public or private sources*. This means that both women and children have the right to be free from violence in the home, school and community including forms of violence inflicted by the state, such as state sanctioned acts of torture, cruel, inhuman, or degrading treatment or punishment.

This chapter seeks to answer the following questions:

- How are violence against women and violence against children defined globally and in South Africa?
- What is known about the extent of violence against women and children in South Africa?
- How are these forms of violence understood through the lens of intersectional feminist theory and a decolonial perspective?
- How do we understand the intersections of VAC and VAW across the life course?
- In what ways do VAC and VAW intersect?
- What are the implications for policy and practice?
- What are the conclusions?

What do we know about VAC and VAW in South Africa?

The first *National Gender-Based Violence (GBV) Prevalence Study* conducted by the Human Sciences Research Council (HSRC) estimates that lifetime prevalence of physical and/or sexual IPV experienced by women ages 18 and older was 24%.[7] This estimate is lower than the South African Demographic Health Survey which found 26% of women aged 18 years and older had experienced physical, sexual, or emotional violence by an intimate partner in their lifetime.[8] Violence by an intimate partner can also be fatal, with national estimates of intimate partner femicide (IPF) showing that South Africa remains the country with the highest recorded rate of IPF globally (5.5/100 000 female population), almost five times the global average.[9]

The *Optimus Child Abuse Study*, a dedicated child abuse study, reports that 42.2% of children had experienced some form of maltreatment (sexual, physical, emotional abuse or neglect), by an adult who was meant to be taking care of them.[10] Furthermore, 9,9% of boys and 14,6% of girls experienced lifetime sexual victimisation before the age of 18 years. It also found that 25% of children reported exposure to violence between parents and caregivers or experienced violence by parents or caregivers towards them in the household.[10]

Furthermore, community-based studies are showing that violence is far more prevalent. The *Birth to Thirty* Plus (Bt30+) study revealed that over 90% of the birth cohort were exposed to several forms of violence, including physical and sexual abuse, at some point in their lives.[11, 12]

Importantly, violence is rarely a once off experience. Instead early experiences or exposure to violence in the home can increase the risk for later vitimisation and perpetration either as a child or into adulthood,[13, 14] which is central to our understanding of the interconnections of violence across the lifecourse. Physical punishment and IPV are the most common forms of violence experienced and/or witnessed by children in the home.[7, 10] However, we are cognisant that psychological or emotional abuse is seldom measured in studies, rendering this form of violence relatively invisible. The Bt30+ found that nearly half of preschool children were reported to have experienced physical punishment by parents or caregivers, which included acts such as cargivers using their hand to smack or spank or slap the child, and the use of a belt or some other object, for

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many these forms of physical punishment was considered a form of discipline.[12]

How are these forms of violence defined?

The World Health Organization (WHO) categorises violence as self-directed, collective, or interpersonal.[15] Violence in the home is the most common form of violence experienced by women and children which forms part of interpersonal violence and includes intimate partner violence and child abuse/maltreatment by a caregiver or someone in the home.[16] The WHO defines IPV as behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.[15] IPV also involves emotional and psychological abuse used to intimidate, humiliate, control, and isolate one's partner from any relationships with others, including restricting or stopping possible access to help and this definition covers violence by both current and former spouses and partners.[5]

Violence against women

The definition of VAW is not embodied in a single piece of legislation. Key laws include the Domestic Violence Act 14 of 2021 (DVA) and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (Sexual Offences Act).[ii]

The DVA seeks to protect women from domestic violence (not just in relation to intimate partnerships) and defines domestic violence broadly to include abusive behaviours, including physical abuse (assault), sexual abuse (including rape), emotional, verbal or psychological abuse (including intimidation, harassment and stalking), and economic abuse (depriving a person of financial resources).[17] The law also acknowledges the impact on children exposed to domestic violence. The Sexual Offences Act broadly characterises sexual offences and extends the narrowly defined pre-1997 common law definition to include rape, sexual assault, sexual exploitation, sexual harassment, child pornography, incest, bestiality and necrophilia.

South Africa has drawn on the WHO definition to define VAW in the National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF) as any act of GBV that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[18] This definition refers to violence directed at a woman because she is a woman and takes a range of forms including but not limited to: intimate partner violence, non-partner sexual assault; trafficking, so-called honour crimes, sexual harassment and exploitation, stalking, witchcraft related violence, and gender related killings. However, in defining VAW as it relates to the intersections of VAC and VAW in this issue of the *South African Child Gauge* we will focus on IPV as the most common form of GBV experienced in South Africa, as most of the theorising on the intersection of VAC and VAW has been from this perspective.

Violence against children

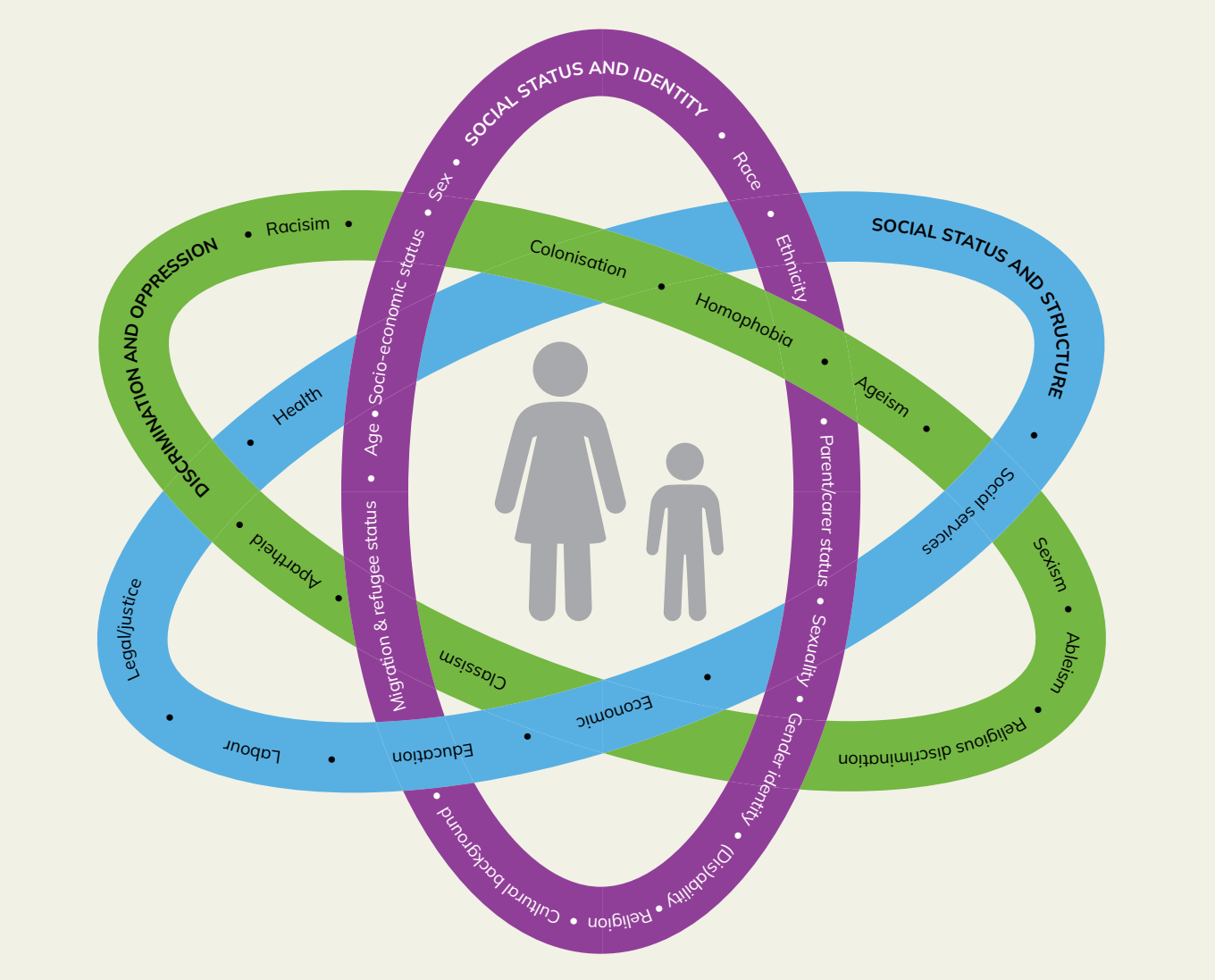
Article 19 of the United Nations Convention on the Rights of the Child (UNCRC) recognises the complexities of VAC and defines violence against children as "all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse".[19] The WHO 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" within the context of a relationship of responsibility, trust or power.[20] More recently UNICEF introduced an International Classification of Violence Against Children that includes operational definitions of all forms of VAC and covers interpersonal and collective violence, both in times of peace and during internal or international armed conflict.[21] These definitions cover situations where the parent or caregiver either commit the act of violence or fail to provide care resulting in potential or actual harm and can result in death of a child.[13] The above definitions outline the core components of VAC and highlight how violence extends beyond physical injuries to include emotional and psychological dimensions and can occur across a range of settings and relationships. VAC can extend from the home to the community and *vice versa*, for a child this experience is multi-layered and interrelated.

The Children's Act provides definitions for abuse, exploitation and neglect and outlines specific measures for their prevention, early detection and response.[22] Section 1 of the Act defines abuse as bullying, exploitation, physical, sexual, emotional or psychological harm. It also defines neglect as "a failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs" of the child. The Act further defines sexual abuse as sexual molestation, using a child for sexual gratification, deliberately exposing a child to sexual activity or pornography, or the commercial sexual exploitation of a child.

In addition, the Sexual Offences Act defines specific sexual offences targeting children including sexual exploitation, grooming, and child pornography.[23] It also imposes a duty

ii For a more comprehensive analysis of the legal and policy framework see page 113.

Figure 1: Intersectionality – how power, privilege, discrimination and oppression interact with violence against women and children



Adapted from: Ellsberg M, Fulu E, Warner X, Potts A, Dixit D, Ullman C. *Ending Violence Against Women and Girls: Evaluating a decade of Australia's development assistance.* Canberra: Department of Foreign Affairs and Trade. 2019.

on everyone to report sexual offences against children and regulates the inclusion of children's information in the National Register for Sex Offenders, while also eliminating the differentiation in the age of consent for consensual sexual acts between children and introduces special provisions for prosecution of such acts involving children between 12 and 16 years old.[23]

South Africa's legal definitions are thus aligned with the UNCRC's definition but they fail to consider the co-occurrence of VAC and VAW in the home. The Domestic Violence Amendment Act 14 of 2021 broadens the definition of domestic violence to include intentionally allowing a child to witness, hear or "experience the effects of domestic violence" acknowledging that witnessing violence has the same effect as experiencing violence. This broader definition of domestic violence suggests that women/mothers are responsible for ensuring the safety of their children and have the capacity to prevent them from being exposed to violence in the home (see page 129 for further discussion). But power and control often rests with male partners who may threaten to separate women from their children and legal remedies do not take these complexities into account.[24]

How do we understand the connections between VAC and VAW?

Patriarchy is a system in which men hold power and control over women and children.[25] It has a powerful influence over relationships within the family, as this is a setting where

dominant or hegemonic masculinities[iii] are constructed and maintained.[26] From a young age, children learn gender roles that reflect and perpetuate this imbalance. Women and children are undervalued, while men are accorded greater privilege and authority. In these settings, men may also use violence to subordinate women and children and to maintain control.

An intersectional feminist lens helps us understand the complex interplay between child abuse, motherhood and IPV, and how they are rooted in the power dynamics between men and women, and between mothers and children. For example, mothers' use of violence in the home can be seen as a manifestation of the ways in which they themselves have been victimised or oppressed as women and as mothers.[27]

Intersectional feminism also draws attention to the structural and historical roots of violence and discrimination, and how, over time, these power dynamics have given rise to deep-rooted inequities. It also centres the lived experiences of marginalised people – such as LGBTQI+ individuals, people with disabilities, and racial or ethnic minorities.[28] As it is only by addressing the specific experiences and challenges faced by these marginalised groups, that it is possible to identify and combat the structural inequalities that underscore and drive their experiences of violence (see Box 2). These challenges then intersect and reinforce each other in powerful ways where, for example, poor black women's experiences of discrimination and marginalisation increase their vulnerability to violence.

How does a decolonial perspective contribute to understanding the drivers of VAC and VAW in South Africa?

South Africa's extreme levels of gendered violence have their roots in a violent history of colonisation, imperialism and apartheid that created the social conditions that allowed various forms of gendered violence to thrive. The structural violence, restrictive laws and political oppression of these eras also gave rise to racially-defined hegemonic masculinities that promoted strength and dominance over women.[29]

Decolonial theory proposes that colonialism led white men to objectify, exploit and abuse colonised women while simultaneously denying it happened and blaming it on

iii Hegemonic masculinity is an idealised view of men and how they should behave within a given society and this cultural narrative of the 'ideal man' helps to normalise the dominance of men over women.

Box 2: Left behind and locked out: the urgent need to protect LGBTQI+ learners in South African schools

Juliana Davids[i]

To truly address the intersections of violence against women and children, it is essential to consider queer adolescents.[1] For LGBTQI+ learners across South Africa coming out or beginning a gender transition is not simply a personal milestone; it is an act of bravery undertaken in hostile terrain. Despite constitutional promises of equality, dignity, privacy, and bodily and psychological integrity, school environments are often unsafe for learners whose sexual orientation, gender identity, gender expression or sex characteristics (SOGIESC) do not conform to dominant norms.[72-74]

These learners often attend schools without gender-neutral bathrooms, safe reporting channels or inclusive sexuality education. They are subjected to ignorance masked as discipline, or silenced under the guise of "maintaining cultural values".[75, 76] Teachers, unsupported by policy, may ignore, enable or even perpetrate violence, whether through misgendering,[ii] moral shaming or refusal to protect LGBTQI+ learners from peer harassment.[73] The structural violence faced by these adolescents is compounded by the intersections of race, class, geography and language. While wealthier, urban schools may have access to external resources or more progressive governing bodies, many township and rural schools are still waiting for the Department of Basic Education (DBE) to provide the basic tools needed to create inclusive and affirming learning environments.[74] In this vacuum, it is often learners themselves, some as young as 13 or 14 years of age, who are forced to advocate for their own dignity, sometimes in the face of adults who question their legitimacy.

The consequences are not only emotional and psychological but developmental. Discrimination in school settings erodes self-esteem, increases risk of dropout and contributes to higher rates of depression, anxiety and suicide among LGBTQI+ youth.[77, 78] Schools should be places of safety and opportunity, not sites of trauma and exclusion. But without a nationally adopted, enforceable SOGIESC framework, South Africa continues to fail some of its most vulnerable children.

i Triangle Project
ii Misgendering: referring to someone (especially a transgender person) using a word, pronoun or form of address that does not reflect their gender identity.

colonised black men.[30] This colonial logic continues to influence the interplay of power and privilege through social and economic inequalities in our society which all contribute to the normalisation of violence in contemporary South Africa.

Apartheid has also had a profound effect on family life for women and children. The migrant labour system created an environment where large numbers of men worked away from their rural home and families for large parts of the year.[31] Many fathers were thus absent in the lives of their children and did not fulfil a meaningful parenting role.[32] In addition, patriarchal gender norms dictate that child-rearing is widely perceived as a women's domain, permitting men to be uninvolved in childcare even when they are present in the household.[32] Instead, fatherhood is primarily associated with the role of being a provider, and even in their absence, men maintain the role of decision maker and disciplinarian.

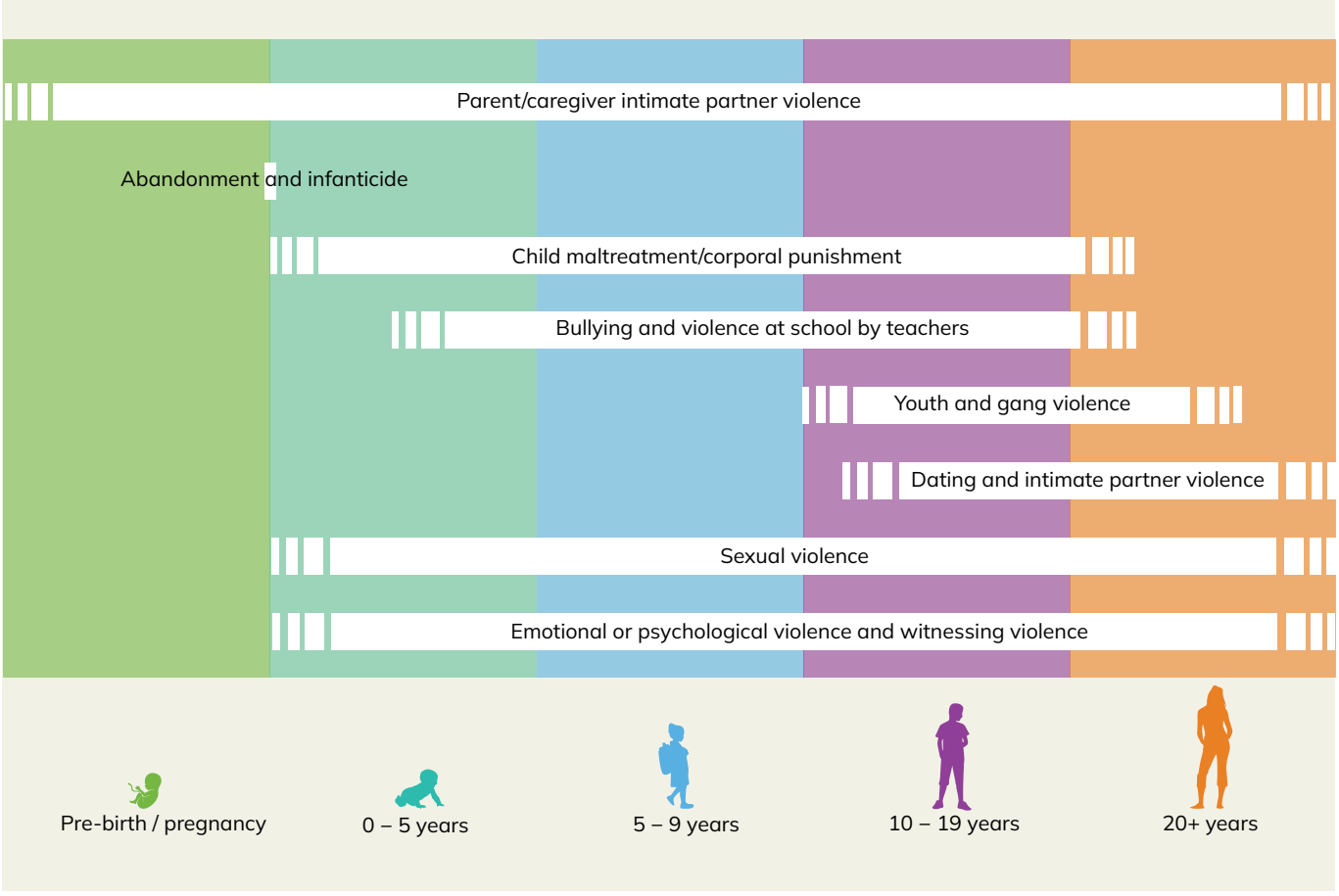
Single-parent families are widespread in South Africa, leaving women to carry a double burden of care, and the associated stresses of caring and providing for their children often results in harsh and inconsistent parenting practices.[33]

Violence across the life course

Women and children's experiences of violence is rarely a once-off experience. Instead, they can occur across the life course – with early childhood experiences of violence leading to an increased risk for revictimisation or perpetration of violence in adulthood.[34, 35] A life-course perspective is critical in understanding the intersections of violence against women and children as it highlights the prevalence of different forms of violence at different stages of life and how these types of violence reinforce one another across the lifespan.

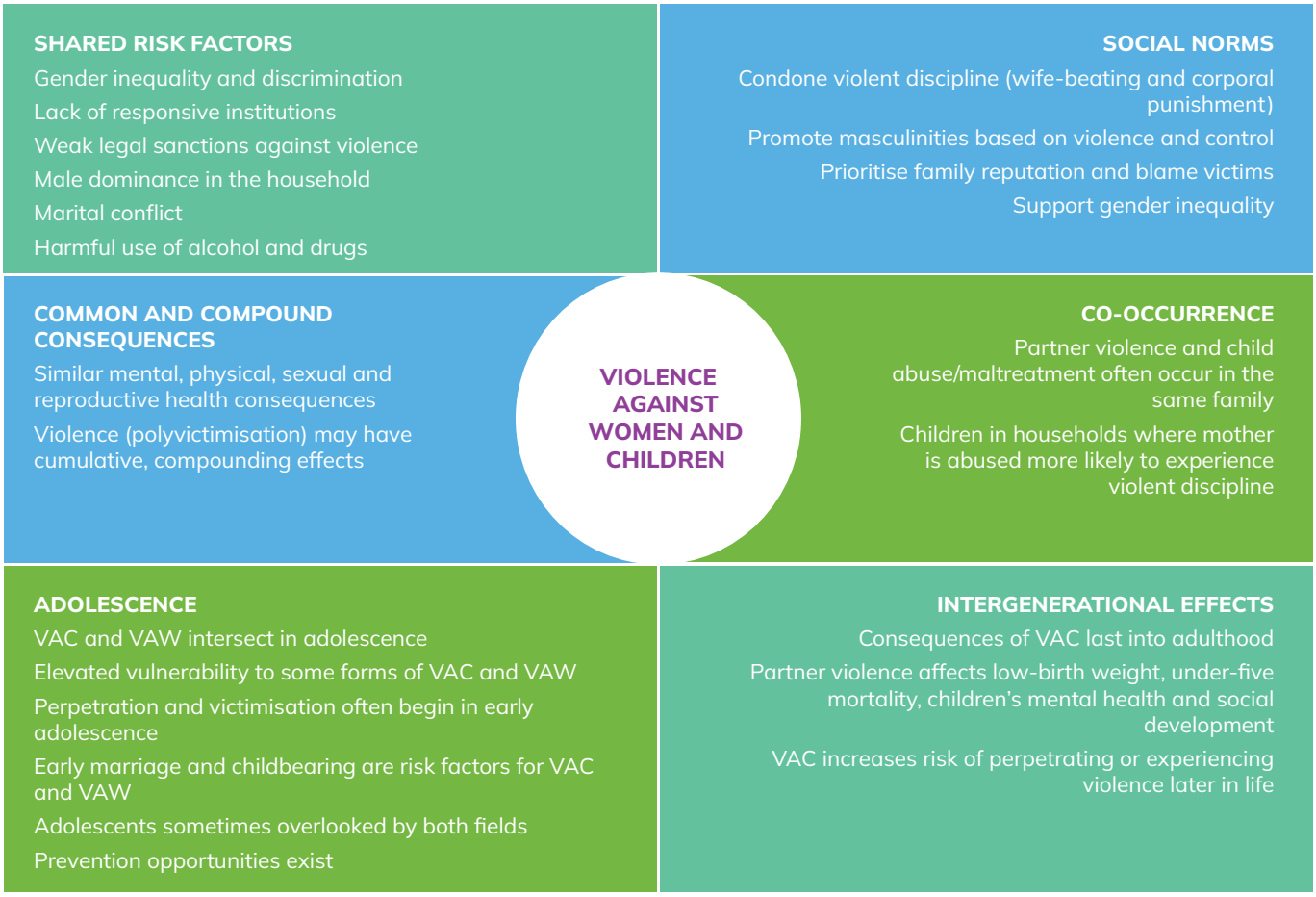
- IPV during pregnancy is associated with increased levels of depression, anxiety and stress, as well as suicide attempts, and poor maternal mental health can extend into the postpartum period compromising maternal-infant attachment and breastfeeding.[36] A longitudinal study found that IPV and the associated stress experienced by mothers during pregnancy can also affect foetal brain development and increase the risk of behavioural problems in children.[37]
- The co-occurrence of IPV and VAC in the home increases the risk for children to experience violent discipline by both male

Figure 2: Violence across the life course



Adapted from: Titi N, Tomlinson M, Mathews S, Jamieson L, Kaminer D, Seedat S, et al. Violence and child and adolescent mental health: A whole-of-society response. In: Tomlinson M, Kleintjes S, Lake L, editors. *South African Child Gauge 2021/2022*. Cape Town: Children's Institute, University of Cape Town; 2022.

Figure 3: Intersections of violence against women and children



Source: 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.

and female caregivers.[38] The Bt30+ study found that close to half of preschool children experienced physical punishment by their parents.[12]

- Violence against children, such as violent discipline and exposure to IPV in the home, increases the risk of children becoming either victims or perpetrators of violence[39, 40] and gives rise to an **intergenerational cycle of abuse** increasing the risk of young women becoming victims[41] and young men becoming perpetrators of IPV.[40] In addition, parents tend to reproduce their own experiences of being disciplined as a child, with those who experienced harsh and punitive parenting more likely to use corporal punishment on their own children.[42]
- Adolescence highlights the gendered pattern of interpersonal violence. Violence among boys rises sharply and male-on-male violence is the leading cause of death among adolescent boys aged 15 – 17 years.[43] Older adolescent boys are more likely to be the victims of homicide, while adolescent girls are at increased risk of sexual and IPV (dating violence) – with one in three adolescents girls in community surveys reporting forced sexual initiation.[44]

The social norms that underpin these practices, enable the transmission of gendered violence across generations.[14, 35, 45-47] A life-course perspective therefore allows for a better understanding of the pathways to victimisation and perpetration of violence – and how violence can be prevented.

Interconnection of violence against women and violence against children

There is growing evidence that VAC and VAW are interconnected. These forms of violence often co-occur in the same households, have shared risk factors and present in communities where the social norms promote the use of violence.[2] Guedes and colleagues identified six pathways through which VAC and VAW intersect. In the discussion below, five pathways are highlighted, as the common and compounding consequences have been integrated into our understanding of intergenerational effects of VAC and VAW.

Social norms

Social norms that condone violent discipline, promote violent masculinities and prioritise family reputation over safety and well-being of individuals, all underpin gender inequality.[48, 49, 50] Both forms of violence are pervasive in communities which condone the use of physical punishment of women and children and promote violent masculinities and gender inequitable relationships.[2] In South Africa, as elsewhere, prevailing social and cultural norms promote a gendered hierarchy with men in a superior position to women and children, where men's violence towards women and children is widely tolerated – and used to express masculinity, enforce gender norms and discipline children.[51] In this context, men's use of violence to control the behaviour of their female partners and children is associated with their search for respect and power.[52] Male-dominated households and marital conflict in the household have been found to increase the risk for physical punishment and child abuse.[38]

The co-occurrence of VAC and VAW in the household

VAC and VAW often occur within the same household and are fueled by shared risk factors and social norms. Investigating the drivers of VAC in South Africa, it was found that exposure to conflict and violence in the home increases the risk of a child becoming both a victim and perpetrator of violence later in life.[53] Exposure to violence in the home also normalises violent and coercive behaviours.

Intergenerational effects

Experiencing child maltreatment and witnessing partner abuse in the home as a child increases the risk of becoming both a perpetrator and a victim of sexual and intimate partner violence as an adult.[54] The intergenerational effect of VAC is also gendered. Exposure to childhood violence increases the risk for males to become a perpetrator of sexual and intimate partner violence and for females to become a victim of intimate partner violence.[38] The consequences of VAC extend into adulthood, while exposure to violence in the home has effects on school performance, risk-taking behaviour, mental health outcomes and long-term social and economic costs to society.[55] A South African study showed an association between sexual assault in childhood and increased risk of physical or sexual intimate partner violence in adulthood.[56] In addition, witnessing violence in the home was found to be associated with increased risk for perpetration of intimate partner violence.[53] Mental health (anxiety and depression) of mothers who experience IPV appear to increase their risk for harsh parenting practices, including physical punishment of their children with caring maternal relationships seen as an important protective factor for children living in households affected by partner violence.[57]

Adolescence

Adolescence is a period of heightened risk for both victimisation and perpetration. Adolescent girls are particularly vulnerable to multiple forms of gendered violence including sexual violence, dating or intimate partner violence and harmful cultural practices.[58] The pattern of youth violence highlights the risk of young men becoming both victims and perpetrators of violence, with devasting consequences such as death and long-term disability. The victim-perpetrator relationship shows that boys are more likely to be victims of peer-on-peer violence while for young women are more likely to experience dating violence during adolescence.[4] The heightened risk of these forms of violence can result in a cycle of interrelated consequences that are more common for girls than boys, such as HIV, unintended pregnancy, negative mental health outcomes, and school drop-out, among others.[59] Furthermore, adolescence is a critical development stage for the onset of mental health problems and if unaddressed young people are at increases risk for delinquency, peer aggression including dating violence perpetration.

Shared risk factors

VAC and VAW are driven by a web of interrelated factors such as childhood trauma, negative role-modelling during childhood, increased likelihood for victimisation (females) and for perpetration (males), and the displacement of aggression, all of which become pathways through which these intersecting forms of violence manifest.[26] The most common risk factors that drive VAC and VAW include gender inequality, male dominance, relationship conflicts and harmful consumption of alcohol.[2]

- *Food insecurity* is another contributing factor. It increases stress and tension within households. while the pressure on men to fulfil their role as providers can leave men feeling angry and frustrated and more likely to inflict violence on their intimate partners. For example, a 2019 study of men in a peri-urban settlement near Johannesburg found that food insecurity doubled the odds of them perpetrating IPV.[60]
- *Gender inequality* manifests in multiple ways. It underpins the use of violence in the home, promotes violent and controlling behaviours of men over women, and allows violence to be normalised and tolerated.[52] The power imbalances that drive IPV also influence the power dynamics between parents and children, with violence used to assert dominance over both women and children.[38]

Box 3: Girls and young women with disabilities – Opportunities for support and violence prevention

Jill Hanass-Hancock and Bradley Carpenter[i]

Gender-based violence (GBV) disproportionately affects women and girls with disabilities, who often experience multiple and intersecting forms of violence, including intimate partner (IPV), non-partner and caregiver abuse. In fact, women with disabilities are twice as likely to experience IPV compared to their peers without disabilities, and this risk increases with the severity of the disability.[82]

Some forms of violence are also disability-related.[83] Disability-related violence (DRV) encompasses physical abuse, neglect, sexual exploitation, financial abuse, coercion and psychological mistreatment, often stemming from the belief that people without disabilities are superior.[83, 84] DRV can take many forms, including name-calling, disability shaming, physical rejection (such as slapping or pushing), withholding essential assistance or equipment, restricting movement or manipulating medications.[83-86]

Evidence also suggests that some perpetrators view women and girls with disabilities as easy targets, assuming that they will not be believed or are unable to report violence against them.[83, 84] Violence occurs in both institutional and private settings, with individuals with disabilities at heightened risk due to their reliance on others for care and support.[83, 86]

Women and girls with disabilties also experience barriers in seeking healthcare and reporting violence against them, this includes: not being aware that violence against them is a problem or where to get help; fear of not being believed, facing further violence or losing caregiver support; lack of confidentiality; reliance on abusive partners/family for clinic visits; and communication barriers, especially for Deaf women without sign language interpretation.[83, 84]

In other words, women and girls with disabilities face higher risks, more severe violence and greater obstacles to disclosure and support than their peers without disabilities. Disability-inclusive GBV policies, staff training, caregiver support and accessible reporting systems are therefore urgently needed.

Strategies for caregivers

- Create a supportive environment where issues can be discussed.
- Promote autonomy, including expressions of likes and dislikes and consent to different activities.
- Ensure privacy and choice, in particular when a person with disabilities accesses care and support.
- Train yourself in disability-sensitive communication and violence prevention.
- Remain vigilant about potential abuse, including from yourself and other caregivers.

Strategies for schools

- Ensure the school provides comprehensive sexuality education (CSE) that is accessible to learners with different types of disabilities.[87]
- Collaborate with local clinics to ensure referrals to clinics that are accessible and trained to accommodate people with disabilities.

Strategies for healthcare workers

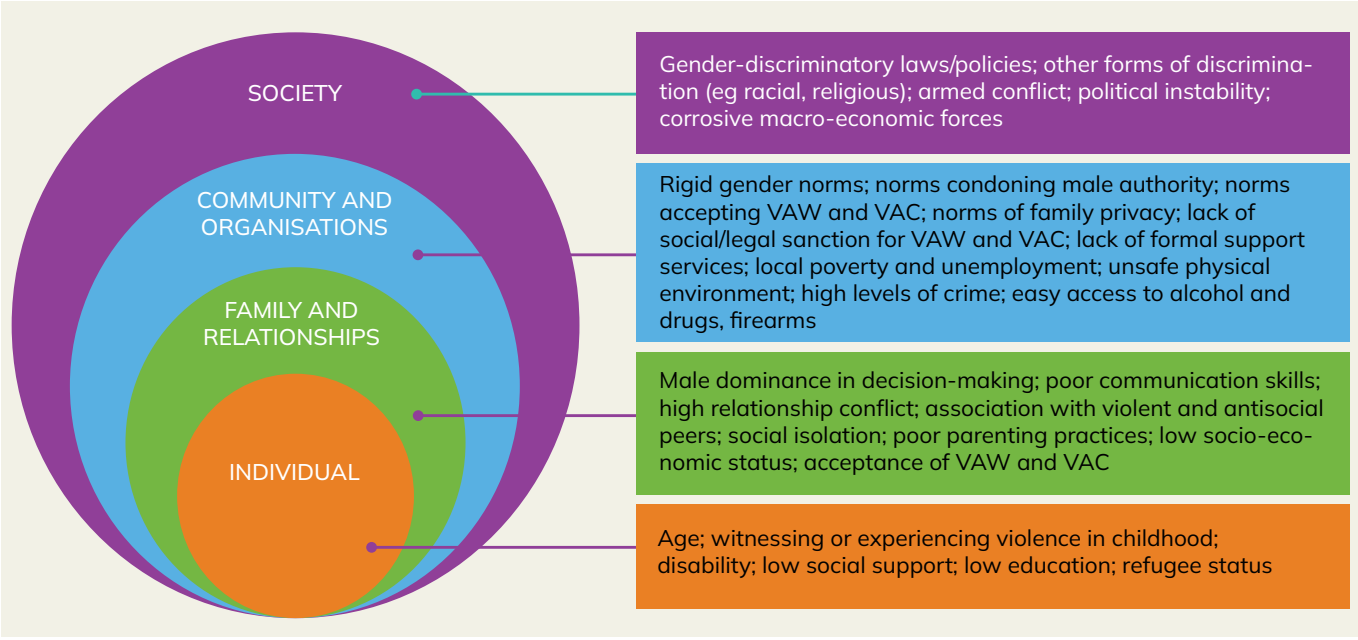
- Ensure that healthcare workers know how to work with people with disabilities.
- Collaborate with local organisations and schools serving people with disabilities to facilitate referrals and develop accessible services.
- Conduct a disability audit at the clinic to identify gaps and ensure more inclusive and accessible care.[88, 89]

i Gender and Health Research Unit, South African Medical Research Council

- *Male dominance* in the household is underscored by patriarchal masculine ideals and influences parenting, with the use of harsh parenting practices by both men and women strongly associated with IPV in the home.[38] In addition, parenting practices are particularly gendered during adolescence with boy children less likely to have their whereabouts, companions and activities monitored and this has been found to be a strong predictor of behavioural problems.[42]
- *Partner conflict* manifests in aggressive and coercive behaviours and violence against women in intimate partnerships, affecting parent-child relationships and increasing the risk of children being victims of violence.[61]

IPV is associated with men's harmful alcohol use and that in turn increases women's alcohol use.[53] In South Africa, harmful consumption of alcohol was also found to increase the risk of dating violence during adolescence as a period of heightened risk.[62]

Figure 4: Shared risks for violence against women and against children



Source: Delany A, Mathews S & Berry L. *Preventing Volence Against Women and Violence Against Children: A toolkit for practitioners.* University of Cape Town. 2025.

Socio-ecological model

The social-ecological model has been used as a framework for understanding the complex drivers of violence, by drawing on the work of Bronfenbrenner[63] to identify risk and protective factors at the individual, relationship, community and societal levels. The goal is to understand how factors operating at different levels of the system interact in complex way to influence people's behaviour in order to design interventions that can prevent VAC and VAW.

What are the implications for policy and practice?

Since democracy, South Africa has introduced a comprehensive statutory framework aimed at upholding and protecting the rights of women and children. South Africa has adopted and incorporated various international legal instruments aimed at protecting women's and children rights that has shaped the country's policies and legislation. For example, women's rights in the family to be protected from violence by an intimate partner are protected by the DVA. The DVA also provides mechanisms for victims of domestic violence to obtain a protection order, for the arrest of the perpetrator, and for police protection to prevent further domestic violence. The Act also requires the police to refer women and children to shelters.

The Children's Act provides the foundation for prevention and early intervention programmes to prevent violence as well as a system to identify, refer, support, care for and rehabilitate children who have suffered violence. The Criminal Procedure Act 51 of 1977 and the Sexual Offences Act establish and regulate the criminal justice system responsible for arresting, prosecuting, convicting and sentencing perpetrators of sexual violence against women and children.

Although South Africa has drafted a progressive set of legislation to combat violence against women and children, there is limited improvement in the response to and implementation of this legislation.[64] For example, only one in every three rape cases are reported, with only one third of reported cases getting onto the court role and less than 10% of cases resulting in a conviction – this figure is far less for children.[39]

Failures in the system to protect women and children resulted in activists calling on President Ramaphosa to urgently address the high rates of rape and murder of women and children.[65] This culminated in a landmark Presidential Summit on Gender-Based Violence and Femicide in November 2018 and the establishment of an interim steering committee that led to the development of a National Strategic Plan to address Gender based violence and Femicide (NSP-GBVF). The NSP-GBVF is "a multisectoral, coherent strategic policy and programming framework drafted to facilitate a coordinated national response to the crisis of gender-based violence and femicide by the government of South Africa and the country as a whole".[18] The NSP-GBVF aims to strengthen accountability and coordination of sectors (government, civil society and academia) through the implementation of the framework and provision of key interventions targeting the drivers of GBV. While the NSP was

Box 4: Gender transformative programming

Shanaaz Mathews[i]

Gender transformative programming aims to challenge unequal gender and power relations and promote gender equality in order to support violence prevention outcomes.[79] Gender transformative programmes may include participatory processes that encourage critical and personal reflection about gender roles, norms and inequalities; and that promote positive, more equitable behaviours and norms.[80] This approach focuses on:

1. Addressing gender inequalities, power imbalances, norms and dynamics and paying attention to the intersections between gender, race, age, ethnicity, religion, etc.
2. Strengthening norms that support gender equality to create more inclusive, enabling environments
3. Promoting the relative position of girls, women and marginalised groups
4. Transforming underlying social structures, policies and norms that perpetuate and legitimise gender inequalities.

Generally, this approach aims to move beyond a focus on individual girls and women towards redressing power imbalances that reinforce inequalities based on gender, race, ethnicity, etc. Such efforts often require participation and leadership by local actors at community level.[81] Evidence suggests addressing gender inequalities is an effective characteristic of effective violence prevention programming.

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conceptualised to address violence against both women and children an analysis by the Centre for Child Law reveals that children are a subsidiary focus.[66] This is a missed opportunity to provide an integrated framework that targets the intersections of violence against women and children at the highest level.

The need for an integrated response

The World Health Organization has developed the RESPECT [67] and INSPIRE[68] frameworks grounded in the principles of human rights and gender equality. Both frameworks contain a set of evidence-based action-oriented steps enabling policymakers and programme implementers to design, plan, implement, monitor and evaluate interventions and programmes to prevent violence against women and children. The INSPIRE framework keeps children at the centre while the RESPECT framework focuses on strategies to end violence against women and girls.

The evidence is clear that violence is preventable, but it requires us to ideally implement prevention programmes that reach the most vulnerable early.[69] The prevention to response continuum is important to consider as prevention and response efforts are both essential and interlinked – but their timing and purpose differ.[70] Preventing violence means stopping violence before it starts or reducing the frequency and severity of further

Figure 5: International strategies to end violence – how do INSPIRE and RESPECT compare

INSPIRE: End violence against children		**RESPECT**: Prevent violence against women
Implementation and enforcement of laws	→	Put in place and facilitate enforcement of laws and policies*
Norms and values	→	Transformed attitudes, beliefs, and norms
Safe environments	→	Environments made safe
Parent and caregiver support	→	Child and adolescent abuse prevented
Income and economic strengthening	→	Poverty reduced
	→	Empowerment of women
Response and support services	→	Services ensured
Education and life skills	→	Relationships skills strengthened
Multisectoral collaboration	}	Coordination and partnership across sectors
Monitoring and evaluation	}	Strengthen monitoring and evaluation systems

Source: UN Women and Social Development Direct. *RESPECT: Preventing violence against women. Strategy summary.* P. 2.2020.

episodes of violence where it has previously occurred. By contrast, response is about providing services and support to individuals who have experienced violence. The public health approach to violence prevention categorises prevention efforts as primary, secondary or tertiary prevention depending on the timing of the intervention (see Figure 6).

- **Primary prevention** aims to target interventions before an individual has experienced an incident of violence and can be either universal or targeted. Universal primary prevention programmes are aimed at an entire population or group. For example, community mobilisation or activism to change harmful social norms. In contrast targeted or selective prevention programmes are targeted at specifc groups or individuals considered to be at higher risk.
- **Secondary prevention**, also known as selective prevention, aims to detect violence early and directs programmes at high risk groups. This includes, for example, support for vulnerable teenage parents and substance abuse programmes targeting individuals or families already experiencing violence.
- **Tertiary prevention** includes response programmes that aim to meet the immediate and long-term needs of survivors of violence to promote recovery and to limit the impacts of violence. Such programmes can also focus on strengthening institutional capacities to provide more accessible and quality services to women and children.

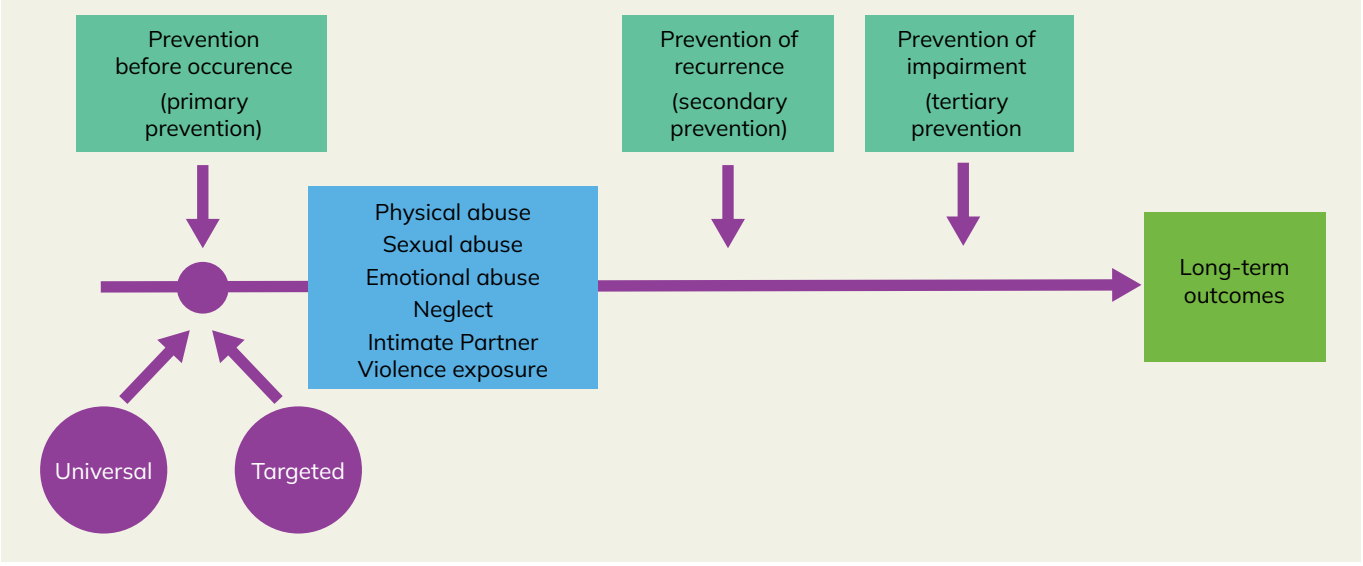
The evidence of what works to prevent violence against women and violence against children through joint programming is still an emerging area. The most recent systematic review[71] identified only 30 unique interventions from 16 countries that targeted IPV with outcomes in both. And of these, only 20 interventions targeted both IPV and VAC in their design. The majority of the interventions (n=19) focused on primary prevention and included community-based, school-based and couples interventions, parenting programmes and cash transfers. The remaining 11 interventions were response interventions, but they were mainly from high income countries and focussed on psychotherapeutic programmes for IPV survivors and their children, therapeutic programmes targeting male perpetrators, and improving practitioner knowledge and coordination.

Baccus and colleagues argue that programmes need to transform harmful gender norms and move beyond a focus on parenting and couples to include the community in order to achieve a sustainable reduction in violence.[71] This includes an emphasis on gender transformative programmes that challenge and transform unequal power relationships (see Box 4). There is still an urgent need to expand our evidence of promising approaches to prevent VAC and VAW in low and middle income countries such as South Africa as this is critical to move the field forward, with the potential for greater impact.

Conclusion

Understanding what works to prevent violence against women and children is still an emerging field, but we do know that these problems intersect in ways that have long-lasting effects that require us to carefully consider whether programming can be strengthened to address these problems jointly. The evidence

Figure 6: The prevention continuum



Adapted from: MacMillan HL, Wathen CN, Barlow J, Fergusson DM, Leventhal JM, & Taussig HN. Interventions to prevent child maltreatment and associated impairment. *The Lancet, 373*(9659), 250-266. 2009.

has shown that we need a broader approach than survivor-centred responses that includes preventative interventions to address the multiple risk factors that drive VAC and VAW. Adopting a life-course perspective allows us to understand that violence is not a once-off occurrence. Instead it often drives an intergenerational cycle of violence. In addition, the long lasting intergenerational psychological effects of both these forms of violence require us to also consider integrating a trauma-informed approach in programming (see Box 6). This requires us to integrate an understanding of the impact of trauma on mental health, and to identify and respond as early as possible to the signs and symptoms to limit the long-term negative consequences of VAC and VAW. Programmes have shown great potential to address the prevention of both VAC and VAW simultaneously, but this has to be planned for and carefully considered. The evidence has also shown us that there is great potential to enhance the impact of programmes by addressing these intersections in the design phase. Social norms remain a key driver underpinning both violence against women and violence against children therefore integrating a gender transformative approach is key to reduce both forms of violence.

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Getting it right from the start: Violence prevention for women and children in the first 1,000 days

Aislinn Delany,[i] Phiwe Babalo Nota[ii] and Wiedaad Slemming[ii]

> *"Breaking this vicious cycle [of violence] – for the child, the adult and for society – requires that every child lives free from all forms of violence from the very start."*
>
> *Office of the Special Representative of the Secretary-General on Violence against Children*[1]

Everyone has the right to live free from fear, harm, and violence. Yet, exposure to violence often begins early – in pregnancy and the first few years of life. It is therefore vital to intervene early to address risk factors for violence when they first emerge, to improve children's health, education and social outcomes. Preventing violence in early childhood can also help interrupt the cycle of violence across the life course and across generations.

The early years provide a unique opportunity to strengthen protective factors – such as secure caregiver-child attachment, maternal mental health and social support networks – to promote the safety, resilience and well-being of both women and children.

There is increasing evidence that violence against women and children in the home share common risk factors, are closely connected and can reinforce each other.[2] It is therefore crucial to adopt an intersectional approach and to develop effective prevention strategies that address the family or household as a whole, and not just women or children in isolation.

Effective violence prevention also requires collaborative efforts that bring together a range of sectors – health, social services, education, justice and community-based systems – to address the underlying drivers of violence. Within this multisectoral approach, the health sector plays a pivotal role through the provision of a range of maternal and child healthcare services. These routine contacts with pregnant women, caregivers, infants and families offer entry points for preventing violence and promoting safe and supportive family environments.

This chapter explores the opportunities for integrating violence prevention strategies into health services for women and children in the first 1,000 days of life. It focuses on the first 1,000 days – from conception until the child's second birthday. This is for two reasons: first, to emphasise the importance of early intervention during this rapid period of development, when the benefits of intervention are amplified;[3] and second, to align with the 2015 National Integrated Early Childhood Development Policy (NIECD Policy), which mandates the health sector with the responsibility for providing services to vulnerable children under two years and their families[4]. While the focus here is on the first 1,000 days, it is important to sustain multisectoral violence prevention efforts across the life course.

The chapter highlights how both women and children are particularly vulnerable to violence during this period. It provides a brief overview of strategies that are recognised to be effective in preventing violence against women and children; and then explores how these can be integrated and strengthened within health services.

The chapter focuses on child maltreatment and intimate partner violence (IPV). IPV is the most common form of violence experienced by women,[5] although other forms of gender-based violence during the first 1,000 days, including obstetric violence,[6] may intersect with IPV and increase women's vulnerability.

Why is it important to prevent violence in the early years?

Pregnancy and the first few years of a child's life hold enormous promise for shaping lifelong health and well-being, offering a unique opportunity to support safe, nurturing environments. Yet it is also a time of heightened vulnerability for both women and children, with stresses that can increase the risk of violence and long-term harm.

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Table 2: Examples of risk and protective factors for violence in the first 1,000 days

Risk factors	Protective factors
• Age and developmental capacity • Disability • Pregnancy • Witnessing or experiencing violence in childhood • Attitudes and social norms that condone violence, including physical punishment • Harmful gender norms, including around who is responsible for caring for infants • Low socio-economic status, financial and food insecurity • Poor caregiver mental health • Unprocessed trauma and anger • Misuse of alcohol and/or drugs • Limited social support • Limited access to services	• Strong attachment and bonding • Responsive caregiving • Understanding of infants' needs and development • Greater gender equality in intimate relationships • Shared caregiving for infants, toddlers • Support system to assist families with responsive care • Empowerment and support for women, including income support and economic empowerment • Support and accountability for men • Support services (screening during antenatal care, well-baby services, parent support groups etc.) • Safe environments for infants, women

Pregnancy and the first years of childhood lay the foundation for healthy growth, learning and development. Secure and nurturing relationships between an infant and his or her caregivers build a sense of security and resilience.[7] In contrast, exposure to violence in the home in early childhood – whether experienced directly or witnessed – can have profoundly negative and lasting consequences.

The brain undergoes rapid growth and organisation in early childhood, and exposure to violence can disrupt the architecture of neural circuits in the brain, with long-term consequences for the child's ability to manage emotions, think, and connect with others[8] (see Box 5). It also increases the risk of children experiencing and/or perpetrating violence later in life, feeding into intergenerational cycles of violence.[5, 9, 10] While these impacts are not specific to the first 1,000 days, infants are especially vulnerable to child maltreatment in the home because of their dependence on caregivers and limited interaction with others outside the home.

This is also a period of increased stress and vulnerability for women, with a heightened risk of IPV.[11, 12] A 2015 longitudinal study in Durban found that more than 20% of the women in their sample experienced at least one act of physical, psychological

Box 5: Violence, toxic stress and the developing brain

Kirsten A Donald[i]

The first 1,000 days of life are a sensitive window when the brain grows and develops at the greatest rate of any time during the whole human lifespan. During this period, exposure to violence or neglect may cause emotional harm, but also may alter biology in ways that can become embedded and difficult to change.[43]

Violence towards a mother in pregnancy activates her stress response, raising cortisol levels that cross the placenta and shape foetal brain development.[44] After birth, witnessing or experiencing violence triggers the infant's own fight, flight or freeze response. While short bursts of stress hormones protect in moments of danger, repeated exposure can keep the body chronically on high alert.

In early life, such chronic stress reshapes the brain's set-points, altering the growth patterns and connections of important areas of the brain that are responsible for managing fear, memory and impulse control. These changes can leave a child less able to learn or regulate emotions, predisposing them to poorer cognitive and health outcomes across the life course.[45]

The consequences can be both immediate and long-term. Children exposed to violence show higher rates of emotional difficulties, school struggles, asthma, infections and later chronic disease.[46] In the longer term, trauma in the early years may fuel a cycle of violence: those who experienced multiple forms of childhood violence are more likely to be involved in violent relationships as adults, either as victims or perpetrators.[47] Early intervention offers the chance to break intergenerational cycles and support healthy brain development.

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or sexual IPV during pregnancy, and nearly a quarter of the women had at least one such experience during the first nine months following childbirth.[13]

Pregnancy can trigger or worsen violence in relationships, including among teens, often due to changes in power dynamics, financial stress or a partner's perceived loss of control.[14] This violence harms both mother and child, causing physical and mental health challenges for women such as depression, anxiety, post-traumatic stress disorder and chronic pain.[15] Violence during pregnancy also increases the risk of miscarriage, premature labour and low birth weight.[13] These impacts can impair a woman's capacity to care for her child, disrupting bonding and attachment and increasing the risk of child maltreatment.[10]

What are the risk factors for violence in the home during the early years?

Historically, violence against women and violence against children have been treated as distinct and separate issues, with limited attention paid to how they intersect or influence one another. But recent research highlights that these forms of violence often co-occur within the same households and share the same risk factors.[2]

Examples of shared risk factors for women and children include gender inequality and discrimination, male dominance in the household, marital conflict, harmful use of alcohol and drugs, a lack of responsive institutions and weak legal sanctions against violence.[2]

Some risk factors for violence may be more pronounced at certain stages of life. In the early years, attachment and bonding are crucial for building secure relationships that promote resilience and reduce the likelihood of child maltreatment.[7] Poor caregiver mental health can be both a cause and consequence of violence, while strong social support and attention to caregiver mental health can serve as protective factors for both women and children. More gender-equitable caregiving for babies and young children can also help to reduce risk.[16] The misuse of alcohol and drugs is another risk factor that can

Table 3: Nurturing Care Framework

NCF domain	Links to violence prevention	Interventions
Good health	• Physical and mental ill health in the home can increase stress, increasing the risk of violence. Alcohol and substance use are risk factors for violence, while mental health concerns are both a risk factor for and consequence of violence.	• Health services (antenatal and postnatal care) are key entry points for identifying and responding to violence. • Health workers can be trained to screen for substance abuse, mental health and violence, provide immediate care and refer for further support.
Adequate nutrition	• Food insecurity and financial stress are risk factors for both IPV and child maltreatment.	• Income support (of sufficient value) can improve food security and reduce financial stress and dependency. • In Tanzania, a programme that combined nutrition and parenting interventions that actively involved fathers was found to reduce mothers' exposure to IPV.[20]
Responsive caregiving	• Responsive caregiving helps prevent violence by strengthening emotional bonds, supporting emotional regulation, reducing caregiver stress and modelling non-violent behaviour to create safe and secure environments for both children and adults.	• Gender-transformative parent and family support programmes that promote responsive caregiving as well as care for the well-being of caregivers; actively engage men as well as women; and challenge harmful gender and social norms have been shown to reduce both IPV and child maltreatment. • Such interventions can include peer support groups, home visits and curriculum-based programmes.
Safety and security	• Providing safe, stable and nurturing environments free from physical and emotional harm is core to violence prevention.	• Interventions include ensuring access to safe housing and communities for women and children.
Early learning	• Stimulating environments provide protection by promoting healthy child development and reducing the risk of neglect, abuse or isolation. Engaging with caregivers can offer needed social and emotional support.	• Childcare or early learning programmes that promote non-violence through engagement with caregivers can contribute to violence prevention both within these settings and at home.

exacerbate violence in the home[2, 17] and can contribute to foetal alcohol syndrome in infants.

Understanding risk and protective factors outlined in Table 2 can help identify opportunities for prevention. This includes efforts to address the underlying risks or drivers of violence and strengthen protective factors.

Why integrate violence prevention strategies for women and children in the first 1,000 days?

Given the lasting impact of early adversity, there have been calls for integrating violence prevention and early childhood development (ECD) services.[18, 19]

Nurturing care for infants starts in the home, with parents and caregivers playing a central role in creating safe and loving environments (see Table 3). This is emphasised in the 2018 Nurturing Care for Early Childhood Development Framework,[7] which also highlights the important role of health systems in promoting and supporting nurturing care for young children.

In South Africa, the package of services to support the holistic development of infants and young children is defined by the NIECD Policy. The policy recognises the health sector's ability to reach pregnant women, new parents and caregivers, and young children, and it designates the Department of Health – in close collaboration with the Departments of Social Development and Basic Education – as responsible for services to children under two years. The policy expands the health sector's role beyond its traditional focus on delivering health and nutrition programmes for pregnant women, new parents and children to include parenting support and the promotion of learning and play opportunities for children from birth to two years, offered through health facilities and home visits by community health workers for those at risk of poor developmental outcomes.[3, 4]

The NIECD Policy acknowledges the importance of preventing violence in early childhood but does not identify violence prevention as a priority. Other recent policies with an explicit focus on violence prevention – such as the National Child Care and Protection Policy (2019), the National Strategic Plan for Gender-based Violence and Femicide (NSP-GBVF, 2020), and the Integrated Crime and Violence Prevention Strategy (2022) – have a stronger focus on the need to start prevention efforts in early childhood, recognising that early exposure to violence affects outcomes later in life.

For example, the prevention pillar of the 2020 NSP-GBVF includes integrating non-violent and gender transformative approaches into evidence-based parent support and ECD programmes.[21] The NSP-GBVF tasks the Department of Health with providing services to survivors – such as immediate care, mental health support and the collection of forensic evidence – but also identifies a role in prevention. This includes training health workers in gender-based violence prevention; incorporating violence prevention into substance abuse, sexual and reproductive health (SRH), and HIV prevention interventions; and equipping lay mental health workers to provide community level support.[21]

South Africa's policy framework recognises the importance of starting violence prevention early in the life course, and the role of the Department of Health in advancing this through antenatal, postnatal and child health visits in the first 1,000 days. But there has been less focus on how to use these services as an entry point to support both women and children by identifying interconnected risks, providing care and facilitating referrals to additional support services.

What do we know about what works to prevent violence?

Two global frameworks – INSPIRE[22] and RESPECT[23] – identify evidence-based strategies for preventing violence against children and violence against women, respectively. Both are built on public health approaches to preventing violence and apply evidence-based, population-level strategies to address risk and protective factors across the life course highlighting the importance of multisectoral collaboration.

Selected strategies from these frameworks that are relevant to the early years include:

- **Challenging harmful social and gender norms.** This includes addressing beliefs that caregiving is solely a woman's responsibility, that men should not be involved in early childcare, that children need to be punished physically to learn, or that women should tolerate abuse to keep the family together. Interventions that promote shared caregiving, positive discipline and equal decision-making within households help shift these norms and reduce violence against both women and children.[24] Gender-transformative programmes that engage fathers of young children and their partners – such as Bandebereho[25] in Rwanda (see Case 1) and REAL Fathers[16] in Uganda – have shown positive results in shifting attitudes and behaviours and reducing IPV against women and violence against children.
- **Parent and caregiver support** is especially important for vulnerable families in the early years. This support can be provided through antenatal support groups, parenting or family support programmes, couples programmes, or initiatives targeting new fathers – all aimed at supporting caregivers and fostering healthy relationships. A key lesson emerging from programme evaluations is that engaging both women and men is more effective in reducing IPV than

Case 1: Bandebereho – Working with men and their partners

The Bandebereho programme in Rwanda is a gender-transformative programme that works with fathers of young children to prevent violence in the home.[25] The programme was adapted to the Rwandan context from Program P and implemented by the Rwanda Men's Resource Centre and Equimundo. It engages men and their partners to promote reproductive, maternal and child health, men's caregiving and violence prevention. It uses fatherhood as an entry point to promote gender equality and encourage positive changes in men's relationships with their partners and children, shifting underlying power dynamics.

During the first randomised control trial, fathers of young children and soon-to-be fathers attended 15 small group sessions led by trained peer facilitators (fathers). The sessions consisted of critical reflection, discussion and skills-building, and their partners attended eight of the sessions. Local health providers and police participated in selected sessions, and the programme also trained health providers and sponsored community-level activities or campaigns.[41] These sessions aimed to transform harmful gender attitudes and promote more equitable, caring and non-violent relationships.

The randomised controlled trial evaluation found that Bandebereho substantially reduced rates of intimate partner violence and harsh punishment against children, even six years after the intervention.[25] The emphasis on working with men and women to challenge inequitable norms, build skills and improve the quality of both couple and parent–child relationships is seen as critical to the lasting reductions in violence.[25] The focus on the transition to fatherhood – a time when men and their partners are more likely to be open to change – is also likely to have contributed to the lasting effects.[25]

Bandebereho is currently being scaled up and institutionalised in the health system, in partnership with the Rwandan government, through the training of community health workers to deliver the programme as part of their routine work.[42]

working with women or men in isolation,[26] and that parent support programmes that overlook IPV may be less effective in reducing violence in the home.[27]

- Other key strategies include creating **safer physical environments** (see Case 14 on p.93), addressing structural drivers of violence such as poverty through **income support and women's economic empowerment,** and ensuring access to **effective response and support services** to prevent the recurrence of violence and mitigate its impact.

While these strategies may not initially appear to be health system interventions, they are integral to a public health approach that prioritises preventing violence rather than only responding to its effects.

What are the opportunities for strengthening violence prevention in the first 1,000 days?

The health sector has frequent contact with pregnant women and young children and therefore has the potential to serve as a gateway to help women and children access services and support from other sectors. There are clear entry points for integrating violence prevention into health sector services during the first 1,000 days, either through the direct actions of health workers or by using health facilities as platforms for delivery.

Some interventions can be embedded within the health system, while others involve referrals to other services as part of a multisectoral approach.

- Antenatal and postnatal clinic visits for well-baby care and immunisation offer opportunities to **strengthen screening** for substance abuse, mental health problems and exposure to violence. South Africa's National Integrated Maternal and Perinatal Care Guidelines[28] support screening in all three areas. Rather than universal screening for IPV or child maltreatment, the World Health Organization advises that health workers assess for violence when risk factors or indicators of abuse are present.[29, 30] Risk assessments and safety planning in cases of IPV should also consider the needs and safety of children in the home, including those who witness domestic violence, and it is essential to ensure privacy and safety to support safe disclosure[29].
- **Training and capacity building** for health workers is crucial to ensure they can: screen for violence safely and sensitively, in line with clinical guidelines;[29] provide first-line support; and make appropriate referrals. This includes training on survivor-centred approaches, legal reporting requirements, managing the potential tensions between child protection and women's rights to privacy and autonomy, and navigating referral pathways to support services for women and children (see Case 2: Philisa)

- Since the inclusion of a chapter on **mental health** in the National Maternal and Perinatal Care Guidelines in 2024, there have been calls to strengthen training programmes to equip health workers with the skills needed to provide primary level mental healthcare.[31] This should be supported by clinical supervision, mentoring and investment in well-functioning referral pathways.[31]
- The revised **Road to Health Book** offers another opportunity to strengthen appropriate screening. Protection of children is a key pillar of the Road to Health Book, but it is currently focused on protection against preventable diseases and injuries.[32] The book also includes a section on children who need extra care in order to identify potential social risk factors,[33] but this does not specifically include violence in the home. A more explicit focus on violence could be incorporated but would need to be accompanied by training of health workers on the clinical guidelines, first-line support and referral pathways.
- Antenatal and postnatal care and well-baby visits also provide an opportunity to implement **gender-transformative strategies** that actively involve men by encouraging them to attend clinic visits and support their partners during childbirth or referring them to structured interventions that support men's own parenting journey (see Case 1 and Case 3).
- **Adolescent- and youth-friendly services** offered at clinics play a role in violence prevention by providing access to SRH services, which can empower young people to make informed decisions and reduce their vulnerability to sexual and gender-based violence. These services are particularly important for adolescent girls and teen mothers, who often face heightened risks of violence, stigma and exclusion. The NSP-GBVF calls for integrating and strengthening GBVF prevention components in SRH services.[21]
- **Public communication and community messaging initiatives** such as MomConnect and the Side-by-Side campaign offer opportunities to expand violence prevention messaging, promote engagement of fathers and challenge harmful gender and social norms. Messages can focus on violence prevention strategies, such as managing stress and anger, building healthy relationships, encouraging shared

Case 2: Philisa: Child protection services at Red Cross War Memorial Children's Hospital

Fatima Khan and Rowan Dunkley[i]

"Philisa" is a Xhosa word meaning "to be healthy, to heal, or to make someone feel well." This word forms the foundation of Philisa's mission: to bring healing and wholeness to every child, parent and family member affected by abuse and violence.

Established in 2023, the Philisa unit at Red Cross War Memorial Children's Hospital aims to provide holistic, trauma-informed care for children who have experienced any form of abuse. The objective is to empower and equip healthcare professionals to identify vulnerable children and families early on – allowing the healing process to begin from the very first encounter. Through targeted training and ongoing support, doctors' and nurses' confidence and competence in managing these complex and sensitive situations have significantly improved. A dedicated interdisciplinary healthcare team ensures each child receives the highest standard of care, always within the context of their unique social environment.

South Africa is among the most violent countries in the world. Since inception, Philisa has seen a troubling increase in all types of child maltreatment. One particularly concerning trend is the strong link between intimate partner violence and pediatric injuries. The youngest patient affected by such violence was a three-week-old baby caught in a domestic dispute. He sustained multiple injuries, including a traumatic brain injury and a femur fracture, after a cupboard was pushed and fell on both him and his mother. Further x-rays revealed fractures consistent with abuse occurring soon after birth. A coordinated, multidisciplinary approach – including both medical and surgical care – was crucial in managing his injuries.

Thanks to the dedication of the social work team and psychologist, Philisa was able to develop a safe, comprehensive discharge plan that prioritised the well-being of both mother and child. This included medical and neurodevelopmental follow-up, psychosocial support and integration with community-based resources to ensure continuity of care and long-term safety.

Despite the emotional toll of these cases, staff remain deeply grateful to play a role in protecting children and supporting their healing. It is hoped that through Philisa, each child touched by trauma is given a chance to feel safe, seen, and begin to heal.

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Case 3: Male partners' experiences of early pregnancy ultrasound scans in Soweto, South Africa

It is unusual for men in South Africa to attend antenatal visits. This is despite evidence that suggests that including fathers or male partners in perinatal programmes positively helps strengthen children's attachment,[i] emotional regulation[ii] and cognitive development.[39] Such interventions can also positively impact men's well-being and their relationship with the mother and child.[39]

The Healthy Pregnancy Healthy Baby Study in Soweto, South Africa, aimed to explore the experiences of male partners who attended early pregnancy ultrasound examinations.[40] Pregnant women attending ultrasound examinations were invited to bring their partners with them, and both completed questionnaires that included questions on antenatal attachment (the emotional bond that develops between a caregiver and the unborn child before birth). Based on a sample of 102 mother-partner pairs, the study found that participating in the ultrasound examination had a positive effect on men and their thoughts regarding their developing baby, with 30% stating that they were ready or excited to be a father. Twenty-eight percent believed their relationship with the mother was stronger as a result of participating in antenatal care.

Based on these findings, the researchers argue that health services in South Africa should accommodate partners/fathers and encourage them to attend antenatal care, including pregnancy ultrasound scans. Simple gender-transformative interventions such as this are needed to encourage more men to be involved from conception, potentially addressing individual, familial, societal and structural barriers to involvement of fathers in longer-term maternal and child care.

i Attachment can be understood as the emotional bond between an infant and his or her caregiver(s).
ii Emotional regulation is the ability to understand and manage our feelings.

childcare and decision-making, and promoting alternatives to physical punishment.

- The NIECD Policy envisions community health workers (CHWs) conducting **home visits** to vulnerable mothers[iii] and caregivers of young children to support maternal and infant health and optimal child development. These visits offer an opportunity to introduce gender-transformative strategies, provide first-line mental health support, promote responsive care of young children, and strengthen safe, nurturing relationships in the household beyond the mother and child. They also provide an entry point for referrals to evidence-based parent or family support services that consider both the couple's relationship and their relationship with their child(ren), and incorporate other mechanisms that have been found to reduce both IPV and child maltreatment, such as improving communication and conflict resolution skills, challenging harmful social norms, and increasing awareness of the impacts of IPV and child maltreatment on children.[27] Clinic- and community-based support groups for women or parents and-babies offer similar opportunities.
- The NIECD Policy also recommends **pre-delivery registration** for the Child Support Grant (CSG) to ensure that infants benefit from birth. While the CSG has demonstrated multiple benefits for children,[34] uptake remains lower among caregivers of younger children, especially those under one year.[35] Expanding antenatal care services to include CSG registration could also serve as an entry point for connecting women with other forms of **income support** including the Social Relief of Distress grant and proposed Maternal Support Grant[36] as well as child maintenance and economic empowerment programmes. Such support has the potential not only to improve maternal and infant health but also to reduce women's financial dependence on abusive partners, thereby enhancing their ability to leave violent relationships.

What are the systemic challenges?

Maternal and child healthcare services therefore offer critical opportunities for violence prevention, but implementation is constrained by several systemic challenges.

- Key services outlined in the NIECD Policy such as home visits by CHWs are not fully operational,[37] hindered by funding constraints and concerns about overburdened CHWs. Parent-support programmes – mostly outside the health sector – tend to be small-scale, are not sufficiently gender-transformative, and many rely on structured curricula that do not account for the diverse needs and family forms in South Africa[37].
- Referral systems are often unclear, underfunded and fragmented, with separate pathways for women and children hindering integrated care and support. There is

iii The NIECD defines vulnerable mothers as including include teenage mothers; mothers with problems with mental health, substance use and/or survivors of domestic violence; and mothers of children with developmental difficulties and/or disabilities.

an urgent need to invest in response services, including psychosocial support and shelters that serve both women and children. Such intersectional approaches are essential, but they must carefully balance children's right to protection and women's right to autonomy (see page 129).

- Despite policy commitments in the NIECD Policy and NSP-GBVF that support multisectoral collaboration, siloed operations, weak coordination mechanisms and limited accountability have undermined implementation.[37, 38] Realising the potential for intersectional violence prevention in the first 1,000 days will require careful consideration of frontline capacity, training gaps and resourcing. Without sustained investment and explicit policy support, these efforts risk being treated as peripheral to core service mandates.

Conclusion

Preventing violence against women and children must begin early in life and be sustained throughout the life course. This chapter argues that the health sector has a vital role to play – particularly during the first 1,000 days of life – by integrating family-centred, gender-transformative strategies into routine maternal and child health services.

Integrating violence prevention for both women and children into routine health services during the early years offers an accessible and cost-effective way to reach vulnerable women and children at scale. However, systemic barriers such as limited resources, weak coordination, and the need to navigate siloed referral pathways hinder effective delivery. To be effective, violence prevention must be recognised as essential to young children's development and prioritised in the revised NIECD Policy, with support from broader policy tools such as the Medium Term Strategic Framework.

Identifying entry points to address violence against women and children within maternal and child health services can strengthen violence prevention and response efforts in South Africa. While integration may not always be feasible, improved collaboration and greater awareness of the intersections between these forms of violence can improve intervention effectiveness. Investing early in violence prevention lays the groundwork for the lifelong health and well-being of women and children, upholding their rights to life, dignity, and safety.

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Preventing violence across gender and generations: An integrated response to violence in the home

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Violence in the home is one of the most pervasive social issues in South Africa. It disproportionately affects women and children, ripples out across generations, and has its roots in both historical and ongoing structural inequalities. Moreover, cycles of violence within families can become increasingly violent over time and more difficult to disrupt in the absence of robust prevention, support and response interventions.

This chapter examines the intersections of violence against women and children in South African households. It then identifies opportunities to adopt a more integrated approach to domestic violence across the prevention-response continuum. To understand how these interventions can be more effective, it is essential to consider the social unit in which many of these dynamics unfold: the family.

What does 'family' mean in South Africa?

Families in South Africa take many different forms, and the concept of family is used to signify an array of different kin and care networks. This fluid understanding reflects the country's complex social and historical realities, including the enduring legacies of colonialism and apartheid.

The nuclear family, often viewed as the norm, is in fact one of the least common family forms in the country. Instead, extended households predominate, with many comprising two or even three generations, particularly in rural provinces such as Limpopo, the Eastern Cape and KwaZulu-Natal. In some cases, grandparents take on primary caregiving responsibilities for grandchildren in so-called skip-generation households. A large proportion of families are also headed by single parents reflecting a consistent decrease in couple-headed households over recent decades, while one in five children do not live with either biological parent.[1] This phenomenon has its roots in the migrant labour system, and patterns of caregiving continue to extend across multiple households and geographic locations.

The percentage of children living with their biological fathers has steadily declined – from 45% in 1996 to 36% in 2023. At the same time, the proportion of children living with men who are not their biological fathers has increased from 31% in 1996 to 40% in 2023.[2] Family life is often dynamic and dispersed, with children and breadwinners regularly moving between homes. Although rare, child-headed households – many of which emerged during the height of the HIV/AIDS crisis – are also recognised as a family form under South African law. All of these arrangements speak to the resilience and adaptability of families in the South African context.[3, 4]

While families can provide critical sources of care, belonging and protection, they can also be environments where violence is normalised and perpetuated. Violence against women and children remains one of the most persistent and damaging dynamics within the home. These forms of violence are not isolated phenomena; instead, they often co-exist within the same households, reinforcing one another and creating complex cycles of harm that ripple across generations.

To address this reality, it is essential to examine the specific forms, perpetrators and gendered patterns of violence that occur within households, and how these intersecting forms of harm shape the lives and futures of children and women. A clear understanding of these dynamics – and the gendered power imbalances that underpin them – is also key to developing effective interventions that reduce violence in the home and interrupt its transmission from one generation to the next.

How do violence against women and children intersect in the home?

Violence in the home takes countless forms, from physical and sexual abuse to neglect, coercive control and psychological abuse, and other behaviours that violate children's dignity, safety and well-being. The two predominant forms of violence perpetrated in the home are intimate partner violence (IPV) and child maltreatment. These forms of VAC and VAW tend to co-occur in the same families as IPV increases the risk of children witnessing and/or experiencing violence in the home.

Violence in the home therefore occurs across generations and has lasting consequences. It is known to reinforce socio-

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economic disparities due to high rates of violence-related mortality and morbidity (injuries, disabilities, mental health impacts and other long-term health consequences), and it also takes a staggering toll on emergency services, first responders, healthcare systems, social support systems and the economy.

Gendered experiences of household violence

In South African households, experiences of violence are deeply gendered. Boys are more likely to experience physical violence at home, often under the guise of discipline, reinforcing harmful norms that equate masculinity with aggression.[5] Corporal punishment, though legally banned, remains widespread, with boys facing harsher physical punishment than girls, contributing to cycles of violent behaviour in adulthood.[6] Girls, while less frequently subjected to physical discipline, face heightened risks of sexual and emotional abuse within the home, often at the hands of male family members or intimate partners.[5]

Power dynamics within households play a defining role in how VAC and VAW intersect and reinforce one another. While men are more likely to experience violence in public or community settings, they are typically safe at home – unlike women and children, for whom the home is often the most dangerous place. In patriarchal family structures, men occupy positions of authority, while women and children are subordinated, creating conditions where male control is normalised and violence becomes a tool to enforce that dominance.[7-9] This male dominance is a key shared risk factor for both VAC and VAW. Social norms that condone men's control over women and wife-beating are strongly linked to higher rates of IPV and shape how adults, particularly men, engage with children, often legitimising the use of harsh and violent discipline.[10, 11]

These dynamics not only drive violence but entrench its acceptability within families and communities, silencing victims and deterring help-seeking. Gender inequality lies at the heart of these patterns, reinforcing a cycle of harm that persists across generations.

Exposure to domestic violence and IPV between caregivers further compounds these risks for both boys and girls. Witnessing IPV has been linked to increased anxiety, depression and long-term vulnerability to violence. Boys who witness IPV against their mothers are more likely to perpetrate IPV later in life,[12] while both boys and girls may become victims of violence themselves. The psychological impacts tend to manifest differently by gender: boys are more likely to externalise trauma through aggressive behaviour, whereas girls often internalise their distress, leading to self-harm or later victimisation.[13]

The persistent normalisation of domestic violence, coupled with ineffective enforcement of protective laws, means that many children continue to grow up in environments where violence is an accepted means of control and conflict resolution. This can have indelible and far-ranging impacts on future relationships, future parenting practices and lifelong mental health and well-being. The intergenerational impacts can be tenacious and difficult to disrupt, which means that interventions need to address these patterns early, focusing on prevention strategies that reshape harmful gender norms, provide trauma-informed support, and accessible and reliable protective measures to break the intergenerational transmission of violence.[14]

Despite the prohibition of corporal punishment in schools (1996) and in the home (2019), violence against children in South Africa continues to be widespread, particularly within the domestic sphere. Data from the Optimus Study indicate that 35% of young people reported experiences of physical abuse, while 26% of boys reported exposure to domestic violence.[5, 15] Similarly, approximately one-third of young people (32%) reported lifetime exposure to some form of family violence, with prevalence higher among females (37.6%) than males (25.6%). Sexual violence also remains a pervasive concern. Among adolescents aged 15 – 17 years, 35% reported experiences of sexual abuse. Gendered patterns of victimisation were evident: girls were more likely to report forced intercourse (15%), whereas boys were more frequently subjected to non-contact forms of abuse, such as coerced exposure to pornography (18%).[5] Moreover, among children who experienced sexual abuse by a known adult, 10% reported repeated abuse on four or more occasions, and a further 30% reported such incidents occurred two to three times. As noted in the Optimus Study, a considerable proportion of violence against children remains "unreported and unrecorded" (p. 3).[5] Multiple factors contribute to this underreporting, including the limited capacity of younger children to disclose experiences, fears of retaliation among older children, and the complicity or silence of parents when violence is perpetrated either by themselves, other family members, or by influential individuals within the community.

It is important to mention at this juncture that domestic violence is not a separate criminal offence in South African law, but instead falls under various criminal categories such as assault, assault with intent to do grievous bodily harm, crimen injuria, among others, and the violation – or 'breach' – of a protection order. The South African Police Service do not disaggregate 'crime data' in a way that distinguishes domestic violence from other criminal offences, although they have on occasion reported 'crimes against children' and 'crimes against women' – though how these aggregated offences are defined is somewhat ambiguous. We therefore have no statistics on

domestic violence that result in a criminal charge. However, the remedies at the disposal of a complainant in terms of the Domestic Violence Act 116 of 1998 (as amended) are as follows: (a) the right to lay a criminal charge; (b) the right to apply for a protection order; or (c) the right to lay a criminal charge as well as apply for a protection order. In terms of section 16(1) of the National Instruction of the Act[16] "all *domestic violence* incidents which are reported to a police station must be recorded in the Domestic Violence Register (SAPS 508(b)) and it is the responsibility of the station commander to ensure that an accurate record is kept of all *domestic violence* incidents". Section 16(3) also states that police members must fully document their responses to every incident of *domestic violence* on a "Report of Domestic Violence Incident" – Form (SAPS 508(a)) regardless of whether or not a criminal offence has been committed. There are further instructions about reasons for non-arrest, maintaining and forwarding copies of protection orders and warrants of arrest, and safety monitoring notices. These instructions imply that all complaints of domestic violence – whether criminal charges or referrals for a protection order – would be recorded and available, including any actions taken – or not taken – by the SAPS. However, to date, these data have not been published in the public domain. Recent estimates released by the Department of Justice and Constitutional Development indicate that the number of applications for protection orders increased from 250,000 to 1,000,000 from 2023/24 to 2024/25, though the reason for this extraordinary surge is not clear other than 'historic and outstanding' backlogs.

In many households, mothers – who are often the primary caregivers – report higher use of corporal punishment than fathers, a trend linked to their greater involvement in day-to-day childcare.[15] While global studies indicate that men are increasingly participating in unpaid care work, women – especially mothers – continue to carry the bulk of this responsibility, particularly in relation to raising children.[17-19] In South Africa, the majority of children live with and are raised by women, often including grandmothers. This close caregiving proximity, combined with the pressures of daily care and potential exposure to IPV, may contribute to mothers' increased use of corporal punishment. This is not to excuse violence, but to underline how unequal caregiving roles and limited male involvement can compound women's risk of using harsh discipline. Research also points to strong links between social acceptance of violence against women and children: In a study across 25 low- and middle-income countries, mothers who believed wife-beating was justified were significantly more likely to view corporal punishment as necessary, and their children were more likely to experience psychological or physical violence.[20]

Case 4: Peace Discipline – A toolkit to support non-violent discipline

Karen Quail[i]

Most South African adults grew up in a context in which the use of corporal punishment, shaming and other coercive methods were the norm. Many do not have a model of non-violent discipline, nor know what methods exist and how to use them.

The Peace Discipline toolkit introduces parents and teachers to a range of non-violent discipline tools. Used appropriately, these tools enable adults to be firm, address problem behaviours and teach appropriate, respectful behaviour, without hurting children or making them feel afraid. In this way, Peace Discipline provides parents and teachers with options to choose from. The tools are not good or bad in themselves. Rather, they are effective when selected and used in ways that are well attuned to the specific context and the needs of the child.

The toolkit is underpinned by a systematic overview of the available evidence on non-violent discipline,[60-61] and illustrated with stories drawn from the experiences of parents and teachers across South Africa.

Methods are usually taught in-person or online, usually in a course of six weekly sessions. Some courses are open to anyone, others are run for specific schools or organisations, and teachers get CPD points for attending since they are registered with the South African Council of Educators. Shorter talks and individual coaching sessions are also available. Course fees are flexible to reduce financial barriers to attendance. Free online resources include the toolkit on peacediscipline.com and videos on the Peace Discipline YouTube channel.

See peacediscipline.com for more information.

i Peace Discipline

What are the key drivers of violence in the home?

Research across high-, middle-, and low-income countries consistently shows that VAC and VAW are shaped by a set of overlapping risk factors. These include marital conflict, family breakdown, economic stress, male unemployment and entrenched norms of male dominance in the home.[7] Risk is further heightened in households where children live with men who are not their biological fathers – a dynamic particularly relevant for further research in South Africa, where 40% of children reside with adult men who are not their biological fathers.[2]

A broader body of international evidence has identified recurring individual-level risk factors for male perpetration of VAC and VAW. These include exposure to violence in childhood, adolescence and young adulthood, antisocial behaviour, substance abuse, depression and attitudes that support gender inequality or condone violence.[7, 10] In the Global South, four shared risk factors emerge most strongly: gender inequality, male dominance in the household, partner conflict and harmful alcohol use.[9]

Gender inequality influences everyday decision-making and power dynamics in families, rendering both women and children more vulnerable. In households governed by patriarchal norms, men who perpetrate violence against women often use similarly aggressive parenting tactics with children. Ongoing partner conflict – often expressed through coercion or aggression – destabilises caregiving environments, while harmful alcohol use, particularly among men, is a well-established driver of IPV and linked to adolescent dating violence in South Africa.[8]

In South Africa, broader patterns of violence further illuminate how gender and power intersect in harmful ways. Men are the primary perpetrators – and also the majority of victims – of violent crimes such as murder and assault.[21, 22] However, women face a disproportionate burden of sexual violence, most often within intimate relationships and in their homes. These patterns highlight the role of harmful masculinities and the long-term effects of childhood trauma. Men tend to externalise early experiences of violence – often by using violence themselves – while women are more likely to internalise these experiences through self-harm or behaviours that increase vulnerability to further abuse.[23-25] This reinforces the urgent need to address childhood exposure to violence as a root cause of both VAC and VAW.

Social norms also play a powerful role in enabling and sustaining violence. Norms that uphold family honour and privacy often silence victims, prioritising reputation over well-being. This undermines women's ability to seek help, and also shapes children's experiences – particularly boys, who may be less likely to disclose sexual abuse due to rigid norms around masculinity.[7, 11] In South Africa, dominant gender norms continue to validate male control, especially in contexts of poverty, where women's economic dependence on men further limits their ability to leave abusive relationships.[8]

Together, these intersecting risk factors – structural, relational, individual, and normative – paint a clear picture: the drivers of VAC and VAW are deeply intertwined. Ignoring this overlap risks missing the opportunity to address violence holistically and disrupt intergenerational cycles of harm. There are however also clear indications of what protective factors are for the intersections of VAC and VAW.

What strategies are effective in preventing VAC and VAW in the home?

In low- and middle-income countries, and across much of the Global South, the most effective strategies for preventing VAC and VAW are those that address both forms of harm simultaneously. Rather than treating them as separate issues, integrated approaches recognise the shared drivers – such as patriarchal norms, poverty, trauma and lack of services – and work across family, community and institutional levels to build more caring, equitable environments.

This requires intervention across the prevention-response continuum – from primary prevention programmes that transform harmful gender norms to social services and a criminal justice system that respond to the needs of both women and children.

Transforming social norms

Changing the social norms that justify violence is central to any serious prevention effort. Patriarchal attitudes that condone wife-beating or corporal punishment underpin both VAC and VAW. Participatory interventions that engage communities in questioning these norms – and that promote equitable, non-violent masculinities – can reduce violence while also addressing related issues like alcohol abuse. Community mobilisation and campaigns that challenge social norms are particularly effective when they create space for collective reflection and action.[9]

Gender-transformative and positive parenting

Parenting programmes that promote positive discipline and stronger parent–child relationships are key protective factors. However, to be fully effective, these programmes must be gender-transformative – by addressing inequalities within the household, such as the unequal burden of care on mothers, and ensuring that fathers are engaged not just as disciplinarians but as nurturers. Programmes that combine parenting support

with community engagement have shown reductions in both IPV and the use of harsh punishment against children.[9, 26]

Adolescence as a window of opportunity

Adolescence is a high-risk period and a critical window for prevention. School-based programmes that promote gender equity, teach healthy relationship skills and strengthen connections between learners, educators and families can reduce dating violence and sexual abuse. Supporting adolescents to delay early marriage, cohabitation and childbearing is a shared priority in efforts to prevent VAC and VAW.[9]

Community support and collective action

Strong, caring communities are one of the most important protective factors. Whether through faith-based groups, extended families or informal networks, communities that actively challenge the idea that violence is a 'private matter' make it easier for survivors to seek help and for prevention efforts to take root. When violence is openly discussed, and collectively condemned, it begins to lose its grip.[26]

Addressing structural drivers and economic stress

Poverty, unemployment and overcrowding create conditions that heighten family stress and increase the likelihood of violence. Economic empowerment programmes that include a gender-transformative focus – such as addressing men's roles and women's access to resources – can reduce household tension and offer families safer, more stable foundations.[8, 26]

Coordinated and responsive services

Service providers often encounter families experiencing both IPV and child abuse, yet very few systems are equipped to respond holistically. Cross-sector training and coordination – between health, education, child protection, and legal services – can improve detection, reduce re-traumatisation and ensure that survivors receive appropriate support. Services must also be made accessible, survivor-centred and sensitive to the needs of both women and children.[9]

Healing trauma, supporting mental health

Exposure to violence often leaves lasting emotional scars, and unaddressed trauma can perpetuate cycles of harm. Interventions that offer counselling and psychosocial support – for both women and children – can break this cycle. Therapeutic spaces that validate survivors' experiences, foster emotional healing and build awareness around the impacts of IPV are crucial for long-term well-being and prevention.[8, 26]

Gender-transformative parenting programmes, therapeutic support and the equitable redistribution of care work have shown particular promise in disrupting the cycles of violence,[27-29] and in supporting healthier relationships and outcomes across the life course.[26, 30]

Gender-transformative parenting programmes

Gender-transformative programming aims to challenge and transform traditional gender norms, power relations and gender roles – particularly those that sustain violence and inequality. It does so through conversations and activities that challenge harmful and violent masculinities and by strengthening the capacity of women, girls and boy children to understand their rights (see Box 4 on p. 43). These approaches can be integrated into a range of programmes to promote gender equity within homes, schools and communities – including parenting programmes.

A growing body of evidence points to the need for an integrated, family-centred response to the intersections of VAC and VAW within the home. While parenting programmes focused primarily on mothers have shown positive results, the most profound and sustained reductions in VAC and VAW are achieved when men are actively engaged as co-parents and caregivers (see Case 5). Without this engagement, programmes risk falling short of their transformative potential.

Engaging fathers and male caregivers is also essential given the central role that patriarchal gender norms play in sustaining violence against women and children. Gender-transformative approaches that explicitly invite men's participation, challenge harmful masculinities and promote shared caregiving and decision-making have shown particularly promising results.[31] and are recognised as essential elements of effective programmes to prevent both intimate partner violence and violence against children by transforming relationships and power dynamics within the home.[31-33]

Working with men and boys

While most prevention and response programmes focus on women and girls as victims, there is a need for initiatives that also address men and boys – as potential change agents and as survivors of violence. Evidence-based interventions with boys and men have proven to be crucial in preventing violence in households by challenging harmful norms and promoting positive masculinities. Research indicates that when men are actively involved in caregiving and adopt more equitable attitudes, the likelihood of violent behaviour within households decreases.[34]

Organisations like Equimundo: Center for Masculinities and Social Justice and Sonke Gender Justice have developed

Case 5: Parenting at the Intersection – The Global Parenting Initiative's role in preventing violence against women and children

Lauren van Niekerk[i] and Jamie Lachman[ii]

The Parenting for Lifelong Health (PLH) suite includes age-specific, in-person group programmes for babies, toddlers, kids and teens, delivered in low-resource settings globally including throughout Sub-Saharan Africa. These interventions are designed to build positive parenting skills, strengthen co-parenting and promote non-violent, equitable family relationships.

Rigorous evaluations show that PLH programmes can achieve reductions in both child maltreatment and intimate partner violence (IPV). In South Africa and Tanzania, PLH for Young Children and PLH for Teens have led to significant decreases in harsh discipline, improved co-parenting and increased emotional connection between caregivers and children. Adaptations with an explicit focus on preventing violence against women and engaging fathers have demonstrated sustained reductions in both child maltreatment and IPV, with positive effects persisting over time.[62-64] In the Philippines, a randomised controlled trial of a culturally adapted PLH programme embedded within the government conditional cash transfer system demonstrated sustained reductions in both child maltreatment and IPV one year after the intervention.[65] The trial, conducted with 120 low-income families in Metro Manila, also showed significant improvements in positive parenting behaviours, parental self-efficacy and reductions in dysfunctional parenting practices.

Despite these successes, in-person delivery models face limitations, particularly in engaging men and embedding gender-equitable content. Father participation remains lower than that of mothers in many settings, often due to entrenched gender roles, work schedules and the perception that parenting is "women's work". Early adaptations of PLH in Zimbabwe have begun to address existing gaps by explicitly integrating reflexive, gender-equitable content woven throughout each module. This approach critically engages participants with culturally embedded patriarchal norms while tailoring both content and delivery to better include and support male caregivers. By embedding gender equity across the entire curriculum, the programme fosters sustained reflection, challenges traditional gender roles and promotes equitable caregiving practices, thereby enhancing male caregiver involvement and advancing violence prevention.[66]

Digital innovations such as ParentText and ParentApp for Teens and the Early Years have been developed to overcome these barriers, with ongoing adaptations to further engage fathers and address gender norms.[66, 67] Qualitative insights from South Africa, Uganda and Zimbabwe suggest that when men do participate, whether in-person or digitally, they reflect more deeply on their roles, report improved relationships with partners and children, and become advocates for non-violence in their communities.[66, 68-70]

Harnessing parenting to prevent violence

The Global Parenting Initiative (GPI) is a five-year research-within-implementation project aiming to reduce child sexual abuse and promote learning through play through the evaluation and scale-up of parenting programmes in the Global South. Anchored by nine studies conducted across six countries (South Africa, Tanzania, Uganda, Malaysia, Philippines, and Thailand), the GPI combines rigorous research grounded in prevention and implementation science with technological innovation, capacity building and advocacy to transform how parenting support is provided at scale in low-resource settings. It builds on over 10 years of research designing, evaluating and disseminating a programme suite developed by Parenting for Lifelong Health[4] and is funded primarily by the Oak and LEGO Foundations. Across multiple contexts, these interventions have demonstrated significant reductions in both harsh parenting and intimate partner violence.[62, 71-74] Due to the challenges of scaling in-person parenting programmes, the GPI has been testing digital and blended versions of PLH programmes as a means to reduce the financial and human resource burden of delivery while increasing access to those who do not normally engage in parenting programmes, including male caregivers.[72, 75, 76]

Mechanisms for change

PLH programmes work through several key mechanisms:

- **Building parenting skills:** PLH programmes are grounded in social learning theory and provide caregivers with practical tools for non-violent discipline, emotional regulation and positive communication to improve parent-child interactions and reduce harsh parenting.[66, 77]
- **Reducing mental health problems:** The programmes

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ii Child and Family Global Health, University of Oxford; Parenting for Lifelong Health; OpEd Project

incorporate simple mindfulness-based and cognitive behavioural therapy activities to reduce depression, anxiety and stress symptoms among caregivers and adolescents, and improve family well-being.[65]

- **Promoting co-parenting:** PLH encourages both mothers and fathers to share caregiving and household responsibilities, fostering more equitable family dynamics and improved co-parenting partnerships.[63, 64, 66, 71]
- **Challenging harmful norms:** Where gender-equitable approaches are integrated, content addresses gender roles and expectations, supporting men to see caregiving as a strength and fostering respectful partner relationships.[66, 70, 78]
- **Community mobilisation:** Peer groups and trained facilitators foster collective change by supporting parents as advocates for non-violence within their communities, strengthening social norms against violence.
- **Digital innovation:** App-based and chatbot-based delivery platforms such as ParentApp and ParentText extend the reach and accessibility of evidence-based parenting content. These digital tools are co-designed with female and male caregivers and are continually adapted to better engage fathers and address gender norms.[67]

Implementation insights and challenges

The implementation of PLH programmes across diverse contexts has generated valuable lessons about what enables success and what barriers remain to achieving the greatest impact on VAC and VAW. Drawing on both quantitative outcomes and qualitative feedback, several key factors have emerged that support effective delivery and highlight persistent challenges.

Successes:

- **High-quality facilitator training and local adaptation:** Skilled, well-supported facilitators who are trained to adapt content to local cultures and languages significantly enhance engagement and programme impact, enabling effective responses to diverse family needs.[62, 66]
- **Trauma-sensitive and gender-transformative approaches:** Embedding trauma-sensitive and gender-transformative elements fosters emotional regulation, empathy and respectful communication, contributing to reductions in harsh discipline and intimate partner violence.[66, 67, 78]
- **Community engagement and peer support:** Group sessions, community mobilisation and digital peer networks promote collective ownership of non-violent, equitable parenting, strengthening family bonds and shifting gender norms.[67, 68, 71]

Challenges:

- **Gendered participation:** Parenting programmes in South Africa continue to be attended mostly by women, reflecting entrenched norms that position caregiving as a female responsibility and often exclude fathers from active involvement.[68, 69, 73]
- **Barriers to male engagement:** South African men face stigma for participating in parenting programmes due to caregiving being feminised. Additional barriers include time constraints from irregular or precarious employment, lack of targeted outreach and limited male-friendly spaces, all of which hinder male participation.[66, 80]
- **Digital divide:** Limited access to smartphones, internet and electricity in rural or low-income urban areas excludes marginalised families from digital interventions, restricting equitable programme reach.[62, 67]
- **Cultural resistance:** Efforts to engage men and address gender norms often encounter resistance in communities with strong traditional beliefs about masculinity, requiring sensitive adaptation and ongoing dialogue.[66, 80]

Conclusion

The GPI is making a significant contribution to a growing body of literature demonstrating that parenting interventions can reduce violence against children and women. However, the most significant and lasting impacts are achieved when men and fathers are actively engaged and gender-transformative approaches are integrated. To fully disrupt cycles of violence and create safer, more equitable families, the next generation of parenting programmes must prioritise the inclusion of both women and men as partners in caregiving and prevention.

community-based programmes that engage men and boys in dialogues around gender equality, emotional regulation[iii] and non-violent conflict resolution. Programmes such as MenCare South Africa Parenting Programme, Program P and the adaptation of Program P titled Bandebereho (Case 1 on p. 52) have demonstrated success in reshaping fatherhood, promoting healthier relationships and reducing the acceptance of violence as a disciplinary tool and IPV. An important factor of success of

iii Emotional regulation is the ability to understand and manage our feelings.

Box 6: Trauma-informed care

Edith Kriel, Jelly Beanz

Trauma-informed care is an approach that recognises the widespread impact of trauma and understands how it can affect a person's brain, body, emotions, health, behaviour, and relationships.[81] Children are especially vulnerable, as trauma can disrupt their developing brains and leave them in "survival mode," struggling to trust, learn, or regulate emotions. Adults, too, may live with the impact of past harm, including lingering or reactivated effects of GBV. Many women affected by GBV carry trauma that shapes their health, relationships with men, and parenting, sometimes re-triggered when their children are exposed to violence.[82]

A trauma-informed approach recognises how GBV shapes lives across generations and, therefore, in practice, this approach promotes safety, healing, and resilience across the life course. As highlighted in Jelly Beanz's August 2025 training on Trauma-Informed Care for Abused Children,[83] professionals can anchor their practice in principles that prioritise safety, trust, empowerment, and cultural sensitivity.

Central to this approach is creating environments that are safe, consistent, and supportive. When children feel secure and supported, they are more likely to engage, learn and grow. It requires being emotionally present in ways that help people feel seen, valued, and secure, whether they are children or adults. Instead of asking, "What's wrong with this person?" we ask, "What has happened to them?" This shift in perspective prevents re-traumatisation and opens pathways to healing. Applied well, trauma-informed care promotes recovery, disrupts cycles of violence, and supports long-term well-being.

these programmes is that they are embedded in state services and delivered by community health workers in Rwanda and social auxiliary workers in South Africa.[29]

Furthermore, school and community-based programmes that teach boys socio-emotional intelligence (SEI) are also showing promise. These programmes foster emotional regulation, empathy and non-violent forms of conflict resolution[35] and help boys grow into socially connected and less violent men. This is an emerging area of work, with interventions being developed by organisations around the world – most often through engagement with boys and caregivers in school settings. Implementing SEI curricula with boys, and addressing themes of boyhood within schools, offers a structured opportunity to challenge and transform the gender norms boys are exposed to. It also enhances boys' engagement in education.

These interventions, grounded in evidence and adapted to local cultural contexts, illustrate the potential of early prevention efforts in shifting harmful gender dynamics and fostering safer home environments for children. They also highlight the need to intervene both within – and outside – the home environment to shift dynamics within the home.

Working beyond the home

Institutional protective factors, such as school attendance, community cohesion and access to health and social services, also play a crucial role in preventing violence in the home. For example, the healthcare system has a critical role to play in identifying and supporting pregnant women and new mothers who have experienced IPV, or who are struggling with food insecurity, substance abuse or mental health problems in order to intervene as early as possible to prevent violence across the life course (see First 1,000 Days chapter on p. 48). Similarly, schools have the potential to serve as critical intervention points where educators can identify at-risk children and provide support (see Schools chapter on p. 72), and community-based programmes that strengthen neighbourhood networks and promote collective action against violence can create safer more supportive communities (see Community chapter on p. 84).

Despite a strong international evidence base demonstrating effective prevention interventions, research findings remain scarce in South Africa. This is due to range of challenges including the absence of dedicated and enduring funding to support research on prevention programmes, the state's lack of capacity to implement these programmes at scale, and limited state investment in prevention programmes due to a persistent focus on 'response systems'.

Integrating criminal justice and social services

A holistic response to violence in the home requires seamless collaboration between the criminal justice system, health and social services, education, civil society organisations and communities. Initiatives such as the National Crime Prevention Strategy of 1995 and the Department of Justice's vision of an 'integrated justice system' have emphasised the need for a coordinated approach. These early initiatives emphasised the importance of increasing the efficiency and effectiveness of the

criminal justice process and improving coordination among both criminal justice and allied agencies (health, social development and education) and constructing integrated information and case management systems. Yet South Africa has struggled to integrate these systems effectively.

However, implementation of integrated measures has been inconsistent, if not almost absent. Not only is there a distinct lack of cohesion between women-focused and child-focused interventions, but there are also statutory, structural and administrative partitions between social development and criminal justice systems. This means that women and children who are exposed to, or who experience violence, are 'managed' by different legal structures and support systems, as opposed to being responded to in a holistic way as a family 'unit'.

Integrating criminal justice and social system responses is essential for addressing violence in the home in South Africa. One of the only examples of this approach are the Thuthuzela Care Centres (TCCs), but these are now at risk due to the withdrawal of funding from USAID and changing priorities of other international funding agencies. There are other possibilities on the horizon for a more cohesive approach addressing violence in the home – at least on a policy level. On 20 February 2025, the Deputy Minister of Justice and Constitutional Development revealed that the South African Law Reform Commission's Project 151 – Review of the Criminal Justice System will include a more "victim-centred", "well-informed, evidence-based dialogue" on the right to safety.[36]

By combining gender-transformative programming, institutional prevention mechanisms, and trauma-informed care (see Box 6), a more cohesive and effective approach can be developed. Through collaboration and evidence-based interventions, it is possible to break cycles of violence and build safer, more equitable communities for future generations. The National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF), has the potential to be one of the coordinating mechanisms for this – where government departments and civil society organisations rapidly identify the gaps in prevention and response services, support broad-reaching violence prevention programmes, and simultaneously ensure the immediate safety and well-being of victim/survivors of violence in the home.

This requires a system in which case management information and measures are synchronised so that services for women and children interact with each other proactively to protect survivors and prevent additional harm. The integrated management of sexual offences through the TCCs demonstrates both the benefits and potential of implementing such a holistic approach in the South African context.[37, 38]

Yet Brenda's story (Case 6 on p. 66) highlights a series of systemic failures and missed opportunities in both preventing and responding to violence in the home.

Table 4 on p. 67 then highlights the opportunities for intervention, and what could and should be done to provide more responsive and integrated care. It also includes best practice examples from South Africa and the continent. While the holistic approach that it outlines may be unobtainable in the short term due to limited resources, it does provide a road map to enhance our responses to the intersections of violence against women and children.

Conclusions and recommendations

Violence in South African homes is deeply entrenched and disproportionately affects women and children. This violence is intergenerational and cycles of violence within families tend to escalate over time if they are not effectively addressed. To break these cycles, an integrated approach is crucial, encompassing early prevention and swift, consistent and just responses when violence occurs.

This chapter underscores the critical role of gender-transformative programming in challenging and changing traditional gender norms, power relations and harmful gender roles that sustain violence and inequality. The authors recommend prioritising interventions with men and boys to promote gender equality, emotional regulation and non-violent conflict resolution, alongside strengthening the capacity and ability of women and girls (and boy children) to understand their rights.

Given the inextricable links between violence against women and children, interventions must be integrated to meet the needs of both women and children. To ensure effectiveness, this chapter strongly recommends proactive interaction and greater synchronisation between the criminal justice system and social services in order to uphold women and children's rights to safety, healing and justice. Ultimately, by combining gender-transformative approaches, trauma-informed care, and seamless collaboration across sectors, South Africa can start breaking the cycles of violence and fostering safer, more equitable homes and communities for future generations.

Recommendations:

- Review legislation, protocols and other legal remedies relating to violence against women and violence against children in the home and family ensure better alignment and coordinated responses, rather than the parallel, but disconnected, approaches currently featured in law and policy. This includes reviewing both substantive law as well as processes and procedures to ensure that they are mutually reinforcing when responding to the co-occurrence

Case 6: Brenda's story – A series of missed opportunities to prevent and respond to violence in the home

Dysfunctional family life

Brenda's earliest memories include: seeing her father drunk; bringing other women to the house to 'sleep over' and hitting her mother. Brenda's early childhood was marked by instability with her constantly moving homes and changing schools. Her father was unable to hold down a steady job which resulted in her family losing their house. Although her parents were married, Brenda rarely lived with both due to frequent separations caused by her father's abuse.

When she turned seven, her mom became pregnant. Yet, her father continued to emotionally and physically abuse her mother with the abuse spilling over to the children as a form of discipline. Although her father often promised to change: "He went back to his old habits, drinking and performing and so on". Brenda started taking on parental responsibilities from a young age: "I started making food and cleaning the house and I had to go to their [her sisters] parent meetings and go pay school fees… We were a lot on our own".

At 13, Brenda also started talking on the role of her mom's protector. Her mother recounted: "If her father hit me, Brenda's always the one that goes to the police station and lay a charge". At times Brenda's support of her mom also resulted in her father being physically violent towards her.

Rape

At 16 Brenda asked her father's friend for a lift home. He said that he first needed to collect something from his apartment. Brenda thought: "Its fine, he lives at the police barracks. I mean, what can happen?" It was at the police barracks that he raped her.

Brenda later reflected how this was when she started "being naughty". She started lying to her parents and staying out late. On weekends, she would associate with "wild friends", drink excessively and take drugs, trying to forget the psychological pain she was experiencing. She also started skipping school and her performance dropped from being a straight A student to failing subjects. She also complained of severe headaches and stomach pains.

For a while her mother noticed the changes in her behaviour and thought something was wrong, but she was preoccupied with going through a contentious divorce after enduring years of domestic violence.

Support systems failures

It took Brenda six months to disclose the rape to an aunt because she blamed herself. The family then reported the rape at the local police station. Brenda only knew the perpetrator by his nickname, but was able to describe "where he stays, what car he drives, his number plates, everything". However the investigating officer said he could only open a case once they had his full name and surname.

It was only then that the police sent Brenda to a Thuthuzela Care Centre (TCC) for a medical examination. Although the TCC is meant to provide 24-hour service, the staff told Brenda and her mom to return on the Monday as the rape occurred over six months ago. When she returned no one explained what the procedure would entail. Her mom reflected: "I actually thought for a child, to go through that, and just do the procedure without making her feel comfortable and explain everything" was problematic. According to her mom the doctor just arrived in the room and told Brenda to lie down. She said: "[T]hey could have given her a lady for a doctor. She was never sexually active before so why must an awful male doctor – you know – it's very uncomfortable for me, also for her''.

Psychosocial support services

Counselling services were not provided at the TCC, but she was referred to a dedicated counselling service for adolescent rape survivors. But her mother raised concerns about privacy as she could hear what was being said in the session from the reception area: "Anybody could have sat there and then they could have listened to their conversation. I mean, someone that's going for counselling, it must be totally confidential!''

Although Brenda attended counselling sessions, she did not find them useful. She continued to have severe psychosomatic symptoms, with suicidal ideation. Brenda also displayed intense anger towards her perpetrator, and she feared that he would not be convicted.

Counselling was never provided for Brenda's mother, who needed to know how best to support her daughter.

Caregiver's trauma

Brenda's disclosure resurfaced her mother's own experience of sexual violence: ''When I was 14 at that time when I was raped, the way they handled you. You were a rubbish, and no decent guy will ever get involved with you. He knows that you were raped, and he won't get involved with you''.

She struggled to leave her abusive husband as she often felt worthless. These feelings deepened with the disclosure of Brenda's rape and made it harder to support Brenda. This may be one of the factors undermining Brenda's recovery.

Table 4: Opportunities to strengthen South Africa's response to violence against women and children

	Red flag	Duty bearers	Opportunity for supportive intervention	Practice models in South Africa and the Global South
Prevention	Poverty	South African Social Security Agency (SASSA), Department of Basic Education (DBE)	Access to social security and free government services help alleviate poverty and reduce financial stress.	Child Support Grant, Social Relief of Distress, school fee exemption, and nutrition programmes.[39]
	Unemployment	Department of Labour	Women's economic empowerment programmes enhance autonomy but are best combined with gender norms change.[40, 41]	The IMAGE programme combines a group-based microcredit programme, with gender and HIV training.[42]
	Harsh parenting	Department of Social Development (DSD)	Parenting programmes teach non-violent discipline, strengthen relationships and improve communication reducing harsh parenting and IPV.	Parenting for Lifelong Health (p. 62) offers guidance on positive parenting.
	Pregnancy	Department of Health (DoH)	Antenatal care is opportunity to identify IPV and refer for support services.	Safe and Sound is a nurse-led intervention for reducing IPV during pregnancy.[43]
	Divorce	Court or family advocate	Children's voices should be heard during divorce proceedings and legal professionals trained to identify signs of violence and trauma and refer.	Organisations such as FAMSA and the Family Law Clinic[44] offer holistic services to families going through divorce.
Early intervention	Alcohol abuse	DSD, local government	Reducing harmful alcohol use can reduce IPV.	The Common Elements Treatment Approach (CETA) reduced IPV and hazardous alcohol use among couples in Zambia.[45] Bulungula Incubator is also running a successful multipronged alcohol harms reduction programme in rural communities.[46]
	Physical fights, worsening emotional and physical abuse	Family/ community	Family strengthening programmes equip men and women with skills to build caring, equitable and non-violent family environments. Family and neighbours can identify and support children at risk of abuse, neglect, and exploitation.	See Building Stronger Families on p. 158. Isolabantwana is a child protection programme that trains community members to look out for children in their communities and refers cases to social workers for intervention and support.[47]
	Child attending parent meetings and paying school fees	DBE	Schools can offer psycho-social support services to children and their families.	In Isibindi Ezkoleni, school-based child and youth care workers provide on-site support and home visits to vulnerable learners and their families.[48]
	Child reporting IPV	SAPS	The mother should be supported to apply for a protection order, seek support or even find safety elsewhere.	There are many simple guides and resources to help women find a shelter (0800 001 005 toll free helpline) or navigate the legal system (*It's An Order! Protection Orders Must Protect!*)[49]
Identification	Sudden changes in behaviour and physical illness	Family	Caregivers and teachers should be trained to spot the signs and symptoms of trauma and to respond empathetically and without blame.	PLH for Teens reduced violence in the home and helped families protect teens from abuse in the community.
	Skipping school and failing are indicators of trauma[50]	DBE	Real-time tracking of attendance, academic performance and well-being can help schools identify vulnerable children with psycho-social needs.	The Early Warning System in Zimbabwe aims to prevent school dropout. It recognises that violence and abuse increase the risk and refers children to psycho-social support services.
	Six months to disclose – children frequently delay disclosure due to fear of caregivers' reactions or disbelief, and unsupportive social environments.[51]		Many children choose intermediaries – older siblings, family members or trusted adults – to initiate disclosure on their behalf. A holistic, context-specific approach engages community figures – like religious leaders, teachers, law enforcement, and NGOs – in building environments that encourage disclosure.	The DBE has a formal protocol for managing and reporting sexual abuse and harassment in schools. Jelly Beanz trains professionals to offer Psychological First Aid and adapt physical environments and systems to provide trauma-informed care.[52]

	Red flag	Duty bearers	Opportunity for supportive intervention	Practice models in South Africa and the Global South
Response	SAPS refuse to open a case.	SAPS	Police officers often refuse to open cases against their colleagues due to fear of reprisal, because they are overburdened and want to improve their performance stats. Asking the victim to provide extra details forces her to retell her story potentially causing revictimisation.	The Independent Police Investigative Directorate conducts independent and impartial investigations into criminal offences, including rape, by police officers, whether on or off duty.[53] Service providers need training in trauma-informed care to avoid silencing children or causing secondary harm (see course offered by Jelly Beanz on p. 64).
	Fear that the perpetrator will not be prosecuted	SAPS	The victim has the right to be kept informed about progress with the case especially in relation to decisions about bail.	Court preparation programmes are offered by the state and NGOs such as the Teddy Bear Foundation. These programmes teach children about their rights and what to expect from the legal process.
	Come back on Monday	Thuthuzela Care Centres (TCCs), National Prosecuting Authority (NPA) and NPOs	Immediate access reduces the financial and emotional burden on the victim – and most TCCs report that there is a higher demand for services after hours and during weekends.	National guidelines emphasise patient-centred care, which includes respecting the survivor's preferences and autonomy. Most TCCs that operate 24 hours a day have NGOs assisting them.
	No counselling given at the TCC		Containment counselling is short-term, crisis-oriented support given to rape victims. Its purpose is to stabilise, protect and empower the survivor to navigate medical exams, police reporting and legal procedures without feeling pressured or re-traumatised. It reinforces the survivor's sense of control rather than letting them feel things are being 'done to them'.	TCCs often work with NGO partners to provide onsite containment counselling and referrals to external services. The Philisa programme (see page 53) and the Teddy Bear Foundation's medico-legal clinic both provide specialised medical facilities for children who have been abused or neglected and a training service for medical professionals working in the child protection field.
	No information given or consent taken		In trauma-informed care, consent and empowerment are foundational principles because they address the powerlessness and loss of control that many survivors of trauma have experienced.	Mum must give written consent[54] AND the child should be fully informed of the process and give consent (Children's Act Regulation 32). See the Children's Act Guide for Health Professionals.[55]
	Male doctor		Medical exams after sexual assault can be traumatic. Offering a female examiner, while not mandatory, aligns with trauma-informed care principles and avoids revictimisation.	If a female forensic nurse or doctor is not available, children should be provided with additional support through the examination to make them feel safe.
Psychological recovery (healing)	Lack of privacy	DoH, DSD, NGOs	Maintaining strict confidentiality is both an ethical and legal obligation – it builds trust and promotes healing and is essential to keep the victim safe.	The Health Professions Council of South Africa's guidelines on confidentiality apply to forensic, medical and mental health services.[56]
	Ineffective intervention		Trauma-Focused Cognitive Behavioural Therapy is designed specifically for children and adolescents who have experienced sexual abuse or other traumatic events. This approach combines cognitive-behavioural techniques with a strong caregiver component. [57]	Specialist counselling services for child victims are provided by Jelly Beanz, Teddy Bear Foundation, Childline South Africa and Masithethe.
	No support for caregiver of abused child		Family engagement strengthens recovery, but most caregivers need advice on how to support their children after sexual abuse and to avoid vicarious trauma.	Why my child? is a guide for parents, guardians and caregivers of child victims of sexual abuse. It explains what to expect, when to get help and outlines the court process.[58]
	No counselling for mum to deal with her own trauma		Violence against women and children are interconnected and intergenerational. Service providers should therefore take complete history and connect mum with services to deal with historical trauma.[59]	MOSAIC's SAFE-PR project (p. 127) aims to address systemic barriers that survivors face when seeking help by bringing together key stakeholders in communities to coordinate referral pathways and fostering continuous communication.

of violence against women and children.

- Develop prevention and intervention responses that recognise the overlapping risks of violence over the life course. This, in some cases, may address the sometimes hazy margins between victims and offenders, such as young boys who are both exposed to – and perpetrate – harm or violence.
- Embed evidence-based training in frontline services, for example, by including gender transformative violence prevention screening and intervention training in the pre- and in-service training of social workers and primary healthcare providers.
- Promote and support trauma-informed initiatives that focus on households, gender norms and conventions, and the escalating cycles and cumulative impacts of violence and trauma across the life course and across generations, rather than on specific 'categories' or 'populations' of victims and offenders.
- Advocate for the development of a simple, but robust, documentation system with harmonised indicators, disaggregated data, and linked administrative systems; in order to create a surveillance system which provides comprehensive view of the co-occurrence of violence against women and children, including nature of reports, overlapping risks, services rendered, and health and judicial outcomes.

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Addressing the intersections of violence against women and children: Schools as catalysts for change

Patrick Burton[i]

Violence against women and children is pervasive in South Africa, and the ramifications extend across generations. Understanding the intricate connections between these forms of violence and identifying effective intervention strategies is therefore crucial in fostering a safer and more equitable society and ensuring that the rights of both women and children are realised.

Violence against women (VAW) and violence against children (VAC) are not isolated phenomena but are often interconnected and mutually reinforcing.[1] While in the past VAC and VAW have been treated as two distinct phenomenon, there is increasing recognition of the intersections between them, and calls to adopt a more integrated approach to preventing and responding to the experiences of both women and children.[2, 3]

Violence against children in schools takes many different forms[4, 5] including physical violence (such as physical fights, assaults by peers or teachers and corporal punishment), psychological violence (such as verbal abuse, humiliation, threats or exclusion), sexual violence (including sexual harassment, dating violence, assault exploitation or grooming by teachers), and bullying (which may include both physical and psychological components). Violence or abuse also takes place online through technology-facilitated sexual exploitation or abuse, cyberbullying, or online exclusion. Similarly, discrimination based on gender, sexual identity, race, class or ethnicity may manifest as physical, emotional or sexual violence. School-related gender-based violence has also emerged as an important and useful framing of violence against women and children within the school environment, and is linked to gender norms, gender identities and power imbalances that are usually rooted in traditional notions of male control and dominance over women's bodies and lives.

This chapter explores how violence against women and children intersect within the school environment, and how these experiences can shape adolescents' trajectories into adulthood. It provides an overview of what is known about the intersection of VAC and VAW within South African schools, and it concludes by outlining evidence-based strategies to prevent and respond to violence in schools, including examples of promising programmes and interventions from South Africa.

How violence in school shapes learners' futures

Exposure to violence, whether as a victim or a witness, has profound and lasting effects on individuals, shaping their attitudes, behaviours and future relationships.[6] Children who witness domestic violence, for instance, are more likely to experience emotional and behavioural problems, have difficulty forming healthy attachments, and are at a higher risk of perpetrating or experiencing violence in their own relationships later in life.[7-9] Similarly, children who witness or experience violence within the school environment are more at risk of experiencing or perpetrating violence in adulthood.

This intergenerational transmission of violence can be understood through a pathways to violence framework, which examines the various risk and protective factors that influence an individual's likelihood of engaging in, or being subjected to, violence.[8] For example, social and cultural norms that are accepting of violence in all forms, including gender-based violence, intimate partner violence and corporal punishment, can increase later risk of violence.[10] Structural factors such as socioeconomic disadvantage, lack of access to education and opportunities, exposure to community violence, and weak social support systems can also increase the risk of violence perpetration and victimisation.[11, 12]

Schools are key sites where different forms of violence overlap and reinforce each other. Learners may be exposed to or experience bullying (including cyber-bullying), sexual violence, physical violence, hate, discrimination and harsh physical discipline including corporal punishment.

Experiences within schools, where children spend most of their waking hours, can shape children's perceptions of

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relationships, self-worth and social capital. They play a pivotal role in the lives of children, serving as both a place of learning and a microcosm of society.[13] Schools may reinforce the violence and abuse they experience in their homes or communities, or they can serve as interrupters of violence and spaces that feel safe for children.

What are the immediate and long-term impacts of school violence?

Exposure to violence in any environment at a young age increases the risk of later victimisation, as well as perpetration of violence and other antisocial behaviour. Schools, if considered holistically, are environments where children not only acquire scholastic knowledge, but also where they learn how to be, do and live together. Violence in schools impacts negatively on all these processes, creating instead, a place where children learn fear and distrust, where they develop distorted perceptions of identity, and self-worth, and where they acquire negative social capital if the threats to their safety are not effectively managed.

The intersection of VAC and VAW in schools is particularly critical because of its impact on gender norms. Female learners, who are more vulnerable to sexual harassment and gender-based violence both at home and in school, often internalise messages of gender roles and norms that promote subordination and diminished self-worth.[14] This internalisation can have long-term implications, including poorer academic performance, higher school dropout rates, and an increased risk of intimate partner violence (IPV), and VAW in particular, in adulthood.

Schools are often the place where adolescents start to explore their own sexuality, sexual identity and romantic relationships. As adolescents start to explore these aspects of their life, they simultaneously become more vulnerable to dating violence as well as violence and discrimination if their identities or relationships are perceived as not heteronormative.

Sexual violence against girls in schools can also result in pregnancy, further increasing the likelihood that girl learners will drop out of school, exacerbating other vulnerabilities and lifelong impact of violence. School-related gender-based violence (GBV) and teen pregnancy are closely linked through a series of mutually reinforcing risk pathways. These pathways are bidirectional: teen pregnancy can increase the risk of GBV, while GBV can increase the risk of teen pregnancy.[15-17] Teen pregnancy often results from sexual coercion in and around schools by peers, teachers and other adults within the school environment.[15] Structural factors such as poverty, inequality and economic vulnerability may also push adolescents into transactional sex with older men, including teachers, in exchange for uniforms, clothes or food. This victimisation all occurs within a broader environment of gender norms which reinforce male dominance, and limit girls' agency.

Teen pregnancies, like all forms of violence children experience, often result in children dropping out of the formal education system. Studies have shown that children who drop out of school are less likely to attain the level of education that can serve as a protective factor against VAW. In contrast, schools that promote gender-equitable norms can help challenge these harmful patterns. For example, school-based interventions that model and promote gender equity can mitigate the risk factors associated with both VAW and VAC.[18, 19]

School safety is therefore a fundamental precondition for learning. Schools are both a key location where children who have been abused may be identified and where long-term harm resulting from abuse within the home or school itself may be identified and addressed.[20] Interventions that target shared risk factors such as harmful gender norms and economic stress can effectively address both VAW and VAC simultaneously.[21] Schools can create a safe and supportive environment for children and young people by addressing the structural drivers of violence, and by equipping children with the tools to establish healthier relationships and positive social norms.

What do we know about violence against children in schools in South Africa?

Prevalence data on violence against children within the schools in South Africa is limited but illustrates similar trends. In the 2016 UBS Optimus Foundation Study, one in three children reported experiencing physical violence from peers at school, with similar rates for bullying and verbal abuse.[22] This data is broadly consistent with the two national school violence studies (NSVS) conducted in 2008 and 2012 by the Centre for Justice and Crime Prevention.

Data from the Optimus Foundation study also highlighted the impact of sexual violence, with both boys and girls reporting nearly five times as much substance misuse, nearly four times as much high-risk sexual behaviour, and around three times as many mental health problems, if they also reported sexual abuse.[20] This data highlights how many of South Africa's children are exposed to multiple risk factors across different settings, that then increase their risk for further violence and poly-victimisation.

A lesser explored form of violence in schools is that perpetrated against educators. While the NSVS provided limited data on violence perpetrated by learners against teachers, some evidence did emerge of verbal, sexual and physical abuse – in particular perpetrated by male learners

Box 7: Technology-facilitated violence against women and children

Patrick Burton[i]

Digital technologies have expanded the ways in which women and children are exposed to violence, intensifying existing harms and increasing their reach and impact. Technology-facilitated violence (TFV) often mirrors the violence that women and children experience in real life, and it includes exposure to harmful online content, sexual exploitation and abuse,[ii] cyberbullying and harassment, hate speech, doxing[iii] and privacy violations.

Digital technology is evolving at an exponential pace, often exposing children to new forms of risk before adults are aware of them, or aware of how to mitigate them.[51] This demands a more systemic approach to managing risks and preventing harms, with a focus on the institutional drivers of violence, within both the physical or digital environment. This includes the schools where children spend a significant part of their waking hours.

TFV against women and children share common drivers,[52] and are often grounded within a culture of coercion, control and manipulation and influenced by patriarchal norms and values.[53] For example, men may use smart-home devices to control and abuse their intimate partners and children living in the same household.[54, 55] Digital technologies can also increase the points of contact for other forms of interpersonal violence through – facetiming, video-calling, sexting or distributing or demanding sexual images or videos, often with concurrent threats should the victim fail to comply – including threats to disseminate content to the child's school, family or wider community. Teachers (and in particular female teachers) may also be subject to TFV perpetrated by learners or other teachers.

TFV against children can have a negative impact on short and long-term health, often resulting in poor mental and physical health outcomes, and a negative impact on school performance, and increased risk of suicide and self-harm.[56-58] In addition, children often fail seek help for technology-facilitated abuse due to feelings of shame or embarrassment or fear of being blamed, which further compounds the trauma.

Such behaviours impact directly on children and young people's experiences at school, yet schools also have the potential to play a critical role in creating a safe environment, and in identifying and supporting children who have been exposed to TFV.

- **Prevention strategies** include addressing harmful gender norms and practices, including structural and cultural norms that condone or promote gender inequality,[iv] wider violence prevention education programmes (delivered through and outside schools)[59] and whole-school prevention programmes.[60, 61] Media and digital literacy programmes are also essential in helping children identify and manage risks they encounter online.[62, v] Schools can also pay an important role in helping parents develop skills so that they can help their children to be safe online.
- **Early detection and intervention** have been shown to disrupt cycles of harm and be effective in minimising trauma. Here, schools have a critical role to play in identifying signs of trauma and abuse and intervening to provide and refer for support and interventions.[vi] This includes knowing how to respond when learners or staff are being harassed, bullied or experiencing other forms of technology-facilitated violence, including how to limit to the degree possible further distribution of digital material and how to intervene with learners perpetrating abuse and violence.
- Schools should **support victims and hold perpetrators to account**. This can be done through ensuring that children and all victims have access to trauma-informed interventions that can improve recovery outcomes and reduce their risk of re-victimisation. These need to be age-appropriate and tailored to meet children's developmental

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ii There have been many different terms used to describe violence and abuse that children experience online. The recent shift away from terms such as online child sexual exploitation and abuse (CSEA) to technology-facilitated CSEA better represents the ways in which CSEA often moves from the digital to the physical environment and vice-versa.

iii Doxing is the act of publicly revealing the personally identifiable information of an individual without their consent online or through a digital platform, including information such as their name, address, school, telephone number or other private data. This is usually done with the intent to intimidate or harm the individual.

iv These can extend to structural barriers to girls or women accessing digital technology itself, and related to this, inequalities in technical digital and media literacy, which increase risks for women and girls, while also creating further structural barriers to help-seeking and accessing services.

v Digital literacy refers to the skills required to successfully and safely navigate the digital environment (eg knowing how to block accounts or unwanted messaging, set safety and privacy settings and so on). Media literacy refers to the ability to critically understand and engage with media effectively and responsibly. This encompasses skills necessary for active participation in a media-saturated society.

vi Tools such as safety-by-design and privacy-by-design are critical to this, but are offered by platform, apps and service providers. Schools can ensure that whatever software or technology they introduce have been developed on the basis of safety and privacy-by-design principles.

needs. It is also essential that teachers, service providers and school management take the experiences of children seriously and do not under-estimate the trauma and harm that can result from children's experiences online.

- These steps should all be **embedded into broader policy and regulations**. For example, where digital technology or Edtech is utilised by schools, national government should ensure that policies and procedures are developed to evaluate the safety of the technology and provide ongoing guidance to schools and educators on its use, as well as ensuring accountability mechanisms to manage its use within school.[63] All school safety policies, regulations and strategies should explicitly embed child online protection and technology-facilitated safety rather than approaching them as 'add-ons'.[vii]

As a final note, there has been increasing calls for the banning of cell phones altogether within schools. While this is seen as an effective option for keeping children safe from TFV in schools, there is little evidence to support this approach,[64] and substantial arguments that this approach can in fact undermine the development of the technical and digital skills that children require to both stay safe and build resilience.[65, 66] Children often depend on digital technology to access information on sexual and reproductive health, and to seek help when they encounter abuse or exploitation,[15] and this approach serves as a barrier to all of these important sources of information and supports, while also jeopardising the concurrent rights, such as their rights to education, health and as embodied in the CRC's General Comment 25, on Children's Rights in relation to the Digital Environment.[67]

vii This includes ensures the availability (and awareness of) reporting structures for learners and teachers, and associated response and feedback measures, and the recording and reporting of disaggregated incident data, as well as prevention measures.

against female teachers. Over half of the school principals interviewed in the survey had received reports of verbal abuse, while 12% received reports of physical abuse, and 3% reported sexual violence against teachers by learners.[23] More recent studies focusing on specific provinces provide greater detail: in a 2023 study in Limpopo province, teachers describe learner to teacher violence and harassment, including physical, verbal and sexual (including sexualised touching), which resulted in clear impacts on the quality of teaching and teachers well-being.[24] A 2024 study in Shoshanguve on violence perpetrated against early-career teachers revealed ongoing experiences of physical, verbal and sexual violence perpetrated by both school management and learners, the majority of which went unreported.[25] These experiences are all enabled by norms and values within the school environment that tolerate violence, and in particular sexual violence against women as well as girl learners.

What prevention initiatives exist in South Africa?

Schools are a powerful platform for intervention as the place where children spend most of their waking hours – and as such they have the potential to either entrench or disrupt the intergenerational cycle of violence.

Several measures and interventions have been implemented to try and address violence in South African schools. For example, at a national level the National School Safety Framework, Safety in Education Partnership Protocol between the Department of Basic Education and the South African Police Service, the Regulations for Safety Measures at Public Schools, the National Strategy for the Prevention and Management of Alcohol and Drug Use among Learners in Schools, the National Drug Master Plan and the National Anti-Gangsterism Strategy are all intended to create a school environment that is safe and free from violence. Importantly, the National School Safety Framework provides the basis for a whole-school approach (discussed later in this chapter), while many of the other initiatives aim to contribute to specific modalities that contribute to individual aspects that should be integrated within a whole-school approach. The National Department of Basic Education (DBE) has also initiated the *STOP, WALK, TALK* bullying prevention programme, and the Western Cape Department of Education has introduced a *Safer Schools* programme, and an after-school *Game-Changer* programme.

While many of the above strategies and initiatives have been in place for some years, the Gender-Responsive Pedagogy for Early Childhood Education is a new initiative designed to support educators in creating gender-inclusive learning environments for young children. Piloted by the DBE in KwaZulu-Natal, it provides teachers with practical tools and strategies to challenge gender stereotypes and promote gender equity in early childhood development.[26] This approach recognises the importance of starting early to promote gender equitable norms at a time when children's understanding of gender is first starting to take root. Early childhood caregiving environments, both at home and within the early years at school, influence lifelong risks of both victimisation and perpetration

of violence, with implications for both preventing violence against women and violence against children.[27] Initiatives such as the Gender-Responsive Pedagogy for Early Childhood Education should ideally be linked to concurrent interventions that promote non-violent forms of discipline in homes and early learning programmes to ensure a comprehensive foundation for learners.

Schools as an intervention point

Schools have a pivotal role to play in disrupting the cycle of intergenerational violence by providing safe environments, comprehensive education and targeted interventions. By addressing the root causes of violence and promoting healthy relationships, schools can empower students to break free from patterns of abuse and build a more positive future for themselves and their communities.

Schools' capacity to foster mental health and resilience in children, especially those from disadvantaged backgrounds, can be transformative.[20, 23] Schools also offer access to children and adolescents for significant durations during critical developmental stages and possess resources, infrastructure and values conducive to fostering positive health, mental well-being and resilience in young people. They can provide a safe and structured environment for learners who may be experiencing trauma or adversity outside of school.

One avenue for interrupting intergenerational violence lies in providing education on healthy relationships and conflict resolution. Curricula can be developed to teach students about consent, communication and respect, equipping them with the skills to navigate relationships in a healthy and non-violent manner. Furthermore, schools can implement conflict resolution programmes that teach students how to resolve disputes peacefully and constructively.

Moreover, schools can foster a culture of empathy and respect through social-emotional learning (SEL) programmes. SEL is the process of acquiring the skills to recognise and manage emotions, develop caring and concern for others, make responsible decisions, establish positive relationships and handle challenging situations effectively. By teaching students how to understand and manage their emotions, build empathy and resolve conflicts peacefully, schools can create a more supportive and inclusive environment that reduces the likelihood of violence.

These associations are strongly rooted in theories of the normalisation of violence and social and emotional learning. For example, teachers who have experienced or been exposed to violence themselves may come to view aggressive behaviour as an acceptable way to manage conflict and misbehaviour in the classroom as well as in their own homes.[28, 29] This normalisation can lead them to replicate similar behaviours when disciplining students. Similarly, and drawing on social learning theory, some studies suggest that individuals often adopt behaviours they have experienced or witnessed. Teachers who have been victims of interpersonal violence may lack exposure to or training in non-violent conflict resolution strategies, making them more prone to use corporal punishment within the school environment.

How can school-based strategies address the intersections of VAC and VAW?

A growing body of evidence on what works in preventing school violence, with particular import for addressing the intersection between violence against women and violence against children, has emerged over the past two decades. The strongest evidence appears to support a number of different components, that may be offered either as stand-alone components or as part of multi-modal approaches. These include modelling and promoting gender-equitable norms, social and emotional learning, teacher training, safe disclosure, providing support for pregnant learners and learner mothers, and addressing structural inequalities.

Disrupting the intergenerational transmission of violence

One of the most compelling arguments for school-based interventions is their potential to disrupt the intergenerational cycle of violence. Research has consistently shown that early exposure to violence increases the risk of later victimisation and perpetration. Children who experience abuse are more likely to drop out of school, experience mental health issues, and eventually enter into abusive relationships as adults. This cycle is perpetuated when the same social and cultural norms that condone violence are passed from one generation to the next.

Interventions that include a gender transformative focus on early identification, SEL, and teacher training provide a means to break this cycle. By intervening at critical points – such as when children first exhibit signs of trauma or when teachers are in need of support – schools can alter the trajectories that lead from childhood exposure to adult victimisation. For instance, programmes that promote healthy relationship education and challenge traditional gender norms have been shown to reduce the risk of IPV and other forms of gender-based violence. A recent review shows that adolescents who participate in school-based relationship education programmes are more likely to recognise and resist abusive behaviours in both their peer groups and family settings.[30]

Modelling and promoting gender-equitable norms

Schools are pivotal in shaping attitudes toward gender roles and relationships. When violence against women is normalised both at home and in school, it reinforces the acceptance of abusive behaviours. Promoting gender-equitable norms from an early age is critical for preventing IPV and other forms of violence against women and other forms of gender-based violence.[19] School-based curricula that incorporate lessons on healthy relationships, gender equality and conflict resolution can help counteract harmful stereotypes and encourage more respectful interactions. For example, the PREPARE programme implemented by the South African Medical Research Council in South Africa, and the Connect With Respect (CWR) intervention in Tanzania, Zambia and Eswatini have yielded positive outcomes in the reduction of violence and associated behaviours by promoting gender-equitable norms and improving learners' knowledge and skills.[31] It is also crucial to include teachers in these programmes to ensure that changes in behaviours and attitudes among learners are reinforced by the same messaging and behaviour among teachers.

Social-emotional learning

Social-emotional learning (SEL) interventions have emerged as one of the most promising strategies for mitigating the long-term impacts of early exposure to violence within the home and schools. SEL programmes teach children skills such as emotional regulation, empathy and conflict resolution. There is strong evidence that SEL programmes reduce aggressive behaviour, improve social competencies and lead to better academic outcomes.[31, 32]

Case 7: The Right to Play Intervention, Pakistan

Right To Play has worked with children and young people in Pakistan to shift the social norms that perpetuate and condone violence against women and girls.[33] Through its schools-based Sport and Play programme, teachers are provided with curricula and trained to challenge the acceptability of violence against women and girls. The programme encourages boys and young men to adopt positive forms of masculinity and supports girls and women to develop their abilities to express themselves and act as leaders. A study evaluating Right To Play's intervention in Pakistan found that this structured play-based life-skills intervention helped reduce school-based peer violence and depression among school children.[34]

Case 8: Skhokho Supporting Success, South Africa

In South Africa, the Skhokho intervention is a comprehensive gender-transformative intervention aimed at reducing sexual violence. It includes a focus on promoting gender equity and reducing violence through, among others, a combination of SEL initiatives and teacher training. Importantly, it also premised on the importance of integrating school and family support and alignment and includes a discrete parenting component. Early evaluations indicate that Skhokho has led to measurable reductions in physical aggression and gender-based violence in school settings as well as in the family. Importantly, the intervention addresses the role of teacher well-being in perpetuating violence, training educators in non-violent disciplinary practices and trauma-informed care. This dual focus – on both students and staff – exemplifies how along with shifts within the home environment, schools can disrupt intergenerational patterns of violence by altering the environment in which children learn and socialise.

In environments where children have been exposed to violence, SEL can be transformative. By helping children develop healthier coping mechanisms and resilience, SEL programmes directly counter the normalisation of violence and the replication of violent norms, attitudes and behaviours into adulthood.[31] There are several examples of evidence-based programmes offered through and to schools that have achieved positive outcomes in reducing violence, such as the Right to Play intervention in Pakistan (see Case 7).

Teacher training and safe disclosure

Creating an environment where children feel and are safe to disclose violence is equally important. Like many victims of gender-based violence and violence against women, children often fear disclosing and reporting of violence, and in particular sexual violence, as they fear blame, retribution or not being taken seriously.[35, 36] Yet reporting and help-seeking is an important step in not only addressing the abuse itself, but also dealing with the trauma that results from the victimisation. When schools foster an atmosphere of trust and support, children are more likely to report abuse. Whole school approaches that focus on school climate consistently demonstrate increased students' confidence in reporting abuse while also facilitating timely community interventions.[37] Such proactive measures can limit the immediate harm and prevent long-term negative outcomes.

Teachers and school counsellors are often in the best position to detect early warning signs of abuse. Signs such as sudden changes in academic performance, social withdrawal and emotional distress can be indicators of violence within the home, school or community. School staff, including teachers, who are able to identify these early signs significantly improve the referral and intervention process.[38] Training programmes that help teachers recognise early indicators of trauma can help prevent the escalation of violence.[39]

Moreover, teachers who receive training in trauma-informed practices are less likely to replicate the violent behaviours they may have witnessed or experienced. This shift not only benefits the learners but also contributes to a more positive, safe and supportive school environment. When teachers learn how to manage classroom conflicts without resorting to physical punishment, they set a critical example for children, reinforcing the idea that non-violence is both possible and preferable. Teacher training, when combined with shifting gender norms and values and SEL programming can be particularly effective in medium to longer term outcomes (see Case 8: the Skhokho intervention).

Modelling non-violence in the classroom, through the use of positive discipline, rather than corporal punishment, is also essential. Corporal punishment violates children's rights to dignity and protection from violence, undermines trust in teachers, and causes lasting physical, psychological and educational harm, including increased aggression, anxiety and school avoidance.[40, 41] It normalises violence as a problem-solving tool and is linked to poorer academic performance and damaged teacher–student relationships. Effective alternatives that foster a positive school climate include positive discipline, restorative practices, SEL programmes, and clear, consistent non-violent behaviour management, all of which maintain order while promoting respect, empathy and learner engagement.[42]

New sanctions for corporal punishment issued by the South African Council of Educators (see page 16) recognise the need for teacher training and rehabilitation with an emphasis on anger management and non-violent discipline. This is an important step forward in protecting individual learners and creating a safer, more supportive school environment.

Providing support for pregnant learners and learner mothers

Pregnant and mother adolescents are particularly vulnerable to experiencing bullying, social exclusion and stigma in school settings.[43, 44] In addition, they face heightened social and economic vulnerabilities which can increase their risk of experiencing intimate partner violence, both during pregnancy and motherhood.[45] These experiences can, in turn, negatively impact their education and health and well-being outcomes, including contributing to underperformance at school, potential school dropout and poor mental health.[44, 46] It is thus crucial in preventing and responding to VAC and VAW to include a specific focus on the needs of pregnant and mother adolescents in schools.

Case 9: Khanyisa Ngemfundo toolkit to help teachers support pregnant learners and learner mothers

Jane Kelly[i]

Teachers are well-positioned to create a supportive environment and respond to the support needs of pregnant and mother adolescents but may feel ill-equipped to do so. In recognition of this, the Khanyisa Ngemfundo research team, in collaboration with the Department of Basic Education, created an evidence-informed training toolkit and accompanying videos for teachers.[47] Drawing on research data from educators, school governing board members, civil society organisations, adolescent mothers and their peers, the toolkit aims to:

- help teachers understand the unique challenges pregnant and mother adolescents face in and outside school, including risk of social exclusion and violence;
- empower teachers with interpersonal skills to improve their engagements with these adolescents, such as active listening and providing non-judgmental support; and
- support them to develop solutions and procedures that are appropriate to their own context.

Recognising that teachers cannot provide support alone, the toolkit includes suggested activities for how schools can partner with health and social services, such as mapping available services in their community.

The toolkit is intended as a practical resource to strengthen the capacity of teachers and school communities to better support pregnant and mother adolescents. By fostering empathy, improving communication, and encouraging collaboration with other sectors, it aims to contribute to more inclusive and responsive school environments.

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Case 10: Violence Prevention for Peaceful and Inclusive Communities – Early prevention for long-term impact

Luxolo Matomela[i]

Intervening early in the life course can reduce children's exposure to violence and neglect, while fostering protective factors like secure attachments and positive parenting. The Violence Prevention for Peaceful and Inclusive Communities (VPPIC) programme therefore aims to support the development of early violence prevention programmes to break the intergenerational cycle of violence and build more resilient individuals and communities.

The VPPIC programme aims to create a positive caregiving environment for children from birth to 12 years old – by equipping their caregivers, educators and community workers with knowledge and skills, and by creating safe supportive environments in early childhood development centres, schools and extracurricular programmes. The programme tackles violence against children and violence against women simultaneously allowing for more effective prevention by targeting shared root causes, including power imbalances and harmful gender norms. This integrated approach contributes to safer, healthier families and communities.

The VPPIC has been working in partnership with Department of Basic Education and other stakeholders from civil society, local government and communities to develop early prevention programmes that are evidence-based and attuned to local needs.

It does so by building the capacity of local stakeholders so that they are better able to plan, implement and monitor early prevention services, and by facilitating collaboration across different sectors to strengthen synergies and coordination.

Lessons learned from the initial pilot in three hotspots for gender-based violence in Tembisa, KwaMashu and Rustenberg has helped build a strong foundation from which to guide local efforts to prevent violence and create safer and more inclusive communities.

i GIZ: Deutsche Gesellschaft für Internationale Zusammenarbeit

The DBE's Policy on Prevention and Management of Learner Pregnancy in Schools (2021) explicitly recognises the needs of pregnant and mother adolescents. It commits to (i) creating a supportive environment that enables them to continue and complete their education, and (ii) ensuring that schools provide a non-judgmental environment to support their physical and psychological health and dignity.[48] This is important because evidence shows that school retention and completion is protective for both adolescent mothers and their children.[49, 50]

Addressing structural inequalities

Structural factors such as poverty, discrimination and community violence play a significant role in perpetuating cycles of abuse. The pathways to violence framework acknowledge that these factors interact with individual experiences to create cumulative risk. As noted earlier in this chapter, schools are microcosms of the community and the social and physical environment in which they are located. Schools that operate in disadvantaged areas often face additional challenges, including overcrowding, limited resources and higher exposure to community violence. Policies and programmes that address these structural inequalities – through resource allocation, supportive policies, and community development initiatives – can create safer and more conducive learning environments.

Whole school approaches

While there is a growing body of evidence on the efficacy of the above strategies, there is both a degree of inter-connectedness between many of these approaches, and a multiplier effect which are often best embedded within a whole-school approach.

Intersecting all of the above strategies, and foundational to whole school approaches, is the critical opportunity that the school environment offers to identify children at risk, establish equitable, pro-social and healthy norms and values, and intervene and support children at an early age. Early identification of abuse and violence, and of children-at risk of violence or abuse, provides the opportunity to disrupt trajectories and pathways, preventing trauma and harm from escalating as well as interrupting root causes before they become entrenched. This requires a school climate that supports and enables early intervention, help-seeking and that is intolerant of violence and violent norms, and that can support trauma-informed intervention. This requires:

- school management that share a common vision and culture and that are equipped with the tools and competencies to create a wider school environment that reflects this culture
- psychosocial support services (including school-based counsellors and social workers) who share this common

Case 11: Good School Toolkit

The Good School Toolkit adopts a whole-school approach that aims to transform "the entire school eco-system by engaging various stakeholders, teaching learners how to deal with conflict in non-violent ways and how to intervene when they see violence, while also addressing the power imbalances between learners and between teachers and learners".[31]

The approach recognises that creating and maintaining a safe school in which children can thrive requires more than just physical safety. It also requires the commitment and support of all those who are part of the learning experience – including teachers, learners, school management, parents and the wider community. Furthermore, it requires a commitment to ensuring that children not only are safe, but feel safe, empowered and listened to. The Good Schools Toolkit provides the best example of a whole-school approach that focuses on creating a positive school climate for learners.

Figure 7: Entry points through which the Good School Toolkit influences the operational culture of schools

Source: Naker D. *Operational Culture at Schools: An overarching entry point for preventing violence against children at school. Background paper. In: Ending Violence in Childhood Global Report 2017. Know Violence in Childhood.* New Delhi, India. 2017.

vision and are appropriately equipped to support its realisation, and

- parents and caregivers who support and strive for these same outcomes and are equipped with parenting skills that are aligned with and seek to entrench the common values, norms and expectations.

Whole-school approaches thus seek to address the entire eco-system of the school by engaging a wide range of stakeholders with a vested interest and mandate in creating safe, inclusive schools in which children can learn and thrive.[31] These approaches draw on a range of stakeholders – government, community, teachers, parents, children and school

Case 12: South African children and pornography

Marita Rademeyer[i]

South African children are accessing pornographic materials online at an unprecedented rate, with 53% of 9 – 17-year-olds having seen sexual images online.[68] Exposure is happening at very early ages with an estimated 10% of pornography users in the UK aged ten or younger.[69]

Exposure to sexual content online carries the potential for harm, though effects differ by age, developmental stage and context. For younger children (for example ages 8 – 11), initial exposure often leads to confusion, shock, fear or disgust; in a recent study from Ghana, children exposed to pornography reported feeling sad, confused and surprised.[70] Recent studies suggest that while pornography is not universally addictive, high frequency or problematic pornography use is associated with significant risks – especially for children and adolescents – including increased impulsiveness, poor decision-making and memory problems.[71]

A further concern, particularly in environments where open conversations about sex and sexuality is taboo, is that pornography may be children's primary source of sex education. A content analysis of pornographic videos found that 88% of scenes portrayed physical and/or sexual violence. Such content normalises violence especially during sex.

The harmful effects of pornography can be mitigated by sex education, providing opportunities for open age-appropriate conversations with children about what they encounter online, and by raising awareness among caregivers and teachers. Installing and maintaining appropriate software on electronic devices can mitigate risks for younger children, but has been shown to be less effective for older children, as they learn how to get around parental controls. Timely interventions can mitigate the adverse effects of early exposure.

Strategies for caregivers

1. Build a strong and healthy relationship with your child so he or she can tell you anything.
2. Have open and frequent conversations with your child about bodies, sex and sexuality.
3. if your child is young, secure your child's online environment through blocking, filtering and accountability software, but regularly check your child's browsing history and discuss. As your child enters adolescence, allow them more freedom and trust but ensure you remain available to discuss what they encounter online.
4. Spend time helping your child use the online environment safely.
5. Avoid scaring, threatening and warning. Fear-based approaches are not effective in preventing exposure.
6. Develop a family media plan that applies to everyone to balance screentime with family time, sport, exercise, homework and sleep.

Strategies for schools

1. Establish effective cyber and child protection policies.
2. Use firewalls and protective software on school devices to prevent unauthorised access to information, and test if children can get around them.
3. Learning about healthy sexual behaviours should be a continuous two-way conversation that starts in primary school.
4. Teach digital literacy. Help children learn what an 'online reputation' is and how to keep it positive. Help them take charge of the language, emojis and pictures they send, and what personal information they share online.
5. Work with parents to ensure that they understand the impact of online risks, including pornography, on their children and how to keep them safe.
6. Educators need to be trained to deal with their own discomfort and develop the skills to identify signs and indicators and to provide trauma informed responses when children have been exposed.

i JellyBeanz

administrative staff – to foster a school climate in which children feel safe and can learn and thrive. One of the best examples, with the strongest evidence, is the Good School Toolkit, designed and implemented by Raising Voices in Uganda. This integrates many of the components discussed above.

Conclusion: Schools as catalysts for change

In conclusion, the intersection between VAC and VAW in schools is symptomatic of the broader, intergenerational cycle of violence that is evident in South Africa (and many other societies). Viewing this violence within the broader context and pathways that children follow, from home to school and into the broader society, highlights how early exposure to abuse — whether at home or in school — sets children on trajectories that increase their vulnerability to both victimisation and perpetration later in life. Violence in schools not only disrupts the learning process but also shapes harmful perceptions of self, identity and social interaction, perpetuating cycles of violence and abuse that extend well into adulthood.

By adopting a comprehensive, integrated strategy that prioritises behaviour change through SEL and challenging inequitable gender norms, within the broader school environment that is supportive, enabling and peaceful, schools can effectively address the complex interplay between VAC and VAW. Through integrated strategies that include SEL, trauma-informed teacher training, early identification of abuse, and robust family and community support, schools can actively interrupt the pathways that lead to the normalisation and transmission of violence. By addressing both the immediate manifestations of violence and the broader structural and cultural factors that underlie it, school-based interventions can reduce the prevalence of VAC and VAW and promote healthier, more equitable relationships. There is a robust evidence base that comprehensive, integrated approaches are effective in reducing violence and supporting long-term behavioural change.

Ultimately, the role of schools extends beyond the teaching of academic curricula: it is here that children learn to navigate complex social dynamics, develop emotional resilience and build the foundations for future relationships. By harnessing this potential and implementing evidence-based, holistic strategies, schools can play a pivotal role in breaking the intergenerational cycle of violence, ensuring that children – and, by extension, women – grow up in safer, more supportive environments.

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Beyond awareness: Engaging communities in preventing violence against women and children

Mercilene Machisa[i, ii, iii] & Sebenzile Nkosi[iv, v, vi]

Violence against women and children is deeply entrenched, and it erodes the safety and dignity of individuals, families and entire communities. In South Africa, the persistent shadow of systemic violence and segregation, coupled with wide economic disparities, continues to shape everyday life. These challenges, reinforced by deeply ingrained patriarchal norms interwoven with cultural and religious beliefs, create fertile ground for the perpetuation of violence against women (VAW) and violence against children (VAC).[1]

Historically, efforts to prevent VAC & VAW at community and societal levels have often taken the form of sporadic, recurring mass awareness campaigns led by government departments or civil society organisations through donor-funded projects.[2-4] These include heightened media coverage and campaigns during the annual 16 Days of Activism (November 25 to December 10), the focus on women's rights during Women's Month in August, and the commemoration of International Women's Day on March 8. However, government has since rebranded the 16 Days of Activism as the "365 Days of No Violence" campaign to promote year-round awareness and action. Despite this rebranding, sustained campaigns running throughout the year remain limited, and evidence suggests that awareness-raising alone has little effect in reducing VAC and VAW. Instead, efforts to shift deep-seated community norms require engaging communities in norm and behavioural change [2-4]

Community engagement adopts a more sustained and collaborative approach by creating spaces where community members, practitioners and researchers work together to jointly address issues that affect community well-being and drive changes in norms and behaviour. Communities include people who live in the same area or those who share the same characteristics, beliefs or experiences, and individuals are often members of more than one community.

Rather than imposing top-down solutions, and viewing communities as passive recipients of aid, collaborative approaches regard communities as valued partners who play an active role in shaping interventions to prevent VAC and VAW.[5, 6] These approaches are then used to build sustained ownership and meaningful participation.[6, 7] This paradigm shift entails meaningful community engagement and authentic participation that leverages local resources and prioritises the invaluable lived experiences and intimate knowledge of community members to inform interventions.[7] It calls for external actors – including researchers, practitioners and policymakers – to work with communities in ways in which decision-making power is shared and community voices drive the process. Meaningful community engagement in preventing VAC and VAW is essential for promoting social connectedness, shared responsibility, and empowering members to challenge harmful social norms and support women survivors and vulnerable children. Furthermore, engaged communities have enhanced local capacity for collective action, enabling them to mobilise and advocate to hold legal and protection systems accountable for addressing the underlying drivers of violence and improving responses.[8]

This chapter outlines a range of approaches that practitioners, policymakers and researchers can draw on to meaningfully engage communities in preventing VAC and VAW. It considers: What specific approaches can practitioners, policymakers and researchers use to meaningfully and effectively engage diverse community actors in participatory, survivor- and child-centred prevention efforts? What illustrative examples exist from the South African context, and what are the current knowledge gaps regarding the benefits and impacts of these approaches?

How can communities engage with legislation and policy?

Efforts to prevent VAC and VAW at the community level require key actors, such as legislators, policymakers and the media to remain closely connected to grassroots realities. These actors play a crucial role in shaping legal, policy and public discourse and influencing social norms and behaviour at scale. However, their efforts will be most effective when they are informed by

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evidence – and are responsive to the lived experiences and inputs of communities on the ground.[3, 4] Ensuring meaningful channels through which community members can engage with and influence these high-level decision-making processes helps strengthen the relevance and impact of prevention efforts. This two-way interaction supports the development of enabling frameworks, responsive policies and positive media narratives that authentically reflect the voices of those affected by VAC and VAW, thereby amplifying community-level initiatives and driving sustainable social change. Moreover, applying a gender and child-centric lens at all levels of this multi-layered engagement is essential. It guarantees that women's and children's perspectives and needs remain central in decision-making processes, helping to redress power imbalances and ensure inclusive policies and programmes that empower women and children rather than marginalise them.

Engaging communities about legislation such as the Domestic Violence Act and Sexual Offences Act is essential to empower them with knowledge about their rights and the laws' implications. This is best achieved through accessible, culturally relevant programmes such as public education events and community dialogues that clarify legal concepts like protection orders and mandatory reporting, ensuring community members understand both the protections and potential risks, such as increased family tensions.[9] Creating safe spaces for community members to discuss their experiences and concerns supports

Figure 8: Risk and protective factors for VAC and VAW at the community level

Source: Mathews S, Jamieson L, Lake L, Smith C. *Violence can be prevented.* [Poster]. Cape Town: Children's Institute. University of Cape Town. 2014.

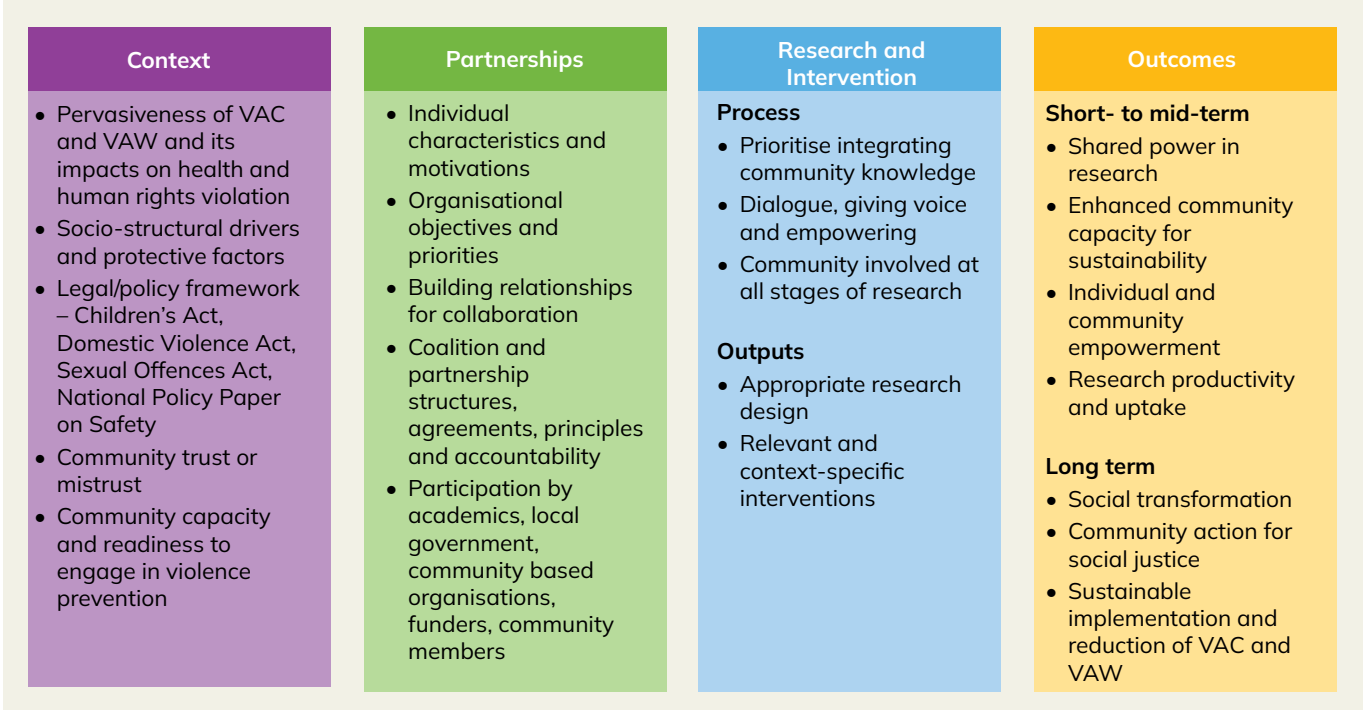
ongoing education and helps them navigate laws, advocate for themselves, respond to VAC and VAW, and support survivors. Continuous capacity-building initiatives further strengthen communities' ability to engage with legal systems effectively and promote informed responses to VAC and VAW. Ongoing dialogue between legislative, policy and media stakeholders and community members ensures accountability, while collaboration with local leaders, service providers and survivor advocates enhances this engagement by connecting communities to support services and referral systems.[10]

How can communities be engaged to identify community-level risks and protective factors?

Community-based participatory approaches (CBPA) can be used to help communities identify the specific risks, protective factors and social determinants of VAC and VAW in their context. These methods actively involve community members in identifying and analysing critical issues that drive violence – such as gender inequality, patriarchal norms and economic disparities. This should include participation in each stage of the public health approach – from defining the problem to prioritising changeable factors, developing interventions, evaluating outcomes, and monitoring impact. CBPA centres the lived experiences of community members, revealing not only risks such as poverty, unemployment, crime, substance abuse, weak sanctions against violence and low social cohesion but also protective factors like strong social networks and community ties, high social cohesion with mutual trust and a shared sense of belonging, active community participation in addressing violence, access to quality education and economic empowerment opportunities, and coordinated community resources and services (see Figure 8).[11, 12] In this way CBPAs ensure that prevention efforts are grounded in the unique realities and strengths of each community rather than assuming uniform drivers across contexts.

It is important to recognise how community-based risk and protective factors are interconnected with the broader societal and structural drivers of VAC and VAW. Engaging communities directly using CBPA helps to provide a more nuanced understanding of how macro-level inequalities translate into localised risks and how community strengths can be leveraged to enable effective prevention. For instance, socioeconomic disparities (a structural driver) can manifest at the community level as concentrated poverty and unemployment (community risk factors), that weakens social cohesion and increases vulnerability to violence.[12, 13] Similarly, deeply entrenched patriarchal norms and gender inequality, which are structural drivers, can contribute to community risk factors such as the normalisation of violence and a culture of silence around abuse, while hindering the development of protective factors like women's empowerment and gender-equitable social networks.[13]

Figure 9: Key ingredients of community-based participatory research and collaboration to prevent VAC and VAW



Adapted from: Sánchez V, Sanchez-Youngman S, Dickson E, Burgess E, Haozous E, Trickett E, et al. CBPR Implementation Framework for Community-Academic Partnerships. *American Journal of Community Psychology*. 2021;67(3-4):284-96

How can community partnerships and collaborative initiatives help prevent VAC and VAW?

Community-based participatory approaches are also useful in establishing effective partnerships, coalitions and collaborative initiatives by prioritising equitable relationships and inclusive community structures (see Figure 9).[5] These approaches require researchers to move beyond the traditional 'expert' mindset and embrace a role as co-learners, recognising the value of lived experiences and localised knowledge of community members alongside the expertise of researchers and practitioners.[5, 6] This ensures that collaborations are built on mutual respect and shared ownership from the outset. The collaborative approach ensures that initiatives are culturally relevant, context-specific, and more likely to be accepted, driven and sustained by the community.

Another key application of CBPAs is in the formation of community coalitions, which bring together diverse stakeholders under a structured partnership agreement. Coalitions enhance engagement through establishing clear terms of reference, determining and aligning shared goals, and supporting the co-development of interventions.[14, 15] Moreover, embedding interventions within community structures and building local capacity through collaborative training programs and resource networks ensures that effective interventions and strategies are not reliant on external actors and can continue to be implemented and adapted over time.[2, 16]

How can communities co-develop interventions to prevent VAC and VAW?

Communities can be engaged in identifying needs, designing, implementing, and evaluating interventions to ensure alignment with local contexts and priorities. The co-development process emphasizes dialogue, listening, reflection, and shared decision-making to reduce power imbalances and centre lived experiences. It builds trust and strengthens community cohesion by supporting collaboration within a safe and respectful environment (see Figure 10 on p. 90).[17]

Successful co-development requires a genuine commitment to equitable power-sharing, with experts relinquishing control to enable meaningful community participation. Researchers must address challenges such as communities' experiences with top-down approaches and local power imbalances. Co-development processes in VAC and VAW prevention should also align with feminist principles. This includes focusing on gender, challenging inequalities, embracing intersectionality, maintaining collaboration, doing no harm commitment and ensuring that researchers remain accountable to communities.[18]

Ethics committees and funders must be more flexible and supportive of participatory research methods that are iterative, time-consuming and resource intensive. Co-development requires longer project timelines and increased resources to enable relationship-building and adaptation.[17]

Participatory approaches and engagement strategies must be designed to meet the needs of the target group. For children, age-appropriate methods, safe spaces, confidentiality, and clear reporting and referral pathways are essential. Facilitators need training in these techniques and must address practical considerations like timing and transport. For adults, using local languages and literacy-appropriate materials is vital. Skilled facilitators with the ability to resolve conflict and build consensus can help ensure inclusive, respectful discussions. In gender-sensitive contexts, separate women's and men's groups create safe environments, especially in patriarchal communities where mixed groups risk reinforcing inequities. Across all groups, co-development should uphold values of non-violence, respect, trust, equity, active listening and collaboration to facilitate a creative, inclusive process.

How can communities challenge social norms?

Social norms are critical in perpetuating violence against women and children. In this context, social norms encompass the widely accepted beliefs and behaviours within a community that normalise or excuse violence. These norms often manifest as rigid gender roles, where men hold power and women are expected to be submissive, creating an environment where violence is seen as acceptable or even justifiable.[19]

For children, it can manifest in acceptance of corporal punishment as a form of discipline and the perception that children are passive recipients of adult decisions, lacking the agency to contribute to solutions for issues that affect them.[20] For women, this can mean accepting unequal treatment, limited access to resources, and an increased risk of experiencing various forms of violence.

Community-based participatory approaches can be used to actively involve community members in identifying, understanding, challenging and redefining harmful social norms that perpetuate VAC and VAW. Participatory methods can be used to facilitate the collaborative design or co-development of interventions that resonate with the community's cultural context. They are also useful to support community mobilisation and efforts to promote critical reflection and collective action. They can also be used to involve community members in monitoring and evaluating if prevention interventions have succeeded in shifting norms and behaviours.

Box 8: The role of culture and masculinities in violence against women and children

Teresa Abel[i] and Malose Langa[ii]

South African society often portrays men as the perpetrators of gender-based violence (GBV). While this view reflects the lived experiences of most victims and survivors of GBV, it is also important to consider how many boys grow up as silent witnesses to domestic violence, internalising harmful gender norms and trauma that then shape their future relationships and sense of identity.

Creating safe spaces for dialogue

A different narrative is emerging through Breaking the Cycle: Empowerment Initiatives to Disrupt Gender Based Violence – a project implemented by the Centre for the Study of Violence and Reconciliation (CSVR) in select GBV hotspots in Gauteng and the Western Cape – including Tembisa, Moroka, Diepsloot, Delft and Mitchells Plain. As part of this process, the CSVR and Department of Social Development hosted a series of men-only dialogues which provided a safe space for men to reflect, share experiences and examine the pressure exerted on men by traditional masculinity.

Conversations centred on gender norms, perceptions of masculinity and fatherhood, and how toxic masculinities shape the role of men in GBV. The conversations also explored how to shift the mindsets of the participants and the communities at large, from perceiving men as perpetrators of violence to seeing men as peacemakers. This approach provided the men with a platform to speak freely without fear or judgement. And it aligns with global evidence that meaningful male engagement must be trauma-informed, context-specific and grounded in an understanding of power and identity.[42, 43]

From defensiveness to critical reflection

For many participants, the first breakthrough is simply being heard. As one of the men puts it in an interview, "When it comes to GBV, men feel like they are no longer involved, or they are no longer important in the community where they are treated like monsters. The only thing is that they are seen as perpetrators more than anything. There is also a trauma in men that goes with that."

This deep sense of exclusion undermines men's confidence to engage in community conversations and initiatives addressing GBV. For some men, this was the first time they had spoken publicly about GBV, not just as something they witnessed or perpetrated, but as something they survived.

In some communities, GBV is largely seen as a women's issue or a concern for the government to handle, but this perception has shifted significantly among men who participated in the study. A participant reflected, "Now men know their part, they are part of the community, and they have the right to voice things out, and to express their emotions openly".

Culture and masculinity in transition

The men-only dialogues offered a safe space that helped men confront how patriarchal norms, socio-economic challenges and emotional repression are shaping their view of masculinity. The conversations explored the traditional ideas of men as strong, stoic and self-reliant and how this discourages male victims of violence from seeking help.

One of the most compelling discussions revolved around the concept of positive fatherhood. Some of the men admitted that being a father is a big part of their identity, and considered non-violent discipline, open communication and mindful behaviour as key to positive parenting and families' well-being.

Fathers expressed a strong desire to pass on healthier versions of masculinity to their sons. Harmful gender norms are often internalised during adolescence, so engaging adolescent boys is another powerful tool for breaking the cycle of violence across generations as was shown in Langa's book Becoming Men[44] where adolescent boys started to embrace positive masculinities that promote fairness and equity.

Research shows that men continue to link their masculine identity to the dominant provider role. These expectations have deep psychological consequences, especially when social or economic conditions make them unattainable and often manifest as emotional distress, strained relationships and resistance to shifting gender roles.[45, 46]

The men-only dialogues have reframed what is acceptable, respected and aspirational within male social circles. One man who participated in the dialogues noted, "We are talking about men championing men. We do

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not need to be apologetic when people say that men are perpetrators. We are here to rebuild and restore."

Conclusion

Participants emphasised that men need opportunities to explore their identities without being cast by society as inherently violent or emotionally defective. Young boys and men also benefit from being introduced to alternative masculinities that are grounded in care, vulnerability and respect.

Excluding boys and men in GBV conversations breeds silence, defensiveness and resistance, but strategic inclusion paves the way for accountability, healing and solidarity. For these shifts to be sustained, they must be embedded in community structures and linked to economic empowerment and mental health support. Building alliances with faith leaders, educators and traditional structures can help embed these new masculinities into everyday social life and ensure community ownership of the change process.

Social norm change interventions aim to shift these deeply ingrained beliefs and behaviours by challenging harmful norms and promoting more equitable and respectful relationships. These interventions move beyond individual-level approaches to address the broader social context in which violence occurs.[8,21] Designing these interventions requires a deep understanding of the specific social norms driving violence within a community, using participatory approaches tailored to different groups. Implementation must address biases and power dynamics within the community and among external actors. It must also ensure participant safety and include ongoing monitoring of progress. A common social norm addressed by interventions is the belief that violence against women and children is a "private matter" to be resolved within the family. These interventions emphasise that VAC and VAW are societal issues requiring community-wide action that empowers members to intervene safely, support survivors, and hold perpetrators accountable.

Successful community-level and social norm change interventions often depend on strong community ownership, involvement of local leaders and culturally relevant messaging. Challenges include resistance from those benefiting from existing power structures, limited resources, and weak sustained commitment. Addressing these challenges requires a shift from consultation to collaboration or community leadership as this helps to build trust, strengthen ownership, and engage key influencers early. Supporting communities to identify relevant solutions and leverage local assets can reduce resource constraints, while embedding interventions within community structures enhances sustainability. Lessons from effective programming emphasise long-term engagement, continuous monitoring and adapting to local contexts, highlighting the importance of CBPA principles in preventing VAC and VAW.[22]

Examples of effective social norm change interventions that apply participatory methods in African contexts include the SASA! (Start Awareness Support Action) programme in Uganda which used a combination of community mobilisation, training, and media to challenge gender inequality and promote respectful relationships.[23] The Indashyikirwa programme in Rwanda is another example of a national-level programme that combined community mobilisation, economic empowerment, and improved access to justice to address gender-based violence.[24] Like SASA!, Indashyikirwa emphasised community ownership and utilised culturally relevant strategies to promote gender equality and challenge harmful norms by working with couples. Other social norm change interventions, include community-based dialogues such as the One Man Can Programme implemented in South Africa that aimed to create safe spaces for men to reflect on their attitudes and behaviours related to gender and violence.[25]

Most evidence-based social norm change interventions have focused primarily on addressing violence against women.[21] Meaningfully engaging children in interventions to prevent violence is challenging as it is essential to weigh up the value of their lived experiences against the need to protect them from further harm. While some programmes, such as SASA!, aim to address both VAC and VAW within the same framework, VAC remains a secondary outcome, and children's voices and unique perspectives are still underrepresented in intervention design and evaluation.[21, 24]

Social norm change interventions have largely focused on women and girls as victims, with less attention to children's (including boys) distinct vulnerabilities. Ideally, interventions should integrate the perspectives and needs of both women and children, recognising that violence affects them differently. For example, interventions focused solely on preventing women's experiences of intimate partner violence often miss the direct impacts on children who witness or experience household violence.[21] Likewise, initiatives promoting positive parenting of children can be strengthened by explicitly addressing gender norms and power dynamics within families, to ensure a more holistic response to VAC and VAW.[21]

Figure 10: Key principles and practices to guide the co-development of interventions to address VAC and VAW

Adapted from: Gibbs A, Mannell J, Ndungu J, Burgess R, & Washington L. *Implementing the co-development of interventions to address violence against women and girls: A short primer.* University of Exeter, South African Medical Research Council, Institute for Global Health, University College London, Project Empower & SVRI. 2023

How can children be effectively engaged in violence prevention?

To effectively involve children in research and social norm change interventions, CBPAs should prioritise building genuine partnerships that value children's knowledge and share power. Adults in violence prevention must recognise their biases and employ participatory, flexible processes that enable power sharing and that build children's agency and trust. Researchers and practitioners need to support children in developing their critical reflection and communication skills, enabling them to become collaborators in research and active stakeholders in service delivery planning and monitoring.[26] This involves encouraging children to contribute to policy development and shifting away from traditional, didactic approaches towards interactive dialogues and participatory methods that amplify children's voices on issues affecting them. Effective child engagement includes using age-appropriate and culturally sensitive approaches, utilising participatory tools such as drawing, drama, storytelling, photovoice, digital storytelling and group dialogues to facilitate their expression within a psychologically safe environment.[26]

How can communities mobilise to take local action?

Community mobilisation to prevent VAC and VAW involves key interconnected steps. It begins with providing accurate information and raising awareness about the risks, causes and consequences of VAC and VAW so that communities recognise violence against women and children as a local issue. Beyond awareness, critical consciousness then enables groups to question deeper social and structural drivers of violence such as unequal gender norms. Empowerment occurs when community members move from being passive recipients of information to active decision-makers, gaining confidence and capacity to develop and implement locally relevant solutions. These steps work together to drive meaningful social change.[8, 22]

The National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF) highlights the crucial role of local community and faith-based actors in preventing and responding to VAC and VAW.[27] The capacity for local action can be enhanced by gender transformative training and the empowerment of community champions – including people from faith-based organisations, traditional leaders and women's rights groups. Community champions can take action by organising community awareness-raising events, leading community dialogues, advocating for policy change, and managing local media campaigns. Such activities increase community activism, create genuine ownership, and ensure interventions align with local priorities. The aims of community mobilisation can include promoting collective reflection, challenging harmful social norms, and motivating communities to take consistent, direct action against VAC and VAW.[8, 22]

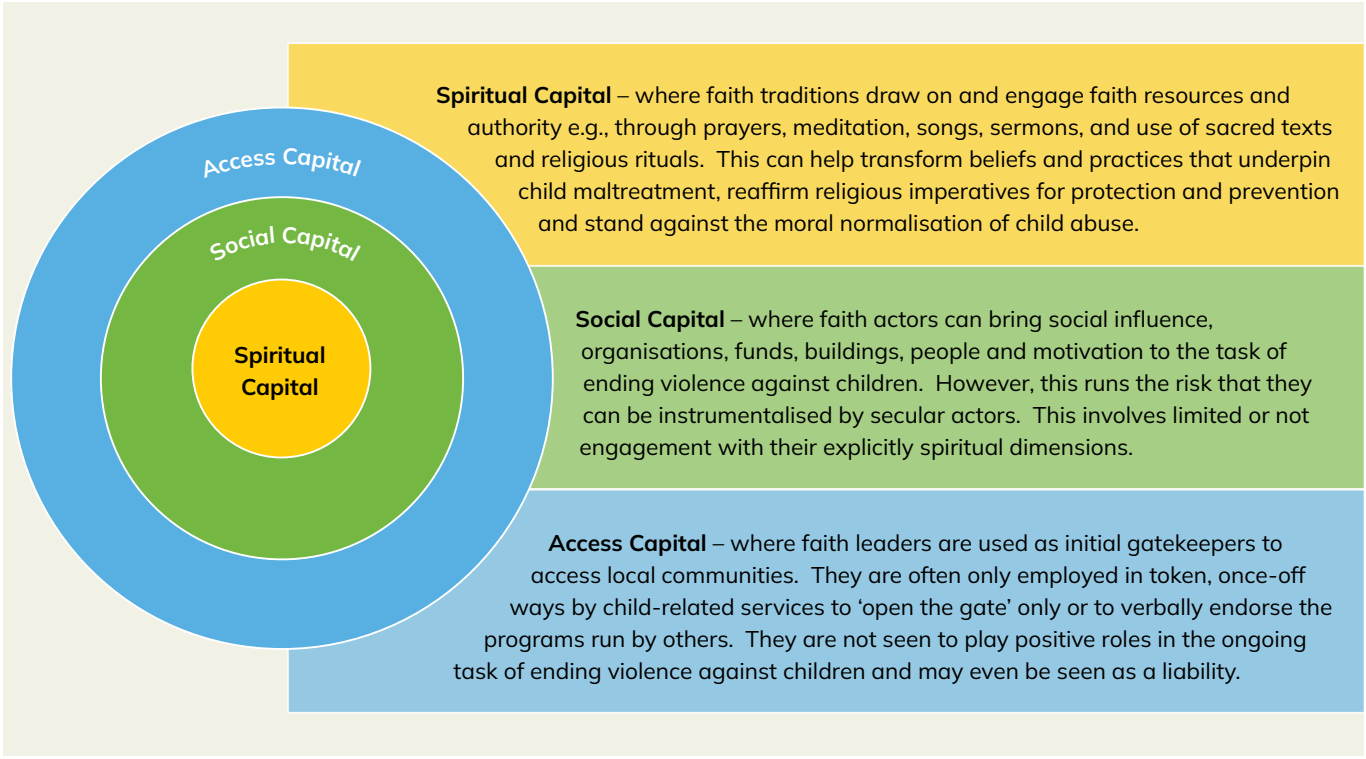
How can faith leaders be engaged to prevent VAC and VAW?

Faith leaders hold significant spiritual and moral authority, making their engagement vital in combating violence against women and children (see Figure 11).[28, 29] Effective partnerships require researchers and practitioners to understand community structures, as well as spiritual values and beliefs about gender roles, child discipline and violence. Involving faith leaders in intervention design ensures prevention messages align with faith and community contexts and can be integrated into worship and programmes for diverse groups, and messages are specifically tailored for women, men, youth and children. Co-developing strategies to celebrate women's leadership in worship and decision-making is also key to promoting gender equality. As educators and community advocates, faith leaders can prevent child abuse by integrating child-centred approaches grounded in justice, respect, and dignity.[28, 29]

What is the role of traditional leaders?

Traditional leaders – whether holding government mandates, inheriting lineage or serving as cultural custodians – exert significant influence over customary laws and practices that shape roles and societal value of women and children. Their engagement is therefore crucial in addressing violence against women and children, including working with them to identify both the positive and negative impacts of traditional practices on violence and gender equality. Partnering with traditional leaders offers an opportunity to reshape or eliminate harmful cultural practices, thereby empowering women and children, encouraging their full involvement in family and community life, and protecting them from abuse.[28]

Figure 11: Faith leaders have spiritual, social and access capital that can be leveraged for VAC and VAW prevention



Source: Palm S, Eyber C. Engaging the mechanisms of faith? How faith communities can contribute to ending violence against children. The Thinker. 2024, 98(1):37-48

Case 13: The role of faith communities in ending violence against women and children

Selina Palm[i]

Eighty-four percent of the world's population identify as people of faith across diverse religious traditions. For many, their faith provides an authoritative or influential guide for all aspects of their beliefs and behaviours, especially marriage, family life and ethics, shaping how children are raised, and with beliefs and values also passed on intergenerationally. However, research also shows that religion is a mixed blessing[47] in the task of ending violence against women and violence against children. It can underpin or help transform social norms that do harm. Emerging evidence suggests the need to intentionally engage with the diverse mechanisms of faith and their roles in helping all children thrive without violence.[48-50]

SVRI is the largest global initiative focused on advancing research on violence against women and violence against children in low- and middle-income countries. Their Africa-centred Community of Practice on Faith and Gender-Based Violence[51] started in late 2024 and already has over 700 members. This includes a working group dedicated to faith and ending violence against children. In 2025, the group co-designed and co-delivered a 12-week pilot course to 30 participants from diverse faith traditions and seventeen countries entitled Faith and Helping Children Thrive without Violence.[51] Graduates, including many faith leaders, described the course as personally transformational:

> "One of my most profound personal shifts (on this course) was re-understanding child discipline not as control, but as connection. I grew up in a context where "good parenting" was often measured by obedience and fear. This course helped me reflect on how deeply those ideas are internalized even by well-meaning people of faith and how we can interrupt that cycle with nurturing care, compassion, and sacred trust." (course graduate)

By intentionally centring the experiences of practitioners and survivors, the course helped to shift power dynamics and amplify marginalised voices, while the emphasis on creating a safe space for personal reflection and shared learning enabled participants to share their feelings and build connections across religious, professional and geographic divides:

> "In most classrooms, the moment I say I'm a survivor the air changes. I see it and feel it. The discomfort, the doubt, the quiet dismissal. But here I spoke, and the room leaned in. No one cut me off with jargon. No one hid behind diplomacy. When I said, "this sounds noble, but harms children", they listened because survivor testimony isn't an add-on here. It's the heartbeat of the work." (survivor/course graduate)

i Sexual Violence Research Initiative

How can communities support survivors?

Communities and structures can be engaged to support survivors of VAC and VAW by leveraging and building local resources to establish safe, accessible support mechanisms – especially when formal services are limited.[30] Community-based initiatives such as "safe homes" provide vital protection, especially in rural and peri-urban areas. These safe homes, are exemplified by projects like the Green Door campaign, led by the Gauteng Department of Community Safety which involved residents, councillors, community policing forums, and other stakeholders collaborating with the police to protect the women and children in the community. This includes training local residents to offer initial assistance and linking them to security networks to prevent perpetrator access. This creates safe environments close to survivors' homes, complementing formal shelters and fostering community ownership of prevention and support efforts. Integrating psychosocial support through trusted community organisations, establishing clear referral pathways, ensuring confidentiality, and implementing mandatory reporting protocols are also critical. Careful evaluation of safety and ethical considerations, including child safeguarding and informed consent in high-risk settings, is essential to ensure the safety and protection of both survivors and supporters.

How can local service providers prevent and respond to VAC and VAW?

The 2016 White Paper on Safety and Security[31] has a strong focus on early intervention, victim support and criminal justice. Engaging all community stakeholders – including healthcare workers, teachers and police – is crucial in supporting these objectives and ensuring a comprehensive coordinated, empathetic response to survivors of VAC and VAW.[10, 32] Frontline providers are often survivors' first contact, and their

response influences survivors' trust and willingness to seek help. Police interactions shape trust in justice, while teachers and healthcare workers can identify abuse early and facilitate referrals. Comprehensive training and ongoing orientation of these providers are essential to ensure sensitive, coordinated victim-centred responses that reduce stigma and bias. Without this engagement, negative attitudes and misunderstandings hinder effective violence prevention, leading to mistrust and poor survivor health and justice outcomes. Responsibility for delivering this training often falls on NGOs, and funding constraints frequently result in piecemeal or inconsistent implementation.

Sustainable impact requires government commitment to allocate dedicated resources and integrate training within formal service structures, ensuring that all frontline providers, across health, social, and justice sectors, receive standardised and ongoing capacity building. Sustained capacity-building across community stakeholders and service providers is vital to transform attitudes, strengthen services, and reduce the incidence and impact of violence against women and children.[10, 32]

How can communities improve safety?

Crime Prevention Through Environmental Design (CPTED)[33] can help prevent violence against women and children by adapting the physical environment to minimise crime risks and enhance residents' sense of security (See Figure 12). This involves actively involving community members to identify local concerns, map harassment hotspots and collaboratively develop safety plans. These plans focus on improving infrastructure such as lighting, maintaining clear sightlines, controlling access, and securing public spaces to prevent them becoming targets for crime.[33, 34]

Social CPTED complements these improvements in physical infrastructure by addressing the social dynamics within neighbourhoods. It focuses on building social cohesion, promoting community connectivity and strengthening

Case 14: VPUU's Emthonjeni Project – an integrated approach to addressing the intersection of violence against women and children

Phetang Mabeba[i]

In the urban landscapes of South Africa's townships, violence is not a singular epidemic but a complex, interwoven web. Witnessing violence within the family and greater community is seen as 'normal', with little awareness that children are at risk. But children living in Monwabisi Park and other informal settlements are not just subject to physical violence. They are also exposed to the structural violence of apartheid spatial planning and cultural violence (social norms that condone the use of violence against women and children).

In these contexts, early childhood development (ECD) centres can serve as an important mechanism to protect children from harm and to nurture their optimal development, but many children in these communities don't attend early learning programmes (ELPs). The Violence Prevention through Urban Upgrading (VPUU) therefore introduced the Emthonjeni project to engage communities in co-creating out-of-centre ELPs for young children living in informal settlements.

Emthonjeni are public spaces around communal water taps, which have been upgraded in collaboration with community members, parents and children to create safe, open-air classrooms for children who are not enrolled in ECD centres. Each Emthonjeni serves as a dynamic, multifunctional space where people can gather – with clean water, trees, tables, seating and a safe place for young children to learn and play. These spaces help build social cohesion, improve safety, and serve as catalysts for an attractive and vibrant neighbourhood.

Facilitators are recruited from the community and equipped with the skills to promote play-based learnings using the Unlimited Child curriculum, educational toys and other learning materials Each child's clinic card is checked regularly, and parents are encouraged to visit a clinic for vaccinations. Attendance is monitored to assist with impact evaluation, and safety is ensured by working together with parents, neighbourhood watch groups and community leadership. Facilitators also run regular parent workshops which help build relationships of trust and create a safe space in which women can reach for support.

The World Health Organization has identified investments in ECD as the most impactful and cost effective way to reduce poverty, ill-health and criminality by giving all children a fair start in life.[52-54] In this way, VPUU's Emthonjeni Programme hopes to break the cycle of violence by connecting 80% of children in a community to an early learning programme.

i Violence Prevention through Urban Upgrading (VPUU)

Figure 12: Using environmental design to prevent crime and violence against women and children

Adapted from: Cozens P & Love T. (2015) A review and current status of crime prevention through environmental design (CPTED). *Journal of Planning Literature*, 30(4): 393-412.

collective efficacy, for example, by encouraging residents to support one another, confronting harmful behaviours and actively participating in crime prevention.[33, 34] Social CPTED can include neighbourhood watch programmes, safety awareness workshops, gender-based violence campaigns, community dialogues, conflict resolution training and youth empowerment initiatives. Building of partnerships between residents, local authorities and police, promoting community participation in crime prevention efforts, and ensuring that the police are responsive to community needs and concerns are also crucial components of community safety. Increased police visibility, particularly in hotspot areas, can help to deter violence against women and children and enhance feelings of safety.

Combining physical and social CPTED creates a holistic approach to community safety. Physical improvements provide the foundation for safer environments, while social strategies engage residents in sustaining safety through mutual support and collective action. South African examples like the Violence Prevention through Urban Upgrading (VPUU) programme and initiatives supported by the German development agency GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit) demonstrate that integrating infrastructure upgrades with community dialogue and empowerment strengthens neighbourhood safety.[34, 35] The VPUU focuses on upgrading infrastructure and public spaces in underserved communities to reduce crime and improve safety. This includes interventions like improved street lighting, the creation of safe pedestrian walkways, and the development of community parks and recreational facilities.[34] GIZ supports a range of community-based crime prevention initiatives, often working in partnership with local governments and community organisations to implement programmes tailored to specific local contexts.[35]

Programmes should ideally take a holistic approach which includes trauma informed interventions, working closely with affected people to deliver tailored support and promote community healing and resilience.

How can communities heal collective trauma?

Community trauma in South Africa is deeply rooted in systemic violence, inequality, and social exclusion, negatively affecting both individual well-being and social cohesion. High rates of violence against women and children worsen this trauma, perpetuating cycles of harm. Community healing extends beyond individual therapy to include approaches that create collective spaces for recovery and resilience, addressing both psychological impacts and the social conditions that sustain violence. These approaches recognise that trauma is not only experienced individually but also disrupts social cohesion and well-being at the community level. By centring collective healing, empowering local structures, and integrating trauma-informed approaches, these interventions address both the psychological impacts of violence and the broader social conditions that perpetuate harm. By enhancing social cohesion and enhancing emotional resilience, community healing directly supports efforts to prevent VAC and VAW and can help break the cycle of trauma and violence in affected communities.

Global evidence shows trauma-sensitive programmes delivered through community centres, schools and workplaces improve mental health, reduce isolation and build resilience.[36-38] Restorative justice programmes focusing on dialogue and accountability reduce repeat offenses and strengthen community bonds.[39] Peer support and survivor advocacy turn personal healing into social change, while creative arts offer emotional release and collective remembrance.[39] Trauma-informed support groups provide safe spaces for survivors, children, and families to process experiences and develop coping skills. For children, trauma support is often integrated into school and community settings through age-appropriate activities such as art, play therapy and storytelling, which help children process trauma in a non-threatening way.[38] By working with families, support groups can focus on strengthening family relationships, improving communication, and equipping caregivers with trauma-informed parenting skills.[38] In child- and youth-care centres, trauma-informed care programmes train caregivers to recognise signs of trauma, respond with empathy, and create stable, nurturing environments for children.[38]

Community healing initiatives also often include creative expressions such as community art projects or memorial events, which provide alternative avenues for emotional release and collective remembrance. [39] These initiatives require collaboration with community structures and leadership, including faith leaders and traditional authorities, to ensure that healing processes are culturally relevant and accessible.

In South Africa, effective community healing processes are diverse and contextually grounded often including dialogue platforms, trauma-informed support groups, creative expression through art and music, and restorative justice circles. Dialogue platforms, such as the SAFE-PR Platforms used by MOSAIC, facilitate open communication and shared understanding, allowing community members to process traumatic experiences together.[30] Restorative justice circles, as implemented in communities like Manenberg and Lavender Hill, are another approach.[39] These circles provide structured spaces for open communication, conflict resolution and collective healing, supporting the rebuilding of trust and resilience among families, and the broader community on issues affecting children.

Case 15: The WEAVE[i] Collective – Unravelling the power of women's movements in addressing violence against women and girls

Thelma Oppelt and Benita Moolman[ii]

The WEAVE Collective (Women Engaged Against Violence Everywhere) is a global initiative committed to addressing violence against women and girls. Researchers and activists from Australia, India, South Africa and Nicaragua collaborated to document feminist movements' contributions to engendering policy to end violence against women and girls at local, national and global levels. Using feminist and Indigenist methodologies, WEAVE centres marginalised women's voices, and highlights historical struggles, political milestones and ongoing activism. The global study examines themes of patriarchy, state repression, systemic racism and decolonisation across borders. In an era of shrinking democratic spaces, WEAVE encourages building solidarities to inspire collaborative learning and fostering collective resistance and knowledge-sharing.[55]

The global project sheds light on the lessons learnt by feminist movements in addressing violence against women and girls. In Australia, feminist movements expose the systemic erasure of indigenous women's rights which have been disregarded and ignored in government policies. The erasure of indigenous women perpetuates the dehumanisation of indigenous communities. In Nicaragua, feminist activism, once central to legal reforms, now faces severe repression under an authoritarian regime, with women's rights organisations being dismantled and annihilated through government criminalisation of women's activism. In India, the state enforces carceral control over women, suppressing feminist activists who challenge patriarchal and caste-based violence. In South Africa, feminist movements navigate fluctuating state responses, from early post-apartheid collaboration to later hostility, continually resisting gender-based violence through protest and policy advocacy. While they have played a key role in shaping legal reforms, they still face state ambivalence and social backlash particularly with regards to policy implementation.

WEAVE highlights how feminist movements not only demand policy change but also ensure that laws reflect real experiences.[56] By weaving together personal stories and empirical evidence, women's movements create lasting impact, reshaping societies to end violence.

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While children are often included in these healing processes/dialogues, they are not consistently or actively engaged to lead these processes. Another example of a dialogue approach is the Violence Prevention Forum (VPF), which brings together government, civil society and researchers working on violence to promote evidence-based interventions and promote an ethic of mutual care and inclusion among, further strengthening the ecosystem for violence prevention.[32, 40]

Examples of trauma-informed community healing approaches involving children in South Africa include the work of organisations like the Seven Passes Initiative, Net vir Pret, and the Hantam Community Education Trust, which lead holistic youth violence prevention programmes. These organisations implement holistic approaches that engage children, work closely with families, and provide age-appropriate support in both school and community settings. A key feature of these initiatives is their focus on building safe, inclusive environments where children can openly discuss challenges and develop coping skills. For example, programmes often include creative arts, sports, and dialogue circles that encourage self-expression and emotional processing. Tools such as persona dolls and calming music help children manage bullying and discrimination while supporting their development.[41]

Nonetheless, reviews of community healing interventions reveal several challenges. Limited resources, a shortage of trained mental health professionals, and fragmented NGOs hinder programme reach and sustainability. Volunteer-led support risks secondary trauma and burnout among lay counsellors, requiring strong support systems. Stigma and power dynamics can reduce participation and community ownership. Measuring impact is difficult because standard tools often miss nuanced outcomes like shifts in community trust or restored social bonds. Much evidence is qualitative and context-specific, limiting generalisability. More research is therefore needed to identify effective healing components, adapt interventions to diverse settings, and scale programmes sustainably. Supporting and retaining lay counsellors, integrating indigenous knowledge and using trauma mapping are crucial. More research is also

needed to evaluate how community healing intersects with creating safer community environments and the prevention of VAC and VAW.[38]

Conclusions and recommendations

This chapter demonstrates the need for a paradigm shift in the prevention of VAC and VAW – from superficial awareness campaigns to genuine forms of community engagement that empower community members as active agents of change. It emphasises that meaningful solutions emerge when communities are deeply involved as active drivers of change and can challenge top-down approaches that treat them as passive beneficiaries. Effective community engagement is crucial for empowerment and local action, enabling communities to gain a deep understanding of local risk and protective factors in order to co-create contextually relevant solutions, and sustain social norm and behavioural change initiatives over time.

The chapter highlights how engaging communities in VAC and VAW prevention requires diverse, integrated approaches targeting multiple community actors while prioritising local capacity building. Successful strategies require sustained partnerships that build local leadership and capacity in VAC and VAW prevention by empowering local leaders, community structures and service providers through collaborative training and ongoing support.

Partnerships with external actors and institutions can further strengthen community efforts by linking them to broader societal systems, reinforcing prevention initiatives. Central to these efforts is the active participation of women and children in shaping solutions and advocacy. In particular, the chapter stresses the critical importance of including children as integral members of their community through the use of participatory and age-appropriate approaches in order to design child-friendly interventions and empower them as advocates for change.

The chapter also underscores the need for community healing to address collective trauma and promote social cohesion and elements essential for sustainable VAC and VAW prevention. It emphasizes the importance of trauma-informed interventions embedded within schools and communities, that support survivors, and build local capacity to enhance emotional resilience and overall community well-being.

Community healing initiatives, such as dialogues, arts-based activities and memorials, help strengthen social cohesion and social networks. These trauma-informed approaches are most effective when strategically layered within educational, empowerment, social norm and behavioural interventions.

The chapter also highlights the critical role of community engagement in safety and built environment planning as a key component of preventing VAC and VAW. While safety and physical environment planning have standalone impacts, their effectiveness is significantly amplified when integrated with social CPTED and social norm and behavioural change interventions. Furthermore, community action must build upon systemic and structural interventions, as violence at the community level often rooted in broader structural inequalities. This includes interventions to actively transform harmful social norms that are shaped by patriarchy, gender inequity and restrictive cultural and religious beliefs.

Despite these promising directions, numerous challenges to effective community engagement were acknowledged. These included difficulties in establishing equitable partnerships that value local knowledge equally alongside expert knowledge, and in dismantling entrenched power hierarchies that favour top-down approaches. The chapter also stresses the need to strengthen local capacity so community members can meaningfully co-develop, advocate for, implement and evaluate interventions. There is some evidence that community participation is often limited when involvement is voluntary, unpaid or lacking in incentives, especially in resource-constrained settings. In addition, children are often excluded from prevention efforts, highlighting the necessity of recognising their agency and safely involving them in intervention design.

Finally, the chapter cautions against short-term or superficial efforts, as achieving meaningful and lasting change in preventing VAC and VAW in communities requires sufficient dosage and intensity of social norm change interventions. Significant gaps in rigorous research and evaluation of community-level interventions remain. Studies often focus narrowly on individual outcomes and risk factor changes, and frequently overlook the broader, interconnected impacts of violence prevention on protective factors such as social cohesion, community responses and support, as well as the links to legislation and policies. These broader impacts are essential for effectively reducing violence against both women and children at the community level and in society at scale.

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Bridging the divide: Building an enabling ecosystem for ending violence against women and children

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Violence against women (VAW) and violence against children (VAC) are deeply entwined global challenges, rooted in broader social, economic and institutional systems. Both forms of violence share common drivers, including gender inequality, harmful social norms, economic stressors and exposure to violence in households and communities.[1]

Research evidence increasingly supports the value of integrated approaches that recognise and address the intersections between VAC and VAW.[2] These forms of violence often co-occur within households, with children witnessing intimate partner violence (IPV), which in turn increases their risk of experiencing or perpetrating violence later in life. A recent systematic review of interventions targeting IPV and VAC among parents and caregivers across sixteen countries found that programmes that address both forms of violence simultaneously, particularly those focusing on communication, conflict resolution, and harmful gender norms, are more likely to produce sustained impact.[3] Interventions that helped participants reflect on the consequences of IPV and VAC for children, as well as therapeutic programmes that addressed trauma, were especially effective in disrupting cycles of harm. While most of these integrated models have been implemented in high-income settings, the findings underscore the potential for coordinated prevention and response efforts, particularly those that engage families holistically, to deliver more effective, efficient and scalable solutions. In low- and middle-income contexts, where evidence gaps remain, there is an urgent need to adapt and test integrated models that leverage health, social and community-based services to support both women and children. When designed with care and context in mind, integrated strategies can make better use of limited resources, strengthen family resilience and foster safer communities.[4-6]

Addressing the intersections between VAC and VAW is a formidable task. The ecosystem in which this work takes place is still at a point of innovation, learning and refinement. While there has been progress within the field, there is still much that we do not know and much of the existing evidence does not come from intentional integration, but from either a VAW-dominant or VAC-dominant perspective.[3] In the early stages of the development of the field of violence prevention, programming tended to focus on women and children in isolation, with the development of a handful of programmes focusing on VAW and VAC.[7] Of late, there has been increasing recognition of the need to work at the site of intersection, with a pivotal point being the publication of the Intersections between Violence against Children and Violence against Women Research Priorities report.[8]

Our approach to thinking about building an enabling environment for addressing the intersections between VAC and VAW is rooted in the lens of social norm change, work that is complex, layered and not necessarily linear in nature. We locate our thoughts about building a more collaborative ecosystem in the context of the socio-ecological framework.[9] We try to show how to use this lens to think about the role of individuals, the broader VAC and VAW community, and the systemic change required.

What works to prevent violence against women and children?

The systematic review on interventions that prevent or respond to intimate partner violence (IPV) and VAC showed that community-based and parenting programmes can effectively reduce both IPV and VAC when they engage the shared risk factors such as gender inequality, harmful norms and economic stress.[3] Mechanisms of change include improved communication and conflict resolution, reflection on norms, non-violent discipline, and enhanced emotional regulation. Parenting programmes were particularly successful in promoting safer caregiver–child relationships but often failed to address gender dynamics explicitly.[3] The review found that community-level interventions tackled power imbalances and harmful masculinities more directly, but rarely included structured content on VAC. While most prevention efforts in low- and middle-income countries focus on primary prevention, response interventions remain limited, particularly those that support both women and children simultaneously. Notably, integrated interventions are still rare, underscoring the need for more coordinated, multisectoral strategies that disrupt

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intergenerational cycles of violence and attend to the realities of families experiencing multiple forms of harm.

Global frameworks like INSPIRE and RESPECT offer a robust foundation for preventing violence against women and children. They synthesise decades of evidence into practical strategies that address the drivers of violence at multiple levels of the socio-ecological system. But frameworks alone are not enough. Their power lies in how they are brought to life, how they are translated into contextually grounded action, embedded in systems and made meaningful to the people most affected by violence. In South Africa, where the intersections of VAC and VAW are shaped by deep structural inequality, layered trauma and resilient forms of resistance, these strategies must be adapted to fit both the landscape of risk and the opportunities for transformation.

The RESPECT framework offers a comprehensive approach to preventing violence against women by addressing the structural, relational, and individual factors that contribute to such violence. Developed by the World Health Organization (WHO) and UN Women, it brings together seven mutually reinforcing strategies, each designed to tackle different dimensions of risk while promoting protective factors as illustrated in Figure 13. Rather than functioning in isolation, these strategies work best when applied in combination, forming an integrated response to a deeply entrenched problem.

Figure 13: RESPECT – Seven strategies

Source: World Health Organization. *RESPECT Women: Preventing violence against women.* Geneva, Switzerland. 2019.

At the heart of RESPECT is the recognition that strengthening relationship skills (such as open communication, shared decision-making and conflict resolution) can reduce tensions and prevent violence within families and intimate partnerships.[10] Alongside this, empowering women socially and economically is critical. When women have access to education, employment and spaces for leadership, they are better positioned to negotiate safety and autonomy in their lives.

The framework also underscores the importance of accessible, survivor-centred services. Healthcare, legal support, psychosocial counselling and social protection systems must be responsive and coordinated to provide meaningful assistance to women experiencing violence. These services, however, cannot function in a vacuum. Broader economic insecurity must also be addressed, particularly through targeted poverty alleviation initiatives that reduce financial dependence and create pathways toward stability and safety.[10]

Creating safe environments, whether in schools, public spaces or the workplace, is another cornerstone of the RESPECT framework. This involves both physical infrastructure and social accountability mechanisms that reduce the likelihood of violence occurring and make it easier for women to seek help when it does.

The framework also makes explicit the intergenerational nature of violence. Preventing abuse in childhood and adolescence is not only critical for the well-being of children but is also a powerful means of reducing future violence against women. Parenting support, nurturing early care and school-based interventions all play a role in breaking cycles of harm.[10]

Finally, RESPECT calls for the transformation of the underlying attitudes, beliefs and norms that justify or excuse violence. Shifting social norms around gender and power requires sustained community engagement, institutional reform and the amplification of voices that challenge the status quo.

Crucially, these strategies must be supported by an enabling environment: political will, legal frameworks and dedicated funding all matter. Policymakers are called upon not only to implement effective interventions, but also to create the conditions in which these interventions can thrive. That includes investing in the leadership of women's rights organisations, strengthening institutional capacity and building systems that can adapt and scale.

Figure 14: INSPIRE – End violence against children

Source: World Health Organization. *INSPIRE: Seven strategies for ending violence against children.* Geneva: WHO. 2016.

The INSPIRE framework (Figure 14) presents a unified set of strategies for preventing and responding to violence against children. Developed by global partners including the WHO, UNICEF, and the World Bank, it offers both a vision and a practical guide for governments, civil society and communities seeking to create safer environments for children. At its core is a simple but urgent message: violence is preventable, not inevitable; and coordinated, evidence-informed action can make a measurable difference. INSPIRE brings together seven strategies, each one addressing a key driver or protective factor.

The first centres on the implementation and enforcement of laws. This includes prohibiting corporal punishment, addressing child marriage and sexual exploitation, and ensuring that justice systems respond in ways that protect rather than retraumatise children. Laws alone do not end violence, but they provide a critical foundation for shifting behaviours and strengthening accountability.[11]

Alongside legislation, the framework highlights the importance of norms and values. Deeply embedded cultural beliefs often justify or conceal violence, particularly when framed as discipline or rooted in gender inequality. By challenging these social norms through public education campaigns, peer group dialogue and community leadership, we can begin to change the attitudes that make violence seem acceptable.[11]

The third strategy focuses on creating safe environments. Children are vulnerable not only in homes but in schools, neighbourhoods and public spaces. Interventions here range from improved urban lighting and safe school routes to mobilising communities to to increase surveillance and take collective action against known risks. Support for parents and caregivers is also essential. Many forms of violence stem from stress, lack of support or intergenerational trauma. Parenting programmes that promote positive discipline, emotional regulation and child development knowledge have been shown to reduce harsh punishment and improve parent-child relationships.

Because economic hardship often intensifies family stress and increases exposure to harm, INSPIRE also promotes income and economic strengthening. Initiatives such as cash transfers, access to social protection and financial support for female-headed households can reduce children's vulnerability to neglect, exploitation and abuse.

Where violence has already occurred, children need responsive and accessible services. This includes healthcare, legal assistance, psychological support and reintegration services. Effective systems are child-centred, trauma-informed and designed to avoid further harm while promoting healing and accountability.[11]

The final strategy centres on education and life skills. School attendance alone reduces vulnerability, but it is also a site for prevention. Equipping children with skills in emotional literacy, respectful relationships and critical thinking not only reduces their risk of experiencing violence, it also helps interrupt cycles of perpetration later in life.

Taken together, these seven strategies form a holistic, layered approach. Like the RESPECT framework, INSPIRE recognises the value of integrated, multisectoral action, calling on policymakers to align efforts across education, health, justice, social development and economic policy. It also stresses the importance of building an enabling environment, where investments in children's safety are matched by leadership, coordination and sustained commitment over time.

What are the risk and protective factors?

While RESPECT and INSPIRE provide the strategic scaffolding for violence prevention, it is equally critical to understand the specific conditions that fuel risk or enable protection. Violence does not emerge in a vacuum, it is shaped by a web of individual experiences, relational dynamics, institutional failures and structural inequalities. What follows is a synthesis of risk and protective factors across key domains of life: from the first thousand days of a child's development, through the home, school, and community, to the broader socio-political environment. This mapping offers a clearer picture of where and how to intervene, revealing not only what drives violence, but also what protects against it.

Understanding the conditions that give rise to violence, and those that protect against it, requires a layered view of people's lived environments. Risk and protective factors do not sit neatly in silos. Instead, they accumulate and interact across developmental stages and social contexts. Below is a narrative synthesis of key patterns that shape the likelihood of violence across the life course. We draw on risk and protective factors discussed in previous chapters.

In the first thousand days of life, pregnant women, new mothers and their infants and particularly vulnerable. Risk factors such as witnessing violence, lack of responsive caregiving, maternal mental health challenges, and low social support can impair bonding and emotional regulation.[12] Disability, refugee status, unprocessed trauma and economic stress further compound vulnerability. Protective factors in this period include strong attachment, caregiver empowerment, and access to antenatal care, parenting support and early childhood education and care.

In the home, risks intensify when there is conflict between partners, poor communication and caregiver stress, or when non-biological fathers are present in caregiving roles. The use of violent discipline, approval of physical punishment and gender inequality all contribute to harm. Protective conditions include healthy communication, family cohesion, critical reflection on discipline, access to economic support, social assistance and caregiving networks like extended family.[6]

School environments also present both threats and opportunities. Risk factors include poor management, weak policies, gang influence, association with violent peers and educators' use of violence. Protective factors include safe spaces, inclusive and supportive teaching, strong school leadership, teacher training and the development of social and emotional skills to help learners and teachers regulate their emotions and resolve conflicts without resorting to violence.[13]

At the community level, risks are tied to rigid gender norms, social norms condoning violence, weak or absent services, access to alcohol and weapons, and environments marked by crime, gangs and poor infrastructure. Protective features include community outreach, neighbourhood organising, strong leadership, collective action, faith-based support and access to responsive services and childcare .[14]

Finally, at the societal level, structural inequalities such as discriminatory laws, political instability, underfunded services and macroeconomic exclusion create a hostile backdrop for safety. Yet, legal and policy reform, enforced sanctions, quality education and employment, regulation of harmful industries, public campaigns and strong advocacy movements can shift the broader terrain toward justice and safety.[15]

Mapping these patterns gives us a more granular understanding of what sustains violence as well as what prevents it. It also underscores the necessity of acting across systems and levels, rather than relying on single-point interventions.

How can the system be strengthened?

Understanding where violence takes root and where it can be interrupted offers a powerful entry point to prevention. But to transform these insights into sustained change, we must act across systems. This is where the socio-ecological model becomes vital. It helps us map the levels at which risk and protection operate and to think through the relationships between them. The model encourages us to see violence not just as the product of individual behaviours, but as shaped by the interplay between personal histories, relational dynamics, institutional structures and broader societal norms.

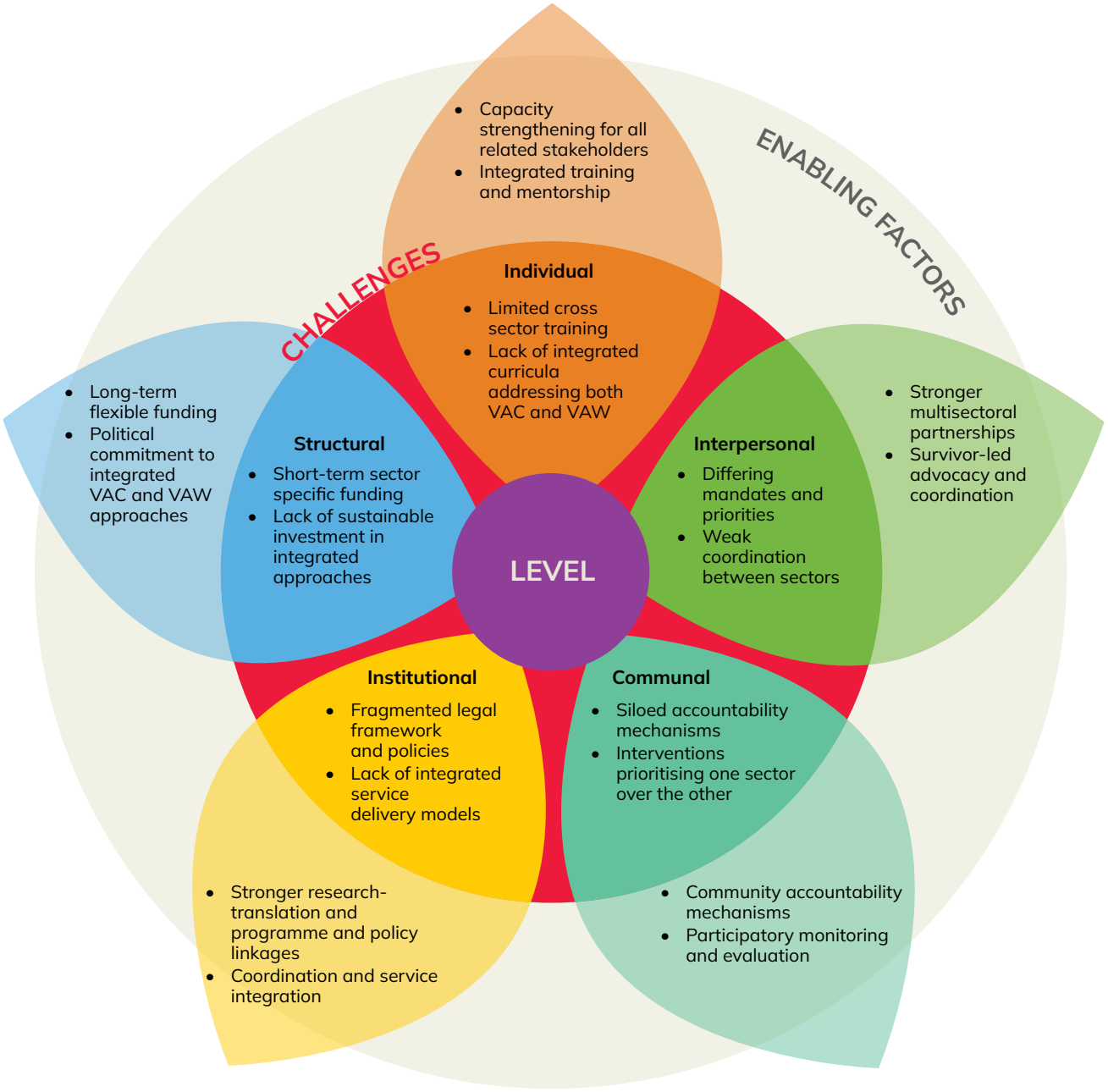
Given the shared drivers that underpin both VAC and VAW, prevention efforts must move beyond isolated interventions. A whole-systems approach is needed, one that engages actors across every level of society to create environments where violence is neither tolerated nor inevitable.[16] The socio-ecological model provides a powerful framework for structuring this work. It helps us understand how violence is produced and disrupted through the interplay between individuals, relationships, institutions, communities, and broader social and political forces.

First developed by Bronfenbrenner, the socio-ecological model also serves as a practical guide for designing and implementing integrated responses. It encourages a shift away from narrow, individual-level interventions toward a broader understanding of the structural and systemic drivers of violence.[17]

However, operationalising this model remains challenging. Many prevention programmes continue to focus on a single group – women, children, parents or couples – without addressing the broader systems in which violence occurs. Achieving scalable impact requires intentional, multi-level strategies that connect efforts across individuals, families, institutions and society as a whole.[18]

Applied in the South African context, the socio-ecological model also makes visible the fault lines in our current prevention ecosystem. At the household level, caregivers often navigate extreme stress with limited social protection. Schools struggle with violence spilling over from surrounding communities. Communities face barriers related to gender norms, under-resourced services and weak institutional trust. Nationally, prevention is undercut by fragmented budgeting, siloed mandates and uneven enforcement of laws.

Figure 15: Strengthening the integration of VAC and VAW – challenges and enabling factors



Yet the model also illuminates the potential for change. It reveals where entry points exist and how they can be sequenced and aligned for impact. The following section draws from this framework to map the enabling and constraining factors that shape the implementation of integrated programming to address violence against women and children at every level of the system.

Individual level: Enhancing capacity and bridging knowledge gaps

Addressing violence at the individual level refers to interventions that focus on personal experiences, behaviours and capacities, whether by supporting survivors in their healing, working with perpetrators to change harmful behaviours, or equipping caregivers and children with skills to navigate relationships in safer, more equitable ways.

Efforts to address violence at the individual level, whether through survivor support, caregiver engagement, or work with perpetrators, often serve as the first point of entry into violence prevention. Yet interventions at this level frequently operate in isolation, targeting women, children, parents, or couples without adequately addressing the interconnected systems in which violence occurs. While behaviour change and healing at the individual level are vital, these outcomes cannot be

Case 16: Sugira Muryango – Using home visits working with fathers in Rwanda

Gabriel Phend,[i] Kathryn Nooni, Candance Black[i], Lauren Pisan[i], Sunand Bhattacharya[i], Vincent Sezibera[ii] and Theresa S. Betancourt[i]

Sugira Muryango is an evidence-based home-visiting intervention that uses active coaching and father engagement designed to improve responsive parenting, promote play in early child development and prevent violence in Rwanda's most vulnerable families. Sugira Muryango's 12 modules are delivered weekly over three months by a trained government workforce, the Inshuti z'Umuryango (IZU) or friends of the family child protection volunteers.

The intervention engages male and female caregivers and covers topics such as conflict resolution, violence prevention, early childhood development and the importance of play, stimulation, health, hygiene and good nutrition. Local government and community buy in for the intervention is fostered through PLAY Collaborative meetings to solve implementation barriers at each level of the implementation ecology from the national level steering committee to district, sector and village engagement. In the three districts where Sugira Muryango is currently scaled, the programme has elevated IZUs' visibility and effectiveness as trusted frontline workers, contributing directly to national and district goals in early childhood development, violence reduction, child protection and family promotion.

Lessons learned from expanding delivery of Sugira Muryango with the IZU workforce highlight the need to embed quality monitoring and professional development scaffolding when taking evidence-based interventions to scale.[29] Frontline workers must receive continuous support from supervisors in order to maintain quality and realise the same effects on children and families found in the previous randomised controlled trials that established the effectiveness of the intervention pre to post delivery and at one year of follow up.[30, 31] An ongoing trial with Sugira Muryango is testing the effectiveness of a mobile app and digital dashboard to support IZUs and their supervisors to maintain quality service delivery in a cost-effective and scalable manner that can be sustained by government partners after the trial.

In Rwanda, traditional gender roles have often relegated fathers to the periphery of child-rearing, with mothers typically assumed to be the primary caregivers. However, efforts like the Sugira Muryango programme are challenging this norm by promoting father engagement in childcare responsibilities and decision making. Utilising a home visiting model provides a unique opportunity to meet fathers where they are. IZUs then work with families to identify a time that works best for both male and female caregivers. On average 79% of male caregivers complete all 12 modules. During these sessions, fathers are learning the importance of engaging in play with young children, sharing in caregiving responsibilities and contributing positively to family dynamics. This shift aims to reduce violence within households, while seeking to improve children's well-being and break cycles of poverty. Recent analysis from a longitudinal study that followed a cohort of households from the original cluster randomised trial in 2017/18 demonstrates that male caregivers who participated in Sugira Muryango are more likely than typical male caregivers to engage in stimulating activities with their children (eg reading books, telling stories, singing songs, teaching the alphabet) four years after completing the programme.[32]

Nonetheless, as the programme moves into greater scaling, there is some evidence of elements of the programme experiencing a "voltage drop" in their effects on IPV when delivered by the IZU workforce as opposed to the effectiveness study. The programme is responding by enhancing both the manual and the training materials to ensure strong and consistent messaging on family violence reduction and greater support to the IZU workforce via role-play based training on how to reduce risks of IPV across a range of households and helping families to connect to local social services to ensure safety and ensure that the programme is well-embedded within the 'whole of government'.

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sustained without attention to the wider ecological conditions that shape risk and protection.

In the South African context, the *Parenting for Lifelong Health (PLH)* programmes offer a strong example of individual-level interventions that centre both caregivers and children. Developed through cross-sector collaboration and adapted for low-resource settings, these programmes focus on strengthening parenting skills, promoting non-violent discipline

and building emotional connection between caregivers and children. The PLH Teen programme, in particular, has demonstrated promising results in reducing family conflict, improving communication and decreasing the use of harsh discipline. These interventions work not only by shifting behaviours, but also by helping caregivers reflect on the impact of violence in their own lives and relationships, an important step in breaking intergenerational cycles of harm.[19]

A central barrier to integration at this level is the absence of a shared conceptual and operational framework across the VAC and VAW sectors. Differing definitions, research traditions and programmatic approaches can result in fragmented efforts, where responses are duplicated, under-coordinated, or fail to capitalise on key intersections. For example, practitioners may work with mothers experiencing IPV without addressing the implications for their children, or support traumatised children without considering the violence endured by their primary caregivers. In South Africa, the pressure on overburdened service providers, limited cross-sectoral training and siloed case management systems make integrated practice especially challenging.

To shift the field, capacity-strengthening must be reimagined as a systemic endeavour, not an individual burden. This means investing in shared tools and language, building platforms for co-learning between the children and women's sectors, and ensuring that frontline workers are supported to implement integrated, survivor- and child-centred interventions. Research institutions also have a role to play in developing intersectional data, standardised indicators and ethical methodologies that reflect lived realities where VAC and VAW co-occur.

Importantly, capacity-strengthening must also acknowledge the limitations of focusing solely on individuals without transforming the relational and structural dynamics that drive violence. Without simultaneous attention to gender norms, economic stressors, and institutional capacity, interventions risk locating responsibility with survivors or caregivers alone. A more sustainable path lies in positioning individual change within a broader web of support, where families, services and social structures work in concert to disrupt harm and foster safety.

Practically, this means creating spaces for relationship-building between child protection officers, VAC and VAW specialists, educators, healthcare providers, law enforcement and social workers. Interdisciplinary training, shared referral protocols and joint case management systems are key tools, but without interpersonal trust and communication, these tools often sit unused or applied inconsistently. Similarly, in the prevention ecosystem, it would require more collaborative efforts between researchers, practitioners, donors and governments.

Interpersonal level

The interpersonal level in the socio-ecological model refers to the relationships between people – between caregivers and children, partners, peers, service providers and survivors. In the context of this paper, it also captures the human interactions between those working across the violence prevention ecosystem: from healthcare workers and social workers to educators, researchers and community organisers. These relationships form the connective tissue of an integrated response to violence. But without trust, shared understanding and accountability, even the most technically sound interventions risk collapsing under the weight of institutional silos.

At this level, integration hinges not only on systems design but on the quality of relationships within and across sectors. When health, education, justice and social development services operate in isolation, survivors are too often left to navigate fragmented systems. Programmes duplicate efforts, referral pathways break down and early intervention opportunities are missed. A whole-systems approach to preventing and responding to VAC and VAW requires these sectors to work together, not just in theory, but in daily practice, to deliver survivor- and child-centred care that reflects the complexity of people's lives.

One of the most persistent challenges to integration at this level is the siloed nature of service provision. Although women and children often experience violence in the same households, services have historically been developed for one or the other. For example, research on South African shelter services revealed that while women and children may be housed together, services for children are often secondary or underdeveloped.[20] Coordinated case management systems, shared referral protocols and joint training programmes remain rare, despite their proven impact.

Survivor-led advocacy adds another critical dimension to this level. Networks like the Global Survivor Network and the Brave Movement show how empowering survivors as leaders can help transform justice systems, strengthen accountability and foster more responsive services. In South Africa, this is mirrored by the work of the National Shelter Movement, provincial Violence Against Women Networks in KwaZulu-Natal, the Cape Flats Women's Movement in the Western Cape, and the Women's Inkwelo Network in the Eastern Cape. These movements play an essential role in amplifying survivor voices, particularly in underserved and rural areas. Children, too, can be leaders in this space – initiatives such as the Children's Parliament and Child Government Monitors working with the Commissioner for Children in the Western Cape offer models for

Case 17: Takalani Sesame – Using mass media to promote male caregiver engagement in advancing child wellbeing

Fathima Rawat, Erika Jooste, Mari Payne and Bheki Khoza[i]

Takalani Sesame designed a mass media campaign to increase father's involvement in their children's development through play. An evaluation assessed changes in caregiver knowledge, attitudes, behaviours, caregiver-child interactions, time spent in guided play, reduction of gender stereotypes, child autonomy in activity selection, and the adoption of nurturing parenting practices. The purpose was to measure the effectiveness of the mass media content and identify learnings for future interventions.

The #BondThroughPlay social media campaign, targeting male caregivers, ran from 12 August to 11 October 2024 and exceeded its goals, achieving 1.94 million YouTube video views (47% above the KPI) and 16.4 million impressions (18% above the KPI). Audience reach in key provinces was high, with Gauteng reaching nearly two million viewers, followed by the Eastern Cape and Free State. The campaign's success was driven by optimised, dynamic thumbnail designs and influencer alignment with target demographics. Adjustments midway included an increased focus on mothers.

The content successfully promoted positive father-child relationships, supported male caregivers' involvement in childcare and encouraged male caregivers to become more involved in their children's lives, not only in terms of financial provision but also in terms of emotional support. The mass media content effectively challenged gender stereotypes associated with fatherhood in South Africa especially where male caregivers have a gendered thinking in how to play with their children. See, for example, the video: Play Play Play[33] where Zikwe discovers why dads shine when they bond with their children through play

Key outcomes included:

- **Increased father-child engagement:** Fathers experienced more confidence and joy in playing with their children, leading to more frequent and quality interactions.
- **Gender-neutral play:** Children demonstrated increased autonomy in choosing play activities regardless of gender, challenging traditional stereotypes.
- **Positive parenting practices:** Fathers exhibited more nurturing interactions and positive parenting practices.
- **Support from mothers:** Fathers reported and increased sense of support from mothers in child engagement.

Control group participants were exposed to the campaign in the last four weeks of the study, and even this minimal exposure to the campaign messaging contributed to heightened awareness and engagement with the promoted themes.

The findings highlight how mass media content and platforms can be used as an effective tool to foster engaged fatherhood and challenge gender stereotypes. The alignment between adult and child perspectives on play and gender roles suggests a positive feedback loop reinforcing engaged fatherhood. However, the study also revealed the need for ongoing interventions to address deeply ingrained norms. The role of gatekeeping behaviours and the importance of co-parenting dynamics were identified as critical factors influencing father-child relationships.

The research underscores the transformative power of targeted media content in reshaping parenthood. By strategically leveraging Digital Media and TV to engage adults and children, these findings can be translated into practice at scale. This approach not only has the potential to enhance father-child engagement but also to promote gender equity and positive family dynamics, paving the way for a more inclusive and supportive parenting environment. The evaluation underscores the need for multifaceted interventions that integrate media campaigns with community programmes and policy initiatives. Future research should focus on linking attitude shifts to behavioural changes and strategies to further enhance the effectiveness of such interventions.

i Sesame Workshop International: South Africa

how child survivors and young advocates can hold government accountable and shape policies that affect their lives.

Interpersonal collaboration also extends to relationships between institutions and sectors. Multi-stakeholder partnerships – between civil society, government, donors and international agencies – are essential for bridging the gaps between research, policy and practice. Strong interpersonal relationships within these coalitions foster trust, shared learning and mutual accountability. They help ensure that policies are rooted in real-world needs and that interventions remain relevant and scalable. While not specifically focused on VAC and VAW, the Violence Prevention Forum (VPF) is an example of an initiative that manages to get this right.[21] The VPF is a dedicated platform for bringing together researchers,

policymakers, practitioners, government officials and donors to align evidence, priorities and action across sectors.

Community level: Building collective infrastructure for integration

At the community level, the focus of intervention shifts from individuals to collective systems and the networks, institutions and social relationships that shape everyday experiences. Community-level strategies aim to shift collective norms, strengthen informal accountability and create safer, more supportive environments where violence is less likely to occur and more likely to be addressed. In South Africa, this includes community-based organisations (CBOs), faith leaders, traditional authorities, educators, health workers and local activists, each of whom plays a role in shaping the values, responses and safety nets that surround women and children.

Despite growing awareness of the intersections between VAC and VAW, many community-led initiatives continue to operate in silos, divided by donor priorities, institutional mandates or disciplinary training. This fragmentation results in duplicated interventions, disjointed services and missed opportunities for synergy.[22] Importantly, the issue is not a lack of will. Many community actors recognise the value of integration. The problem lies in moving from symbolic partnerships, such as co-branded events or memoranda of understanding, to practical, sustained collaboration that is adequately resourced and responsive to the full range of survivor needs.

True integration requires more than cooperation. It demands shared training, aligned programming and mechanisms for joint decision-making and accountability. This includes building coordinated case management systems and integrated service delivery models that reflect the interconnected risks and experiences of women and children.[23] It also means enabling local actors to co-design solutions that are culturally relevant and embedded in the social fabric of their communities.

Co-located service models, such as South Africa's Thuthuzela Care Centres (TCCs), offer important insights. Originally designed to provide integrated support for survivors of sexual violence, TCCs bring together healthcare, legal and psychosocial services in one site. However, the model has not evolved to adequately support survivors of domestic or sexual violence. Most centres lack child-friendly spaces, rely on overburdened staff and often prioritise services for women over those for accompanying children. As a result, families seeking help may receive fragmented care, an outcome that undermines the very logic of integration. Without clear referral protocols, adequate funding and cross-sector training, integration risks becoming a strain rather than a solution.[24] While promising as a concept, the focus has largely been on sexual violence against women and children, with limited adaptation for domestic violence and VAC. It holds tremendous potential if appropriately extended and adapted.

Community-led initiatives to change social norms offer another promising entry point for integrated prevention. Programmes that address corporal punishment, intimate partner violence and gender inequality as interconnected issues tend to have greater impact, particularly when they engage families as systems. Parenting interventions that promote non-violent discipline while also addressing intimate partner dynamics have shown strong outcomes across diverse settings.[25, 26] These models work best when they are grounded in local realities and delivered by trusted community actors.

However, these efforts cannot be sustained without flexible, long-term funding. Short project cycles and rigid donor requirements often force grassroots organisations to compete rather than collaborate. The recent withdrawal of major donors, such as USAID, has further destabilised this ecosystem, leaving shelters, community-based care, and trauma services vulnerable to collapse. These wraparound services are often the first point of access for survivors, yet they remain chronically underfunded and institutionally marginalised.

Ultimately, building an enabling community environment for addressing VAC and VAW is not simply about convening stakeholders. It is about supporting them, through resources, capacity and political will, to collaborate in ways that reflect the lived realities of survivors.

Institutional level: strengthening policies and systems for integrated service delivery

In the context of this paper, the institutional level refers to the formal systems, structures and rules that govern how services are delivered and how decisions are made. This includes government departments, policies, laws, protocols, organisational mandates, professional training systems and the mechanisms that coordinate different sectors, such as health, education, justice and social development.

While the individual and interpersonal levels focus on people and their relationships, and the community level centres on local networks and collective norms, the institutional level is where power is operationalised through systems. It's where decisions about budgets, service standards and accountability are made and where integration between responses to VAC and VAW can either be enabled or blocked.

In this layer, integration is not just about shared values or collaborative intentions, it requires explicit mandates, clear protocols, aligned financing and cross-sector coordination

Case 18: Free to Grow – Workplace interventions to prevent VAC and VAW

Thandi van Heyningen[i]

Free to Grow is a family violence prevention programme that demonstrates how human-centred design can make social interventions more accessible and effective.

Developed through a partnership between the Institute for Security Studies (ISS), the Seven Passes Initiative, and Tikketai (an agricultural business), the programme responds directly to the needs and realities of working parents, particularly those in low-wage, high-stress environments.[34]

From the outset, the programme was shaped around working parents' real needs and circumstances. Developers engaged directly with employees and management to understand their daily pressures, parenting challenges and barriers to accessing support services. This process revealed that time, transport and financial constraints often prevented caregivers from accessing community-based support and programmes. In response, *Free to Grow* was designed to be delivered during paid work hours, in order to remove some of these obstacles.

A series of 12 weekly sessions focused on building practical skills in stress management, interpersonal skills and non-violent parenting. Content and facilitation methods were informed by participants' feedback and lived experiences, ensuring cultural relevance and psychological safety. Facilitators were drawn from a local community-based organisation, creating a trusted, empathetic learning environment.

By centring the design on participants' needs, the programme created a safe, supportive space where employees felt comfortable reflecting on their behaviour and learning new skills. As a result, employees reported improved family relationships, better emotional regulation and reduced conflict at home and work

This human-centred approach not only improved participants' family relationships but also enhanced workplace morale and productivity. By responding directly to employees' needs and embedding the intervention into the workplace, *Free to Grow* illustrates how thoughtful, user-informed design can strengthen violence prevention efforts while delivering meaningful benefits to businesses and families alike.

i Institute for Security Studies

mechanisms that embed VAC and VAW responses into the routine operations of public institutions. It's about ensuring that survivors don't encounter fractured systems, and that practitioners across sectors are trained, resourced and required to respond holistically.

The *Diagnostic Review of the State Response to Violence Against Women and Children* illustrates an institutional response by mapping the roles, mandates and performance of various government departments in addressing violence.[27] It highlights how institutions such as the Department of Social Development, SAPS, the National Prosecuting Authority, Health and Basic Education contribute to prevention, protection and justice outcomes.

The review explicitly critiques the fragmentation of efforts and the lack of a unified, coordinated institutional framework, calling instead for systemic reform. It also details how institutional mandates often overlap or conflict, leading to duplication or gaps in service delivery. Despite these challenges, the report represents a significant attempt to hold state institutions accountable by providing evidence-based recommendations for improving coordination, oversight and resource allocation across departments involved in the VAC and VAW response.

Integrated policy responses must be grounded in joined-up thinking – bringing together actors across sectors to break down silos in training, service provision and policymaking. This means creating shared protocols, cross-disciplinary teams and cohesive support systems that enable survivors and their children to access comprehensive care through a single, coordinated pathway. Without institutional commitment to breaking down sectoral silos and embedding integrated service models, responses will remain fragmented, limiting the potential for transformative, survivor-centred change.

Structural level: Aligning funding and governance for systemic change

The structural level refers to the foundational systems that determine how institutions operate: laws, financing frameworks, political priorities and broader governance norms. Unlike the institutional level, which focuses on how services are designed and delivered within sectors, the structural level is about the forces that shape those institutions: who holds power, how budgets are allocated, what gets prioritised and which principles guide national and global responses to violence. In the context of VAC and VAW, structural barriers often take

the form of fragmented funding systems, siloed mandates and policy incoherence. Despite clear evidence of the overlaps between VAC and VAW, governments and donors continue to fund them through separate streams, reinforcing disjointed programming and undermining opportunities for integration.

To drive long-term impact, funding models must shift from short-term, project-based grants toward sustained investment in systems strengthening. Donors and governments must institutionalise VAC and VAW interventions within national budgets to ensure that prevention and response efforts continue beyond donor cycles.[28]

Integrated financing should:

- Support multisectoral collaboration by funding joint initiatives across health, justice, education and social services.
- Prioritise survivor-led solutions, ensuring that funding mechanisms are accessible to grassroots organisations that work at the intersections of VAC and VAW.
- Invest in research translation, ensuring that evidence on the intersections of VAC and VAW informs national and global financing decisions.

At the national and sub-national levels, governments must integrate VAC and VAW responses into core service delivery mandates – rather than treating them as donor-dependent or NGO-driven initiatives. Provincial departments can develop joint implementation plans across sectors, with shared accountability indicators to monitor integration in real time. Local governments, meanwhile, play a pivotal role in resourcing community-based structures, such as local clinics, with the tools and training needed to respond to VAC and VAW. Embedding these interventions into existing governance and budgeting systems is essential to ensure sustainability beyond political cycles.

These efforts take place in an increasingly complex geopolitical climate where global norms around gender and equity are shifting. The removal of terms like 'gender', 'diversity', and 'inclusion' from the United States Departments' lexicon reflects a broader rollback of commitments to equality and rights-based language. This trend risks legitimising regressive policy agendas and undercutting years of advocacy for integrated, survivor-centred responses. Holistic, rights-based approaches must remain at the centre of global policy if real transformation is to occur.

Case 19: The Sexual Violence Research Initiative – A catalyst for collaboration, and a flourishing evidence ecosystem

Ayesha Mago[i]

Founded in 2003, the Sexual Violence Research Initiative (SVRI) is the largest global network advancing knowledge and evidence on violence against women (VAW) and violence against children (VAC). With over 11,000 members, SVRI is a recognised field builder – creating the conditions for evidence to grow, take root and flourish. We connect researchers, practitioners, policymakers and funders across disciplines and geographies to strengthen the field through collaboration, solidarity and shared learning.

Our work is grounded in four interlinked pillars: advancing research and practice; strengthening capacity; promoting partnerships; and influencing change. Over the past 14 years, we have funded 98 grantees in 53 countries, investing more than USD 11 million in locally led research that informs policy, practice and evidence globally. We also provide technical assistance and support a values-driven community of practice grounded in ethics, equity and context. In addition to funding,

SVRI offers practical guidance and resources to support ethical research, thoughtful adaptation, responsible funding and equitable partnerships – ensuring that evidence leads to tangible, lasting improvements in the lives of women and children.

Our biennial SVRI Forum – one of the largest abstract-driven conferences on VAC and VAW – brings together thousands of delegates for cross-sectoral dialogue, learning and connection. It fosters long-term collaboration, amplifies underrepresented voices and builds international solidarity.

We prioritise collective care, recognising it as essential for a healthy, sustainable evidence ecosystem. SVRI's digital platforms serve as a vibrant global knowledge hub, with over 140,000 annual website visits. We share the latest evidence and opportunities through our blog, podcast, webinars, online courses and helpdesk – making research more accessible, engaging and actionable.

SVRI's feminist ways of working nurture a global movement defined by solidarity, care and collective learning. We invite others to join us in building a future where research drives action, and every woman and child can live free from violence.

i Sexual Violence Research Initiative

South Africa's National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF) is an attempt to address gender-based violence at a structural level and to ensure coordinated action, community mobilisation and attention to the socio-economic drivers of violence. These initiatives lay the policy foundation, but the inter-connected work of integration still needs sustained attention. In addition, the policy was developed through a VAW lens and attempts to ensure that it supports integrated approaches to VAC and VAW in terms of both prevention and response, are ongoing.

Another structural-level effort was the Inter-Ministerial Committee (IMC) on Violence Against Women and Children, established in 2012 to coordinate a whole-of-government response to co-occurring forms of violence. The IMC brought together key departments, including Social Development, Health, Basic Education, Police and Justice, to address policy fragmentation and ensure a unified national approach. However, despite its promise, the Diagnostic Review commissioned by the IMC itself found that inter-sectoral collaboration did not meaningfully improve. Implementation remained fragmented, institutional mandates continued to overlap, and coordination forums were largely symbolic. Funding streams were disjointed, accountability systems were weak and collaboration with civil society was minimal. While the IMC laid important groundwork for future multisectoral policy efforts, including the NSP-GBVF, it fell short of its structural mandate to institutionalise a coherent, integrated state response to both VAC and VAW.

Conclusion

Creating an enabling environment for addressing the intersections of violence against women and children requires far more than words. It demands transformation across the entire ecosystem, in the ways that we both prevent and respond to violence. This chapter has argued that integration cannot be realised through frontline programming alone, it must be structurally embedded. That means aligning laws, institutional mandates, financing mechanisms and governance structures to support holistic, intersectional approaches to prevention and response.

The chapters that follow explore these structural levers in depth, offering practical pathways for embedding integration into the core systems of state and society:

- The legal and policy framework must be harmonised to reflect the life-course continuum of violence and provide clear mandates for multisectoral collaboration.
- Financing systems need to shift from fragmented donor dependency toward sustainable, integrated public investment.
- The workforce must be capacitated, across sectors and levels, with the skills, tools and institutional incentives to work together.
- Reliable, disaggregated data systems are critical for making invisible intersections visible and guiding responsive service delivery.
- Leadership and coordination must move beyond ad hoc interdepartmental forums to forge coherent strategies, supported by shared accountability mechanisms.

Figure 16: An enabling ecosystem

The vision is clear: a unified, survivor-centred ecosystem that recognises the complexity of violence and responds with that recognises the complexity of violence and responds with approaches that are equally comprehensive. This will not be achieved through isolated interventions. It requires deep structural alignment, long-term investment, and a political and moral commitment to transform how we see, respond to, and ultimately prevent violence in all its forms.

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An enabling policy environment to stop violence against women and children

Lucy Jamieson[i]

Violence against women and violence against children frequently co-occur within the same households, underpinned by shared risk factors and perpetuated by societal norms that legitimise or tolerate violence. Both forms of violence are associated with adverse health outcomes and contribute significantly to the intergenerational cycle of violence (see Violence chapter on p. 34). South Africa's legal and policy framework should recognise the intersections of violence against women and children across the life course and provide for a continuum of care across different contexts. In addition to laws that criminalise violence and provide for services and programmes to prevent and respond to violence, laws and policies should address underlying risk factors for violence against women (VAW) and violence against children (VAC) such as promoting gender equality and addressing structural inequality. This essay considers the following questions:

- What are South Africa's legal obligations to end violence against women and children?
- Why is an enabling policy environment important?
- Does South Africa have a strategy to respond to and prevent violence against women and children?
- Do the laws support an integrated response to VAC and VAW?
- Are there opportunities for strengthening the policy framework?

The chapter concludes with an overview and some recommendations.

What are South Africa's legal obligations to end violence against women and children?

South Africa's obligation to end violence against women and children in outlined in international, regional and constitutional law.

International law

South Africa is a signatory to several international instruments including, amongst others, the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[1] and the Convention on the Rights of the Child (CRC)[2]. These treaties obligate the government to take appropriate measures to prevent violence, support victims and prosecute and/or rehabilitate offenders.

South Africa has also ratified the International Covenant on Economic Social and Cultural Rights. The United Nations Committee on Economic Social and Cultural Rights has recommended that States parties intensify efforts to combat domestic violence by "providing victims with shelters; ensuring that all cases of violence against women are effectively investigated, that perpetrators are brought to account, and that victims have access to remedies as well as to protection, including in rural areas; and allocating sufficient human and financial resources to ensure the effective implementation of legal protections." (p23) [3]

African Union and regional instruments

At the regional level, Article 1(j) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa defines violence as both actual violence and threats that could lead to violence, recognising the duty of the state to provide victim support services but also implement measures to combat the drivers of violence.[4] Additionally, by signing the Solemn Declaration on Gender Equality in Africa, and the African Union Strategy for Gender Equality and Women's Empowerment (2018 – 2028) South Africa has pledged to campaign against gender-based violence (GBV) and promote gender equity. In 2025, the African Union (AU) adopted the Convention on Ending Violence Against Women and Girls which is focused exclusively on tackling violence.[5] It recognises the intersections of VAC and VAW and emerging forms of violence, such as cyberviolence, and frames violence against women and children as a continental crisis that demands collective action. However, the monitoring and enforcement mechanisms are weak.[6]

International and regional strategies and targets

South Africa adopted the Sustainable Development Goals (SDGs) in September 2015. The SDGs portray VAC and VAW

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as global challenges and include specific targets and indicators. Goal 5 aims "to eliminate all forms of discrimination and violence against women in the public and private spheres and to undertake reforms to give women equal rights to economic resources and access to ownership of property".[7] Similarly, the African Union Agenda 2063[8] and Agenda 2040[9] make clear commitments to end violence by working with businesses, civil society, and individuals and partners in the AU.

To help states to fulfil these obligations and aspirations the World Health Organization has developed the RESPECT and INSPIRE frameworks.[10, 11] RESPECT focuses on women and INSPIRE on children, but the strategies map on to each other and both require coordination across sectors (see Figure 5 on p. 43). Both frameworks contain a set of evidence-based action-oriented steps enabling policymakers and programme implementers to design, plan, implement, monitor and evaluate interventions and programmes to prevent violence against women and children (see chapter on Enabling Environments on p. 100).

Constitutional rights

Section 12 of the South African Constitution enshrines the right to freedom and security of the person that protects everyone from violence from all public and private sources.[12] Additionally, section 28 affords children the right to protection from abuse, neglect, maltreatment and degradation, and for their best interests to be of paramount importance in any matter affecting them.[12] The active phrasing (to be protected *from*, freedom *from*) makes it clear that the state has a duty to take proactive steps to prevent violence from happening and to act swiftly to prevent further harm when a woman or a child has experienced violence.[13] Dignity is a core value of the Constitution alongside substantive equality – prioritising the rights of those who are marginalised, such as women and children (section 9).[12] There are also rights to language that speak to the accessibility of services (section 6).[12] Finally, there are a range of socio-economic rights including access to housing, social services, social security (grants) and healthcare that guarantee access to support services (sections 26, 27, 28).[12] Collectively, these human rights instruments oblige the government to:

- establish programmes that tackle the structural drivers of violence
- reduce gender inequalities and change social norms
- prevent violence against women and children from occurring
- provide sanctuary and support when violence occurs
- ensure that the criminal justice system holds perpetrators to account
- provide for rehabilitation in the form of medical and therapeutic services, and
- support survivors to live independently and reintegrate into the community.

South Africa's laws and policies should create an enabling environment to fulfil all these obligations.

Why is an enabling policy environment important?

An enabling policy environment should establish the financial, human resources and systems necessary to prevent and respond to VAC and VAW. Laws and policies set the rules for what services are delivered and how, and who gets to make decisions including the prioritisation of services. They define crimes, set benchmarks for prevention, protection, criminal justice and survivor services and competencies for service providers. Integrated services avoid duplication and make better use of limited resources, so laws and policies should foster collaboration among various stakeholders, including government agencies, civil society and communities, and provide a clear mandate to guide the implementation of a comprehensive prevention and response strategy.[14] They should ensure that resources are allocated equitably and efficiently and that programmes and services are evidence-based. Without an enabling policy environment, efforts to combat violence may be fragmented and ineffective, leading to continued victimisation and limited accountability for perpetrators.[15]

Does South Africa have a strategy to prevent and respond to violence against women and children?

South Africa has passed an array of laws and policies whose primary objective is to prevent and respond to violence against women and children – see Table 6 on p.119. It also has strategic plans and policies that present strategic direction for the country, provide mandates for leadership and coordination, and determine resourcing priorities and funding obligations.

National frameworks to provide strategic direction

The National Development Plan 2030 recognises violence as a significant barrier to growth and development. It adopts a comprehensive approach to reduce violence and build safer communities that combines crime prevention, social reform, community engagement and strengthening institutional capacity.

There are three specific strategies to end violence: the National Strategic Plan on Gender-Based Violence and Femicide, the National Child Care and Protection Policy, and the Integrated Crime and Violence Prevention Strategy. They all

adopt integrated, developmental and rights-based approaches, but differ in their specific focus areas, the structural drivers they prioritise and their implementation pillars. All strategies emphasise an integrated, collaborative implementation model, covering a continuum of care from prevention to survivor support and criminal justice. They recognise that addressing violence requires intervening across the life-course. All call for the review and strengthening of legal frameworks and clear accountability mechanisms.

The National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF) is the overarching strategic policy and programming framework. Its purpose is "to ensure a coordinated national response to the crisis of gender-based violence and femicide by the government of South Africa and the country as a whole." (p. 16)[16] The NSP is supposed to provide a shared conceptual and operational framework that integrates the sectors not just women and children but also disability, LGBTQI+ and sex workers. It directly addresses patriarchal gender norms and gender inequality as the key drivers of GBV. Strategies include challenging and transforming toxic masculinities and shifting behaviour and social norms using evidence-based interventions. The NSP also aims to intentionally address structural inequalities by accelerating women's access to procurement, employment, housing and land, while strengthening child maintenance systems to reduce economic vulnerability. It focuses on transforming economic power dynamics, ensuring safe workplaces and addressing economic dependency and abuse.

The NSP-GBVF has however been criticised for its failure to adequately tackle the impact of GBV on children.[17] Children and child rights advocates called for a dedicated seventh pillar NSP-GBVF to specifically address violence against children in homes, schools, online spaces and harmful cultural practices. Other stakeholders are concerned that if one group is singled it will dilute the power of the NSP to tackle GBV against women and to be inclusive of other vulnerable groups, and that violence against children is already addressed under the National Child Care and Protection Policy and the Children's Act.

The National Child Care and Protection Policy (NCCPP) of 2019 gives effect to children's protection rights.[18] It outlines a range of services designed to support parents and caregivers and describes the building blocks of an integrated child protection system – legal framework; leadership and coordination; human and physical resources; information, monitoring and quality assurance mechanisms; funding and partnerships. It calls for the prioritisation of investments in prevention and early intervention services – including early childhood development – to help families provide nurturing care throughout the life of the child. It aims to build effective child protection services for children who lack family care, experience abuse, neglect and exploitation, and/or are exposed to the criminal justice system. But it does not recognise the intersections of VAC and VAW or explicitly direct services to children who have experienced abuse outside of the family. A glaring omission is support for caregivers whose children have experienced violence.

Figure 17: Six pillars of the National Strategic Plan on Gender-Based Violence and Femicide, 2020

Figure 18: Six pillars of the Integrated Crime and Violence Prevention Strategy, 2022

Source: VPUU. *Session 1: Turning evidence into policies and policies into evidence-based implementation*. Safer Spaces Conference: Preventing Violence in South Africa. 2021.

The Integrated Crime and Violence Prevention Strategy 2022 (ICVPS) outlines a comprehensive, multisectoral approach to ending violence – particularly against women and children.[19] It builds on the 2016 White Paper on Safety and Security and is grounded in the principle that safety is a shared responsibility across government and society. Unique to the ICVPS is the focus on safety through environmental design which aims to enhance physical safety through urban planning (eg lighting, safe public spaces) and encourage creation of recreational facilities and community spaces to reduce opportunities for crime.

Do the laws support an integrated response to violence against women and children?

Developing an integrated response requires that the law recognises the intersections between VAC and VAW, that individual laws do not contradict each other and that together they provide for a continuum of care from prevention to response for women and children across the life course.

Do the laws recognise the intersections of VAC and VAW?

It is critical that the legal framework and policies recognise the intersections between VAC and VAW and ensure that when women access services that their children's needs can be accommodated too. The Domestic Violence Amendment Act 14 of 2021 (DVAA) recognises that children are often victimised or suffer negative consequences when they are exposed to domestic violence. National Minimum Standards on Shelters for Abused Women state that shelters must provide for women and children's basic needs (eg accommodation, food and clothing) as well as support, counselling and skills development.[20] However, most laws and policies that provide for services focus on either women or children with only the slightest reference to the other group or the intersections of violence – see Table 5. For example, the Children's Act 38 of 2005 provides for prevention, early intervention and family support services, or children's removal to alternative care when it is no longer safe for them to stay with their primary caregiver, but it does not cater for children who need services alongside their mother. Ignoring the intersections of VAC and VAW and addressing each group separately means that family members exposed to the violence may be excluded from the healing process.[21]

Is the legal framework coherent?

Often, each government department has its own definitions and understandings of key terms. This lack of a common

Table 5: Focus and scope of violence prevention strategies

Strategy	Focus	Scope of violence
National Strategic Plan to end Gender-Based Violence and Femicide	Focuses on violence against women across the life cycle (prenatal to elderly). Includes women, children and LGBTQI+ persons	Focuses specifically on gender-based violence and femicide.
National Child Care and Protection Policy	Children (from conception to 18 years)	Focuses on securing care and protection from violence, abuse, neglect and exploitation.
Integrated Crime and Violence Prevention Strategy	Communities – women and children are categorised as specific vulnerable groups within this wider context.	Addresses all crime and violence, including social and situational crime prevention.

language hinders communication between professionals across sectors and creates barriers to collaboration. One of the most fundamental terms 'violence prevention' is defined differently across key legislative and policy frameworks.[22] For example, the ICVPS and the White Paper on Safety and Security adopt a public health model, distinguishing between primary, secondary and tertiary levels of prevention (ie services for the general population, at-risk individuals and those already affected by violence). Whilst the NSP-GBVF frames prevention as addressing the risk factors that drive gender-based violence, femicide and societal violence.[22]

Government departments have stand-alone mandates, and they develop and implement legislation independently, with limited consultation with other departments. As a result, some laws contain contradictory provisions. For example, the Children's Act and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (SORMA) differ in respect of mandatory reporting of child sexual abuse. Section 110(1) of the Children's Act only applies to a discrete list of professionals and adults who work with children, whilst section 54 of SORMA[23] obliges any person, adult or child to report a sexual offence.

The standards of proof and the course of action to be taken also differ: The Children's Act requires the reporter to conclude on reasonable grounds that a child has been sexually abused where such a conclusion should be based on an investigation into the signs and indicators. Once a conclusion has been reached, they have a choice of reporting to social services – a designated child protection organisation or the provincial Department of Social Development (DSD) – or the police. Whilst the under SORMA[23] anyone with knowledge, reasonable belief or suspicion that such an offence has occurred must report it to a police official immediately. The situation was further complicated when the DVA was amended to oblige any adult to report incidents of domestic violence involving children[ii] to social services or the police, potentially detracting from women's rights to privacy and autonomy over their own situation.

Recent amendments to the criminal law have improved the coherence of the legal framework in respect of the criminal justice system but the inconsistencies and contradictions between laws and policies across sectors and gaps in the continuum of care – see below – mean that the legal framework is not fully harmonised or coherent.

Does the law provide for a continuum of care from prevention to response?

Prevention tackles the social, economic and cultural drivers of violence, while response services (healthcare, psychosocial support, justice and shelter) address its impacts and help break cycles of abuse. Building a continuum of care from prevention to response is therefore necessary to break the cycle of violence.

Addressing the drivers of violence

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 prohibits unfair discrimination by the government and by private organisations and individuals and establishes Equality Courts to ensure implementation of the Act. Labour laws establish a national minimum wage and provide for four months of maternity leave; however, the Constitutional Court recently ruled that leave should be shared between the parents. The Social Assistance Act 13 of 2004 establishes a series of grants that help poor families; however, the Social Relief of Distress to support adults with no income and the Child Support Grant falls below the food poverty line leaving many women and children live below the food poverty line.

Gun control laws are not aligned with international and regional frameworks as they allow civilians to keep handguns in the home. Alcohol is widely available, the Liquor Act 59 of 2003 and the Prevention of and Treatment for Substance Abuse Act 70 of 2008 aim to reduce the demand and harm associated with substance abuse and include prevention programmes and treatment facilities; however, the Liquor Policy aligned to WHO guidelines has yet to be adopted/implemented.

The lack of affordable private housing and long waitlists for public housing forces women to remain in – or return to – unsafe homes.[24] The Housing Act 107 of 1997 and supporting policies do not recognise domestic violence as 'forced eviction'.[iii] Regulation of the online environment is weak, although the Cyber Crimes Act 19 of 2020 criminalises harmful communications, there is little attention paid to tech-facilitated violence against women and children. Furthermore, critical guidelines developed by the Films and Publications Board including the Draft Industry Code on Prevention of Online Harm (2023), Draft Guidelines on Peer-to-Peer Video Sharing, Draft Guidelines to Determine Whether Content is Harmful are voluntary rather than binding legal instruments.

ii The definition of domestic violence in SORMA now includes exposing a child to domestic violence. This means to intentionally cause a child to— (a) see or hear domestic violence; or (b) experience the effects of domestic violence (section 1).

iii The UN Committee on ECSR in its General Comment No. 7 recognised domestic violence as a form of forced eviction: 'Forced eviction' is the permanent or temporary removal of individuals, families or communities against their will from the home or land they occupy, without their being provided with legal and other forms of protection.

Prevention and early intervention

It is important to intervene early and supporting vulnerable families has the potential to stop violence from reoccurring and becoming more intense or even fatal. Domestic violence is one of the most common reasons for women to present at healthcare facilities, yet injuries and other consequences resulting from domestic violence are seldom documented or identified as such by healthcare professionals.[25] Whilst there is no legislation that compels healthcare workers to screen for domestic violence, a range of existing laws provide for or imply that screening should be conducted as part of routine care.[26] In particular, the General Ethical Guidelines for Reproductive Health 2025 draws on the DVA definitions of domestic violence and reminds HCWs that child can be victims.[27] It advises healthcare professionals to respond to domestic violence by gently screening for abuse, assessing risk, providing supportive care, documenting evidence, informing patients of their rights and legal options, referring them to appropriate services, and developing a safety plan when reporting is uncertain. The DVA provides for the issuing of protection orders to stop perpetrators from committing further acts of violence against the victim – it is early intervention measure. SAPS are also bound to assist the complainant to find suitable shelter and to obtain medical treatment.

Response services

The Services Charter for Victims of Crime and the Minimum Standards on Services for Victims of Crime prioritise women and children who have been experienced violence. These documents emphasise the rights of victims to fair treatment, dignity, privacy, access to information and protection. They require that services are empowering and enabling, and establish a complaints procedure to hold the state accountable when service delivery fails to meet these standards.

Minimum Standards on Shelters for Abused Women specifies that shelter services must provide for basic needs (eg accommodation, food and clothing) as well as support, counselling and skills development. It clearly recognises the needs of children and advocates for a family centred approach with a range of differentiated and integrated services across the continuum of care including assessment and access to therapeutic support.[20] However, it does not clarify how shelters should be financed. The National Strategy for Shelters for Victims of Crime and Violence in South Africa 2013 – 2018 recognises that shelters must provide safe, secure, and protective services to all victims of crime and violence. This national strategy requires provinces to fund shelters and develop provincial strategies in partnership with civil society organisations, but none of these frameworks have legally binding provisioning clauses to fund psychosocial care.

The Mental Health Care Act 17 of 2002 does not explicitly mention trauma counselling or victim support services; however, its broad mandate to provide treatment and rehabilitation services can be interpreted to include trauma counselling. The National Mental Health Policy Framework (2023 – 2030) guides the implementation of the Act and recognises the impact of violence on mental health but does not mention trauma-informed care. The Victim Support Services Bill aims to plug the gap and establish psychosocial services for victims of violent crime and gender-based violence.[28] The Bill promotes the rights of victims, which includes the right 'to be treated with dignity and privacy', and to receive information and assistance, and it sets out which facilities must be available to victims and the standards they must meet. It aims to prevent secondary victimisation by enforcing the implementation of a code of conduct to ensure that employees of 'relevant departments, associated professions and service providers' are sensitive to victims of GBV. It would plug the gap in the legislative framework on the provision of services for women – but the draft was heavily criticised for the over regulation of the women's sector and holding small service providers criminally liable for failure to meet unobtainable standards. While short-term shelters exist, South Africa offers limited long-term housing support for survivors of GBV, and transitioning to permanent housing remains a challenge.

Criminal Justice

The Criminal Procedure Act 51 of 1977, Criminal Law Amendment Act 105 of 1997 (Sentencing) and Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 criminalise sexual abuse and rape, and guide the arrest, prosecution, conviction and sentencing of perpetrators of violence against women and children. These Acts also contain protective measures for vulnerable victims and witnesses. Recent amendments to the criminal law include broadening the scope of victims who can use court intermediaries [iv]and providing for the use of sign language; placing all offenders on the National Register of Sex Offenders; increasing the number of sexual offences courts (SOC) and passing national guidelines to ensure that SOCs are victim-centred and provide

iv Court intermediaries are specially trained professionals appointed by the court to assist vulnerable witnesses – children, individuals with mental disabilities, and older persons – during legal proceedings. Their role is to facilitate communication between the witness and the court by relaying questions in a way that is developmentally appropriate, understandable and sensitive to the witness's needs. The use of intermediaries allows the victim to sit in another room, avoids hostile cross-examination and reduces secondary victimisation.

Table 6: Legislation and frameworks for the prevention of violence in South Africa

	Violence against children			Violence against women	
International	**United Nations Convention on the Rights of the Child** Prevent violence against children, protect children from further harm, support and treat children who have experienced violence		**Convention on the Eliminations of all Forms of Discrimination Against Women (CEDAW)**	**United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power**	**Universal Declaration of Human Rights (UDHR)** Upholds the principle of non-discrimination on the basis of gender
Regional	**The African Charter on the Rights and Welfare of the Child** Prohibits child abuse, and harmful cultural practices	**The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa** Expands on women's human rights in relation to GBV to eliminate all forms of discrimination	**SADC Protocol on Gender and Development** Requires States Parties by 2025, to enact and enforce legislation prohibiting all forms of GBV; and ensure that perpetrators of GBV are tried by a court of competent jurisdiction	**African Charter on Human and People's Rights** Guarantees the rights to freedom from discrimination; equality before the law and equal protection of the law; and personal liberty, including security of the person	**African Convention on Ending Violence Against Women and Girls** 2025 first regional framework addressing intersections.
National	**Constitution of the Republic of South Africa, Act 108 of 1996** Protects the rights of all South Africans to equality, dignity and freedom from all forms of violence, maltreatment, abuse and exploitation while having access to justice and fair treatment				
	Domestic Violence Act 116 of 1998 Provides victims of domestic violence with protection from abuse, accounting for the variety of family and co-residential relationships in South Africa	**Domestic Violence Amendment Act 14 2021** Extends the definition of domestic violence to include victims of assault to any form of intimated relationship, includes online protection orders	**Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (PEPUDA)** Gives expression to the right to equality, Section 8 stipulates that no person may be unfairly discriminated against on the grounds of gender, expressly including GBV	**Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007** Defines rape, sexual assault, compelled rape or sexual assault, and the compelling of persons older than 18 years to witness a sexual offence. Differs from the DVA in that the DVA characterises the relationship between victim and perpetrator as 'intimate' whereas the Sexual Offences Act does not	
	Children's Act 38 of 2010 Holistic range of interventions for children, and their families, including prevention and early intervention programmes, child protection services and therapeutic and aftercare services	**National Child Care and Protection Policy 2019** Prohibits corporal punishment in the home, provides for a continuum of care including programmes for children in conflict with the law	**Criminal and Related Matters Amendment Act 12 of 2021** Accused only granted bail under exceptional circumstances with victims heard in court before bail is decided and before parole decisions are made	**Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act 13 of 2021** Recognises sexual intimidation as an official offence, increases reporting duty for those who suspect child abuse, extends national register for sex offenders to all perpetrators and making it public	
	Sector Funding Policy (SFP) Ensures equitable funding for social services and reserves funding for prevention programmes	**National Policy Guidelines for Victim Empowerment (NPGVEP)** Promotes a victim-centred, rights-based approach to response services and ensures a coordinated, multisectoral and departmental approach to address the needs of victims			
		National Policy Framework: Management of Sexual Offence Matters Attempts to enhance the NPGVEP, recognises LGBTQI+, immigrants and refugees and awaiting trial detainees and incarcerated offenders			
	National Development Plan 2012 Aims to have all people living in South Africa feel safe and have no fear of crime by 2030; through strengthening the criminal justice system, creating a professional police service, demilitarising the police, having an integrated approach to safety, building community participation and addressing the underlying root cause of violence				
	National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF) Is the overarching strategic policy and programming framework				
	2016 White Paper on Safety and Security Promotes an integrated and holistic approach to safety and security, recognising the role of the state, civil society, private sector and citizens to achieve this	**2016 White Paper on Policing** Separates 'police focused' from broader policy on safety and security, and aligns police services to rest of public service	**Integrated Crime and Violence Prevention Strategy 2022** Involves state beyond policing at national, provincial and local levels to respond to crime-related issue in a coordinated and focused manner	**Community Safety Forums Policy** Provides a framework for integrated, localised safety planning that is coordinated and aligned to national and provincial priorities	

Adapted from: Amisi MM, Naicker SN. Preventing violence against women and children: An evidence review. *ISS Southern Africa Report*. 2021, 2021(46):1-44.

a range of victim support services. Anyone with an interest in the well-being of the victim, including family members, can now apply for a protection order with the written consent of the victim. This allows third parties to apply where the victim is ambivalent, in denial or fearful of retribution. Other measures include online application processes and the ability to serve notices electronically within 24 hours.

Is the entire life course covered?

Laws and policies should address all stages of the life course. However, vulnerabilities increase during pregnancy, the early years and adolescence,[29] so laws and policies should recognise and respond to specific needs at these stages.

Pregnancy and the early years: The Maternal Perinatal and Neonatal Health Policy[30] and related guidelines[31] identify intimate partner violence (IPV) prevention as a vital intervention. IPV is associated with poor maternal and child health outcomes, and healthcare workers (HCWs) can play a central role in identifying abuse, conducting safety assessments and referring patients. The guidelines prompt HCWs to respond empathetically and outline reporting duties and the importance of addressing secondary trauma. Violence during pregnancy is addressed in health policies but does not translate into critical tools such as the Road to Health Book – (see p. 53). The National Integrated Early Childhood Development Policy recognises that young children are particularly vulnerable to abuse and neglect, often within their own families, and emphasises the need for targeted interventions to protect and support children during this formative period.[32] It advocates for screening, assessment and referrals of pregnant women and mothers of young children for mental health, substance abuse and domestic violence. Counselling and prevention services to strengthen families, reduce stress, and decrease the likelihood of violence occurring within the home.

Adolescence: The Department of Basic Education (DBE) has published a suite of laws, policies and strategies to address school-based violence and risk factors affecting learners. Key legislation includes the South African Schools Act 84 of 1996 and the Basic Education Laws Amendment Act 32 of 2024 which ban corporal punishment and impose stricter penalties for violations. Despite these measures, 20% of learners in KwaZulu-Natal still experienced corporal punishment in 2024.[33] The Life Orientation curriculum promotes life skills, sexual abuse awareness and healthy relationships. DBE's Care and Support for Teaching and Learning Programme is being enhanced to foster peacebuilding. Preventing violence is a priority area in the National Adolescent and Youth Health Policy along with services to promote mental health and remove attitudinal barriers to service access. Goals include the provision of 24-hour, easily accessible post-violence treatment in non-judgemental settings; referrals to counselling services; the rollout of evidence-based gender-based transformative programmes and school-based violence prevention programmes (see Schools chapter on p.72).

The Older Persons Act 13 of 2006 does not refer explicitly to IPV or GBV, but it does address abuse in all forms, including those that can occur within intimate or domestic relationships.

Are vulnerable groups protected?

Discrimination on the grounds of sexual orientation intersects with and compounds risks of the GBV, and LGBTQI+ activists and scholars have called for the constitutional rights to equality and dignity to be translated into special protections in the legal framework.[34] There is now a dedicated law that addresses the intersection of gender-based and homophobic violence. The Prevention and Combating of Hate Crimes and Hate Speech Act 16 of 2023, defines a hate crime as any offence motivated by prejudice or intolerance toward the victim's actual or perceived characteristics, such as sexual orientation, race or gender. The conviction will be explicitly recorded as a hate crime in the offender's criminal record, and their sentence may be more severe as prejudice is considered an aggravating factor. The law also contains directives on training and other measures to be undertaken by the police and the prosecution services.

Does the law contain clear mandates for coordination and leadership?

Intersectoral collaboration helps to reduce duplication of services, saves money and results in joined up services for users.[35] Promoting intersectoral collaboration includes developing shared strategies and plans, a common language, intersectoral training and common indicators to monitor progress.[36] The NSP-GBVF incorporates these elements and establishes a structure to drive implementation — the National Council on Gender-Based Violence and Femicide (Council). However, the Council is yet to be established as the *National* Council on Gender-Based Violence and Femicide Act 9 of 2024 was returned Parliament following objections from civil society. Concerns include the balance between civil society and government representatives, the Council's lack of authority to drive change,[37] potential duplication with the Commission on Gender Equality,[38] and inadequate resourcing[37, 39].

The National Policy Guidelines for Victim Empowerment outline institutional arrangements for coordinated victim support, define departmental roles, and provide for Victim Empowerment Management Forums to oversee implementation

Case 20: Protecting LGBTQI+ learners from discrimination and psychological violence

Juliana Davids[i]

In South Africa, learners who identify as lesbian, gay, bisexual, transgender, queer, intersex, or otherwise gender non-conforming (LGBTQI+) are often forced to navigate school environments that are not only uninformed but actively hostile. For adolescents who are in the process of coming out or transitioning, school can become a site of psychological violence, bullying, public humiliation and institutionalised exclusion.[53, 54]

For example, a group of lesbian and trans girls at a high school in rural Western Cape began wearing uniforms that aligned more closely with their gender identities and expressions. The school then demanded that they write formal letters to the principal. The lesbian identified girls were told to "declare" that they were now identifying as boys, and the two trans girls to state they were identifying as girls and would be treated "accordingly". The school claimed this was necessary to “maintain order” and to avoid “confusion” among staff and other learners.

Rather than recognising gender identity as an inherent, self-determined aspect of a person’s dignity, the school imposed a binary framework, and it weaponised bureaucracy to police learners’ identity.[55]

This violates children’s constitutional rights:

- The distinct treatment of these LGBTQI+ learners constitutes direct discrimination based on sexual orientation and gender identity (Section 9).
- Forcing minors to write letters that disclose, deny or rationalise aspects of their identity under institutional pressure, amounts to a breach of their right to bodily and psychological integrity (Section 12) and undermines their dignity (Section 10).
- In doing so, the school undermined the best interests of the child (Section 28(2)) by creating a hostile environment that further traumatised vulnerable adolescents.

The absence of clear, enforceable policies and protections leaves LGBTQI+ adolescents at the mercy of individual school leadership, governing bodies and educators, many of whom lack the training, political will or support to address incidents of discrimination, bullying or exclusion.[56, 57] Schools and educators are left to interpret issues of gender and sexuality based on personal beliefs, misinformation, disinformation in the midst of the anti-gender movement, or conservative community pressure.[53, 58] This puts LGBTQI+ learners, especially Black, rural and working-class youth at disproportionate risk.

The urgent need for SOGIESC protections in South African schools

The Department of Basic Education's 2021 draft Guidelines for the Socio-Educational Inclusion of Diverse Sexual Orientation, Gender Identity, Expression and Sex Characteristics (SOGIESC) held promise as a proactive, system-wide intervention. The Guidelines adopt a whole school approach, and place a responsibility on the principal, management team, school governing body, educators, learners and parents to create an inclusive environment that respects the dignity of all learners. They promote the use of gender-neutral language, affirm learners’ rights to wear uniforms that align with their gender identity and to be referred to by their chosen names and pronouns, and provide for supportive health services and physical infrastructure eg bathrooms and changing rooms.[59]

The stalling of this process sends a chilling message: that the rights of queer learners are still negotiable.[54] Resistance to the SOGIESC guidelines is not a minor bureaucratic delay, it is a form of systemic violence that denies vulnerable learners much needed protection.

i Triangle Project

and evaluation of services. Similarly, the Integrated Crime and Violence Prevention Strategy emphasises local participation and community leadership in GBV prevention and response.

Mandates for intersectoral coordination are embedded in most key laws and policies. For example, the National Policy Guidelines for Victim Empowerment, National Integrated Early Childhood Development Plan, Older Persons Act 13 of 2006, Children’s Act and White Paper on Safety and Security all emphasise collaboration and establish inter-departmental structures to integrate, coordinate and monitor the implementation. Granting a mandate for coordination to multiple structures and bodies perpetuates the struggle for power.[40] Even when they provide clear responsibilities and roles for different stakeholders, the absence of a single overarching governance structure continues to hinder integrated service delivery. In addition, these structures predominantly take a top-down approach to

coordination and need to be complemented with community-based coordination to ensure integrated service delivery on the ground – see Coordination chapter on p.125.

Is there provision of sustainable funding and resources?

Violence has a huge cost to society and places a financial burden on the economy,[41] and there is a compelling economic argument for strategic investment in services to prevent and respond to VAC and VAW – see Finance chapter on p. 138. However, in a country with limited resources, funding policy needs to maximise the value of expenditure. This means that policy should reduce the fragmentation and duplication of services, and invest strategically in long-term programming to ensure sustainability.[42, 43] It should also be flexible to allow organisations from different sectors to provide holistic services to both women and children. Currently, civil society organisations shoulder much of the victim support burden, often with inadequate and inconsistent government subsidies,[44] leading to criticism from the international community.[45] Although the Children's Act obliges provinces to fund child protection services, spending on prevention programmes is discretionary. There is no legal mandate to provide funding for violence prevention services and no operational funding policy.

In 2023, after years of deliberation and consultation, National DSD published the draft Sector Funding Policy (SFP).[46] The SFP sets a standard for how provincial DSDs fund social services including those provided for by NGOs. It aims to ensure that existing services are equitably funded and to progressively expand access to developmental social services going forward. It lists priority services and provides a method for determining how much will be allocated for specific services - including reserving a proportion for prevention services such as parenting programmes, GBV prevention, substance abuse and social crime prevention among young people.[v] However, the current status of the policy is uncertain. National DSD has stopped referring to it in its Annual Performance Plan,[47] and it is not being followed by the provinces as evidenced by funding cuts in Gauteng and KwaZulu-Natal.[48]

What are the opportunities for strengthening the policy framework?

The South African Law Commission's Project 151: Review of the Criminal Justice System proposes reforms to the Criminal Procedure Act (CPA) and related laws to improve efficiency and fairness and to foster a more victim-centred justice system.[49] Key recommendations include expediting bail applications and regulating adult diversion and alternative dispute resolution (ADR) in criminal matters to ensure that restorative justice principles are applied consistently and equitably. Offences that could be referred to ADR include domestic violence, contravention of protection orders, rape, sexual assault and attempted murder. Proposals include personalised and targeted diversion programmes such as anger management to decrease GBV.

There are several opportunities to strengthen the policy framework:

- Finalise the National Council on Gender-Based Violence and Femicide Act and establish the GBV Council.
- Insert provisioning clauses into the Victim Support Services Bill to mandate national and provincial governments to ensure adequate funds to respond to VAC and VAW.
- Implement the Sector Funding Policy to ensure sustainable support for NGOs and encourage long-term provincial investment in critical services.
- Prioritise violence prevention in the forthcoming review of the NIECD Policy and introduce clear mandates for coordination.
- Regulate alcohol sales and advertising through the Liquor Amendment Bill [B21-2025] to reduce consumption and harmful social norms surrounding alcohol use.
- Align the Children's Act with the DVA by inserting definitions and introduce identification and referral mechanisms for caregivers who have experienced violence.

Conclusion

An enabling policy environment is essential for addressing the root causes of violence, and effectively preventing and responding to violence against women and children. The NSP-GBVF sets out the strategic vision to address and combat gender-based violence and femicide in South Africa. It seeks to strengthen the implementation and enforcement of a wide range of existing laws and calls for reform where gaps or weaknesses are identified. Overall, the legal framework provides for a continuum of services, but there is a greater emphasis on criminal justice and response services than on prevention and psycho-social support. Different population groups are covered by different laws and policies leading to the fragmentation of services and competition for resources. Integrated services have proven impact and improve the outcomes for women and children,[35] but breaking the historical silos requires a legal and policy framework that has clear roles and responsibilities for different sectors and duty bearers, along with mandates for coordination and leadership. This needs to

v The Violence Prevention Forum has developed a series of short guides to help NPOs and other stakeholders to understand the specifics of the policy and how it will affect them see: Social Development: Sector Funding Policy - Violence Prevention forum

go beyond creating more national coordination structures to provide tools that support integrated case management and interdisciplinary, cross-sectoral training; mechanisms for joint leadership and decision-making; and shared indicators to promote mutual goals and accountability.

From a life-course perspective there is little specific provision for pregnant women, young children and adolescents. Children are a subsidiary focus of the NSP-GBVF and the needs of boys as the victims of violence and as group at risk of exposure to violence in the home and community are poorly considered. Incorporating men and boys into prevention strategies would help address the root causes of violence and promote healthier masculinities.[50]

Long-term sustainable funding of integrated programmes and fair compensation for NGOs would ensure that they could invest in reaching strategic goals rather than compete for survival or donor priorities.

South Africa's laws and policies provide for a broad array of services and a framework for coordination. While there is still room to improve and strengthen the legal framework, the major concern is the implementation gap. The lived experiences of women and children indicate that legislative measures alone are insufficient to safeguard them from violence.[51] The diagnostic review assessing the efficacy of programmes and institutions designed to combat violence against women and children uncovered systemic deficiencies and highlighted a pervasive lack of political commitment to effectively address the escalating prevalence of such violence.[52] Services across the board remain underfunded (see Finance chapter on p.138), and fragmented (see Coordination chapter on p. 125), and professionals are not trained to deal with trauma (see Human resources chapter on p. 151). As a result, survivors often face systemic failures in law enforcement, healthcare, social welfare services and the justice system, which compound their trauma and perpetuate a cycle of violence. Refining the legal framework will only help transform society if it is coupled with effective implementation of the existing laws and policies.

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Leadership and coordination for systems change: Working at the intersection

Matodzi Amisi[i] and Tarisai Mchuchu-MacMillan[ii]

Violence against women (VAW) and violence against children (VAC) intersect, sharing risk factors and driven by similar social norms. They frequently co-occur particularly in the home, and have intergenerational continuity, where children exposed to intimate partner violence (IPV) in early childhood are likely to grow up to perpetrate violence or become victims.[1] Numerous cases illustrate that women and children often experience violence simultaneously within the same household and are impacted by interrelated traumas and systems of harm.[2] Recognising this, there is increasing advocacy for work at the intersection of violence against women and children.

Internationally, organisations like UNICEF have called for increased coordination of efforts between organisations working to address VAC and those addressing VAW.[3] However, fragmented prevention and response to VAC and VAW persist for several reasons:

- Historically these fields have developed in parallel, establishing separate policy frameworks, terminologies, ways of working, rights based treaties, legislation and lead agencies, both globally and at the national level.[4, 5] VAC interventions are often grounded in child welfare and safeguarding principles, focusing on the best interests of the child, statutory reporting duties and protective care models. In contrast, VAW responses are more likely to centre survivor autonomy, empowerment and a gendered analysis of power and control. These differences matter, particularly in decisions around disclosure, consent, and engagement with formal systems such as the police, health and courts.
- The design of services has also been in parallel, resulting in fragmented responses that fail to meet the complex needs of survivors across age groups.[2] For example, women experiencing IPV are often supported by a domestic violence shelter, while their children are referred to a separate child protection agency, resulting in duplicated assessments, conflicting service plans or contradictory safety strategies.
- Concerns persist about the potential risks of a coordinated response to VAC and VAW. Some fear that women's needs will be deprioritised over the rights of children, while others worry that powerful women's organisations will overshadow children's concerns.[1]

Using a conceptual framework based on systems change theory as outlined by Kania, Kramer, and Senge,[6] this chapter shifts from analysing visible, structural issues to examining the deeper, less visible conditions that sustain this fragmentation. Kania et al. argue that change must happen at three levels. The first is the explicit level, involving policies, practices and resource flows. The second, semi-explicit level, involves relational shifts, including changes in relationships, connections and power dynamics among stakeholders. The final level, which they identify as essential for transformative change, is the implicit level, entailing shifts in mental models, such as deeply rooted beliefs and assumptions.[6]

Applying this framework and drawing on past experiences, this chapter argues that efforts to coordinate responses to VAC and VAW will falter if they focus solely on the most visible level – such as establishing new structures, changing legislation or establishing new operational standards – and fail to address the relational and conceptual barriers that hinder coordinated responses. These barriers include tensions arising from legal mandates, power struggles between sectors, and deeply ingrained assumptions that frame VAC and VAW as separate rather than interconnected issues.

This chapter focuses on three multisector platforms – the National Violence Prevention Forum and the SAFE Platform and the Western Cape Violence Prevention Unit – to demonstrate how transforming the ways in which organisations meet and engage with one another can offer space for kinds of shifts in mental models through joint learning and the building of relationships between organisations in the women and children's sectors to enable working at the intersection of VAC and VAW.

The chapter is divided into three sections. The first section defines coordination and other related terms. The second highlights ongoing challenges to VAC and VAW coordination, such as the proliferation of coordination structures and the

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inconsistent recognition of the intersection of VAC and VAW in policy frameworks. It also covers relational and operational issues, including conflicting legal requirements, interpersonal tensions, and power dynamics that undermine trust between stakeholders. Finally, the chapter identifies pathways for change to address these challenges.

What is coordination, and why does it matter in addressing the intersections of VAC and VAW?

According to UNICEF Innocenti's seminal papers on intersection, a coordinated approach means promoting, recognising and ensuring alignment and synergies between laws, policies, systems, services and programmes to meet the needs of both victims and survivors of VAC and VAW. They argue that coordination needs to take place at both at a policy and implementation level.[3, 7] On the policy level, this includes harmonising legislation, cross-sector accountability frameworks, and sustainable governance mechanisms. In practice, it means empowering duty bearers with the tools, relationships and discretion to engage in real-time joint problem-solving and to decide when coordination, integration, or parallel but synchronised actions are most appropriate. At its core, coordination involves intentionally linking actors, mandates and decisions,[8] and developing a shared understanding of risk and safety, while balancing the distinct yet overlapping needs of women and children as there are times when separate, specialised prevention and response services might still be needed for women and children.[7] Thus, coordination has to be seen as a continuum ranging from working in parallel to full service integration. Coordination is also inherently relational. It depends on trust, mutual recognition and the ability to manage disagreements without increasing fragmentation.

In this chapter, coordination and collaboration are used interchangeably to refer to different degrees of working together. However, they represent different levels in the continuum of systemic alignment.

- **Coordination** involves deliberate alignment of services and actors to reduce duplication, clarify roles and streamline referral pathways. It can occur without fully integrating services and systems and is often the first step towards improved cooperation.[9]
- **Collaboration** denotes a deeper level of joint planning and implementation, often involving shared decision-making.
- **Service integration** refers to the formal combination or harmonisation of services, usually at the level of delivery. This may involve co-location, shared case planning or joint training protocols. Integration is most appropriate where cases of VAC and VAW intersect, such as in family-centred interventions or joint risk assessments. However, integration should not imply a one-size-fits-all approach; instead, it should be guided by the specific risks, rights, and safety considerations of both women and children.[10]
- **Collaborative case management**, by contrast, focuses on joint planning and problem-solving around a specific case, often involving a multidisciplinary team. It may be time-bound and context-specific, without requiring institutional integration. It relies on information sharing (within legal and ethical boundaries), trust between practitioners, and survivor-centred decision-making. Collaborative case management can be employed within either integrated or coordinated systems.[11]

These approaches are not mutually exclusive, and the choice between them should be guided by a number of factors, for example:

- The level of intervention: Some policies may address the needs of women and children separately while ensuring they do not work at cross purposes. At the same time, certain advocacy efforts and prevention interventions may need to be conducted jointly as both sectors benefit from prioritising the issues of violence, and well-targeted prevention efforts can address both VAC and VAW at the same time.
- For service delivery, the nature of the violence, the degree of risk and the needs of those affected are important. For instance, in cases where both a woman and her children are at risk within the same household, integrated safety planning may be essential. In other situations, particularly where adult survivors do not want child protection services involved, parallel but coordinated pathways may be more appropriate.

Therefore, a coordinated approach to VAC and VAW will require ongoing negotiations among government, NGOs and funders within the two sectors. While policies and strategies that acknowledge the intersection of VAC and VAW are vital, working at this intersection also demands a shift in mindsets to recognise the interconnectedness of the two issues, adaptive management and decision-making by implementers, alongside interdepartmental cooperation to decide when collaboration is needed, service integration is beneficial, and when working separately serves the interests of both women and children. Although research on optimal coordination strategies between the two sectors is limited, past experiences with implementing multisector plans in the VAC and VAW sectors provide valuable insights into what has not worked before and what shows promise for a successful coordinated response. Next, we look at some of the issues that have made coordination a challenge in the two sectors in South Africa.

Case 21: SAFE-PR – A coordinated response to domestic violence

The Strengthening Actors for Effective Preventative Response Project (SAFE-PR), developed by MOSAIC Training Service and Healing Centre (hereinafter referred to as MOSAIC), aims to advance the rights and safety of women, children and other vulnerable groups in relationships, homes and communities. SAFE-PR works at the intersection of violence against women and children, recognising the complex nature of domestic violence, where children witnessing violence may create tensions between their best interests and those of the mother or caregiver.

SAFE-PR coordinates duty bearers to balance these needs, interlinking resources and ensuring the right stakeholders are involved at the right time to prevent harm. The project convenes local multi-stakeholder SAFE Platforms, consisting of duty bearers and first responders to domestic and intimate partner violence in various communities. These SAFE Platforms are place-based, convening stakeholders in a particular area to connect existing assets and resources, thereby increasing capacity and removing barriers to survivors accessing care, safety, security and justice. SAFE-PR also aims to ensure that protection orders effectively protect survivors and that harm is prevented.

Duty bearers and first responders to domestic violence include the police, social workers, magistrates, clerks, healthcare workers, teachers, neighbourhood watch, religious and traditional leaders and civil society members. Therefore, SAFE-PR stakeholders include personnel from the local South African Police Services, Department of Justice, Department of Health and Department of Social Development, as well as community-based civil society organisations who come together to identify gaps and challenges in advancing the care, safety, security and justice for survivors and to co-create solutions that improve the lives of survivors in the communities they live.

The SAFE Platform aims to foster collaboration and cooperation among these entities to share expertise around a shared objective in ways that will enhance the effectiveness of preventative measures. MOSAIC provides the backbone support for the SAFE Platforms to foster continuous communication amongst stakeholders, connect agreed upon activities and coordinate referral pathways for multisectoral collaboration, and to address the systemic barriers and challenges that affect survivors of domestic violence when seeking services. The aim is to remove barriers to access at a local level and connect stakeholders to work towards meaningful solutions to the pervasive issue of domestic violence and enhance safety in relationships, homes and communities.

Where does SAFE-PR operate?

SAFE-PR currently operates in six communities: Philippi, Mitchell's Plain, Paarl, Heidelberg, Albertinia and Soshanguve. The choice of where to establish SAFE Platform is based on several factors:

- **Existing presence:** MOSAIC's presence within the community helps facilitate legitimacy as the organisation is part of the service delivery chain and of the community. It also makes it easier to leverage collaborative success through existing networks.
- **High incidence of domestic violence:** The community experiences a high incidence of domestic and intimate partner violence, as indicated by official crime statistics and MOSAIC court service data. This underscores the urgent need for intervention and support in these areas.
- **Existing infrastructure:** Each of these locations has some assets such as police stations, courts and other support services to enable community members affected by domestic violence to access justice and support.

How does SAFE-PR work?

- **Platforms/hubs:** SAFE platforms operate at a local community level to connect stakeholders from various sectors. These hubs serve as spaces for collaboration, information sharing and joint efforts in preventing and responding to domestic violence.
- **Convening, meetings and training:** Regular meetings and training sessions help share information, enhance coordination, build supportive relationships and improve the quality of services.
- **Referrals and resource sharing:** SAFE-PR establishes robust referral systems across different sectors and stakeholders to ensure survivors of domestic violence can access a wide range of support and services. This includes facilitating referrals to appropriate service providers, reducing service duplication and maximising resource efficiency to better meet the needs of survivors.
- **Coordination and integration:** MOSAIC provides strong and skilled coordination to ensure that different parts of the system are working together in the most efficient and effective manner. This involves convening stakeholders,

facilitating collaboration, building and maintaining relationships to support effective referrals, collaboration and integration of services.

- **Shared measurement:** SAFE-PR helps establish a shared measurement system with common objectives, indicators and reporting systems. Data collected through this system feeds into a shared public dashboard, enabling all stakeholders to easily track progress. This shared measurement approach fosters accountability, transparency and collective action among stakeholders.

What hampers coordination of the women's and children's sectors?

There are a number of persistent challenges that hamper coordination within and between the women's and children's sectors.

Emphasising structures while overlooking the social dimensions of coordination

Most policies and strategies to address VAC and VAW recognise the importance of multisectoral action and the need for coordinated efforts. Policies have also sought to achieve coordination through structural changes. For example, the National Strategic Plan on Gender Based Violence and Femicide (NSP-GBVF) emphasises that effective implementation requires strengthened multi-sectoral coordination and collaboration across different tiers of government and society, built on relationships of trust. Similarly, the National Child Care and Protection Policy states that "implementation and impact of the Policy must be overseen by effective national, intra and intersectoral coordination mechanisms". Section 5 of the Children's Act 38 of 2005 further requires all organs of state involved in the care, protection and well-being of children to develop a uniform, coordinated and integrated approach to service delivery, underscoring the legislative mandate for intersectoral coordination. The 2016 White Paper on Safety and Security similarly advocates for an integrated and multi-sectoral provision of crime and violence prevention services through intergovernmental structures and mechanisms.

Each policy/strategy in turn establishes structures to coordinate the specific policy objective as illustrated in Table 7. Previous research by the government found in excess of 55 coordination structures across the two sectors, some established by law and others through policy.[12]

Existing and previous efforts to coordinate VAC and VAW, and those, such as the Interministerial Committee on the Root Causes of Violence Against Women and Children (IMC on VAWC) and its technical management team, that aimed to coordinate VAC and VAW, have been ineffective in solving problems and improving coordinated service delivery, and in some cases, they have been dysfunctional.[12, 13] The problem of fragmented service delivery has persisted despite the existence of different mechanisms, both within government and between government and civil society, to coordinate violence prevention and responses.

Part of the dysfunction has been administrative, with the coordination structures being poorly managed, decision-making processes ineffective, and an overall inability to resolve problems. However, it is the semi-explicit conditions, such as institutional rivalry and efforts to protect departmental mandates, that have created acrimonious relationships and made collaboration difficult. Past experiences affirm that the creation of structures is not enough to achieve a coordinated response to VAC and VAW, particularly if they fail to recognise that attaining coordinated service delivery fundamentally involves the decisions and actions of people whose behaviours are shaped as much by their organisational or institutional cultures as by their personal competencies and motivations. To bring the VAC and VAW work together therefore requires an understanding of the semi-explicit and implicit root causes of poor collaboration both within and between the two sectors.

Inconsistent recognition of VAC and VAW intersection at the policy level

South Africa has a comprehensive policy and legislative framework for both VAC and VAW. The 2016 diagnostic review carried out by the Department of Planning Monitoring and Evaluation found in excess of 20 policies, laws and strategies that responded to violence, with some specifically targeting VAC and VAW.[12] Yet over time, the recognition of the intersections of VAC and VAW has fluctuated.

In 2013, the IMC developed the South African Integrated Programme of Action for addressing Violence Against Women and Children. The plan recognised the connections between VAC and VAW, and this formed part of the Safer South Africa programme funded by the Department for International Development (UK), which also aimed to promote interventions that prevent violence against women and children. The integrated plan reflected an understanding that VAC and VAW intersect, and that to prevent violence effectively requires improved coordination between the two sectors. The 2016 White Paper on Safety and Security and its Integrated Crime and Violence Prevention Strategy, and the National Plan of Action for

Children, also recognise the intersection of VAC and VAW and acknowledge the need for coordination between sectors.

However, the recognition of the intersections of VAC and VAW is not sustained in all policies. The NSP-GBVF marked a shift away from the VAC and VAW framework, creating a linguistic and conceptual divide that complicated efforts to integrate children's needs in the NSP. While the term "violence against women" provides clear definitions of the issue and its affected population, gender-based violence (GBV) is a broader term that encompasses all individuals victimised due to their gender, including LGBTQI+ individuals.[14] While this inclusivity is valuable, it often sidelines the specific vulnerabilities of children, as most violence experienced by children falls outside of the GBV framework.

Thus, the NSP-GBVF, despite its ambition, has not fully responded to the intersection of the needs of women and children. This omission was foregrounded at the 2022 Presidential Summit, where the children's sector strongly advocated for a seventh pillar in the NSP-GBVF. This proposed pillar aimed to fully integrate children into the NSP-GBVF by starting with a definition of GBV that recognises how violence experienced in childhood by both girls and boys drives cycles of victimisation and perpetration in later life. The call for a seventh pillar also sought to institutionalise the inclusion of children's sector representatives in national and provincial GBV coordinating bodies, and to ensure that educational interventions on GBV begin at the early childhood development (ECD) level and continue through to high school.

Despite these calls, the resolution for a dedicated children's pillar was not accepted by the Summit Planning Committee. The primary counterargument was that children are already included in Pillar 2 of the NSP-GBVF. However, this position overlooks the interconnections between childhood exposure to violence and lifelong vulnerabilities, as well as the current policy and budgetary constraints affecting children.

It is also important to note that this tension is not new. During the first Presidential Summit in 2018, when the NSP-GBVF was being conceptualised, the women's sector resisted including a broader VAC and VAW framework, citing concerns that conflating women's and children's issues would dilute the specificity of women's experiences and potentially infantilise adult women. As a result, the children's sector was compelled to advocate separately for the inclusion of children, even though the lived realities of women and children, particularly in familial and domestic contexts, are deeply interconnected.

Consequently, at service level collaboration across VAC and VAW remains fragmented, though there are important developments to improve coordination. Box 9 presents programmes with elements that support working at the intersection. Key gaps that remain include siloed service provision, limited integrated case management systems, and a lack of shared training or protocols across the child protection and GBV sectors. More consistent, cross-sectoral approaches are needed to ensure a coherent and survivor-centred response that reflects the interlinked nature of violence in homes and communities.

Conflicting requirements between child protection and women survivors

Organisations providing services to survivors of domestic violence consistently encounter women with children who hesitate to report domestic violence due to fear of losing custody. The Domestic Violence Amendment Act 14 of 2021 (DVAA) makes provision for mandatory reporting of violence against children, which states that, "any person with knowledge, belief, or reasonable suspicion that an act of domestic violence has been committed against a child (under 18) or a person with a disability must report the abuse to the South African Police Service (SAPS)".[15]

Table 7: Coordination structures

Legislation / Policy / Strategy	Coordination structure(s) established / envisioned
2016 White Paper on Safety and Security	Envisions the National Crime Prevention Centre, intergovernmental structures and mechanisms for integrated crime and violence prevention
National Child Care and Protection Policy	National Child Care and Protection Forum
Victim Empowerment Programme (VEP)	VEP management teams at national and provincial levels
Domestic Violence Framework	National Domestic Violence Intersectoral Committee
National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF)	End GBV Collective (informal, coordinating across six pillars)
National Council on Gender-Based Violence and Femicide Act 9 of 2024	Formalises the National Council on GBVF as a statutory coordination structure

Box 9: Services that have the potential to support an integrated response to VAC and VAW

Victim Empowerment Programme

The Victim Empowerment Programme (VEP) provides for the needs of all victims of violence including women and children. It promotes a victim-centred and restorative justice approach, which places the needs of victims at the centre of how the different service providers plan and intervene. It recognises the vulnerability of women and children to sexual and domestic violence, and other forms of violence, and calls for a multidisciplinary approach to responding to violence. While the policy guideline for the VEP does not specifically mention intersections, it provides a foundation for coordination between service providers whose clients are women and/or children.

Thuthuzela Care Centres

The Thuthuzela Care Centre (TCC) model is a national initiative led by the National Prosecuting Authority under its Sexual Offences and Community Affairs Unit. These one-stop facilities aim to provide an integrated and survivor-centred response to sexual violence, and have recently expanded to respond to domestic violence.

TCCs provide immediate medical, psychological and legal assistance to survivors of sexual violence. The centres work closely with law enforcement, the healthcare system and the justice sector to ensure a streamlined and supportive process for survivors seeking justice.

The TCC blueprint recognises the intersection between violence against women and violence against children, as it prioritises services for survivors of all ages and integrates child-friendly facilities within the centres. It also includes provisions for child survivors, such as forensic social workers and specialised interview techniques to ensure cases involving minors are handled sensitively. However, the blueprint does not specify how services should be delivered, particularly in relation to supporting caregivers of child survivors.

This is a critical gap, as many caregivers experience significant trauma themselves when a child in their care has been raped or sexually abused. Some may struggle with feelings of guilt, shame or helplessness, especially in cases where the perpetrator is a family member or someone close to the family. These dynamics can lead to protective behaviours that inadvertently obstruct the child's access to justice or support such as hiding the abuse or withdrawing from services.

Civil society organisations like MOSAIC, which operate as first responders within the TCC model and also provide follow-up psychosocial support, play a vital role in addressing this challenge. They offer direct counselling and support groups specifically for caregivers, to prevent secondary victimisation, and provide emotional tools and trauma-informed resources to ensure that caregivers are empowered to support the child without impeding access to critical services. This integrated approach is essential in creating a safe and enabling environment for child survivors to recover and access justice.

This obligation applies broadly to all adults, not only professionals, and extends beyond the mandatory reporting provisions of the Children's Act. In contrast, the Children's Act only requires mandatory reporting by professionals working with children, and only in cases of sexual abuse, physical abuse causing injury, or deliberate neglect. It does not require the reporting of all situations in which a child may be in need of care and protection.

This broad mandatory reporting obligation in the DVAA is particularly significant because the Act defines domestic violence to include "exposing a child to domestic violence". This means that any adult who suspects that a child may have been exposed to domestic violence, even if the child is not the direct victim, is legally required to report it. Under the Children's Act, 38 of 2005, designated professionals are obliged to submit a Form 22 to the Department of Social Development or SAPS in cases of sexual abuse, neglect or exploitation. Although the statutory bases differ, in practice many stakeholders feel compelled to complete a Form 22 when supporting women whose children have been exposed to domestic violence. While the mechanism in the Children's Act serves to protect children by ensuring prompt reporting. The DVAA's mandatory reporting clause can inadvertently cause harm, as mothers fearing the removal of their children may withdraw from seeking help, further endangering both themselves and their children. This has far-reaching consequences. It potentially undermines women's privacy and agency, especially for survivors who are themselves navigating violent relationships and trying to protect their children. It also raises the risk that a mother may be held responsible for 'failing to protect' her child from exposure to violence, even while she is a victim herself.

Case 22: The dilemma of mandatory reporting

Thandi, a 32-year-old mother of two young children, endured escalating physical and emotional abuse from her partner, Themba. Her children, aged five and eight, witnessed the violence, displaying signs of distress. Seeking safety, Thandi approached a community-based organisation (CBO) linked to the Strengthening Actors for Effective Preventative Response Project (SAFE-PR) in Mitchell's Plain. The organisation provided her with counselling and legal guidance under the Domestic Violence Amendment Act.

However, a social worker from DSD, also engaged in the SAFE Platform, learned about Thandi's situation. Concerned for the children's safety, the social worker initiated a Form 22 report, prompting an official intervention under the Children's Act. Fearing child protection services might remove her children, Thandi panicked, withdrew from support services, and isolated herself and her children, cutting off ties with the CBO and SAFE-PR stakeholders.

SAFE-PR stakeholders recognised that collaboration was essential to balance the rights and needs of both Thandi and her children. The platform facilitated a case conferencing approach, bringing together SAPS, DSD and community organisations to assess risks comprehensively. Trauma-informed social workers and court support workers worked jointly to navigate the complexities of the Domestic Violence Act and the Children's Act without alienating the survivor. Together, they developed a joint response plan that ensured both child safety and Thandi's protection and autonomy.

Recognising the need to address these distinct but interconnected issues, SAFE-PR stakeholders also operated in parallel. The CBO continued to provide confidential support services to Thandi, offering her a safe space to make informed decisions at her own pace. Meanwhile, the social worker monitored child safety without triggering immediate state intervention, allowing Thandi time to access legal and psychological support. MOSAIC as the court support services provider together with the court clerks worked separately to help Thandi secure a protection order, ensuring that interventions for her and her children proceeded without punitive measures.

SAFE-PR stakeholders also integrated survivor-centred and child-centred interventions into a seamless approach. They established a survivor-led process, allowing Thandi to engage with services without additional fear or harm. Cross-sectoral case management ensured continuous, informed communication among SAPS, DSD, the Department of Justice and Constitutional Development and CBOs, preventing unnecessary distress. The platform also promoted long-term family safety planning by integrating shelter services, parenting support and legal advocacy, empowering Thandi while ensuring her children's well-being.

These tensions expose inconsistencies between the DVAA and the Children's Act and demonstrate how misaligned legal provisions can complicate coordination between the child protection and domestic violence systems – systems which, in practice, are often siloed into the "children's" and "women's" protection sectors.

Thandi's case highlights the tensions that arise when duty bearers navigate the intersecting needs of women and children in domestic violence cases. While laws such as the DVAA and the Children's Act aim to provide protection, their practical implementation can sometimes place stakeholders in conflict, particularly around mandatory reporting. To resolve this requires organisations in both government and civil society to work closely together to identify how best to coordinate or integrate services and support in order to advance the rights of both women and children. However, this is only possible when stakeholders have time and space to reflect on cases, learn together and jointly make decisions.

Relational issues that hinder coordination of women and children sector

Transforming the way VAC and VAW sectors collaborate requires fostering relationships that enable sharing of information, joint problem solving and collective learning. New challenges will emerge as organisations work together, and the problems will be different at policy and service delivery levels. However, research and sectoral experience reveal that acrimonious relationships are common, despite the presence of promising collaborative networks. Racial tensions are another key source of conflict within the sectors, often intersecting with issue of class.[13, 16] Stark differences exist between women with formal education and community-based activists and survivor-led organisations. These differences can also be magnified between women's rights and children's rights organisations. While diversity of identities, cultures, experiences and world views within both sectors has the potential to enrich violence prevention efforts, poor management of these differences frequently leads to breakdowns in coordination and collaborative processes.

Case 23: The Violence Prevention Forum – Bringing the women's and children's sectors together at a national level

Since 2015, the Institute for Security Studies (ISS) has convened the Violence Prevention Forum (VPF),[17] a multisectoral platform that aims to promote continuous dialogue and relationship-building among violence prevention stakeholders. The long-term goal of the VPF is to ensure that research evidence and practice-based knowledge inform policies, programmes and practices to prevent violence in South Africa. To achieve this goal, it was necessary for researchers who evaluate interventions to prevent violence to come together with the policymakers from relevant departments and with NGOs who deliver violence prevention interventions to share knowledge and practice. Building trusting relationships between sectors is the basis for improved knowledge sharing and problem-solving.

The VPF has evolved over the past ten years. Initially, the forum brought together policy makers, practitioners and researchers who focused on the prevention of violence against children. These participants, along with the conveners, identified others who could enrich or benefit from the platform. This led to a growing recognition that the platform should incorporate interventions designed to prevent violence against women. Since then, drawing on the findings of research into violence, a shared understanding has emerged that all forms of interpersonal violence intersect and reinforce one another. Now the forum focuses all forms of violence. Over the years this group has grown to about 300 individuals, representing government departments, NGOs, research institutes and development partners.

The VPF provides an organic and flexible space for productive dialogue between sectors. It is organic in the sense that the forum is able to craft engagements that address the needs articulated by participants as these emerge during and between meetings. A driver group comprising representatives from all sectors undertakes an annual assessment of the international and national context, identifying needs and opportunities. It is productive and has led to changes in policy, the resourcing of violence prevention programmes, and has led to collaborations and partnerships between organisations working in VAC and VAW; and between researchers, policymakers, the private sector and NGOs.

What has the VPF learned about enabling multi-sector collaboration?

1. A competent convener is needed

Any multi-sector platform or structure must be convened. A convener can be an individual or an institution that takes responsibility for hosting engagements. The convener identifies and invites participants, mobilises and manages resources and uses its network and influence to call people together. To be a good convener and successfully bring organisations working on VAC and VAW together the convener needs to be credible, be willing to listen to the needs of all sectors, and be reliable, trustworthy, flexible and transparent. The convener must be committed to the overall outcome, and not put their own institutional needs ahead of the needs of the collective.

It is critical for people to want to come to meetings, and to see the value of participating in discussions. This means the convener needs to be clear about what everyone who comes needs and wants from the meeting and what they will leave with and communicate this with participants.

2. Strong administration is paramount

An effective multi-sector platform needs administrative support to provide logistical support, including communication with participants, documentation and record keeping. It is vital to keep track of successes and let people know what they have collectively achieved.

3. Establish rules of engagement

The conditions for fruitful engagement amongst diverse groups with differing views and expectations, requires rules of engagement that have been agreed to by the group. Rules of engagement must be co-developed by the group and form a binding contract. The rules of engagement can be based on a set of agreed values, and can be re-established, or new rules agreed on for every meeting.

The misuse of power is another pervasive issue. Reports indicate that leaders in government, NGOs and donor organisations often use power in ways that are meant to silence dissent rather than encourage democratic governance of the problem of violence experienced by women and children. This pattern has been observed in key national initiatives, including the development of NSP-GBVF,[16] Total Shutdown movement[13] and also in the Shukumisa Campaign. As Vetten notes, efforts to undo hierarchical relations of power between men and women have at times inadvertently fuelled power struggles amongst women – and between women- and child-focused organisations.

Although it is not possible to address all the causes of tensions within and between the women's and children's sectors, the

SAFE-PR platform, and the experience of Violence Prevention Forum (Case 23) and the Western Cape Violence Prevention Unit (Case 24) demonstrate that acting with awareness of these barriers and being intentional about strengthening relationships can unlock collaboration. This requires leaders to acknowledge and address power imbalances actively, be it between women and children focused organisations or between organisations in different geographies.

What are the pathways towards effective coordination?

Promote shared understanding of the links between VAC and VAW

Having a shared understanding of the intersections of VAC and VAW is foundational to improving collaboration between the sectors. Further work is needed to build upon the nascent recognition of the intersection of VAC and VAW in current policies. For example, the Integrated Crime and Violence Prevention Strategy promotes the implementation of evidence-based interventions that address the root causes of VAC and VAW, such as gender-transformative parenting programmes, and early interventions to prevent the intergenerational transmission of violence. The NSP-GBVF also brings children's and women's needs together in the national strategy, although with limitations as mentioned above. In addition, there is growing research in South Africa demonstrating the intersections of VAC and VAW, particularly in the home. Together, these provide a basis to initiate cross-sectoral conversations and joint learning exercises that bring together researchers, policymakers and practitioners. Civil society coalitions, such the South African Parenting Programme Implementers Network, that already focuses on children within a family context can be important learning spaces to advocate for more collaboration between the women's and children's sectors, particularly building on the effectiveness of gender-transformative parenting interventions and community interventions to address both VAC and VAW.[18] The VPU illustrates how existing structures can be utilised to introduce new ideas and approaches. When introducing public health informed violence prevention in the Western Cape province, the VPU often used already established community-based crime and violence prevention structures. This helped avoid duplication of effort and prevented resources (both financial and human) from being spread too thin across various forums. However, this approach was not without challenges, it did take longer for new ideas to gain traction and for groups to take action. Nonetheless, the resistance faced, the need to negotiate power dynamics, and the importance of learning to be adaptable while working with rigid reporting and appraisal system of government all represent real life challenges that any coordination efforts will face and can't be overcome by simply establishing a new structure.

Resource existing coordination structures for effective secretariat and convening

While the existence of coordination structures will not automatically lead to collaboration between VAC and VAW actors, they remain important spaces for joint learning and relationship building when they are well convened and facilitated. Yet many coordination structures lack adequate resources, competent convening and sufficient administrative support to function effectively. The NSP-GBVF rightly recognises that the GBVF Council will need to be well resourced with the right people and financial resources to drive effective implementation. To make coordination structures like the GBVF Council and Child Protection Forum effective requires investment in convening capacity, administrative and logistical support for the secretariat in order to create a space that enables complex and ongoing negotiations between the children's and women's sectors. Effective secretariat and convening ensures that there is proper planning for meetings, record keeping, follow-up on decisions made, etc. In addition, they can perform non-technical tasks, such as resolving conflicts or issues that may arise, fostering relationships, maintaining member commitment, addressing problems, and ensuring that meetings are more than just discussions but yield tangible outcomes.

Different approaches exist that can help strengthen convening. For example, the SAFE Platforms use collective impact approach. The collective impact methodology[19] offers a structured, collaborative approach for addressing complex societal challenges by bringing together stakeholders from across sectors, government, non-profits, businesses and communities. Rooted in the principles of a shared vision and coordinated action, this model is underpinned by five key components: a centralised infrastructure, continuous communication, mutually reinforcing activities, shared measurement systems, and strong, facilitative coordination. By aligning efforts and measuring progress collectively, the collective impact approach enables diverse actors to move beyond isolated interventions, fostering systemic change and achieving long-term, sustainable solutions.[6] For example, stakeholders in the SAFE Platforms align efforts around a common goal, with shared measurements and continuous communication. Strong backbone support and a structured approach to convening the SAFE Platforms have built trust between stakeholders, enabled tracking of achievements, and reinforced commitment and participation in the platforms.

Case 24: Using transversal collaboration to tackle social drivers of violence through the Western Cape Violence Prevention Unit

Gwen Dereymaeker[i]

The Violence Prevention Unit (VPU) in the Department of Health and Wellness, Western Cape Government, was established in 2023 to drive collaboration and advocacy for evidence-informed violence prevention through a public health approach. We have adopted an area-based approach to safety (ABT) and aim to create platforms that enable local government and non-government stakeholders living or working in high-crime areas to work together to address the local drivers of crime and violence. Twelve Safety Promotion Coordinators are assigned to these areas to facilitate collaboration.

The approach is flexible and agile, drawing on both traditional government structures and informal networks. Through this process of engagement, we have identified the following ingredients that make people want to work together:

1. **Relationship-building** and establishing trust-based networks takes time and is often undervalued, yet these soft skills are essential to enable hard results.
2. **Finding a structural home** is essential. In most communities there are already a wide range of coordination structures that bring together similar stakeholders and discuss overlapping concerns. Where no violence prevention collaboration structures existed, we created our own. But elsewhere we became active participants in existing platforms. This presented some challenges, as our contributions were less visible and therefore more difficult to reflect in progress reports and performance appraisals, and actioning specific themes typically took much longer than when we had our own coordination structure. We learnt, sometimes the hard way, that navigating power dynamics is part of collaborative work.
3. **A shared agenda** with a clear and specific purpose helps build momentum. Our initial mandate was to coordinate all local safety matters, but we realised it was difficult to rally stakeholders behind such a broad agenda. Therefore, most Safety Promotion Coordinators have focused on more tangible and specific local issues, such as youth at risk, road safety, school truancy or teenage pregnancies.
4. **Quick wins build momentum** and strengthen relationships. These shoots of collaborative work can then serve as a springboard to tackle more complex and long-term challenges.
5. **Informal networks facilitate day-to-day collaboration but are often not sufficient to tackle complex issues** such as the social drivers of violence. Therefore, the Western Cape Government Heads of Department nominated officials to participate in our programme. But this too proved to be challenging, given the lack of internal governance for report-backs and resource allocation, delegation to junior colleagues, and additional workload.

Ultimately, collaborative work can only be successful if it combines both a bottom-up (community-driven) and a top-down (bureaucratic authorisation) approach. This includes clear policy direction and strong empathetic leadership that genuinely listens to community voices and that can then be decisive, and open to doing things differently.

For example, the VPU scaled up the PlanetYouth prevention model leveraging local data collected from teenagers to better understand community-level risk and protective factors. This data provides communities with valuable insights into the challenges and needs of young people in their communities so that they can co-create action plans to better support children and families.

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Strengthen collaboration at a local and case management level

There has been a significant focus on what happens nationally and a tendency to centralise coordination efforts in the Presidency. Centralisation is increasingly seen as a solution to a lack of coordination and poor working relationships between departments and non-government sector. The logic that underpins centralisation is that an office with authority, like the President or Minister in the Presidency, will use their authority to get other departments and stakeholders to collaborate. However, this does not work. Simply instructing people to work closely or collaborate will not improve coordination. These calls for centralisation suggest that relationships have broken down and that organisations can't resolve issues without to being instructed to work together.

Multi-sector and multi-department collaboration between VAC and VAW stakeholders are best achieved through transparent negotiations, decision-making and a commitment to working together across differences. At the provincial and district levels, we need to build capacity to coordinate and integrate services and establish effective referral systems that better respond to the needs of both women and children. Different approaches can be used to achieve this. For example, the Western Cape Violence Prevention Unit applied an Area Based Teams method which creates platforms for local government and non-government stakeholders working in high crime areas to work together. This is a good example of how provincial government can enable collaboration between local stakeholders by intentionally and sensitively building relationships, developing a shared vision, capable convening.

The SAFE Platform model offers an example of how service delivery coordination can be achieved through the Collective Impact approach. This model illustrates how structured, multi-stakeholder collaboration – focused on shared measurement and supported by a backbone structure – can deliver meaningful and context-specific services to survivors. In the Mitchell's Plain SAFE Platform, for instance, stakeholders have created a WhatsApp group for urgent referrals, allowing real-time responses. A backbone partner monitors this group to ensure accountability and follow-up. Additionally, a referral booklet and ticket system have been introduced: the referring partner provides a ticket to the client, while the receiving partner logs and confirms receipt of the referral. This allows the backbone partner to track the client's journey and ensure that services are effectively delivered across the stakeholder group.

Monthly debriefing sessions are held to assess case management processes, enabling shared learning and system improvements. This level of coordination and feedback is essential but requires institutional buy-in and a shift in practice. The current culture of 'protecting cases', compounded by concerns around confidentiality, the Protection of Personal Information Act 4 of 2013 and internal data protection policies, often hinder collaborative case management. Leadership and alignment are critical. Mitchell's Plain, for example, has seen success partly because the National Prosecuting Authority (NPA) anchors the GBV Forum and leads coordination efforts linked to court support. This has helped foster trust and build strong stakeholder engagement.

However, an integrated data system and clear referral pathways are urgently needed to strengthen collaborative case management. Such systems would enable efficient information-sharing, ensure clients receive timely and appropriate support, and ultimately improve outcomes for survivors of violence. Without these, the promise of localised coordination and collaborative service delivery will remain limited.

Provide flexible funding to enable intersectoral service integration for women and children

Intersectoral collaboration requires funding mechanisms that reflect the lived realities of survivors, many of whom are women accompanied by their children. All too often, funding for GBVF-related services is siloed, with support designated either for women or for children, but not both. This lack of flexible and integrated funding impedes the ability of service providers to deliver comprehensive support and undermines the goal of survivor-centred responses.

For example, MOSAIC has, since its inception, provided services to both women and children, recognising that many women who seek support for domestic or intimate-partner violence do so alongside their children. However, the funding MOSAIC receives typically only covers services directed at women. As a result, the organisation is often forced to refer children to designated child protection services. While MOSAIC has strong partnerships and referral networks with children's organisations, the current approach fails to cater to the specific and diverse needs of children, resulting in fragmented care instead of treating the family as a whole. This is particularly a challenge where women have adolescent children who cannot stay in shelters and are often separated from their mothers at a time when they need their support for care and healing the most. If funding remains siloed and does not explicitly support service integration, service providers may end up competing for the same resources or clients. In the worst cases, this could pit the needs of a mother against those of her children instead of aligning interventions to strengthen and support both. It also misses an opportunity to break the cycle of intergenerational transmission of violence by adequately addressing the impact of witnessing IPV or exposure to childhood violence.

Strengthen collaboration and state capacity

In South Africa, the governance landscape necessitates coordination across multiple levels of the state and between different sectors. At least eleven national departments, along with their provincial counterparts, carry statutory responsibilities related to preventing and responding to VAC and VAW. These include, among others, the Department of Social Development, the Department of Women, Youth and Persons with Disabilities, the Department of Basic Education, the Department of Justice and Constitutional Development and the South African Police Service.

Coordination is particularly pressing in responding to VAC and VAW to ensure the alignment of shelter services, child protection interventions, and justice system responses.

What are the systemic barriers?

Despite policy recognition of the need for intersectoral collaboration, several systemic barriers continue to impede effective interdepartmental collaboration.

First, there are persistent weaknesses in the alignment of departmental mandates and institutional frameworks. While each department has made varying degrees of progress within its respective domain, collaboration across departments remains limited. This is illustrated by the implementation of the National Plan of Action on Violence Against Women and Children (PoA), which despite its comprehensive scope and ambition, was only integrated into 33% of departmental plans. The DSD, for example, struggled to translate the PoA's strategic vision into actionable, funded programmes, and experienced difficulties fostering cooperation even within its internal structures, particularly between the children's and women's directorates.[12]

Second, poor cooperative governance, especially in areas where functional responsibilities are shared between national and provincial governments, continues to hinder the development of coherent policy goals and the implementation of nationally agreed strategies. Provinces such as Limpopo, North West, Eastern Cape, and Mpumalanga are particularly affected by these weaknesses. In these contexts, disparities in institutional performance, budget allocations, and human resource capacities exacerbate fragmentation and erode accountability.

Third, capacity constraints in key departments further undermine efforts to build integrated systems of care and protection. The DSD and Department of Women, Youth and Persons with Disabilities (DWYPD), both at national and provincial levels, face chronic human and financial resource shortages, poor institutional memory and weak monitoring systems. These limitations have direct consequences for the implementation of critical legislative mandates, including the Children's Act, and contribute to the overall dysfunction of the child protection system. Without targeted investments to build institutional capacity, especially in under-resourced provinces, collaboration on VAC and VAW will continue to be superficial, uncoordinated and ultimately ineffective.

Recommendations

Ensure flexible funding to support survivor-centred and family-responsive programming

Collaboration and coordination across the women's and children's sectors has the potential to enhance our efforts to prevent and respond to VAC and VAW. Yet funding for the two sectors has historically operated in parallel with different funders and objectives. Intersectional work requires funding mechanisms that are flexible enough to support collaboration and integrated service delivery models. Donors and government partners should prioritise and actively invest in supporting collaborative research and collaborative approaches to service delivery that address the interconnected needs of women and their children. Programmes should not be forced to introduce artificial separations that fragment care; at the same time, evidence-informed differentiation where needed should be maintained. Flexible funding would improve the quality and continuity of care, reduce duplication of services, and enhance the overall effectiveness of VAC and VAW prevention and response efforts.

Invest in applied research and practical tools to strengthen coordination of services

There is an urgent need for more applied research to better understand and address coordination challenges at the service delivery level. This research should inform the development of practical, easy-to-use tools that support frontline practitioners in delivering more coordinated and effective responses. Beyond high-level policy frameworks, service providers would benefit from clear, user-friendly guidance that helps them respond to the intersecting needs of women and child survivors in a holistic and integrated manner. For example, guidance is needed for how to deal with the needs of adolescent children and cases where mothers experiencing IPV are also using violence against their children, as well as how to balance statutory child protection requirements with women's rights, and how to integrate gender-transformative approaches in the delivery of care.

Invest in building trust and relationships across sectors

Relational issues such as lack of trust, competition over funding, racial and class tensions and unequal power dynamics often derail coordination efforts. Coordination strategies must go beyond structural reforms and include intentional investment in relationship-building, cultivating trust and resolving conflict among VAC and VAW stakeholders. This includes regular dialogue, reflection spaces and joint planning efforts to shift organisational cultures and build the relational capital necessary for collaboration. This dialogical approach focused

on strengthening relationships, supporting joint learning and problem-solving can be integrated to existing coordinating structures that have potential to strengthen collaboration – including the National Child Care and Protection Forum, End GBV Collective, National GBVF Council, and National Domestic Violence Intersectoral Committee.

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Public financing to protect violence against women and children

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This chapter recognises the interconnections between violence against women (VAW) and violence against children (VAC) and explores the shape and forms of public funding of this social, economic and cultural challenge. This is admittedly a complex task and it requires us to make assumptions about what could legitimately be recognised as expenditure to combat VAC and VAW. Such an exercise is likely to both over- and under-estimate the public resources available to address VAC and VAW. Accepting a degree of error in estimating the resources available does not invalidate this analysis, instead it prepares the ground for directed and thoughtful proposals about how to rectify this information gap.

The chapter starts by outlining South Africa's legal obligations and then sketches out the continuum of care from prevention to response services. It briefly discusses the social and economic costs of violence using the latest domestic evidence available. It then considers how funding for VAC and VAW is allocated within the South African budget process, before undertaking a preliminary budget analysis of the VAC and VAW sectors. The chapter concludes with a series of recommendations to improve financing to address VAC and VAW.

What are the legal obligations to fund VAC and VAW programming?

Commitments in international and constitutional law

The right to be free from violence is protected by the Constitution (section 12) and it is inextricably linked to the rights to life, dignity and equality (sections 7, 10 and 11).[1, 2] Additionally, children have a right to be protected against maltreatment, neglect and abuse, and to social services (section 28(1)(c)-(d)). South Africa has also ratified several international and regional treaties that protect these rights amongst others the United Nations Convention on the Rights of the Child (UNCRC), the Convention on the Elimination of All Forms of Discrimination Against Women, and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. All of which place a legal obligation

Box 10: What are the core measures of compliance?

Progressive realisation refers to the state's obligation to take "reasonable measures" – effective steps – over time to achieve the full realisation of economic, social and cultural rights. Whilst recognising that states must balance competing priorities and that resources are limited, states must demonstrate that people's conditions are continuously improving. The state must act as expeditiously and effectively as possible. Thus, careful planning, realistic and targeted budgets, and multi-year budgeting are crucial for sustained, long-term progressive realisation of rights.

Non-discrimination Unlike progressive realisation, non-discrimination is an immediate obligation that governments must comply with without delay. To comply, economic policies, including budget allocations, must guarantee the effective enjoyment of rights without discrimination – exclusion of groups who could reasonably be included is not acceptable.

Maximum Available Resources (MAR) is a core obligation under Article 2(1) of the International Covenant of Economic, Social and Cultural Rights, requiring states to demonstrate that they have used all their available resources to fund the progressive realisation of socio-economic rights. Under-spending due to poor planning, lack of capacity, slow disbursement or inaccessible programme design constitutes a MAR failure.

For budget analysis, progressive realisation can be measured by assessing increases in expenditure over time (adjusted for inflation), an increase in the number of beneficiaries of a policy or programme, targeted funding towards disadvantaged groups, and an increase in the overall level of enjoyment of the right.

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iii SECTION27

on the South African government to provide services to both prevent and respond to VAC and VAW (see Policy chapter on p. 113).

The government's budget is central to the realisation of rights because it serves as the primary mechanism through which a state translates its legal obligations into tangible services for women and children.[3] Section 7(2) places an obligation on the state to give effect to all the rights in the Bill of Rights but there are different levels of obligation when it comes to budgeting. Socio-economic rights including healthcare, social security, housing and education are subject to **progressive realisation to the maximum of the state's available resources**. Criminal justice and protection from violence are civil and political rights and not subject to the same legal limitations. However, in practice it is recognised that budgets are limited and that the state must balance competing interests. For example, Article 19 of the UNCRC enjoins the state to take "all **appropriate** legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse…" [emphasis added].[4]

The Constitutional Court has repeatedly held that the state has a positive obligation to protect women and children from violence, including gender-based violence (GBV).[2, 5] The state cannot meet its duty by simply passing laws it must allocate resources, train personnel, provide facilities and implement programmes – and progress can be assessed by applying the core measures of compliance as outlined in guidance from the United Nations Committee on Economic, Social and Cultural Rights (see Box 10).[6]

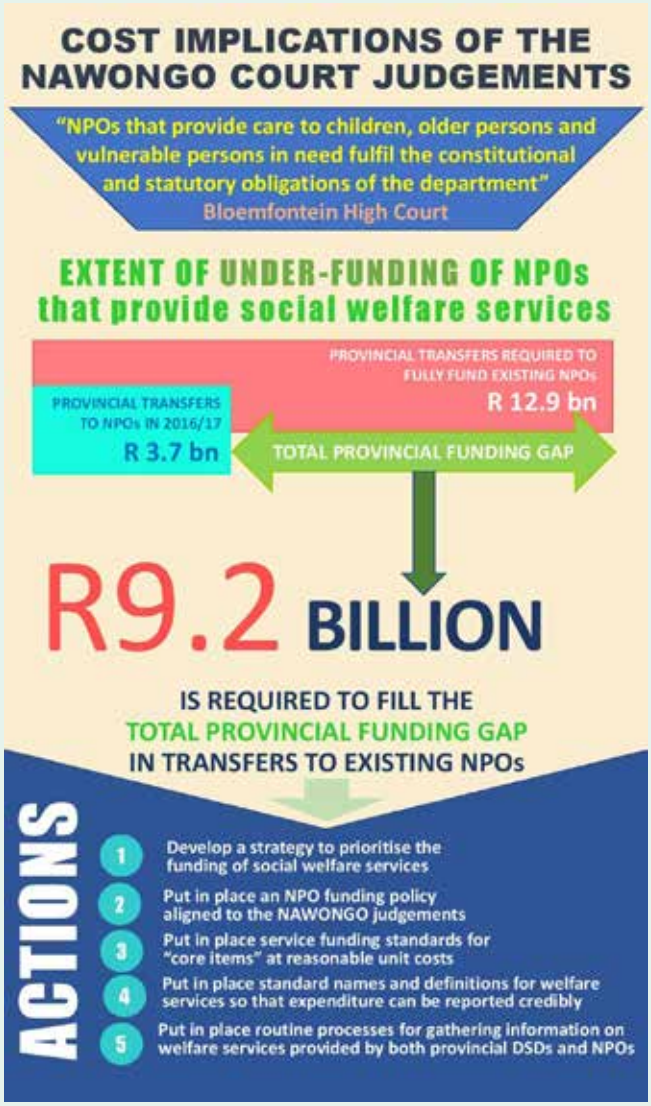
Additionally, the High Court judgments in the National Association of Welfare NGOs *(NAWONGO)* case highlight the necessity for transparent, equitable and effective funding mechanisms to uphold the rights of women and children (see Figure 19).[7-10]

What services are needed?

An estimated 33% of women have reported experiencing some form of violence in their lifetime.[11] This translates into a staggering 7.3 million women, and those who identified as Black African women had a higher estimated prevalence of violence, coming in at almost 36%.[11] More than half (56.3%) of children reported experiencing some form of victimisation, which includes maltreatment and other forms of. There is ample evidence that VAC affects – and is affected by – VAW as outlined in the chapter on violence against women and children on p. 34.

The legal obligations outlined above place a duty on government to take reasonable measures to fulfil a range of rights which includes adequately resourcing and implementing initiatives like the National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF).[12] The NSP-GBVF outlines a comprehensive, multisectoral package of services to prevent and respond to VAC and VAW. This package is broadly based on the continuum of care outlined in the RESPECT framework (see p. 101). It emphasises prevention through (cyber-) awareness programmes and media campaigns to challenge social norms and promote gender-equality. The package also outlines dedicated initiatives such as parenting programmes that teach non-violent conflict resolution and gender-transformation; community worker training; school-based education and the

Figure 19: Cost implications of the NAWONGO court judgments



Source: Government Technical Advisory Centre. *Cost implications of the NAWONGO court judgments.* Pretoria: GTAC.

integration of GBV prevention into programmes to address related social issues such as alcohol abuse and HIV. It also includes the economic empowerment of women via grants and maintenance support, and the development of a standardised, adequately funded core service package for survivors.

Key components of the response package include shelters, Thuthuzela Care Centres, Family Violence, Child Protection and Sexual Offences (FCS) units at police stations, sexual offences courts, victim-friendly justice services, mental health services to promote healing, and reintegration services. The NSP-GBVF further commits to large-scale research and a resourcing plan to ensure sustainable funding for both government and NGO partners. Child protection services and child and youth care centres are also an essential part of the package of services. All services should be grounded in a victim-centred, human rights-based and inclusive approach, and practitioners need to be trained in gender-sensitive and trauma-informed approaches. An integrated response should ensure equitable access to quality care and justice for all survivors, regardless of age, location, sexual orientation or ability.

Local government is explicitly tasked with making public spaces safe and violence-free for all, especially women and children, through for example the rollout of the Safe Parks Initiative.[12] This involves undertaking safety audits, integrating factors like street lighting, and areas of concern into safety plans within Integrated Development Plans (IDPs), and applying a gender analysis to planning in the built environment and budgeting.

Extending the budget analysis to the local government sphere would however considerably complicate the exercise due to the large number of local governments, the non-coincidence of financial years across the three spheres, and the predominantly service delivery-as opposed to the policy- focus of local government. This budget analysis therefore focuses on the national and provincial spheres.

What are the social and economic costs of violence against women and children?

A KPMG study sought to identify the VAW-related costs incurred by victims, government, civil society and businesses.

Table 8: Estimates of the social and economic costs of violence against women and children

Who	Method	Key results	Overall comments
KMPG, 2014[15]	Assumed GBV prevalence rates of between 20 – 30% and subsequently monetised.	Violence against women costs the country on average between 0.9% and 1.3% of the country's GDP.	It would be useful to repeat this study using the estimated prevalence rates of GBV as per the 2022 HSRC GBV National Survey.
Save the Children, 2016[16]	Monetised the Disability Adjusted Life Years (DALYs).	• Physical violence against children: cost 2.6% of GDP annually. • Sexual violence: 0.9% of GDP • Child neglect: 0.16% of GDP • Fatal violence: 0.16% of GDP	Study only considered VAC. Do the prevalence rates used in this study hold across time and do costs increase or decrease over time?
Hsiao et al, 2018[17]	Cost calculations based on DALYs included: • Monetary value of DALYs lost from fatal cases of VAC as well negative health outcomes and health risk behaviours due to non-fatal forms of VAC. • Reductions in earnings due to physical and emotional violence experienced during childhood. • Child welfare costs.	• Considering fatal and non-fatal effects of VAC, the reduction in earnings, and child welfare costs, the authors estimated that VAC costs the South African economy US$15.8 billion or nearly 5% of the country's GDP (in 2015 ZAR).	All estimates are based on reported evidence, and the intensity and severity of VAC could actually be higher. Using the per capita GDP is a solid estimate given the small variation around GDP per capita over the last decade.
Kilburn et al, 2023[18]	Randomised control study in Mpumalanga with eligible young women testing for the impact of a conditional cash transfer on behaviour of young women aged 13 – 20.	• Delayed sexual debut for women who participated in study. • Reduced number of sexual partners. • As a result of factors above, a reduction in Intimate Partner Violence.	Would these results hold in a different provincial context, say Gauteng or the Western Cape?

The study built on previous research commissioned by Parliament in respect of the 2012/13 national budget. Like the parliamentary study, KPMG focused primarily on the national budget but also included the provincial Victim Empowerment Programme (VEP) allocations. KPMG put the estimated cost to government at R513,6 million, less than 2% of the full economic costs of GBV to society.[13]

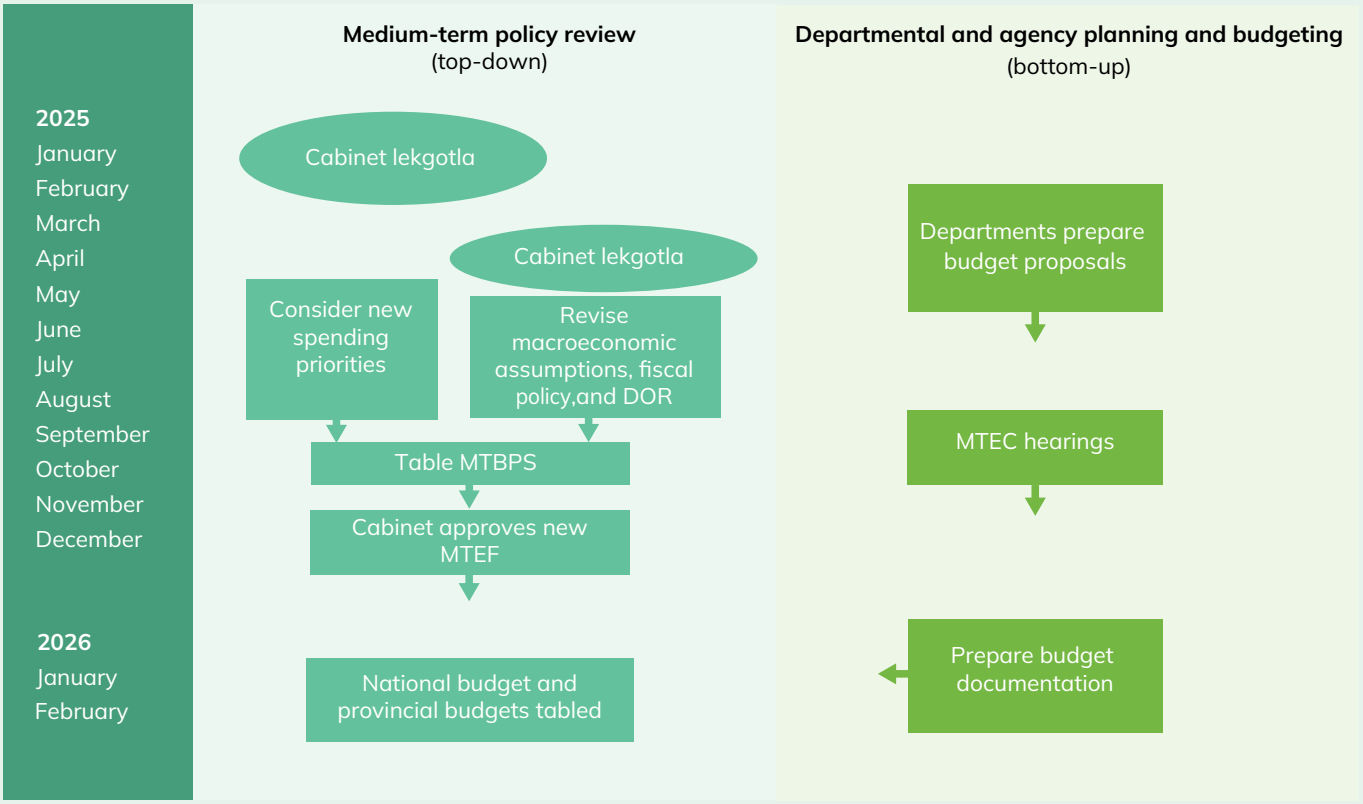
Table 8 looks at local estimates of the economic and social costs of violence against women and children, which range from 0.2% to approximately 5% of South Africa's Gross Domestic Product (GDP). For comparison, the World Bank estimates that crime (including violence) costs the economy close to 10% of its annual GDP. [14]

How is funding allocated during the budget process?

Financing for national and sub-national governments requires careful planning, processes and involving the right stakeholders. In essence, a formal budget process is needed to maximise the probability that centrally set goals are achieved. Conventionally, these goals address the total envelope of revenue and spending; in order to determine what scarce government resources should be allocated to and why; and, how best to ensure that the public gets value for money so that every Rand is stretched to enable effective service delivery.

First, nationally collected revenue is divided vertically between the different spheres of government (national, provincial and local). This is followed by a horizontal allocation of funds within each sphere of government using demographic-based formulas to ensure equitable access to services. Provincial governments have three main sources of revenue, namely the unconditional transfer from the national government (or block grant), conditional grant funding, and their own revenue (which comprises between 3 – 5% of total provincial revenue). Prioritisation decisions at the provincial level are driven, in part, by national policy, as well as the priorities of the Provincial Executive Committee (PEC), headed by the Premier. This prioritisation goes through several iterations (budget draft submissions etc) and around December of each calendar year, provinces receive their final allocations for the next financial year. It is characteristic of the country's Medium-Term Expenditure Framework (MTEF) process where both elements of budget making are involved, namely a bottom-up approach (departments put forward their bids) and a top-down approach (where final decisions about the provincial envelope are made by the extended national Cabinet) as illustrated in Figure 20.

Figure 20: Graphic representation of the national and provincial budget process in South Africa



Adapted from: Folscher A, Cole N. South Africa: Transition to democracy offers opportunity for whole system reform. *OECD Journal of Budgeting (Special Issue) Collaborative Africa Budget Reform Initiative.* 6(2); 61-98. 2007.

South Africa introduced the MTEF for the first time in 1998.[19] Two assessments of the effectiveness of this framework and the annual budget process are discussed here. In 2007, Folscher and Cole indicated that the government has performed extremely well in terms of the grand national goals of aggregate fiscal discipline (to live within your means) and allocative efficiency (to spend the money where it is needed).[20] However, they noted that attempts at extracting maximum value from public expenditures was less successful and remained the greatest public finance challenge at the time of their contribution.

In 2023, Sachs et al provided a useful update and analysis of budget reforms and impact on overall spending in South Africa.[21] Their key contention was that frontline public services were subjected to severe austerity, and that the government has failed in its attempt at fiscal consolidation. Gross national debt remained high and there were serious questions about the credibility of macro-economic forecasts, deviation between planned and actual spending outcomes, and the government's ability to control the country's public sector wage bill. In essence, Sachs et al were questioning the very foundation of the country's public finance system and blamed the chaos on lack of policy coherence at the central level.

National Treasury has championed a series of expenditure reviews to assess the quality of spending (see the GTAC website).[iv] However, these recommendations were not fully integrated in departments' planning and the budget process, which prompted a radical re-think of these issues. In its *2026 MTEF Technical Guidelines*, National Treasury aims for what it calls "a more credible and purposeful approach" to budgeting,[23] centred on three key issues, namely a *service delivery focus, increased value for money for public services, and longer-term fiscal sustainability.* The latter includes, amongst other things, the introduction of a new mechanism called Targeted and Responsible Savings (TARS).

Under TARS the national Cabinet and other executive authorities intend to take a closer look at the recommendations emanating from spending reviews and departments' ability to implement their key recommendations. Critically, it empowers them to cut programmes that are outdated or under-performing and move scarce resources to places that are needed in the re-positioning of the country's public finances. For this process to succeed, it needs a set of rational criteria, which are not only technical in nature (as implied by TARS). There also needs to be a substantive consideration of the priorities that are deemed non-negotiable, such as the protection of children and vulnerable women.

How much is government spending on VAC and VAW services? A preliminary budget analysis

A range of departments across government play a role in preventing and responding to VAC and VAW and this makes it complicated to track. In 2015, the Department of Planning, Monitoring and Evaluation (DPME), together with the Department of Social Development (DSD), commissioned KPMG to conduct a diagnostic review of government's response to violence against women and children.[24] The review included a serious attempt to identify budget allocations related to VAC and VAW in the national and provincial spheres.

KPMG approached the task by distinguishing between what it termed 'direct' and 'indirect' budget programmes (or sub-programmes). The direct programmes were those that specifically referred to VAC and VAW in their purpose, outcomes and/or indicators. The amounts allocated to them

Box 11: The impact of austerity and fiscal consolidation on VAC and VAW

The government's core spending as a share of GDP has experienced a significant reduction since the COVID-19 pandemic and is currently at its 2012 level. Going forward, National Treasury plans to cut core spending by an additional two percentage points. This fiscal consolidation specifically targets the input side of the budget, for example, lowering employment costs, however, salaries for personnel are the largest share of spending on government services like education, healthcare and criminal justice. Continuing to reduce the quantity and quality of inputs will lead to compromised service delivery and performance against policy objectives. "In practical terms, it implies poorer learning outcomes in schools, longer queues for service in hospitals and the court system, and fewer professional staff relative to the effective demand faced by government services overall" (p. 2).[22] Given that VAC and VAW initiatives typically involve police services, judicial processes, healthcare for survivors and social support programmes, these uniform cuts are likely to result in a reduction in the quantity and quality of services available to prevent and respond to violence against women and children.

iv See the Government Technical Advisory Centre's (GTAC) page on spending reviews: https://www.gtac.gov.za/pepa/spending-reviews/

Table 9: 'Direct' national and provincial budget programmes for VAC and VAW

Department	Budget programme
Social Development	Social crime prevention and victim empowerment Care and services to families Child care and protection Child and youth care centres Community-based care services to children
Health	Community-based services
Justice & Constitutional Development	Lower courts
National Prosecuting Authority	Specialised prosecution services
Basic Education	Educational enrichment services
Women	Social, political and economic participation and empowerment
South African Police Service	Crime investigation

Adapted from: KPMG. *Report on Diagnostic Review of the State Response to Violence against Women and Children.* 2016. Table 4.

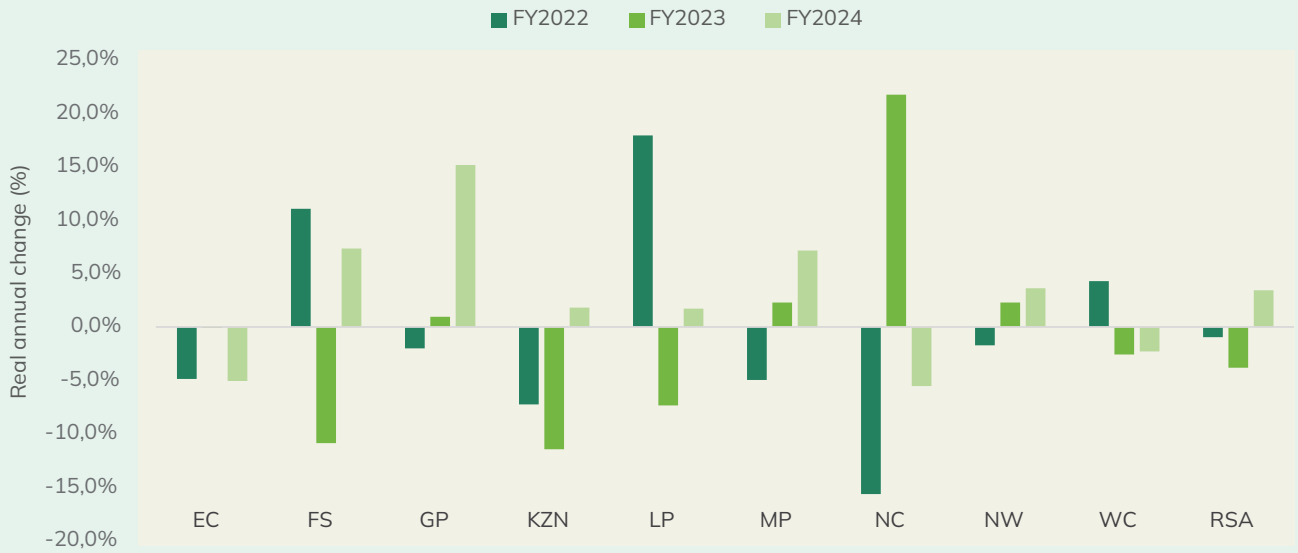
were seen as dedicated funding for VAC and VAW. Table 9 lists the budget programmes and sub-programmes identified as 'direct'. KPMG acknowledged from the start that their use of the term 'direct' did not mean that the full allocation was spent on VAC and VAW. It gave the example of the provincial Victim Empowerment Programme (VEP), which provides services for victims of VAC and VAW, but also for victims of other forms of crime and violence, including traffic accidents.

Using the KMPG classification and with our modifications, direct expenditures on VAC and VAW grew from R60 billion in FY2021 to R68 billion in FY2024 at a real average annual decrease of one per cent. During this period, most 'direct' programmes experienced an average annual decline (see Table 10 on p. 144), with the entire children and families programme of social services declining by 5% on average over this period. Only educational enrichment services (DBE) experienced a positive increase of just under 1% over the same period, but at R10 million, this constituted less than 0.01% of total direct expenditure in FY2024.

The programme on crime prevention experienced a real average decline of 1.1%. Response services in the Justice cluster are funded via spending on the lower courts (where spending declined by 1.2%), while expenditure on specialised prosecution services remained stable at 0.1%.

The provincial community-based services in health programme (health clinics and health centres), is the largest budget in our estimated 'direct' VAC and VAW expenditures. As noted previously, programmes are classified as 'direct' if they explicitly mention VAC and VAW in their objectives or include relevant outcomes or indicators. While the associated budgets are considered dedicated funds, they include services. For instance, whole of the community-based health services budget is counted, even though it includes a broad range of health services not related to VAC and VAW.[24] The overall picture within this budget was one of inconsistent and erratic spending patterns. For example, in FY2023, spending on this programme declined by almost 4% in real terms with the Free State and KwaZulu-Natal experiencing the largest declines

Figure 21: Real annual growth rates on community-based health services by province, FY2021 – FY2024 (FY2021=100)



Source: National Treasury online database (accessed in August 2025)

Table 10: Real average annual growth of 'direct' national and provincial programmes, FY2021 – FY2024 (FY2021=100)

Programme ZAR billion and ZAR million	FY2021	FY2022	FY2023	FY2024	Real average growth rate, FY2021-FY2024 (%)	Level of government
Children and families	6.7B	6.3B	6.5B	6.8B	-4.8%	National & provincial
Social crime prevention & victim empowerment	1.9B	2.0B	2.1B	2.2B	-1.7%	National & provincial
Community-based services (Health)	41.9B	44.4B	45.1B	48.5B	-0.4%	Provincial
Lower courts	5.2B	5.6B	5.8B	5.9B	-1.2%	National
Specialised prosecution services	3.6B	3.8B	4.1B	4.3B	0.1%	National
Educational enrichment services	8.4M	8.8M	9.6M	10.1M	0.8%	National
Women	113.3M	124.6M	112.6M	129.3M	-0.4%	National
Crime investigation	13.9M	14.4M	14.4M	15.5M	-1.6%	National
Crime prevention	40.9M	41.0M	43.0M	46.3M	-1.1%	National
Total	**59.6B**	**62.3B**	**63.8B**	**67.8B**	**-1.0%**	

Source: National Treasury online database (accessed in August 2025)
Note 1: "B" stands for billions and "M" for millions
Note 2: KPMG listed the different sub-programmes of the Children and Families programme separately, but in this analysis, we consolidated them as a single line item which incorporates both direct and indirect expenditures. We have also added crime prevention as an important entry, even though it's scope goes far beyond VAC and VAW.

of -11% and -12% respectively. Expenditures in the Northern Cape were highly positive in FY2022 (22%), while Gauteng experienced the largest real annual increase in FY2024 (15%).

Turning our attention to 'indirect' expenditures, the final list of expenditures chosen differs from what KMPG had proposed in 2015 (see Table 11). Social work scholarships had been discontinued, "children" and "families" were included in the children and families programme under 'direct' expenditures, and given the central role of social grants in improving the lives of South Africans overall, they were considered as a separate expenditure line.

Expenditures on programmes that indirectly impact VAC and VAW grew from R13.1 billion in FY2021 to R16.1 billion in FY2024 at a real average annual rate of 1.7%. Most of these expenditures are focused on response as opposed to prevention services. Expenditures on violence, trauma and medical emergency services grew at a real average annual rate of close to 3% while all other indirect programmes experienced solid positive growth over the period as depicted in Table 12 on p. 146, except for family advocates (-0.3%) and rehabilitation programmes offered by Correctional Services (-3.0%).

The Civilian Secretariat for Police Service handles complaints about SAPS investigations into reports of domestic violence. The provincial expenditures are inconsistent and change in unexpected ways. As an example, the Gauteng province experienced a 31% increase in FY2023 but were expected to have an almost 20% annual decline in FY2024. In fact, it is the large real growth in Gauteng that turned the national average positive in FY2023 as most provinces experienced a negative decline. By FY2024, only the Eastern Cape (13.3%), Mpumalanga (56%) and North-West experienced double digit growth rates, while the overall rate of spending on this programme declined by almost 5% in that same financial year.

Social protection can be seen as a preventative measure against violence, the Kilburn et al (2023) study reinforces the centrality of social grants in combating the social ills of VAC and VAW. Figure 23 on p. 146 examines the spending social grants provided by the DSD. The Old Age Grant shows the largest real average growth rate of close to 3% over this period 2021 to 2024, while the Care Dependency Grant and the Foster Child Grant increased by 2.4% annually. The Disability Grant grew on average by 1.1 per cent, after an almost 2% decline in FY2022.

Expenditure on the elderly, people with disabilities and children in alternative care has been protected. However, the largest group of women and children who would be protected by cash transfers receive the Child Support Grant (CSG). The value of the CSG grew by a mere 0.2% after successive real declines of 1.3% and 0.2% in FY2022 and FY2023 respectively. In fact, the real value of the CSG has eroded since its inception and it is

Table 11: 'Indirect' national and provincial budget programmes for VAC and VAW

Department	Programme
Social Development	Children (included ECD in 2015) Families Social worker scholarships Substance abuse, prevention and rehabilitation ECD & partial care
Health	Violence, trauma and emergency medical services
Education	School sport, culture and media services
Women	Communication and outreach initiatives
Community Safety	Provincial secretariat for police services/ civilian oversight
Justice & Constitutional Development	Family advocates
Correctional Services	Rehabilitation
South African Police Service	Crime prevention

Adapted from: KPMG. *Report on Diagnostic Review of the State Response to Violence against Women and Children. Summary Version.* 2016. Table 5.

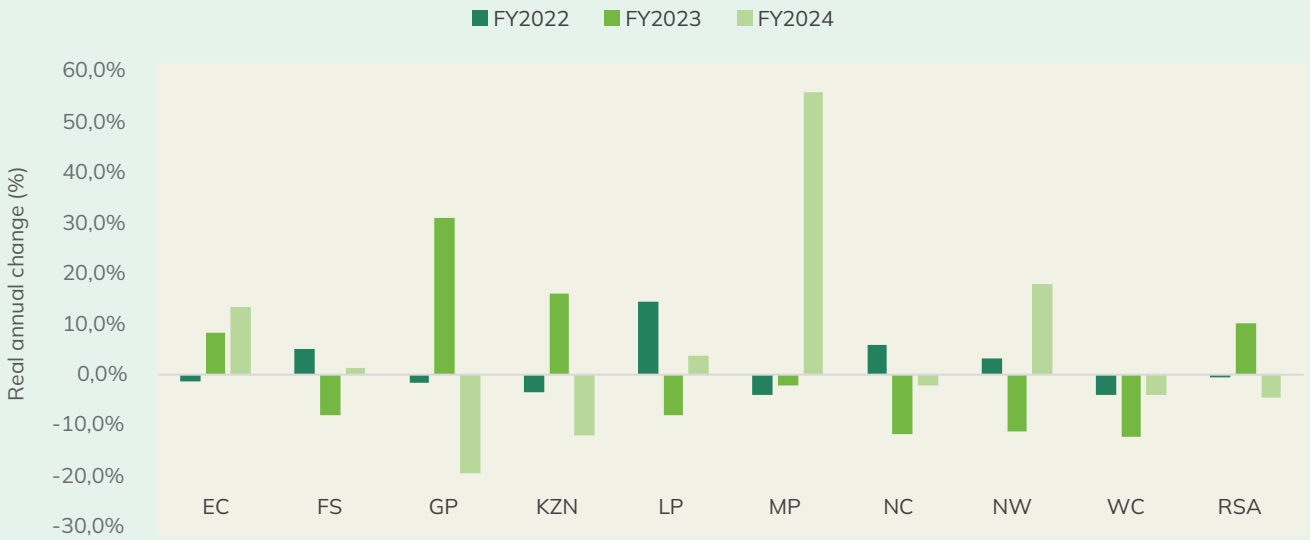
not sufficient to lift children above the food poverty line.[25] Food insecurity is associated with increased physical intimate partner violence perpetration, therefore the reduction in value of the CSG undercuts its value as a violence prevention mechanism.

Does funding support equitable access to services?

An analysis of the provincial DSD's Children and Families (direct expenditure) budget in FY2015 showed that disparities in provincial allocations became even more pronounced when focusing specifically on children from poor families.[v] When looking at all children, KwaZulu-Natal and the Eastern Cape allocated approximately R205 per child which is about 39% of the R530 allocated by the Northern Cape. However, when the analysis was limited to poor children, the gap widened significantly: The Eastern Cape allocated just R264 per poor child, compared to Gauteng's R1,323, which is more than five times higher.[26] UNICEF's similar analysis of childcare and protection[27] confirmed further that the mean amount allocated per child varied enormously between provinces.

Furthermore, South Africa currently lacks uniform funding norms for shelters resulting in significant disparities in the allocation of funds across provinces. In 2020, for example, subsidies ranged from as little as R9 to R71 per person per day depending on the province.[28] These discrepancies affect both the amounts allocated and the specific costs covered, leading to inconsistent support for shelters nationwide. Moreover, there are marked provincial differences in funding levels relative to service needs across all areas, not only shelter provision.[26, 29, 30] Despite provincial governments bearing the responsibility to budget for social welfare services, some have failed to prioritise these services adequately. In some provinces there are significant urban rural divides.[26, 31, 32]

Figure 22: Real annual growth rates in Provincial Secretariat for Police, by province, FY2021 – FY2024 (FY2021=100)



Source: National Treasury online database (accessed in August 2025)

v Defined as those below the upper bound poverty line.

Table 12: Real average annual growth of 'indirect' national and provincial programmes, FY2021 – FY2024 (FY2021=100)

Programme (ZAR billion and ZAR million)	FY2021	FY2022	FY2023	FY2024	Real average growth rate, FY2021-FY2024 (%)	Level of government
Substance abuse, prevention & rehabilitation	1.1B	1.2B	1.1B	1.3B	0.4%	National & provincial
Violence, trauma, and emergency medical services	8.8B	9.8B	10.5B	11.2B	2.6%	National & provincial
School sport, culture & media services	182.2M	281.4M	301.0M	355.8M	19.8%	Provincial
Oversight and provincial secretariat for police	715.0M	763.0M	882.5M	874.0M	1.5%	National & provincial
Family advocates	248.6M	270.0M	288.3M	289.0M	-0.3%	National
Rehabilitation (Correctional Services)	2.0B	2.1B	2.3B	2.1B	-3.0%	National
Total	**13.1B**	**14.5B**	**15.4B**	**16.1B**	**1.7%**	

Source: National Treasury online database (accessed in August 2025)

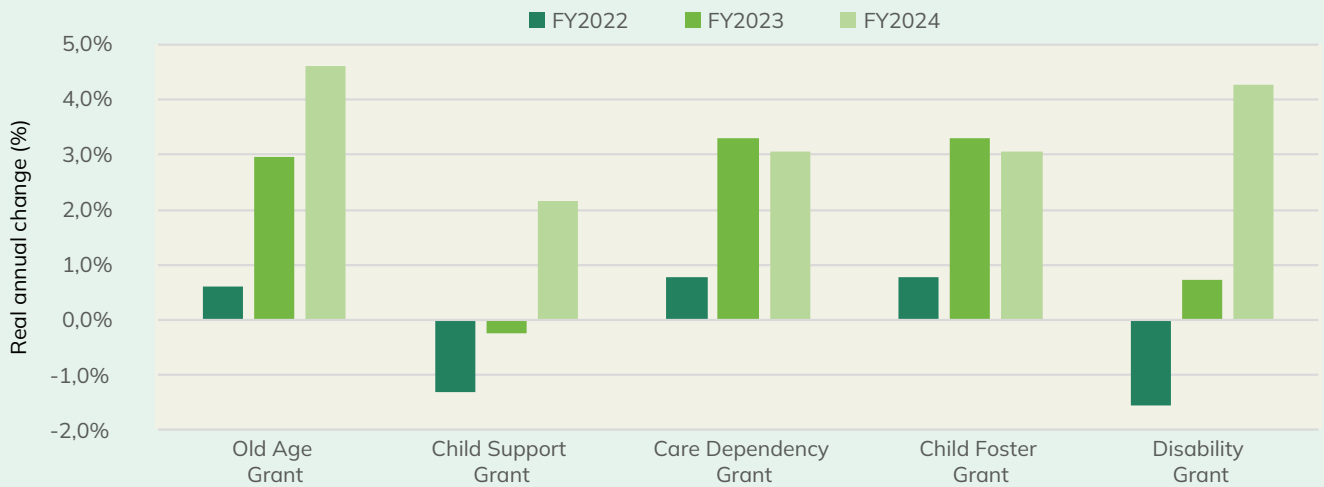
Does public financing of the fight against VAC and VAW meet the core measures of compliance?

This cursory analysis of funding that is dedicated to VAC and VAW suggests that it was subject to the same degree of expenditure cuts experienced elsewhere in the public sector. Cutting funding on nationally agreed priorities is considered a **retrogressive measure** by the courts, therefore South Africa is not meeting its constitutional obligations to progressively realise women and children's rights to health and social services.

The nature of the South African annual budget process, which involves trade-offs among large function groups, does not necessarily offer any relief in terms of the sustained and consistent funding for VAC and VAW. As was mentioned earlier in this paper, expenditure on VAC and VAW cuts across functions, departments and spending entities, thus making it hard to track and direct funding for VAC and VAW. One option is to include 'earmarked' allocations within the provincial equitable shares, but there is no genuine protection for such funds, and these allocations are too small to make a meaningful difference in the total resources allocated for VAC and VAW.

Progressive realisation requires that we see an increase in the overall level of enjoyment of the right. However, data from the Gauteng Care Crisis Committee (Case 25) indicates a decrease in the number of beneficiaries and closure of services.

Figure 23: Real annual growth rates on the main social grants, FY2021 – FY2024 (FY2021=100)



Source: National Treasury online database (accessed in August 2025)

Furthermore, provincial disparities in spending are leading to inequitable access to services which is an infringement of the **non-discrimination** principle.

In a study commissioned by the Government Technical Advisory Centre, Barberton and Abdool[33] used a range of inequality measures to demonstrate the extent of provincial inequities in the financing of social welfare services, the low absolute base of social welfare services, and the persistent real declines in financing across most provinces. Developing a simple per capita measure, which takes social welfare spending divided by the number of poor people per province, they were able to show substantial negative and positive deviations from this imagined per person spending, further reinforcing the degree of variation among provinces in their commitment to social welfare spending. This is primarily an equity and adequacy issue with social welfare budgets and the fact that social development spending continues to be dominated by spending on social assistance.

While much attention is rightly placed on the inadequate funding for GBV services, it is equally important to scrutinise how existing funds are managed. For example, in 2024, the Gauteng DSD returned R554 million[34] in unspent funds to the provincial treasury – a staggering figure considering the acute funding crises faced by GBV shelters in the same province. This paradox exposes deeper systemic issues in the funding landscape which manifest as poor planning, bureaucratic inefficiencies and a lack of accountability in the distribution of public funds. These systemic failures persist despite repeated national and provincial commitments to addressing GBV. In addition to the inadequacy of the funding, administrative processes are bureaucratic and burdensome with delayed payments diminishing the ability of shelters to meet the needs of women and children[31] (see Case 25).

A major structural challenge lies in the siloed nature of budgeting and service delivery. As highlighted in the KPMG review, "siloed budgets are not an effective use of limited funds and do not support effective implementation" (p. iii).[24] Departments continue to plan and manage budgets independently, which prevents the kind of integrated and efficient funding approach necessary for an effective response to VAC and VAW. The current system fails to capitalise on opportunities for streamlined administration, more precise role definitions, and the use of technology to optimise the deployment of a workforce already stretched thin by skills shortages – particularly in the social services sector.[24] Underspending and poor administration contravene the principle of spending to the **maximum extent of available resources**.

Does the difficulty in identifying expenditures and allocations on VAC and VAC necessitate a change in the country's Standard Chart of Accounts[vi]? Not necessarily, as the government is now experimenting with climate and gender responsive budgets, and it remains important that such pilots are seen through comprehensively, and the lessons learned could be used to reform the classification of VAC and VAW expenditures. The expeditious approval and implementation of the DSD Sector Funding Policy (see Case 26 on p. 148) will also help, given its strong focus on prevention and other relevant social welfare expenditures.

The nice fit between the SFP and the tweaked annual budget holds promise for spending on items that have a direct relationship to VAC and VAW. However, while this proposed policy covers a significant proportion of VAC and VAW expenditure, even greater expenditure is covered in health, education and justice budgets, where there are no mechanisms in place to prioritise or protect expenditure on VAC and VAW.

Current government responses to violence against women and children remain heavily weighted toward short-term, acute interventions and the criminal justice system, with insufficient investment in prevention and long-term rehabilitation.[vii] Yet, women's long-term needs extend well beyond immediate safety.

Case 25: The Gauteng Care Crisis Committee – evidence of maladministration

The Gauteng Care Crisis Committee (GCCC), representing numerous non-profit organisations (NPOs) providing essential social services, initiated legal action against the Gauteng Department of Social Development (DSD) due to significant funding delays and administrative failures that jeopardised services for vulnerable populations, including victims of GBV and children in need of protection. They presented evidence to the court that the funding crisis has had tangible impacts on services and beneficiaries, as several GBV shelters, including those operated by People Opposing Women Abuse (POWA) and the Nisaa Institute for Women's Development, were forced to close due to the funding crisis.

vi A standard chart of accounts (SCOA) in the public sector is a framework for classifying government financial transactions to ensure consistency and transparency across all departments.

vii While this chapter does not argue against a prevention orientation, it does present a more nuanced view articulating the need for the government to respond to the excesses of VAC and VAW, while engineering programmatic shifts and reforms that would put prevention at the heart of all government departments.

Case 26: Ring-fencing funding for prevention through the Sector Funding Policy

Carmen Abdoli[i]

In 2023, the national Department of Social Development (DSD) introduced the Sector Funding Policy (SFP), which aligned government's approach to funding developmental social services delivered by non-profit organisations with the NAWONGO rulings.[7]

The NAWONGO case (2010 – 2014) was brought by the National Association of Welfare Organisations and NGOs against the Free State DSD over chronic underfunding of NPOs delivering statutory welfare services. In a series of four rulings, the High Court found that government cannot treat such services as optional subsidies, since NPOs providing care to children, older persons and other vulnerable groups are fulfilling the state's constitutional and statutory obligations. The court required a new funding model that is transparent, equitable, and progressively works toward covering the full costs of mandated services, rejecting the old 'take it or leave it' approach.

A key proposal of the 2023 SFP was that "a fixed percentage of the total budget (of provincial DSDs) must be allocated to prevention and early intervention".[35] Earlier drafts suggested this percentage be set at 5%. The purpose of ring-fencing the funds is to ensure that prevention and early intervention activities[ii] are protected, as statutory[iii] and response services[iv] historically consume the bulk of provincial budgets. It represents a strategic investment in the country's social and economic future.

Although mentioned in DSD's 2023/24 Annual Performance Plan and a November 2024 parliamentary presentation,[36] implementation of the SFP has seemingly stalled. The parliamentary presentation offered no timeframes, and the 2024/25 Annual Performance Plan doesn't mention the policy. This suggests that DSD may have decided not to proceed, raising concerns about government's commitment to comply with the 2014 NAWONGO rulings.[v]

Continued underfunding of prevention interventions undermines progress in addressing the root causes of vulnerability, poverty and violence. Advocacy is needed to pressure national and provincial DSDs to implement the SFP, especially the fixed-percentage rule, in order to secure sustained investment in prevention and early intervention and advance the fight against violence against women and children.

i Cornerstone Economic Research
ii Prevention and early intervention action areas listed by the SFP include positive parenting and family promotion, intimate partner violence, prevention of substance use disorders, and social crime prevention.
iii For example, foster care, child and youth care centres (CYCCs) and services to older people.
iv For example, removing and placing a child at risk of harm in a CYCC or foster care, women's shelters and Thuthuzela Care Centres.
v Including policy implementation within an APP is a clear signal of intent, accountability and commitment, obliging the department to report publicly on progress and achievements against stated objectives.

Continued access to psychosocial services, childcare, housing and income security are critical to their ability to recover and regain independence. Despite the clear importance of these services, they are the least funded. For example, the absence of safe, affordable and government-subsidised post-shelter accommodation for women and their children is a critical gap that leaves many survivors at risk of returning to unsafe environments.[31]

Conclusion

President Cyril Ramaphosa has consistently emphasised the urgent need to end gender-based violence and femicide, and described it as a "national crisis", a "profound violation of human rights", and the country's "second pandemic".[37-39] However, examining the budget against the core measures of compliance – including progressive realisation, no retrogression, non-discrimination, and the maximum available resources – reveals that the South African Government is failing to uphold its constitutional and international obligations to protect women and children from violence.

Going forward the government should address legislative gaps by strengthening the legal framework and ensuring that the Victim Support Services Bill includes robust provisioning clauses. Implementation of the Sector Funding Policy would help standardise agreement processes, improve timelines of payments, and promote a more consultative funding relationship with NPOs.

Over the short- to medium-term, it is unrealistic for the government to abandon its response orientation (and concomitant funding), but it does bear an obligation to move the country to a more acceptable and sustained prevention orientation in the long-term. Given the scale of violence in South Africa and its compounding and intergenerational effects, government should finetune its policy response

Case 27: Children's participation in public budget advocacy

Xolane Ndlovu[i] and Christina Nomdo[i]

> "When I was 14 years old, I spoke to National Parliament about their budgeting and how to make it child friendly (based on the opinions of myself and my fellow Child Government Monitors). The CGMs and the National Treasury then worked together to create "The Cool Kids Guide to the Budget".[40] Being part of this process truly made me feel accomplished. It felt overwhelming, yet I was very proud of myself to have made this type of history (as the youngest person to address a Committee about budget policy)." Tara Hendricks, Child Government Monitor

Since 2020, the Western Cape Commissioner for Children (WCCC) and child government monitors (CGMs) have been actively involved in advocating for the realisation of children's rights and making budget submissions to national, provincial and local government. These submissions aimed to ensure that children's perspectives were included in government budget policy, and that budget allocations prioritised children's services.[41]

For the National 2023 Medium Term Budget Policy Statement (MTBPS), the Commissioner consulted with more than 50 CGMs who recommended a more child-centred approach to governance and more effective child-friendly communication methods such as child-friendly budgets. The CGMs also reviewed the spending priorities of the Western Cape government and made a submission on the 2024/5 budget for the Bitou Municipality.

A deeper analysis of budget implementation occurred in 2024 through the #Followthemoney campaign. The CGMs attended the Western Cape Health and Wellness Budget Vote and requested evidence that the health system was child- and family-focused. The Head of Department of Health and Wellness enabled the CGMs and the Commissioner to visit health facilities where they engaged with healthcare professionals and identified opportunities to enhance the delivery of healthcare services to children. The CGMs then submitted their findings and recommendations to the Head of Health and Wellness in written, oral and poster formats.

These efforts highlight critical opportunities to enable child-centred and child-friendly governance by including the voices of children and considering the impact of budget decisions on future generations.

i Western Cape Commissioner for Children

in order to sustain response interventions whilst steadily expanding the delivery of much-needed prevention and early intervention services. To this end, it would be helpful to develop and cost a minimum core package of VAC and VAW services and prioritise its consistent funding across all provinces. This package should include shelters, Thuthuzela Care Centres, FCS units, prevention programmes in schools and communities, gender-transformative parenting support, and victim-friendly justice services. Its implementation would ensure that survivors receive comprehensive, quality care regardless of where they live. Ultimately, while expenditure analysis is critical, it must be grounded in well-defined questions and aligned with clear, actionable goals. A more integrated, transparent and impact-oriented budgeting process – backed by strong provisioning clauses, costed implementation plans and meaningful interdepartmental coordination – is essential to realise women and children's rights to be free from violence.

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Supporting the workforce to address violence against women and children in South Africa

Suzanne Clulow[i]

Preventing violence against women (VAW) and violence against children (VAC) is a whole-of-society concern that requires a multisectoral response. An important pillar of this response is a well-resourced, dedicated and skilled workforce that spans multiple sectors – including social services, health, social protection, education, justice and law enforcement – and delivers diverse yet coordinated services to communities, families and individuals. The competencies, attitudes and collaborative capabilities of this broad workforce are crucial in ensuring effective prevention and response efforts.

This chapter outlines the core functions and competencies of such workforce and the systems and support that need to be put in place to build its capacity to prevent and respond to the intersections of violence against women and children.

Who is the workforce?

All too often violence prevention and response services are viewed as the responsibility of social workers, and especially those providing statutory services.[ii] But social workers are only one part of a much larger system of care. Educators, health practitioners, mental health professionals, paraprofessionals, community health workers, child and youth care workers, police officers, community development practitioners, lay workers, faith leaders, justice sector personnel, researchers, monitoring and

Table 13: Functions of the workforce in violence prevention for women and children across the continuum of care

	Individual *Prevention and response*	**Family** *Prevention and response*	**Community and organisations** *Promotion and prevention*	**Society** *Promotion*
Interventions	Mental health Victim support Psycho-education Women's and girls' empowerment Social protection Justice Offender support Diversion programmes Substance abuse support Work with men and boys Statutory services	Parenting support Economic strengthening Social protection Family strengthening Early childhood home visits Couples counselling Addressing social norms and gender inequality Work with fathers	Addressing social norms and gender inequality Gender socialisation in ECD centres Community safety Community education, mobilisation and activism Work with faith and traditional leaders Providing safe places for recreation and play School gender equality and life skills education Training and professional development for the workforce	Public service campaigns and announcements Addressing social norms and gender inequality Police reform Networking and collaboration Advocacy Research Development of education curricula Data collection
Workforce	Social service professionals Public services Health professionals Psychological professionals Justice system personnel Educators, ED practitioners Lay workers Faith leaders	Social service professionals Public services Psychological professionals Lay workers Faith leaders	Social service professionals Public services Educators, ED practitioners Education and training providers Lay workers Faith leaders	Government Civil society M&E experts Education and training experts Researchers Faith leaders

Adapted from: United Nations Children's Fund. *Guidelines to Strengthen the Social Service Workforce for Child Protection.* UNICEF: New York; 2019.

i CINDI

ii For example, investigation of child abuse cases, placement into alternative care, diversion programmes for children in conflict with the law, assistance with protection orders, court preparation and victim support services.

evaluation experts, advocates, communities and community leaders all have a role to play in preventing violence and supporting children and families.

Adopting this broader understanding of the workforce is essential to address the drivers of violence at different levels of the socio-ecological system (as outlined in Table 13) and to ensure that women, children and men receive coordinated, accessible and contextually relevant support across the continuum of care.

What functions should the workforce provide to address violence against women and children?

The workforce should be capable of providing a range of services, programmes and interventions across the prevention to response continuum.

Violence is preventable,[1-3] and this is where the largest part of the workforce should be focused.[4] Prevention programmes reduce risks and vulnerabilities to prevent violence from escalating and have greater potential for achieving long-term benefits.[5-7] Prevention should be undertaken universally, targeting violence in general within communities, families and individuals, irrespective of risk or experience of violence, as well as selectively focusing on high-risk groups or families,[8] for example, economic strengthening interventions for low-income households.

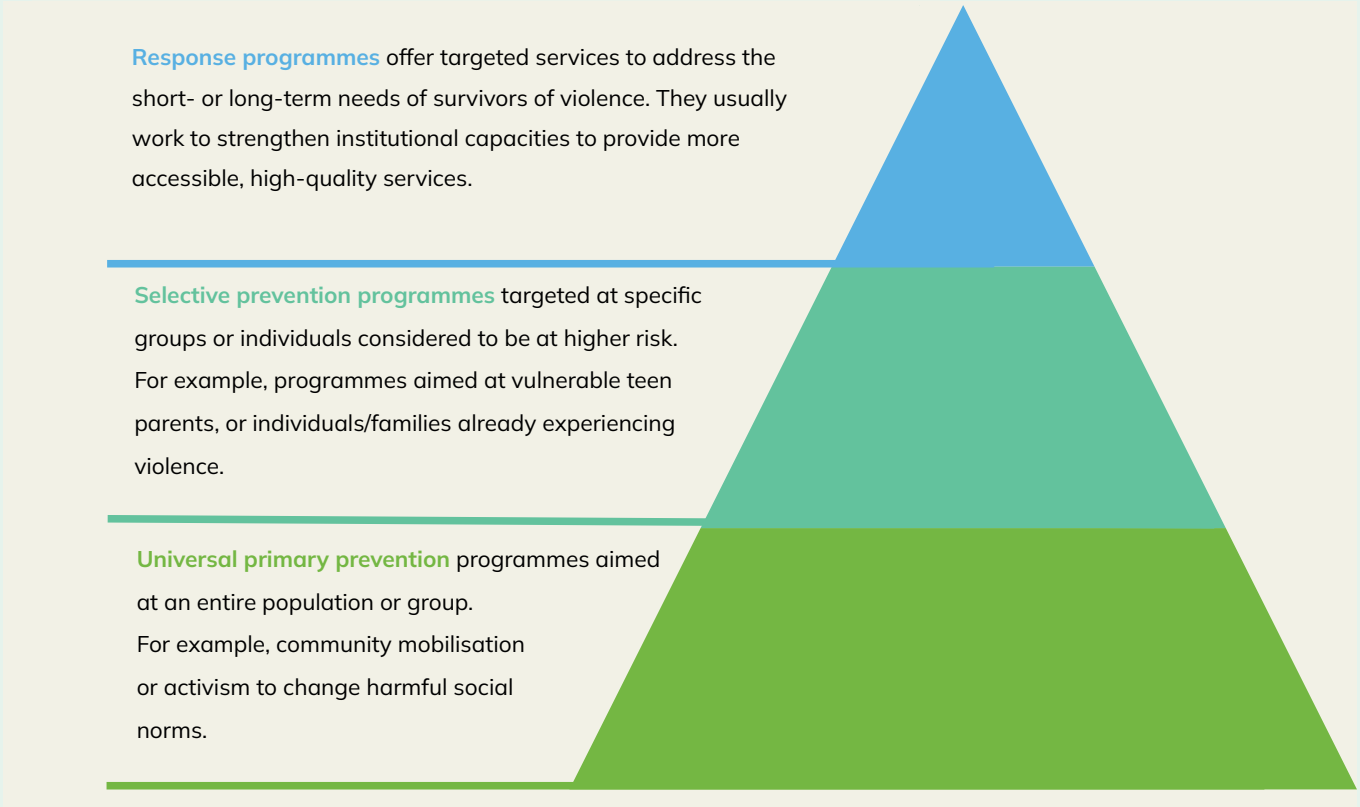
Promotive services work predominantly at the societal level to ensure an enabling environment for violence prevention, particularly regarding policy and law. Six out of the seven strategies in both the INSPIRE and RESPECT frameworks focus on prevention and promotion.[5, 6] Conversely, in the National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF) only two out of six pillars focus on prevention or promotion.

Responsive programmes support women and children who have experienced violence to prevent reoccurrence and reduce its effects.

How should the workforce be structured?

Violence against women and children share common risk factors and tend to co-occur in the same households. The intergenerational effects of this violence highlight the need to co-ordinate services and provide a more integrated response to VAC and VAW.[9] In addition, there is a growing body of evidence that addressing shared risk factors of VAW and VAC can aid in preventing both forms of violence.[4, 9, 10]

Figure 24: The prevention to response continuum



Source: Delany A, Mathews S, Berry L. *Preventing Violence Against Women and Violence Against Children: A toolkit for practitioners*. Cape Town: University of Cape Town. 2025

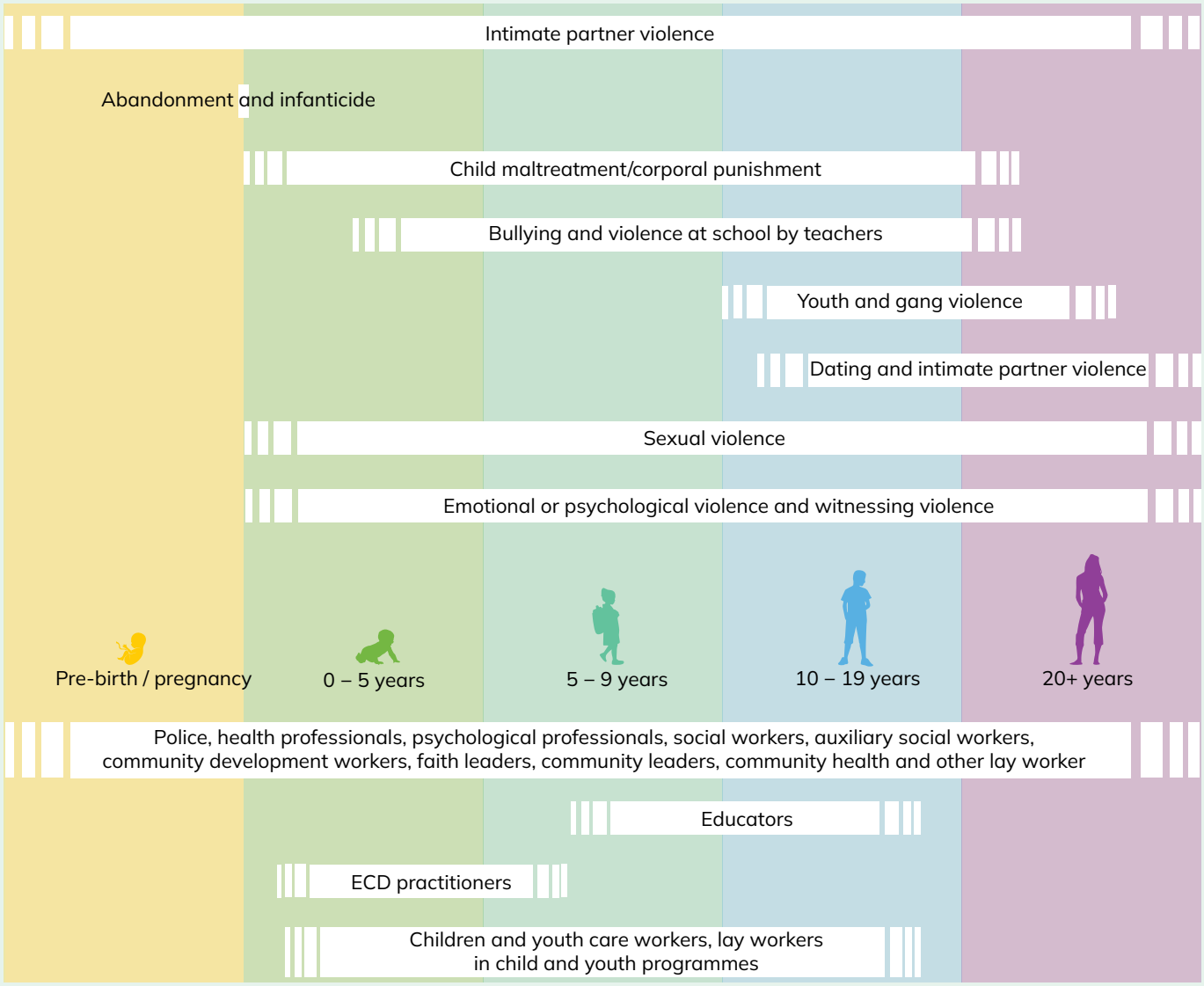
Coordination of services requires planning at both policy and implementation levels in order to develop a shared framework and common language.[11] This includes a well-developed normative framework of laws and policies with clear definitions of roles, functions and competencies for each cadre of worker[12] including professionals, paraprofessionals and community/lay workers within the government, private and non-profit sectors. Intersectoral protocols should also be established to enhance the functioning of this workforce to address the intersections of VAC and VAW supported by a data management system with intersectoral functionality.

Workforce location and concentration are key to effectiveness. The workforce should be structured and adequately resourced to offer both universal violence prevention programmes and targeted services for high-risk groups and individuals.[13]

Adopting a life-course approach is helpful when considering the resourcing and deployment of the workforce as it highlights strategic points for intervention.[5, 6, 9] For example, health facilities are an effective platform for reaching pregnant women, new mothers and young children, while schools are a powerful platform for engaging older children and adolescents. This should be overlayed by an audit of the workforce (formal, informal, government, private, non-profit) to map out current concentrations, gaps, services and potential contributions to violence prevention as well as to plan how to fill gaps, avoid duplication, ensure an adequate coverage of services and guide intersectoral coordination.

At an implementation level, a well-coordinated workforce functions with an understanding of – and respect for – each other's roles and responsibilities, recognising when

Figure 25: Strategic entry points of the workforce in responding to violence across the life course



Adapted from: Titi N, Tomlinson M, Mathews S, et al. Violence and child and adolescent mental health: A whole-of-society response. In: Tomlinson M, Kleintjes S, Lake L, editors. *South African Child Gauge 2021/2022*. Cape Town: Children's Institute, University of Cape Town; 2022.

collaboration, integration and referral are necessary. This should be supported by:

- **Standard operating procedures and referral protocols:** Establishing clear procedures and protocols, even across departments, scaffolds the workforce, avoids task duplication, and ensures efficient screening, referral and service provision.
- **Trust-building:** Normative frameworks alone do not guarantee coordination; trust among role-players is essential. Actively building trust through multi-stakeholder coordination and training structures at different levels is crucial.
- **Cross-sector case management systems:** Implementing systems that span sectors ensures seamless referral, support and follow-up.
- **Co-location of staff:** Strategically situating staff at key service points facilitates integration and creates safe spaces for both women and children, such as providing child-focused services at women's shelters, or parent support groups in child protection organisations, or the integration of services responding for rape survivors provided by Thuthuzela Care Centres.

Key challenges and constraints

However, the workforce in South Africa is currently facing several challenges that limit its effectiveness in addressing the intersections of VAC and VAW. At a policy level, the NSP-GBVF provides a roadmap for addressing violence against women and children in South Africa. It refers to the intersections of VAC and VAW in its introduction but falls short of addressing this more concretely. It has been criticised for its lack of consideration of children's issues and clear, implementable actions for civil society organisations as collaborators in violence prevention.[14, 15]

A comprehensive audit of the workforce and its capacity to prevent violence and achieve policy goals has not been undertaken. The result is under-delivery of services, for example mental health support,[16] and an overfocus on statutory services at the expense of prevention and early intervention[17]. Other role-players' contribution to violence prevention, particularly in the allied fields, may be underacknowledged. For example, the psychosocial support function of community health workers is not routinely measured and yet may be significant in violence prevention,[18] especially since their deployment is based on the social determinants of health which have correlations to risk factors for violence.

The overconcentration of the government-funded social service workforce around statutory services means that the bulk of prevention and early intervention services are provided by the non-profit sector through donor funding.[19] Allowing these critical services to be reliant on outside funding is risky and unsustainable, as the recent reduction of both UK Aid Direct and USAID funds has highlighted. In addition, the contribution of these services to violence prevention may not be sufficiently understood and acknowledged because they fall outside of government data collection systems.

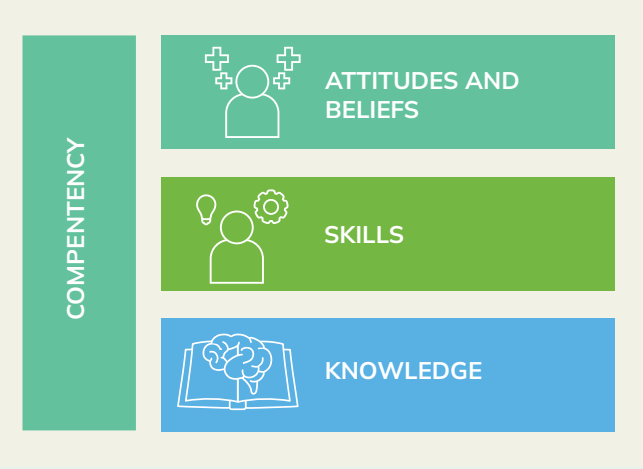
Other challenges to the workforce consistently cited across multiple sectors include high numbers of vacant posts, high staff turnover, lack of equipment and resources, high caseloads, poor working conditions, concerns about workplace safety and low staff morale.[20-23] These challenges are further compounded by the stark urban–rural divide. Rural areas often face the highest vacancy rates, limited access to specialised services, and long travel distances for both practitioners and families, while urban areas, though better resourced, contend with overwhelming caseloads and fragmented services. In addition, a lack of standard operating procedures and protocols,[24] limited training and support, siloed approaches, task creep, poor quality referrals, and professional distrust hinder effective intersectoral collaboration.

What competencies does this workforce require?

Effectively addressing the intersections of violence against women and children requires a workforce equipped with specific competencies. Competencies focus on a person's knowledge, skills, attitudes and beliefs to successfully perform their work.[12, 25]

Below is a set of general competencies put forward in literature. These competencies should be systematically developed and reinforced through multiple pathways, including

Figure 26: Components of competency



Source: United Nations Children's Fund: *Gender Competencies for Service Providers Addressing Violence Against Women and Girls in the Caribbean: Implementation guidance for educators, health workers, police and social workers*. UNICEF: Panama City; 2023.

Case 28: How current services could be strengthened

The current situation[i]

Mihle (13) and Javas (16) were placed in a registered child and youth care centre (CYCC) after being removed from their mother's care due to family violence, abuse and neglect. Before removal, multiple referrals by their school had been made to a social worker, but no follow-up occurred until an Aunt took the children to a child protection organisation. Their mother, Zanele (30), is unemployed, reliant on begging and exposed to repeated physical violence from her partner. Zanele has no ID and is not accessing social grants for the children. Mihle and Javas had witnessed and directly experienced violence, often being left uncared for, and Javas had spent periods living on the streets. Their younger sibling, Aviwe (13 months), remained in the mother's care. Once placed in the CYCC, Mihle and Javas received only general life-skills programmes, with no therapeutic or trauma-informed support. Eight months later, their wish to be reunified with their father had not been addressed. No support was provided to Zanele, and no structured attempt was made to address the underlying drivers of violence in the household or engage with Zanele's partner.

What a coordinated workforce could have done

If the workforce had been better resourced, coordinated and guided by clear intersectoral protocols, a very different response would have been possible:

- Early intervention: A community-based worker (for example a social auxiliary worker, child and youth care worker or NGO fieldworker) could have responded promptly to the school referral, assessing risks for both Zanele and her children.
- **Tailored family support:** Depending on the risks identified, the family could have received a range of support from immediate safety planning to structured interventions provided by a range of stakeholders across government, community groups, civil society organisations, faith based organisations and the private sector. These might have included:
  - psychosocial support to ensure the immediate basic needs of the family are met;
  - parenting support for Zanele, her partner and the children's father;
  - mental health support for Zanele;
  - support from a men's programme specifically looking at intimate partner violence for Zanele's partner;
  - psychological support for the children, including trauma-informed counselling and school-based services;
  - economic strengthening and empowerment support for Zanele, alongside help accessing social grants and documentation; and/or
  - home visits from a community-based worker particularly during the first 1,000 days of Aviwe's life.
- **Protection and justice:** Police, briefed and trained in trauma-informed, survivor-centred practice, could have supported Zanele's safety while minimising harm to the children. A maintenance order could have been secured and enforced to ensure financial support and reduce economic vulnerability.
- **Sustained case management:** A multidisciplinary team — including social workers, health workers, police, schools, NGOs, community and faith leaders — could have worked together under a shared case management system, ensuring accountability and follow-through.

What difference this could have made

- Mihle and Javas could have remained living in a family environment, with their safety secured and parenting support provided.
- Javas could have avoided periods on the street and received appropriate counselling.
- Zanele could have accessed economic and psychosocial support, reducing her dependence on an abusive partner.
- Everyone could have received trauma-informed counselling and support to address the drivers and consequences of violence within the household.
- Zanele and her partner could have been engaged in positive parenting programmes.
- Aviwe's early development could have been safeguarded through regular health and parenting support.
- Collectively these actions could have helped to mitigate the intergenerational cycle of violence.

i Based on an actual case, names have been changed.

Case 29: Child trauma conference

For the past 14 years, Jelly Beanz, a leading South African non-profit in child trauma recovery, has been hosting a Child Trauma Conference. Each year, the conference explores current, evidence-based topics related to child trauma, protection and healing, while showcasing replicable programmes that make a real difference. The Child Trauma Conference is recognised as one of South Africa's leading platforms addressing trauma-informed care, bringing together practitioners, clinicians, researchers, policymakers, media and civil society from across the continent. A key theme of the 2024 conference was the intersection between gender-based violence and child trauma, particularly in the home.

the review and updating of education and training curricula, regular in-service training and professional development opportunities, and ongoing supervision and mentorship. Each worker may have role and context specific competencies in addition to these. Irrespective of their role or function, the overarching principle guiding all workers in the prevention-response continuum must be to 'first do no harm'.

Trauma-informed care

Understanding the pervasive impact of trauma is crucial.[26] The Child Trauma Conference (Case 29) plays a crucial role in building capacity within the sector, so that all practitioners are able to recognise the effects of trauma (including on the workforce itself), identify its signs, and respond in empathetic ways that avoid re-traumatisation, ensure survivor safety and promote healing.[27]

Gender responsiveness

Recognising the gendered nature of violence is essential. The workforce must understand how gender influences safety, healing and empowerment, working in a gender-transformative manner that fosters change.[12, 28]

Cultural competence and inclusivity

Respecting diverse cultural backgrounds ensures accessibility and appropriateness of services. Personnel should tailor interventions to be culturally sensitive and relevant.[28]

Legal and ethical proficiency

The workforce should be aware of laws related to violence prevention and response, including mandatory reporting requirements and survivor and offender rights, as well as ethical codes of practice, and be able to apply these proficiently in their work.

Confidentiality and non-judgmental approach

Maintaining safe spaces is essential. Personnel should uphold confidentiality, where possible, and engage in non-judgmental, survivor-led interactions. See, for example, the Psychological First Aid Guide developed by JellyBeanz and Cindi (Case 30).

Intersections lens

Understanding the intersections of violence against women and children, the rationale for an integrated approach, and its benefits is crucial.[9] Staff should competently apply this lens to enhance intervention effectiveness. See, for example, the Building Stronger Families training programme developed by MOSAIC and the Children's Institute (Case 31 on p. 158).

Collaborative practice

Personnel should work collaboratively across sectors and disciplines to provide comprehensive support, understanding that violence against women and children require a coordinated response.[30]

A commitment to self

A commitment to self-care and ongoing education and training promotes well-being, prevents burnout[31] and ensures the workforce remains adaptable and informed about effective strategies.[32]

Reflective practice

Reflective practice is developed through supervision and mentoring, enabling practitioners to process experiences, manage the emotional demands of the work and learn from practice.[33]

Case 30: Psychological first aid guide

The Psychological First Aid (PFA) Guide for First Responders,[29] developed by JellyBeanz and CINDI, provides a simple, practical approach to supporting children and adults after traumatic events. A central principle of the Guide is that effective first responses must create a sense of safety and trust. The Guide provides two simple frameworks, 'Head, Heart, Hands' and the 'Five Cs of PFA', which equip first responders to engage in ways that are sensitive, survivor-centred and respectful. In doing so, it strengthens the workforce's ability to uphold adult's and children's rights to safe, confidential and non-judgemental care.

Reflexivity and critical thinking

Fostering self-awareness and critical thinking encourages reflexivity and addresses unconscious biases. Reflexivity adds to reflective practice by developing awareness of how one's own values, identities and positions of power shape your professional responses.[34] Staff and management should have an awareness of self and understand how personal norms influence their beliefs and responses.[12] See, for example, the Caring for Boys training programme developed by CINDI (Case 32 on p. 158).

How can the workforce be better capacitated to address VAC and VAW?

A number of mechanisms are necessary to plan, support and develop the workforce's capacity to address violence against women and children in South Africa.

Political will for integration

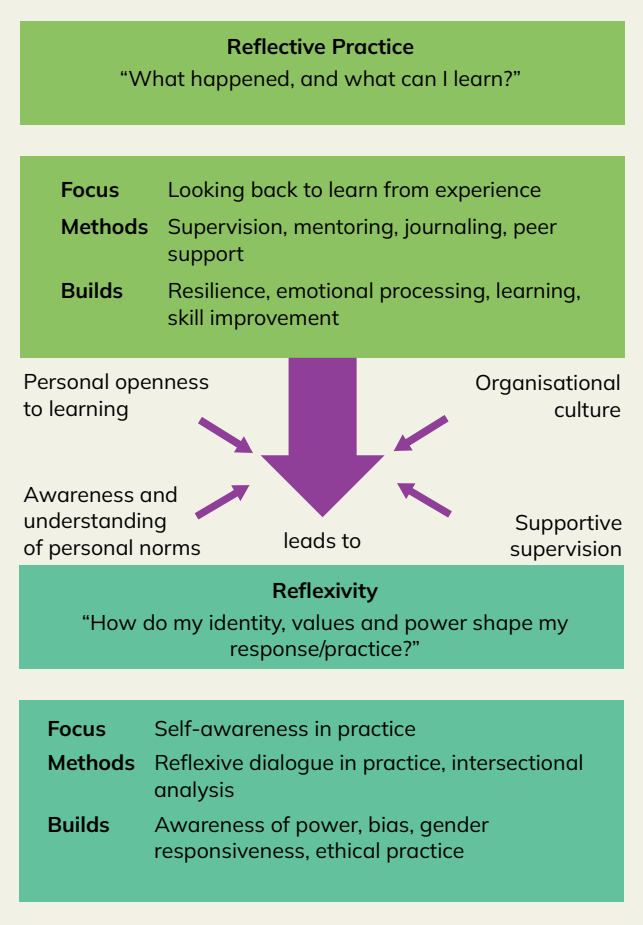
Strong political commitment is crucial to position violence prevention as a public health priority. While South Africa has robust legislation addressing violence against women and children as separate issues, there is a need for integrated policies that recognise their co-occurrence and shared risk factors. For instance, the NSP-GBVF primarily addresses women's issues, with limited focus on children and men. It is critical that the workforce be included in policy development processes to ensure that policy recommendations are grounded in practice.

Proper planning and deployment

A thorough assessment of the workforce across departments is necessary to develop a national plan to strengthen the workforce to address both VAC and VAW in an integrated manner. Consideration must be given to the widespread drivers of violence and the need to have a broad workforce to respond to these challenges. Roles, responsibilities and ratios must be clearly delineated, applying a life-course approach to identify critical intervention points to improve prevention and response to violence. Task-shifting strategies should be applied to optimise utilisation of resources and skills and ensure adequate reach of services. The current imbalance towards response services must be corrected in favour of an investment across the continuum. The workforce across all levels must be included in the development of this plan.

The recently approved Sector Strategy for the Employment of Social Service Practitioners is a step in the right direction in terms of planning. The goal of the strategy is to "strengthen planning, recruitment, deployment, and management of social service professionals towards a more responsive social protection system".[35] The Strategy takes an intersectoral approach including the Departments of Social Development, Education, Health and Justice as well as the non-profit sector.

Figure 27: How reflective practice, with support from other moderators, can lead to reflexivity



Adequate resourcing

Ensuring the workforce is adequately and appropriately resourced is critical. This is an ongoing challenge in South Africa that must be urgently addressed, including the equalising of resourcing across the government and non-profit sectors for subsidised posts.

Standardisation of operating procedures and protocols

Standard operating procedures should be established or reinforced to facilitate collaboration, integration, referral and efficient case management. For example, regulation 33 to section 110 of the Children's Act 38 of 2005 clearly stipulates Form 22 as the required reporting template for cases of child abuse and neglect, yet departments other than Social Development routinely make use of their own internal reporting forms.

Case 31: Building Stronger Families – A gender-transformative approach to preventing violence in families

Tarisai Mchuchu-MacMillan[i]

MOSAIC's Building Stronger Families programme offers a transformative, evidence-based response to the complex intersections of violence against women (VAW) and violence against children (VAC) in South African households. Developed in partnership with the Children's Institute and the University of Cape Town, the 13-week curriculum addresses the shared risk factors of intimate partner violence and harsh parenting by equipping caregivers, men and women in intimate relationships with skills to build caring, equitable and non-violent family environments.

Grounded in deep community engagement and African feminist praxis, the programme fosters critical reflection on gender roles, patriarchy and power imbalances. It promotes healthy communication, shared caregiving and positive parenting through participatory sessions that encourage participants to interrogate their own experiences and shift harmful social norms. Themes such as gender socialisation, non-violent discipline and emotional regulation enable men and women to reframe relationships away from dominance and towards mutual respect and care.

The programme's theory of change recognises that children's safety is inextricably tied to the well-being and empowerment of women. By addressing both couple dynamics and parent-child relationships in a unified intervention, *Building Stronger Families* aims to disrupt the intergenerational cycle of violence. Complemented by individual counselling and community-level campaigns, it fosters behaviour change within relationships and homes while building supportive environments that sustain it.

In a context where patriarchal norms render domestic violence a private matter, this programme creates space for healing, connection and solidarity, enabling families to practice a new, non-violent way of being together.

A **practitioner toolkit**[13] synthesises evidence, lessons learned and practical design considerations for integrated programming. By embedding an intersections lens, the initiative has strengthened workforce capacity to recognise the shared drivers of violence and to deliver **coordinated, gender-transformative interventions** that support safer, more equitable families.

i MOSAIC

Trusting building

Build opportunities for intersectoral collaboration and learning and promote shared responsibility through initiatives such as the Violence Prevention Forum (Case 23 on p. 132).

Education and training

Establish a multisectoral body to collaborate on education and training. The workforce should be trained to understand the intersections of violence against women and children, their co-occurrence and shared risk factors. Working with an intersections lens should be built into relevant further education and training qualifications including in-service training components such as community service.

At an organisational level, working with an intersections lens should be mainstreamed into staff training and support processes. This includes allowing space for staff to reflect on how personal norms and experiences (eg gender or historical trauma) might influence their work and how staff might be affected by these issues within their personal life (eg as a survivor of intimate partner violence).

Care and support for the workforce

Proper care and support, including high quality training, mentorship and supervision, must be provided to the workforce. Organisations themselves must have trauma-informed staff

Case 32: Caring for Boys training programme

The Caring for Boys accredited training programme developed by CINDI builds workforce capacity to engage more effectively with boys affected by sexual violence. Grounded in research from KwaZulu-Natal and Limpopo, the training highlights the unique vulnerabilities of boys and how gendered social norms shape risk and resilience. Through participatory, reflective activities and scenario-based learning, practitioners are encouraged to examine their own perceptions and biases, fostering **reflexivity**. By unpacking social norms and equipping participants with practical tools for communication and gender-sensitive responses, the training takes a **gender-transformative approach** that strengthens services for both boys and girls.

Figure 28: Workforce strengthening framework to prevent violence against women and children

Adapted from: Global Social Service Workforce Alliance. *Framework for Strengthening the Social Service Workforce.* GSSWA. 2013.

policies and procedures to provide proper support and prevent secondary trauma and staff burnout. Working in violence prevention may carry risks for staff which should be clearly identified, mitigated and monitored (see Case 33).

Care for the workforce should be embedded into education and training programmes across all cadres so as to foster self-care and support as practices within the workforce. Organisations should create structured opportunities for reflection, guided debriefing and critical thinking. This requires that supervision extends beyond administrative control to provide safe, supportive spaces for mentorship, reflexive practice and resilience-building.

Use of technology

The use of technology should be explored to support the reach, functioning and effectiveness of the workforce. For example, using technology for violence prevention messaging, improving coordination of referral and case management, data collection, monitoring and evaluating of work, or for supervision and debriefing of staff.

Accountability

Implementing robust monitoring and evaluation systems is essential to hold government departments accountable for their roles in violence prevention and response. Regular assessments and public reporting can ensure adherence to established plans and policies.

Conclusion

This chapter highlights how addressing the intersections of violence against women and children necessitates a well-coordinated, adequately resourced and competent

Case 33: Addressing burnout and supporting staff well-being in South African parenting programmes

Nicola Dawson[i] *and Wilmi Dippenaar*[ii]

Working as a parenting programme implementer can be highly rewarding. A 2025 study conducted by the South African Parenting Programme Implementers Network (SAPPIN) revealed that parenting programme implementers experienced greater compassion satisfaction than non-profit colleagues working in interventions to address gender-based violence and higher overall professional quality of life than those working in statutory services for children.

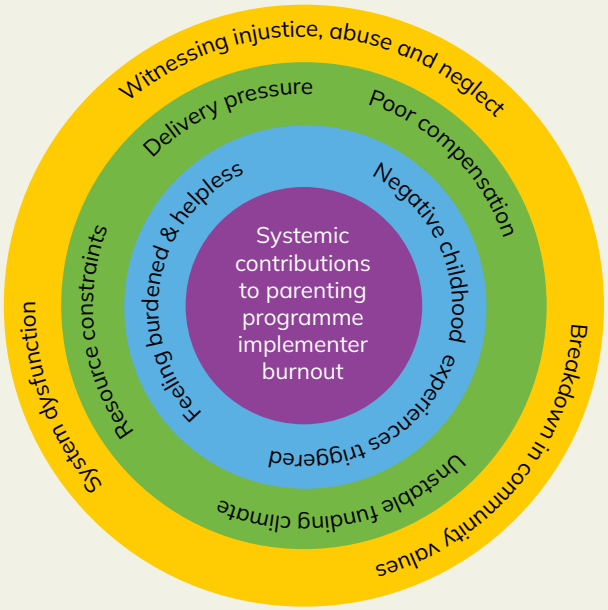
However, implementing parenting programmes can also be personally taxing. The same study revealed similar rates of burnout and secondary trauma to those working in the violence sector.

Despite working from a preventative approach, parenting programme implementers are regularly exposed to stories of abuse, violence and injustice, and are often tasked with providing services in contexts of severe resource constraints and failing systems, while receiving relatively low compensation. Some parenting programme implementers are more affected than others. According to the same study, implementers most emotionally impacted by their work include: those working in township settings, those with more adverse childhood experiences, and those with higher levels of education.

Self-care can support emotional well-being and higher professional quality of life. However, the SAPPIN study revealed that self-care practices[iii] are relatively limited among South African parenting programme implementers – with younger employees and those with more adverse childhood experiences least likely to practise self-care.

The study raises the alarm and highlights the need to better support implementers of parenting programmes. Funding should be allocated to support staff well-being at an organisational level. This includes the provision of reflective supervision, access to trauma-informed somatic-based therapies, and creating conducive work environments in order to support the ethical rollout of parenting programmes.

Figure 29: Causes of burnout



Source: South African Parenting Programme Implementers Network. *SAPPIN Members' Perspectives on Staff Well-being, Well-being Support and Self Care: Research report. 2025.*

i Ububele *Educational and Psychotherapy Trust*
ii South African Parenting Programme Implementors Network
iii Such as 'I listen to my body's signals when it tells me to slow down', 'I take time out each day to do things I enjoy' and 'I maintain social relationships that I value'.

Case 34: Parentline SA

The South African Parenting Programme Implementers Network (SAPPIN) has developed Parentline SA, a WhatsApp-based chatbot adapted from the global Parenting for Lifelong Health digital tools. The chatbot offers a user-friendly support platform for mothers, fathers and caregivers of children from 0 – 18 years. Reliable, bite-size information covering a range of topics is delivered through WhatsApp conversations. Importantly, the app integrates content on both violence against children and violence against women, recognising how these forms of violence intersect in families. Users receive supportive messages on child safety and nurturing care, alongside guidance on building respectful couple relationships and resolving conflict without violence. By weaving these themes into everyday parenting support, the app helps families build safer, more nurturing homes in simple, practical ways.

workforce operating across various sectors. By focusing on prevention, response and promotive services, and by fostering competencies such as trauma-informed care, reflexive and critical thinking, and collaborative practice, South Africa can strengthen its efforts to combat these pervasive challenges. Yet, more needs to be done to support this starting with political commitment to address the intersections of VAC and VAW more comprehensively. Supportive measures including proper planning, adequate resourcing, standardised protocols, trust-building initiatives, comprehensive training, workforce care, technological integration, and robust data collection and accountability mechanisms are essential. Such a holistic approach will ensure that the workforce is not only equipped to respond effectively but also creates an environment where violence against women and children is systematically prevented.

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Illuminating the invisible: The need for multisectoral data and information systems to guide services at the intersection of violence against women and children

Franziska Meinck,[i] Harsha Dayal[ii] and Katharine Hall[iii]

Violence against women (VAW) and violence against children (VAC) are global social justice concerns that have far-reaching consequences across the life-course and place a significant burden on social protection, public health and criminal justice services.

Understanding the intersections of VAC and VAW is critical for accurately diagnosing, preventing and responding to the social dimensions of violence, as it is well established that:

- children who experience violence are more likely to experience and perpetrate violence in adolescence and adulthood;
- child abuse and neglect often co-occur with domestic violence in the home; and
- exposure to violence in childhood increases the likelihood of adults then using violence against their own children.

A 2015 analysis by the South African Medical Research Council (SAMRC) noted that data collection systems on VAC and VAW were immature and that much work would need to be done to establish an effective surveillance system.[1] Many of the conclusions from that report still stand today. The South African National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF) clearly acknowledges the need for integrated information systems that are nationally coordinated and decentralised, for government, researchers and other actors to use.[2] While the NSP-GBVF emphasises that an effective information system is critical for ensuring accountability, the necessary human and financial resources have not been put in place to support the development of an integrated information system. If this accountability mechanism is expected to enable State and non-State actors to monitor the scale of GBVF, track responsive services across sectors and evaluate progress – then it requires every responsible sector to contribute reliable and quality data to the system. The NSP-GBVF presents a 10-year roadmap, and while its focus is on gender-based violence in all its forms, including fatalities for women, the roadmap applies equally to violence against children and to the intersections of VAC and VAW.

This chapter considers what kinds of data are needed and why integrated data systems are important for monitoring the extent and nature of violence against women and children. It discusses why integrated data systems from different sectors are also necessary for enhancing the delivery of prevention and response services. It then considers what data are available in South Africa to support integrated monitoring and responses to VAC and VAW, and how these data systems can be strengthened.

What data do we need?

Data collection, analysis and reporting are key components in preventing and responding to violence against women and children. Any data that are collected on VAC and VAW need to be standardised and accessible, include detail on the relationship between survivor and perpetrator and the type of violence experienced, and be able to be broken down by age and gender of the survivor and the perpetrator. Additional data should also be collected on service provision and utilisation, and factors that increase the risk of experiencing violence (eg family poverty, substance use, crime involvement, poor health or disability) to determine which populations are most affected, identify opportunities for intervention, and plan for services.

There are two main types of data that are helpful in understanding VAC and VAW: i) scientific data which include data from surveys and qualitative studies, and ii) administrative data which includes routine data (eg on the number of users accessing services, and number of facilities) including data from both government and non-governmental organisations.

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Survey data

Survey data, where respondents self-report their experiences of VAC and VAW, or report on behalf of their young children, are essential to establish the prevalence of VAC and VAW, and to monitor and investigate trends. They can also guide prevention and intervention efforts by identifying vulnerable populations and the effectiveness of specific interventions. Regular surveys are a first step to create awareness across all sectors of government and within the population, which is why prevalence measures have been included as indicators of the Sustainable Development Goals.[iv] All States Parties, including South Africa, have committed themselves to reporting regularly against these indicators, which includes collecting, analysing and disseminating data, and sharing this information with stakeholders, including the United Nations and the public.[3]

An example from Kenya shows how repeated surveys can give an indication of trends of VAC: A repeated cross-sectional survey with 13 – 24-year-olds demonstrated a massive decline (from 80% to 56%) between 2010 and 2019 in all types of violence experienced by children, except for sexual harassment among adolescent girls.[4] Factors which contributed to this decline were clear investment by the Kenyan government in a National Action Plan which included children's protection from all forms of violence in the new Kenyan Constitution, increasing the age of marriage from 14 to 18 years, rollout of school enrolment and safe school environments, introducing a cash transfer programme and delivering response, prevention and support services.[4, 5] There was however, little focus on the intersection between VAC and VAW and no surveys investigated VAW over the same period.

Another type of survey is a 'sentinel survey'. Here a survey is carried out with staff of an organisation (eg a non-governmental organisation (NGO), teachers or the Department of Health (DOH)) to seek out cases of VAC and VAW they have encountered in a certain time period; it can also be asked whether these cases were reported to Department of Social Development (DSD) or other services. This can help identify training needs as many child- and healthcare professionals are not trained to identify indicators of VAC and VAW, but it can also give an idea of what the true prevalence might look like, or what services are being provided outside of formal services.

Ideally, any changes in policy and service delivery should be documented alongside repeated surveys in order to attribute change in trends. However, despite their importance in providing more reliable prevalence estimates, identifying training needs and monitoring trends, survey data also have limitations due to memory decay, social desirability bias and recall biases. In addition, very vulnerable populations may not be sampled, remote locations not accessed, questionnaires may not be suitable for those with reading difficulties or sensory impairments, and high mobility can lead to large levels of drop-out in longitudinal surveys, all potentially introducing bias.

Glossary

Prevalence: The number of people who have experienced VAC and/or VAW in a population at the point of measurement.

Data systems integration: The process of combining data from a number of independent sources to eliminate data silos.

Database linkage: The process of joining datasets together so we can make as much use of the information each one contains without having to repeat it across all datasets. It means bringing together the information that we hold about each person in each dataset in order to create one larger dataset with a lot of information on each of the people in the dataset.

Sentinel survey: A method where, for example, trained professionals (sentinels) from various fields such as family doctors, teachers, early years practitioners report cases of child abuse and neglect they encounter. These surveys are then conducted at regular intervals and are combined with child protection data to give a more complete picture of the prevalence across a country.

Repeated survey: Sometimes also called serial health survey. These cross-sectional studies are repeated every few years. Collecting data from different samples of the same population at multiple time points allows us to identify trends or changes over time. Repeated cross-sectional studies are easier to carry out in nationally representative samples and are more cost effective than **longitudinal studies,** where the same population is followed up every few years. An example of a serial health survey in South Africa is the Demographic Health Survey.

iv SDG indicator 16.2.3: Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18. SDG indicators 5.2.1: Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age. SDG indicator 5.2.2: Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence.

Qualitative data

Qualitative research focuses on qualities, characteristics, and concepts rather than numbers. Qualitative data can assist in understanding the why and how, and the experiences of those affected by violence. Qualitative data in VAC and VAW research are essential to track the impact of interventions that have been delivered, understand the quality of services and programmes from the viewpoint of service users and service deliverers, to understand pathways and to conduct process evaluations. Quantitative data can only tell us who has received these interventions, but do not tell us what people liked or didn't like about a service, what the barriers were for them returning to use the service, whether it had an impact in their lives and how their lives changed because of the service, or not.

Practitioners can voice concerns about how practical the service delivery is, where they had gaps in understanding how to deliver the service, and how much this added to their normal workload. A process evaluation then looks at whether all elements of the service were delivered, if everyone attended all sessions, and how the service was delivered (eg was it non-judgmental, was participation good?). An example of a process evaluation of the Parenting for Lifelong Health Teen Programme in South Africa shows that participants felt their parenting practices changed due to creation of an environment that was mutually respectful and conducive to learning alternative forms of discipline.[6]

Administrative data

Administrative data is routinely collected and reported from various sectors eg health, education, police, judicial and social services. Since administrative data are collected on a daily basis, via information captured from users when accessing services, they are also referred to as "routine data". These sources provide data that are collected on a continuous basis, such as information on beneficiaries that departments collect for targeted and responsive interventions. Although these data are collected continuously, processing them and reporting on them usually occurs only periodically – for instance, cases of VAC and VAW are aggregated monthly and reported on. These types of data help providers understand which cases and types of VAC and VAW are identified, known to, and addressed by, services. If managed well and made available for research use and analysis, routine data has far-reaching positive outcomes for each sector.

Administrative data can be analysed to show the prevalence and nature of reported cases of VAC and VAW, and also provide a basis for planning services to improve the location and access to public resources. Several different government departments gather data on sector specific services, in response to violence against children or women detected within their domains:

- South African Police Service (SAPS) – crime statistics, sexual offences against women and children by age and gender, perpetrator, including domestic violence
- Department of Health – hospital and clinic data on injuries, sexual assault, mental health, mortality and also the support services actually provided to survivors. The District Health Information System is the most comprehensive information system for health.
- Department of Social Development – child protection registers (part A and B under the Children's Act)
- Department of Basic Education (DBE) – school safety audits, annual survey data on bullying, corporal punishment and school-based violence
- Department of Justice and Constitutional Development (DOJCD) – domestic violence, protection orders, shelters, court records on cases involving child abuse, neglect, trafficking, sexual offences.
- Department of Correctional services – convicted perpetrators and the National Register of Sex Offenders (NSRO) through SAPS.

Administrative data can also stem from the administrative records of NGOs and community-based organisations. For example, Childline collects data on the number of children and adults who call the hotline in a given time period, the distribution across provinces, the reasons for calling, the number of services provided, and the frequency of engagement with service users.

Administrative data are therefore important for informing and tracking reported cases and for mobilising the necessary resources to provide responsive services to individuals and their families. They can enable assessment of i) whether reported cases are increasing or decreasing, and ii) whether the help provided is appropriate for the reported situation and reaches those who need it. Without adequate tracking, it is not possible to monitor these services and the responsiveness of the system. Administrative data can also be used to flag women and children at particular risk, eg where a police protection order is in place for a woman due to domestic abuse, any linked children could be flagged for assessment. A more proactive, efficient and integrated service response may encourage higher levels of reporting.

The main limitation of administrative data is that its usefulness depends on the quality and completeness of the data collected. Routine data systems are difficult to change once institutionalised, as any change limits comparability of data. Also, administrative data systems should ideally span a

Case 35: The Child Death Review – a collaborative case management system

Shanaaz Mathews[i]

In 2009, the child homicide study estimated South Africa's child homicide rate as 5.5 /100 000 children, more than double the global average.[28] Just under half (44.6%) of child murders were related to fatal child maltreatment.[28] Moreover, child murders were poorly investigated by the police and the lack of coordination between health, police and social services compromised the management and investigative outcomes of child maltreatment deaths allowing perpetrators to 'get away with murder'.[29]

To improve the response, a child death review (CDR) pilot was established.[30] CDR teams are comprised of forensic pathologists, one of whom leads the process, district pediatricians, public health specialists, child protection specialists, police and prosecutors. They meet monthly to review all child deaths that were subject to a medical legal autopsy. Each member brings their own records – medical, forensic, police and social – and shares information as required.

The team does not use integrated case management software or have a dedicated database. The Western Cape Department of Health is in the process of developing a secure platform to host all relevant case information, as well as post-mortem data captured through autopsies. Currently, information, including all the relevant case numbers, is captured on an Excel spreadsheet and held by the lead. The confidential nature of cases requires discretion and the development of clear roles, responsibilities and protocols that can work across different agencies.

A process evaluation found that the CDR pilot strengthened intersectoral collaboration and joint decision making. This helped ensure that all child deaths were appropriately investigated in order to determine the cause of death, identify modifiable risk factors. This information was then used to strengthen systems and accountability – particularly in the case of child maltreatment fatalities – as all agencies have a child abuse mandate.[31] For example, cases identified through the CDR alerted the Department of Social Development to failures by their social work teams and prompted in-service training to ensure that child protection social workers addressed the risks identified by the CDR process in their assessments of child protection cases.

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range of different government departments (eg health, social services, police, justice), to ensure the effective monitoring, referral and tracking of cases, but the systems may be set up separately, limiting possibilities for interoperability through shared platforms.

Data systems that collect regular, high-quality data are needed for adequate monitoring and surveillance, and for identifying prevalence, reporting, access and quality of services, and the links between violence against women and children. Several efforts are underway in South Africa to improve data collection in order to better guide violence prevention interventions targeted at women and children.[7, 8] However, at present, administrative data collection is hampered by the quality and disparity of indicators collected, as is survey data, and while data may be routinely collected, not all organisations routinely report it.

Why are integrated data systems important for VAC and VAW?

To truly understand the intersections between VAC and VAW it is necessary to have data systems that are integrated across relevant sectors, that link data on children and women within a household, and that are consistently maintained and interrogated to make sense of trends and dynamics.

Most commonly, when we speak about integration of data systems, we refer to integration of different administrative data systems. Data collected in criminal justice, for example, may be linked with data from health, education and social development. At a very basic level it could identify numbers of children who might be at risk, ie those whose mothers/caregivers have domestic abuse protection orders, or who were seen by health services for serious injuries likely in relation to domestic abuse, or the numbers of children whose fathers have committed sexual offences.

Integration of self-report survey data with administrative data can offer other important insights on spatial disparities, inequities between social groups and the type of interventions needed. Linking self-reported and administrative data helps in identifying the characteristics of victims and their households, access to services, and hidden cases where no services have been taken up – such as the 80% of children in the Western Cape and Mpumalanga who had experienced sexual abuse or

frequent physical or emotional abuse and never disclosed to anyone,[9] or the 60% of survivors of intimate partner violence (IPV) who never sought help.[10] Sentinel surveys can also be integrated with administrative data to highlight the number of suspected cases of VAC and VAW in a specific setting versus the number actually reported to SAPS.

In South Africa, the possibilities for integration of survey and administrative data are demonstrated by the ground-breaking femicide and child homicide studies.[11, 12] Non-natural deaths were identified through death registries and scrutiny of autopsy reports, and then combined with data on the nature of the crime, extracted from police dockets. These data and the resulting findings can then be used to strengthen existing systems in line with those that emerged from the South African Child Death Review[13] (see Case 35 on p. 165).

Integrated data can therefore make it possible to identify individuals and track the services they receive, as well as to understand which geographic areas or sections of the population need to be targeted for service delivery. It can be used to strengthen the targeting, delivery and timing of prevention programmes. An integrated and well-maintained data system also allows investigation of long-term outcomes of child abuse and neglect and violence against women within the population.[14, 15] However, data systems informing VAW and VAC are currently not interconnected in South Africa, creating a large gap in our understanding of survivor and perpetrator profiles and of what support families need to address both VAC and VAW. The integration of data systems also requires careful thought about the ethical aspects of such an approach and consideration of how to do this without violation of the Protection of Private Information Act (POPIA).

International case studies on integrated data systems informing VAC and VAW provide useful lessons. In Denmark, the civil registration number (equivalent to the South African ID number) is used to access all government systems and services.[16] With this number, each resident's data from various Danish registers can be linked eg children, crime, mortality, births, pensions, education, benefits or health, allowing for analysis at the population level and combination with survey data. Data are completely anonymised by Statistics Denmark which also carries out many of the linking processes.[17] Such an approach requires completeness of birth registration, something that has remained elusive in South Africa and which would need to be prioritised for data systems to be linked comprehensively through ID numbers. In August 2025, the Minister of Health (previously Minister of Home Affairs) stated that civil registration records stood at 89%, meaning that about 11% of South Africans, around 6 million people, are unregistered.[18]

What data do we have to support monitoring and integrated service delivery for VAC and VAW in South Africa?

Understanding what data exists for planning, monitoring and evaluating specific interventions targeted at the prevention of violence against women and children, requires a broader mapping of the type of violence (as the main problem identified through an effective and proactive surveillance system); related primary data source; responsible agency; data description (frequency of collection, variables, who collects) and accessibility protocols. This broad framework was initiated in 2024 by pillar 6 (research and information systems) of the National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF), which includes children and aims to develop effective data collection and management systems. The NSP-GBVF framework is further aligned to a set of indicators in the Medium-Term Development Plan of Government, which will monitor each department's progress in achieving its goals (currently 2025 – 2030). There is, however, no basic set of indicators available in the children's sector (including state and non-state actors), which could serve as an effective monitoring system for VAC in South Africa.

Survey data

The only available survey datasets in South Africa, focussed on child respondents, are the Optimus Survey of 2016[19] which collected data on different types of VAC as well as exposure to family violence, and the National School Violence Study from 2012 which collected data on different types of VAC in the school environment and online.[20] All other surveys use reporting of populations aged 15 or older with a predominant focus on VAW. Where adults are asked about VAC, it is either to report their own experience retrospectively, to report someone else's experience within the household in the past five years, or to report on the disciplining methods they employ with their children. These proxy-reports are less reliable as those carrying out the abuse may be less willing to report it, and they might not know of everyone else's violence experience in a context with low levels of disclosure. This means that these surveys are unable to estimate the true prevalence of the intersections of VAC and VAW in South Africa. Table 14 provides a summary of survey data available on VAC and VAW in South Africa.

The First South African National Gender-Based Violence Study was conducted by the Human Sciences Research Council (HSRC) in 2022. This provided the first clear estimate of the link between VAW and VAC prevalence. Of the women who reported lifetime physical IPV victimisation, many also reported experiencing childhood trauma before the age of 15 years.

Table 14: Available survey data on VAC and VAW in South Africa

Title	Year	Respondents	Types of VAC and VAW measured
Child Abuse and neglect related homicides	2009, 2019	Survey of medico-legal laboratories with autopsy reports of child murders and police interviews	• Child homicides related to abuse and neglect
Demographic and Health Survey	1998	Women aged 15 – 49, adults aged 15+	• Physical IPV • Economic IPV • Sexual Violence • Child sexual abuse
Demographic and Health Survey	2003	Women aged 15 – 49, adults aged 15+, men aged 15 – 59	• Assault • Physical IPV
Demographic and Health Survey	2016	Women aged 15 – 49, women aged 18+ module on domestic violence	• Physical punishment of children • Physical abuse of children • Physical IPV • Emotional IPV • Sexual IPV • Coercive control • Economic IPV • Forced intercourse
Femicide Survey	1999, 2009, 2017	Survey of medico-legal laboratories with autopsy reports of murders and police interviews	• Murder of women by an intimate partner • Murder of women by a non-partner • Suspected rape murder
First South African National Gender-Based Violence Study, HSRC	2022	Men and women aged 18 years+	• Physical IPV • Sexual IPV • Emotional IPV • Controlling behaviours • Economic IPV • Non-partner sexual violence • Childhood physical abuse • Childhood emotional abuse • Childhood sexual abuse • Childhood witnessing DV
Governance, Public Safety and Justice Survey	2018/19 2019/20 2020/21 2022/23 2023/24 2024/25	One participant aged 16+ provides information on behalf of all household members for the past five years or in relation to their or someone else's childhood. The responses are recorded at household (not individual) level.	• Physical punishment in school • Psychological violence in schools • Sexual abuse in schools • Bullying • Physical abuse • Emotional abuse • Sexual abuse • Neglect • Witnessing domestic abuse • Murder • Sexual offences • Intimate partner violence
Optimus Study on child abuse, violence and neglect in South Africa	2014	15 – 17-year-olds recruited from schools and households	• Child sexual abuse contact and non-contact • Child sexual abuse related to gangs and animals • Sexual harassment • Child neglect • Child physical abuse • Child emotional abuse • Exposure to family violence – violence exposure within the home eg caregivers hurting siblings, domestic abuse between caregivers
Victims of Crime Survey (replaced by Governance, Public Safety and Justice Survey)	1998, 2003, 2011, 2012, 2013/14 2014/15 2015/16 2016/17 2017/18	One participant aged 16+ provides information on behalf of all household members	• Sexual offence • Assault • Murder

Nearly half had experienced sexual abuse, 38% had experienced emotional abuse, 32% had been exposed to domestic violence and 29% experienced physical violence as a child.[21]

There are also a number of non-representative data collection efforts specifically focused on the intersections between VAC and VAW. The Birth to Twenty Plus cohort study in Soweto measures both VAC and children's experiences of IPV longitudinally, and across two generations.[22] The INTERRUPT_VIOLENCE study, measures exposure to IPV and childhood abuse as well as other types of violence across three generations.[23] Fediša Modikologo investigates determinants of femicide and the intergenerational cycling of violence by interviewing women who have experienced severe IPV and a subsample of their children, recruited through non-governmental and governmental services and through participant chain referral, and linking them to the national death database.[24]

Comparability of findings between these surveys is challenging due to differences in the ways in which different types of violence are defined, and the age cut-offs across, and sometimes even within studies. For example, in the HSRC study, measurement of abuse in childhood for girls included only incidents in the family until age 15, while for boys it included experiences of abuse in and outside of the home until age 18.[21] Particularly problematic and overlapping across these surveys are the concepts of sexual IPV, sexual abuse and sexual assaults.

Statistics South Africa has conducted annual Victim of Crime surveys since 2011.[v] This collects self-reported data on a wide range of crimes. Those relevant to VAC and VAW include sexual offence, assault and murder. Unfortunately, the data are collected at household level, so are not useful for estimating prevalence, developing a profile of the affected individuals or determining the co-occurrence of violence against women and children within the same household. In the 2024/25 survey, 34,000 households (when weighted) reported instances of sexual offence in the past 12 months, which when multiplied by the number of individuals reported to be affected within each household, produced an estimate of 50,000 individual cases – lower than the number reported to SAPS. The survey also asked (at household level) how many of the households which declared incidents of sexual violence reported all or some of those incidents to the police. Less than half said they had done so.[25] This suggests that the Governance, Public Safety and Justice Survey is likely to under-count sexual violence, and that, even within this under-count, most cases of sexual violence are not reported to SAPS.

Integrated administrative data

Within South Africa, an integrated system is being developed to improve the management and coordination of protection services across the 'social cluster'.[vi] The National Integrated Social Protection Information System (NISPIS) is an electronic information platform comprising of data from DSD, DOH, DBE, Department of Higher Education and Department of Home Affairs (DHA) that are working towards an IT-supported data sharing platform for integrated reporting. It presents the highest decision-making authority of Government in order to strengthen the targeting, planning, coordination, monitoring and evaluation of social protection services.[vii] The intention is to integrate the overarching NISPIS platform with other administrative data systems. These include the Social Development Integrated Case Management System (SDICMS), an internal DSD system that links data from different social services from the public sector and organisations working with civil society. The SDICMS in turn draws on over 15 different databases, including foster care, child protection and gender-based violence registers and the victim empowerment programme.

NISPIS aims to incorporate all these components, together with social assistance data (from SASSA) and data systems from other departments such as Health, Home Affairs, Basic Education, Higher Education, Labour and Cooperative Governance & Traditional Affairs. The potential of an overarching data platform such as NISPIS is promising, but there are numerous challenges that need to be overcome before it is functional as an integrated case management monitoring tool and as a data source. For example, the integrated system relies on an ID number as the primary linking mechanism, but some people do not have an ID number. Some of the subsidiary data systems are not yet fit for purpose. For example, the Victim Empowerment Programme (VEP) database is a register of victims of crime and violence and the services that victims receive. But the VEP encompasses many different processes (the survivor may have to go to hospital, and/or to the courts) and some of these areas are not yet integrated into the system.

The linked NISPIS system is being developed in a phased approach. DSD has the mandate for leading and sharing information. The underlying memorandum of understanding was eventually signed by all but one of the key government departments in July 2024. There are compatibility challenges

v The survey was modified and renamed the Governance, Public Safety and Justice Survey from 2018
vi The social cluster is one of five structures within the South African Cabinet cluster system to support horizontal integration across line function departments.
vii Very little information about NISPIS is publicly available. Much of this section draws on information provided in a meeting between the authors and DSD officials responsible for developing and managing the integrated systems. The DSD team were invited to review this section before publication.

Case 36: Western Cape Department of Social Development – Social work integrated management system

Jaco Londt[i]

Social workers have a high administrative burden when it comes to maintaining client records, writing and filing process notes, managing regular reporting and filling in various social work reports. To reduce the administrative workload and enhance efficiency, the Western Cape Department of Social Development (DSD) developed the Social Work Integrated Management System application (SWIMS app), in partnership with the Department of the Premier's Centre for e-Innovation.

It went live in April 2024 and is currently being used by over 1,100 social workers from the department. DSD has made additional resources available for the further rollout of this system to other government departments and the non-governmental organisations (NGOs). Thus far, 58 social workers from two designated child protection organisations have been trained to use the system. The Western Cape Education Department's social workers have also begun utilising the system.

This system digitises client files and reduces administrative tasks for social workers thereby enabling more contact time with clients, as well as improving compliance with regulatory frameworks and norms and standards. It also minimises the risk of cases slipping through the cracks and strengthens referral pathways between government departments and NGOs.

SWIMS allows social workers to capture forms including process notes and assessments. It also makes provision to upload court documents and complete Form 22s. It keeps a diary to track progress including return dates and court dates to ensure clients receive follow-up care. It encourages social workers to upload data for the whole family/household and should therefore make it easier to identify and support children exposed to domestic violence. The electronic system flags cases and families already known to the system to avoid duplication, and it enables intra-departmental case management so that services can follow the family from one office to another if they move. All this data is also accessible to supervisors so that they can more easily monitor and support social workers and address any gaps in care.

The department will continue to enhance SWIMS and expand its reach. This includes plans to integrate SWIMS with national DSD's Information Case Management System (SDICMS). This should further streamline and reduce the administrative burden of social workers.

i Western Cape Minister of Social Development.

arising from the fact that different departments (and even provinces) use different data platforms. The system only integrates services that are digitised, but not all services are digitised – for example, many social workers still work with paper files. Some of the more remote offices are not digitally connected at all, and there is a need for additional equipment, connectivity and training, all of which will take time and resources. The social work integrated management system in the Western Cape seems a good approach in digitising service user files and reducing administrative work load while ensuring children do not fall through the cracks (see Case 36). While most of the SDICMS components are operational, the integrated system remains far from being comprehensive and it will be some time before either SDICMS or NISPIS can support high-level monitoring of targets and service delivery, or the harvesting of data for research purposes. At present, for example, there are no available data on the extent, management and types of services rendered in respect of reported cases of VAC or VAW. There were plans to begin using NISPIS as a data set in the 2025/26 financial year, but numerous technical challenges still need to be resolved, and questions of confidentiality and POPIA compliance still need to be navigated.

There has been significant investment in strengthening surveillance and monitoring systems in social protection, health and basic education. Some departments release their own data regularly (eg SAPS crime statistics, DBE learner pregnancy, and DHA birth and death registration), yet where they relate to violence they are often not broken down by age and gender, nor do they include types eg police or health reports of child abuse and neglect. Recently, SAPS have entered into an agreement to transfer their data to Statistics South Africa (Stats SA) for analysis and dissemination, and this has resulted in more detailed reporting on different types of crime, disaggregated for children.

Stats SA's "Child Series Volume III", published in 2024, provides trends in reported violent crimes against children over a 13-year period including rape, sexual assault, attempted murder, murder, assault with grievous bodily harm and

common assault (see Figure 30). The numbers suggest an overall decline in reported cases of assault and child rape up to 2021/22 (despite slight growth of the child population over the same period), and a slight increase in reported cases in the outer year.

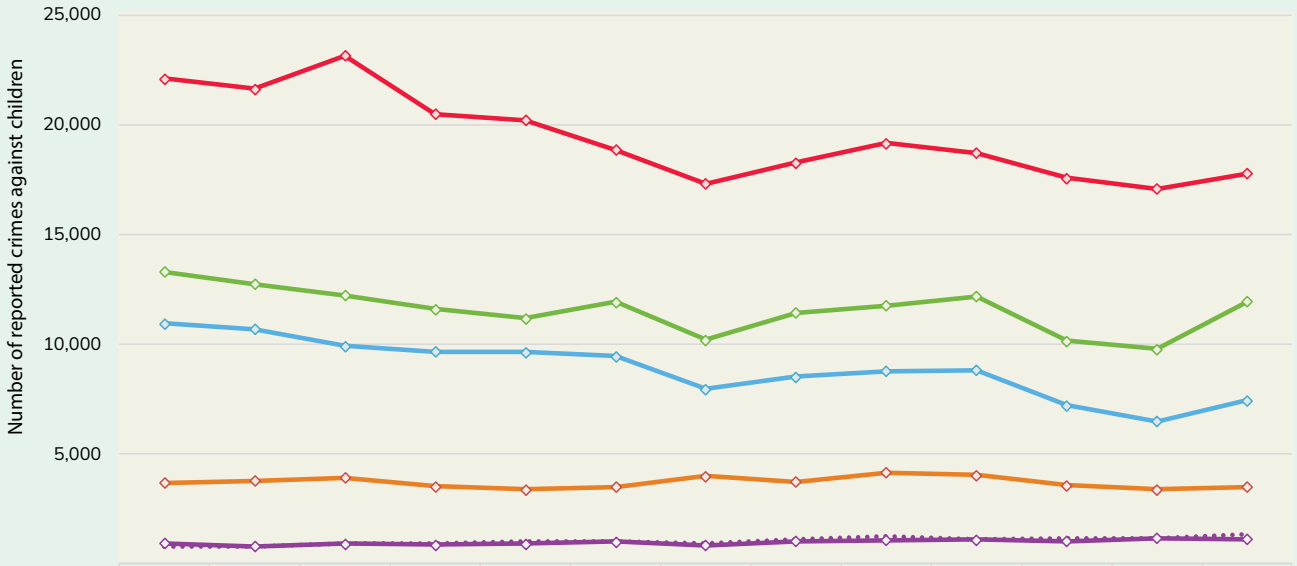
When compared with total reporting (including adults) over a 12-year period from 2010, around 40% of all reported sexual assault cases were children. In 2022/23 a total of 21,313 child sexual offences were reported.[26] Also striking is that of these, 17,800 were cases of rape while just 3,513 were sexual assault. This suggests that sexual assault is massively under-reported to SAPS.

These statistics are not prevalence statistics as they only reflect crimes that were reported to, and captured by, SAPS. This might explain why there are fewer reported cases of sexual abuse than there are of rape, where the physical impact on the child may be more obvious. Similarly, while it is likely that the vast majority of murders are reported, attempted murder is more likely to be under-reported, especially if perpetrated within the family, and this may explain why the numbers for reported attempted murder are as low as those for murder. These statistics are reported to the public only at national level so provide national trends in reported crime. However, SAPS have over the past 10 years started to use their own data to identify crime hotspots in need of service intervention demonstrating the benefits of quality data collection and regular analysis. Other statistics like child protection registration are not published and potentially never analysed, despite the intention of using this data to protect these children from further harm, monitor their cases and access to services, determine trends, and use this information to guide the planning and budgeting of services.[27]

The Integrated Justice System (IJS) is led by the DOJCD, but also includes SAPS, Department of Correctional Services and the National Prosecuting Authority. It represents an integrated platform under development that links the social and criminal justice clusters with the aim of strengthening the investigation of crimes, prosecution and rehabilitation of offenders. The criminal justice system has begun to invest significantly in strengthening their information system, with the development of the 'Femicide Watch' as the most integrated and comprehensive repository that includes data from police services, social development and justice department. This initiative is in response to civil society demands and international pressure by UN agencies to intervene more effectively in addressing the high incidence of VAW in South Africa.

While linked data systems are important for integrated case management in reported cases of violence and abuse, any composite system is only as effective as the quality and

Figure 30: Reported crime against children, 2010/11 – 2022/23



2010/11	2011/12	2023/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
22,114	21,641	23,155	20,502	20,219	18,876	17,336	18,290	19,167	18,726	17,586	17,084	17,800
13,318	12,744	12,243	11,614	11,177	11,927	10,212	11,451	11,773	12,189	10,149	9,776	11,964
10,954	10,705	9,936	9,659	9,635	9,447	7,956	8,521	8,784	8,838	7,215	6,500	7,454
3,700	3,778	3,920	3,521	3,394	3,509	3,986	3,748	4,154	4,031	3,569	3,380	3,513
763	762	918	922	1,003	1,035	915	1,108	1,274	1,109	1,160	1,172	1,360
932	804	909	867	917	1,009	846	1,031	1,086	1,091	1,031	1,160	1,129

Source: Statistics South Africa. *Child Series Volume III: Reported crime against children 2022/23.* Pretoria. Stats SA. 2024.

completeness of its parts. The Optimus Study noted that 18,000 – 20,000 cases of child sexual abuse were reported to the police each year, and that over 60,000 sexual offences cases (including adults and children) were reported to the police in 2013/2014 alone. Yet only 7 – 11% of cases are estimated to be reported – a number that would need to be tested through high quality and nationally representative survey data.[19]

Thuthuzela Care Centres (TCC) are a promising development in integrated, holistic and survivor-centred service delivery at the local level with more than 65 centres across South Africa. This intervention was established by the National Prosecution Authority (NPA), Sexual Offences and Community Affairs Unit in 2006 in order to comprehensively respond to the needs of survivors of sexual assault (including children), with DOH, SAPS and DSD providing integrated services through public health facilities to facilitate easy access. However, the potential for TCCs to be used as a data source for effective monitoring and evaluation of services has yet to be recognised.

Conclusion and recommendations

South Africa has a clear need for research and information systems informing prevention and response to VAW and VAC. This is set out in pillar six of the NSP-GBVF where integrated data collection methods are highlighted as needed to address the intersectional nature of VAW and VAC. Some progress has been made in the digitalisation of administrative data sources in specific sectors, however, to date no basic set of indicators has been developed by the children's sector which could form the basis of an effective monitoring system for VAC. Where data systems have been set up, it is difficult to understand what data they collect and how they function, as there is no publicly available information on this. These challenges lead to poor quality data, difficulty in identifying data gaps and incomplete information that would be vital for routine monitoring. Data on VAW currently exists from health, criminal justice, police and correctional service as well as surveys. Data on VAC is currently only reported through SAPS and some survey data. None of the survey data is linked to administrative data. While one survey reports on the intersections between VAC and VAW, none of the administrative data can currently do this, as there is no linkage between data of women's victimisation or male perpetration of violence to identify children at risk.

Further, plans to integrate data from different sectors are nebulous at best and aim to link on ID numbers, thereby excluding those most vulnerable who currently do not have birth registration. There are also no accessible plans on how data will be collected, how they will be linked and made accessible, and no plans for an analytic unit which would have the skill set and capacity to make sure data are analysed and results interpreted correctly.

Data collection systems informing VAC and VAW should be transparent, paying clear attention to which data are needed, what data are being collected, how and by whom data will be curated, and how they will be made accessible. There is a clear need to identify different levels of coordinated structures at sub-national levels to integrate data and carry out comprehensive analyses to support evidence-informed decision making, enhance service delivery and target the most vulnerable population groups.

Intersections between VAC and VAW often occur because caregivers, who were themselves survivors of violence and abuse, have not received therapeutic and post-violence support. These intersections between VAC and VAW help clarify why effective data systems matter on the ground, and where they can add value beyond academic research, by intervening in social systems to break the cycle of violence through targeted programmes and services.

Recommendations

- Global definitions of child abuse need to be agreed in surveys to ensure comparability of measures and data, and both VAC and VAW measurement have to be included.
- Self-report prevalence surveys (including measurement of VAC and VAW together) need to be conducted at least every 10 years using the exact same measurement to allow comparability of data and monitoring of trends.
- Sentinel surveys should be explored as they have the potential to save resources, compared to repeated self-report prevalence surveys.
- With regards to administrative data, a basic set of indicators needs to be agreed by the different sectors to allow monitoring. Type of violence, age and gender of survivor and relationship to perpetrator as well as identifier should be measured across all data sources, while other indicators can be specific to the respective data sources. Additional indicators should relate to agreed individual or family circumstances of victim or perpetrator (depending on the data source), as well as services received.
- Once indicators are agreed, data entry systems need to be set up in a way that is easy to understand and navigate by staff with the responsibility to enter this data and all service providers need to receive training on how to collect and record this data, particularly where the focus is shifting from a narrow focus on survivors of VAW to also assess children in their care. This might require adjustments to assessment procedures within services.

- Administrative data capture should include reference to geolocation or place names to enable spatial analysis at district level or lower. When analysed, this could inform the targeting of preventative, responsive and supportive services.
- Staff who are responsible for data management within departments need to be capacitated to provide support to staff on the ground inputting the data, and need to be able to monitor and conduct quality checks on data received in addition to being able to compile regular reports on the data they are collecting.
- A national centre needs to be set up and trained in linking administrative datasets with each other and with survey data including the capacity to analyse and interpret these data to provide regular monitoring reports.
- If ID numbers are used for data linkage, then greater efforts are needed to address gaps in birth registration. Since it is unlikely that South Africa will achieve complete birth registration in the foreseeable future, and given that individuals without birth certificates or ID are likely to be among the most vulnerable, data systems need to make allowance for alternative methods of identification and tracking (such as the "quad 7" number system used by the South African Social Security Agency for grant beneficiaries without ID numbers).
- Clear and transparent reporting is necessary to enable scrutiny of how systems will be linked, which data they will contain and where data quality issues are present.
- DSD needs to work towards the analysis and routine reporting of data linked through NISPIS including how they are used to inform service delivery.

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Part 3

Children Count – the numbers

Part three presents a set of key indicators and disaggregates data to make visible inequalities in children's health, education, nutrition, living conditions and access to services. The indicators track progress in the following domains:

- Demography of South Africa's children
- Income poverty, unemployment and social grants
- Child health and nutrition
- Education
- Housing
- Basic services

A full set of indicators and detailed commentaries are available on www.childrencount.uct.ac.za

The Children Count project helps make the situation of children visible within national and provincial data sets. In the same way, the entrance of Mitchell's Plain hospital clearly communicates that women and children are valued and welcome here. Artist: Lovell Freidman.

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, which includes provisions to ensure that no person should be without the basic necessities of life. These are specified in the Bill of Rights, particularly section 26 (access to adequate housing); section 27 (healthcare, 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 healthcare services and social services. While children's socio-economic 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 issues. 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 the standard way for statistics bodies to present national data but 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 themes covered under socio-economic rights. As new data become available with the release of national surveys and other data sources, it is possible to track changes in the conditions of children and their access to services over time. This year, national survey data are presented for each year from 2002 to 2024, and many of the indicators in this issue compare the situation of children over this 23-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 the consequent lockdown.

In 2020 and 2021 the survey was conducted telephonically with a smaller sample of just under 30,000 individuals in 9,000 households, and some of the questions usually analysed for *Children Count* were excluded – notably the time taken to get to school and to health facilities The GHS returned to its full face-to-face sample in 2022.

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 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 (I).

Data sources and citations

Children Count uses a few data sources. Most of the indicators are analysed by our team using data from the GHS, 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, strengths and limitations of each are outlined on the project website. Here are examples of how to reference *Children Count* data correctly:

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

> Hall K (2025) Demography of South Africa's children. In: Jamieson L, Mathews S, Machisa M, Lake L (eds) *South African Child Gauge 2025*. Cape Town: Children's Institute, University of Cape Town.

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

> Hall K (2025) Housing and Services – Access to adequate water. *Children Count* website, Children's Institute, University of Cape Town. Accessed on 15 September 2025: childrencount.uct.ac.za

Each domain is introduced below, and key findings are highlighted.

Demography of South Africa's children

(pages 178 – 183)

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. Weighted numbers from the GHS suggest that there were 21 million children in South Africa in 2024 and 19% of children do not live with either of their biological parents. This does not necessarily mean that they are orphaned: 81% of children who do not have any co-resident parent do have a living mother, and 90% of children without any co-resident parents have at least one parent who is alive but living elsewhere.

Income poverty, unemployment and social grants

(pages 184 – 191)

Child poverty rates increased during lockdown and then levelled off in 2021, before increasing again in most provinces in 2022 and remaining at that higher level in 2023 and 2024 with 68% of children living below the upper-bound poverty line. Social assistance grants are an important source of income support for caregivers to meet children's basic needs and to protect children and their households from income shocks. In March 2025, just over 13 million children received the Child Support Grant (a slight drop from the previous year); 225,000 children received the Foster Child Grant (a substantial and consistent decline in numbers over the past decade), and there has been a gradual but consistent increase in access to the Care Dependency Grant with about 175,000 child beneficiaries in 2025.

Child health and nutrition

(pages 192 – 201)

In 2024, 2.5 million children (14%) lived in households where children are reported to experience hunger; 19% of children lived far from the primary healthcare facility they normally use; and in 2023 83% of infants were fully immunised in their first year of life. Infant and under-five mortality rates peaked in 2003 and then fell sharply following the rollout of the prevention of mother-to-child transmission programme. Child mortality rates dropped sharply during the COVID-19 pandemic, but preliminary estimates suggest that they then rose again to above pre-COVID levels. In 2023, the estimated infant mortality rate was 29 deaths per 1,000 live births and under-five mortality was estimated at 35 deaths per 1,000 live births.

Children's access to education

(pages 202 – 210)

South Africa has high rates of school attendance, with a reported attendance rate of 97% among children aged 7 – 17 in 2024. In the same year, 91% of 5 – 6-year-olds were reported to be attending early learning programmes. Attendance rates do not necessarily translate into improved educational outcomes or progress through school, and school attendance does not necessarily mean that young people will able to continue their education or get jobs. In 2024, a third of young people aged 15 – 24 (36%) were not in employment, education or training. South Africa has failed to make any progress toward the Sustainable Development Goal target of substantially reducing the proportion of youth not in employment, education or training by 2030.

Children's access to housing

(pages 211 – 214)

In 2024, 58% of children were living in urban areas, and 86% of children lived in formal housing. In 2024, nearly 1.6 million children (7% of the child population in South Africa) lived in informal housing – in backyard shacks or informal settlements. There were 3.7 million children living in overcrowded households, representing 17% of the child population – much higher than the share of adults living in crowded conditions (10%).

Children's access to basic services

(pages 215 – 218)

Without water and sanitation, children face substantial health risks that also compromise their nutritional status. In 2024, 73% of children had piped drinking water at home, and 79% have an adequate toilet on site.

Demography of South Africa's children

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

The United Nations (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 2022, South Africa's total population was estimated at 62 million people.[2] The 2024 General Household Survey (GHS), when weighted, produced an estimate of 63 million, of whom 21 million were children under 18 years. Children make up 33% 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 45% of all children in South Africa, compared with 37% of adults. Gauteng, the smallest province in terms of physical size, has overtaken KwaZulu-Natal to become the province with the largest child population: 23% of all children in the country live in Gauteng. Gauteng also has the largest share of the adult population (29%) and the largest share of households. The child population of Gauteng has grown by 63% 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 14%) while the number of children living in the Western Cape has risen by 33%. 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 richest 20%, although there is substantial inequality even within this upper quintile group. Children are concentrated in poorer households, with 64% of children living in the poorest 40% of households (the poorest two quintiles), compared with 45% 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 GHS, which is conducted annually by Statistics South Africa (Stats SA). The GHS usually collects data on about 20,000 households and over 70,000 individuals, though in 2020 and 2021 the survey was

Table 1a: Distribution of households, adults and children in South Africa, by province, 2024

PROVINCE	HOUSEHOLDS		ADULTS		CHILDREN		
	N	%	N	%	N	%	% change 2002 - 2024
Eastern Cape	1,780,000	9%	4,028,000	10%	2,505,000	12%	-14%
Free State	1,024,000	5%	2,012,000	5%	1,041,000	5%	4%
Gauteng	5,981,000	31%	12,246,000	29%	4,777,000	23%	63%
KwaZulu-Natal	3,387,000	17%	7,751,000	18%	4,346,000	21%	5%
Limpopo	1,822,000	9%	3,769,000	9%	2,529,000	12%	4%
Mpumalanga	1,542,000	8%	3,225,000	8%	1,794,000	9%	18%
North West	1,432,000	7%	2,888,000	7%	1,439,000	7%	24%
Northern Cape	388,000	2%	878,000	2%	444,000	2%	12%
Western Cape	2,195,000	11%	5,373,000	13%	2,136,000	10%	33%
South Africa	19,551,000	100%	42,170,000	100%	21,009,000	100%	16%

Source: Statistics South Africa (2025) *General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

conducted telephonically with a smaller sample of just under 30,000 individuals in 9,000 households. The GHS returned to its full face-to-face sample from 2022. The population numbers derived from the survey are weighted to the mid-year population estimates using weights provided by Stats SA. Using previously weighted data (the 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, Stats SA 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. The same population model was used to weight the data from 2018 onwards. Based on the revised weights it appears that the child population has grown by 16%, increasing from 18.1 million in 2002 to 21 million in 2024.

The 2017 mid-year population model, used for weighting the GHS data, is known to be out of date. Any population numbers derived from the GHS (including those in the table below and throughout this publication) should therefore be regarded with some caution. Indeed, there is general uncertainty about population numbers in South Africa, following a substantial under-count in the 2022 Census (especially among young children) and concerns about adjustments to correct for this.[5]

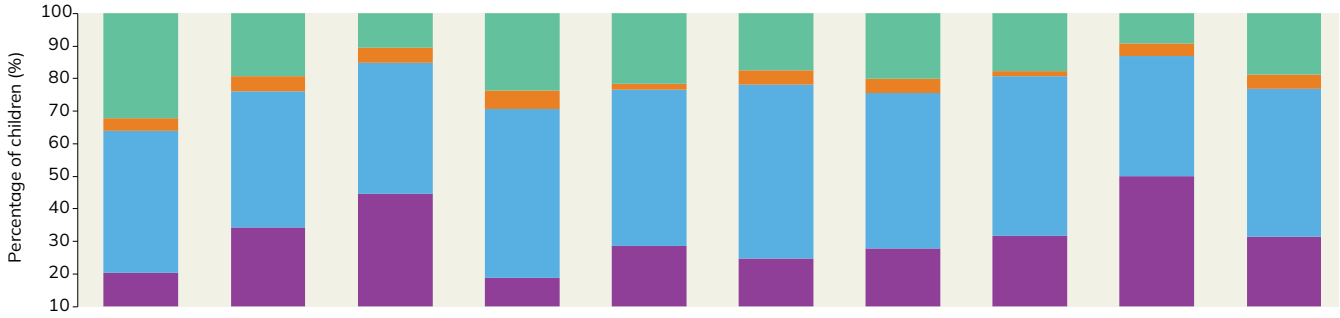
Children living with their biological parents

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.[6, 7] 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.[8-12] 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.[13-15] Virtually all children live with at least one adult, and 89% of children live in households where there are two or more co-resident adults. This indicator tracks 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. In 2024, 31% of children had both their biological parents living in the same household. Forty-six percent of all children (9.6 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

Figure 1a: Children living with their biological parents, by province, 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Both parents	20,3%	34,4%	44,6%	18,9%	28,7%	24,8%	27,8%	31,7%	50,1%	31,4%
	509,000	359,000	2,129,000	820,000	726,000	444,000	400,000	141,000	1,071,000	6,598,000
Mother only	43,7%	41,8%	40,4%	51,7%	48,0%	53,3%	47,8%	49,2%	36,8%	45,5%
	1,095,000	435,000	1,929,000	2,247,000	1,213,000	956,000	687,000	218,000	786,000	9,566,000
Father only	3,9%	4,6%	4,6%	5,7%	1,9%	4,6%	4,5%	1,5%	4,0%	4,3%
	97,000	48,000	220,000	247,000	48,000	83,000	64,000	7,000	85,000	898,000
Neither parent	32,1%	19,2%	10,4%	23,7%	21,4%	17,3%	20,0%	17,6%	9,1%	18,8%
	805,000	200,000	498,000	1,031,000	542,000	310,000	287,000	78,000	195,000	3,946,000

Source: Statistics South Africa (2025) *General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

One in five children (19%) do not have either of their biological parents living with them. This does not necessarily mean that they are orphaned: 81% of children who do not have any co-resident parent do have a living mother, and 90% 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 (50% and 45%, respectively). Similarly, the number of children living with neither parent is relatively low in these two provinces (10% of children in Gauteng and 9% in the Western Cape). In contrast, a third of children (32%) in the Eastern Cape and a quarter (24%) in KwaZulu-Natal live with neither parent. These patterns have been fairly consistent over the years and are probably influenced by the dynamics of labour migration.

Children in the poorest 20% of households are least likely to live with both parents: only 14% of the poorest children have both parents living with them, compared with 72% of children in the wealthiest 20% of households.

Less than 30% of African children live with both their parents, 48% live with their mothers but not their fathers, and 20% live with neither parent. In contrast, around 80% of Indian and White children reside with both biological parents. 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 13% of children aged 0 – 5 years (878,000) live with neither parent, this increases to 24% (1.7 million) of children aged 12 – 17 years.

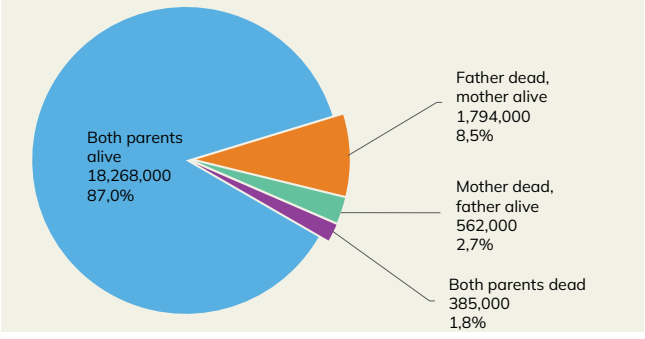
Orphaned children

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 2024, there were 2.7 million orphaned children in South Africa. This includes children without a living biological mother, or father or both parents, and is equivalent to 13% of all children in South Africa. The majority (65%) of all orphans in South Africa are paternal orphans (with deceased fathers and living mothers).

Figure 1b: Children living in South Africa, by orphanhood status, 2024



Source: Statistics South Africa (2025) *General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

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. Contrary to expectations, the number of orphaned children did not increase significantly during the COVID-19 pandemic in 2020 and 2021, and in 2022 the orphaning rates in all categories (maternal, paternal and double orphans) were lower than they were in 2019. This may be because COVID-19 related deaths were most prevalent among older people, while prime-age adults with children were less vulnerable.

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.[16]

In 2024, 3% of all children in South Africa were maternal orphans with living fathers, 9% were paternal orphans with living mothers, and a further 2% were recorded as double orphans. In total, 5% of children in South Africa (950,000 children) did not have a living biological mother and 10% (2.2 million) did not have a living biological father. The numbers of paternal orphans are high because of the relatively high mortality rates among men in South Africa, as well as a greater probability that the vital status, and perhaps even the identity, of a child's father is unknown. Around 290,000 children have fathers whose vital status is reported to be "unknown", compared with fewer than 30,000 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. In 2018, there were 471,000 children who had lost both their parents, but the numbers rose again to over 580,000 in 2019. Subsequently, the number of double orphans dropped back to around 540,000 in 2021, dropped below 500,000 in 2022 and dropped further to below 400,000 in 2024.

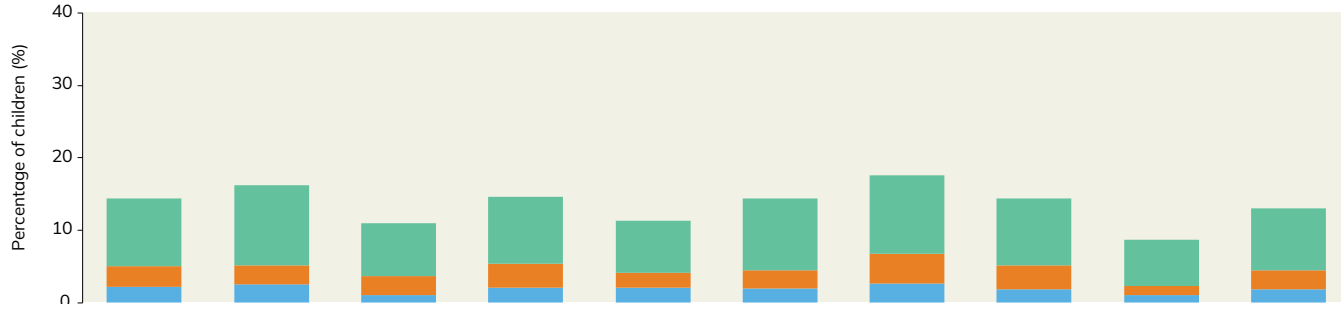
There is some variation across provinces. The Eastern Cape, for example, has historically reported relatively high rates of orphaning, reflecting a situation where rural households of origin carry a large burden of care for orphaned children. In terms of provincial shares, double orphans are concentrated mostly in three provinces: KwaZulu-Natal (accounts for 22% of double orphans), Gauteng (20%) and the Eastern Cape (13%). Together these three provinces are home to nearly 60% of all double orphans.

KwaZulu-Natal has the second largest child population and the highest orphan numbers, with 635,000 children (15% of children in that province) recorded as orphans who have lost a mother, a father or both parents. In the North West, 18% of children are reported to be orphaned, and 16% of children are orphaned in the Free State. The Eastern Cape, Mpumalanga and Northern Cape have the same orphaning rates (14%) but because their child populations are smaller, they have lower numbers of orphaned children. From 2020, Gauteng emerged as the province with the second highest orphaning numbers. In 2024, more than 520,000 children in Gauteng were single or double orphans. A rise in orphan numbers within the province does not necessarily mean that there has been an increase in parental deaths; it could equally mean that children who are orphaned in Gauteng are now more likely to remain there, rather than being sent to another province. In other words, provincial orphaning rates are a reflection both of parental deaths and of the dynamics of extended families, including migration, family ties across provinces, and childcare arrangements. The lowest orphaning rates are in the Western Cape, where 9% of children are maternal, paternal or double orphans.

The poorest households carry the greatest burden of care for orphaned children. Just over 40% of all double orphans are resident in the poorest 20% of households.

The likelihood of orphaning increases as a child gets older. Across all age groups, the main form of orphaning is paternal orphaning (deceased father), which increases from 4% 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, the maternal orphaning rate increases to 5% in children aged 12 – 17 years.

Figure 1c: Number and percentage of orphans, by province, 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
Double orphan	2,2%	2,6%	1,1%	2,1%	2,1%	1,9%	2,7%	1,9%	1,0%	1,8%
	55,000	27,000	54,000	93,000	53,000	35,000	38,000	8,000	22,000	385,000
Maternal orphan	2,9%	2,6%	2,6%	3,2%	2,1%	2,6%	4,2%	3,3%	1,3%	2,7%
	73,000	27,000	122,000	140,000	52,000	46,000	60,000	15,000	28,000	562,000
Paternal orphan	9,3%	11,0%	7,4%	9,3%	7,2%	9,9%	10,8%	9,2%	6,4%	8,5%
	233,000	115,000	351,000	402,000	182,000	178,000	155,000	41,000	137,000	1,794,000

Source: Statistics South Africa (2025) *General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, 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.

In 2024 there were an estimated 30,000 children living in child-only households. This equates to less than 0.2% of all children. Because this household form is rare and even a large population survey like the GHS encounters very few, the confidence intervals in the data are quite wide and the weighted number may lie within a margin of around 10,000 around either side of the mid-point estimate.

Importantly, there has been no increase in the share of children living in child-only households in the period 2002 – 2022, even at the height of the HIV pandemic. If anything, the number has

dropped, and there has been a statistically significant drop in both Limpopo and the Eastern Cape, provinces with the highest baseline numbers. Predictions of rapidly increasing numbers of child-headed households as a result of HIV orphaning were unrealised, and similarly there seems to be no sign of a spike in child-headed households during the COVID-19 pandemic,

In line with previous studies[17] the data suggest that most children in child-only households are not orphans: 85% of children in child-headed households have a living mother and 90% have at least one living parent. These findings suggest that social processes other than mortality influence the formation of these households. For example, a family may decide to leave teenage boys to look after a rural homestead while parents migrate to work because this is a necessary livelihood strategy: the family needs income but the family home also needs to be maintained, or there is no suitable space for co-resident children to join parents in the places where they seek work.

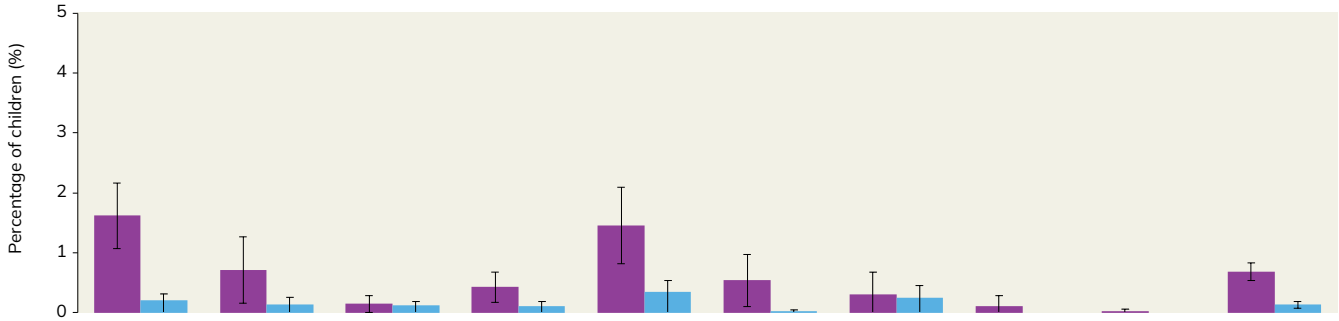
While it is not ideal for any child to live without any coresident adults, it is positive that most children living in child-only households are 15 or older. In the 2024 GHS, less than 20% of children in identified child-headed households were under 10 years of age, while 70% were 15 – 17 years old.

Previous research suggests that child-only households are often temporary arrangements, existing 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] Also, Stats SA surveys use a narrow definition of the household, which requires that members stay in the household at least four nights a week to be counted as part of the household. Some children in the sampled child-only households might have adult family members who return on weekends.

Relative to children in mixed-generation households, child-only households are vulnerable in a number of ways. Child-only households identified in the GHS are overwhelmingly in the poorest 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 GHS. In 2024, only 48 children (unweighted) were identified as being in child-headed households, out of a sample of 24,000 children.

Figure 1d: Children living in child-only households, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2002	1,6%	0,7%	0,1%	0,4%	1,5%	0,5%	0,3%	0,1%	0,0%	0,7%
	47,000	7,000	4,000	18,000	35,000	8,000	4,000	0	0	125,000
2024	0,2%	0,1%	0,1%	0,1%	0,3%	0,0%	0,3%	0,0%	0,0%	0,1%
	5,000	1,000	6,000	5,000	9,000	0	4,000	0	0	30,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

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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 United Nations Convention on the Rights of the Child, article 27, states that every child has the right "to a standard of living adequate for the child's physical, mental, spiritual, moral and social 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 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 living conditions that compromise health and personal safety.

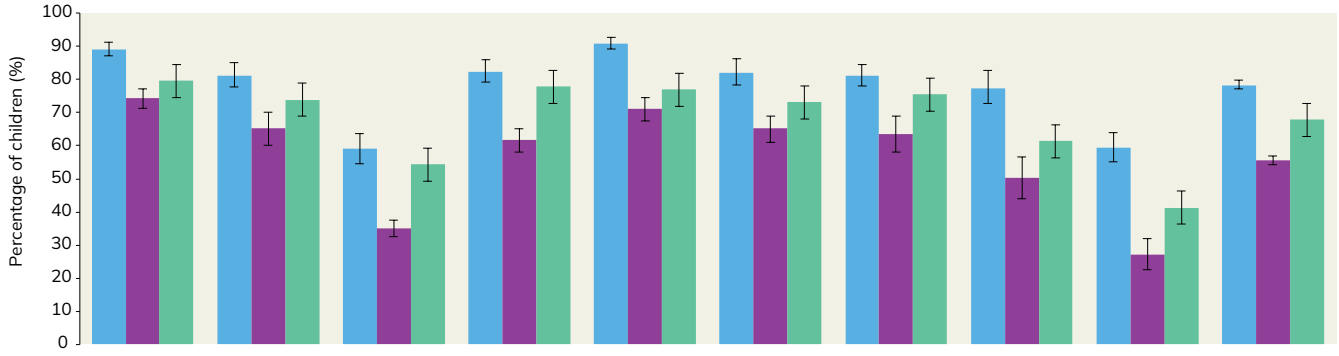
International law and the Constitution recognise the link between income and the realisation of basic human rights, and acknowledge that children have the right to social assistance (social grants) when families cannot meet children's basic needs. Income poverty measures are therefore important for determining 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 poverty threshold used is the Statistics South Africa's (Stats SA) 'upper bound' poverty line that was set at R779 per person per month in 2011 prices. The poverty lines increase with inflation and in 2024 the real value of the upper bound line was R1,634.[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.

Figure 2a: Children living in income poverty, by province, 2003, 2019 & 2024

(Upper bound poverty line: Households with monthly per capita income less than R1,634, in 2024 Rands)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2003	89,0%	81,1%	59,1%	82,3%	90,8%	82,0%	81,1%	77,4%	59,4%	78,3%
	2,544,000	813,000	1,759,000	3,349,000	2,165,000	1,237,000	941,000	302,000	961,000	14,070,000
2019	74,3%	65,3%	35,0%	61,7%	71,1%	65,1%	63,6%	50,4%	27,1%	55,6%
	1,902,000	662,000	1,514,000	2,593,000	1,724,000	1,095,000	905,000	216,000	544,000	11,156,000
2024	79,6%	73,9%	54,4%	77,8%	76,9%	73,2%	75,4%	61,4%	41,3%	67,8%
	1,993,000	769,000	2,598,000	3,382,000	1,945,000	1,312,000	1,085,000	272,000	882,000	14,239,000

Source: Statistics South Africa (2003; 2020; 2025) *General Household Survey 2002; General Household Survey 2019; General Household Survey 2024.* Pretoria: Stats SA. Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

Stats SA publishes two other poverty lines:

- The '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 (R1 109 in 2024 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.*
- The '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 other basic necessities. The value of the food poverty line in 2011 prices was R335 per person per month (R796 in 2024). A*nyone 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 and 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.

Child poverty rates reduced substantially following the introduction of the Child Support Grant (CSG), but 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 had fallen substantially since 2003, when 78% of children (14.1 million) were defined as 'poor' at the upper bound threshold and 53% were below the food poverty line. The reduction in the child poverty headcount over this period was mainly the result of a massive increase in the reach of the CSG.

Child poverty rates increased in the COVID-19 lockdown year of 2020, with the upper bound poverty rate rising by seven percentage points to 63%, and the child food poverty rate rising by six percentage points to 39%. Average poverty rates levelled off in 2021, although they did not decline. Poverty rates then increased again in most provinces in 2022 and remained at that higher level in 2023 and 2024. Across all the poverty measures, poverty rates were higher in 2024 than they were in the pre-lockdown year of 2019. In terms of population numbers, this translates as an additional 1.2 million children below the food poverty line, and an additional 3.1 million children below the upper-bound poverty line, compared with 2019. Given that the child population has grown over the past two decades, the poverty headcount in 2024 was similar to that in 2003, despite an overall reduction in the poverty rate over the two decades. There are substantial differences in poverty rates across the provinces. Using the upper bound poverty line, over 75% of children in the Eastern Cape, KwaZulu-Natal, Limpopo and North West 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 54% in 2024 in Gauteng, and from 27% to 41% in the Western Cape. Child poverty remains most prominent in the rural areas of the former homelands, where 86% of children were below the poverty line in 2024. However, poverty rates have also risen sharply among urban children, with the upper bound poverty rate in urban areas standing at 56% in 2024 (up from 41% in 2019), and the urban food poverty rate at 25% (up from 21%).

There are glaring racial disparities in income poverty: 74% of African children lived in households below the upper bound poverty line in 2024 (up from 61% in 2019). Although poverty rates among Coloured children are consistently lower than for African children, the increase in poverty was even more pronounced in the Coloured population over the period, with upper bound poverty rates rising from 33% in 2019 to 48% in 2024. The lockdown period had no significant impact on poverty rates among Indian and White children.

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 only provides for basic essentials if people make food sacrifices), 51% of children (10.8 million) were poor in 2024 (up from 44% in 2019), and 37% (7.8 million children) were below the food poverty line, meaning that they were not getting enough nutrition.

The Sustainable Development Goals (SDGs) replaced the Millennium Development Goals (MDGs) in 2015 and set a global agenda for development by 2030. Target 1.1 is to eradicate extreme poverty using the international poverty line, which was originally set at $1 per day by the MDGs, then increased to $1.25. It was revised upwards for the SDGs, to $1.90 and again to $2.15. In July 2025, the World Bank announced a further increase in the international ultra-poverty line, raising it to $3 per day.[4] This would translate to R654 per person per month in 2024, using the International Monetary Fund purchasing power parity conversion.[5] This poverty line is extremely low – below survival level – and is not appropriate for South Africa. No child should be below it. In 2024, a quarter of all children in South Africa (24%) lived below the international poverty line.

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. The official national unemployment rate was 29.1% in the fourth quarter of 2019 and 32.5% in the fourth quarter of 2020. It increased further to a high of 35% in the third quarter of 2021 before recovering to 32% in the second half of 2023. It remained around that level through 2024.[7] This official rate is based on a narrow definition of unemployment that includes only those adults who are defined as economically active (ie they are not studying or retired or voluntarily staying

at home) and who had also 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 are unemployed but did not actively look for work in the month preceding the survey, gives a higher, and more accurate, indication of the unemployment problem. In the second 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.[8] Although there was some clawback of jobs, the expanded unemployment rate remained above 40% throughout 2021 to 2024. By the first quarter of 2025, nearly 12 million people were unemployed, out of a potential labour force of 28.5 million.[9]

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. In the last quarter of 2024, the expanded unemployment rate for women was 43%. Of the 13.4 million women who were available and willing to work, 5.8 million could not find work or had given up trying to do so.[9]

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.

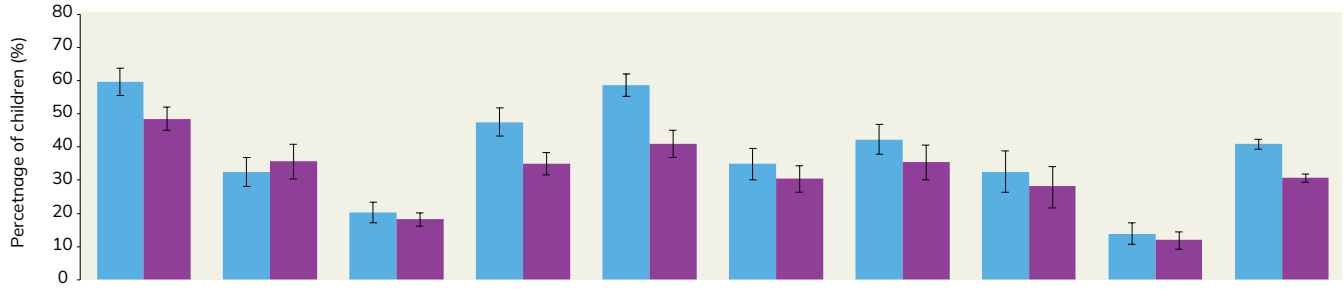
In 2019, before lockdown, 70% of children in South Africa lived in households with at least one working adult. The other 30% lived in households where no adults were working. The number of children living in workless households had decreased by 1.4 million since 2003, when 41% of children lived in households where there was no employment. But by late 2020, the share of children in workless households had increased again to 36% (7.3 million). By 2024 the rate had dropped again, almost regaining pre-lockdown levels. While this shows some recovery, the number of children in households that do not receive income from employment remains worryingly high: nearly 6.5 million children (31%) lived in households where no adults were earning income from employment in 2024.

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. In 2024, nearly 50% of children in the Eastern Cape and 41% in Limpopo lived in households without any employed adults, while over a third of those in North West, Free State and 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 and 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 in 2020 (up from 12% in 2019), and in Gauteng the rate was 23% in 2020 (up from 14% in 2019). By 2024 the Western Cape rates had dropped again to 12% but the Gauteng rate remained persistently high at 18%.

As with the poverty indicators, racial inequalities are marked: 34% of African children had no working adult at home in 2024, while 16% of Coloured children and less than 5% of Indian and White children lived in households without employment income. There are no significant differences in child-centred unemployment measures when comparing girls and boys or different age groups. In the rural former homelands, 47% of children lived in workless households in 2024, while the rate was 20% among children in urban areas.

Income inequality is clearly associated with unemployment. Over 70% of children in the poorest income quintile live in households where no adults are employed.

Figure 2b: Children living in households without an employed adult, by province, 2003 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2003	59,7%	32,4%	20,3%	47,6%	58,7%	34,9%	42,2%	32,6%	13,9%	40,8%
	1,706,000	325,000	603,000	1,935,000	1,400,000	527,000	490,000	127,000	225,000	7,338,000
2024	48,5%	35,8%	18,2%	35,0%	41,0%	30,5%	35,6%	28,3%	12,1%	30,7%
	1,216,000	373,000	870,000	1,521,000	1,037,000	547,000	512,000	126,000	258,000	6,460,000

Source: Statistics South Africa (2004; 2025) *General Household Survey 2003; General Household Survey 2024.* Pretoria: Stats SA. Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

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 caregivers are too poor to do so. Income support for poor children is provided through the CSG – 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. The grant amount was originally linked to the minimum cost of feeding and clothing a child. Its monthly value is increased slightly each year, more or less keeping pace with headline inflation although it has fallen behind food inflation. As a result, the value of the CSG has been eroded relative to the food poverty line, and the CSG no longer covers the cost of a child's minimum nutritional needs.

At the end of March 2025, a monthly CSG of R560 was paid to 13.1 million children aged 0 – 17 years – slightly down from 13.2 million the previous year.

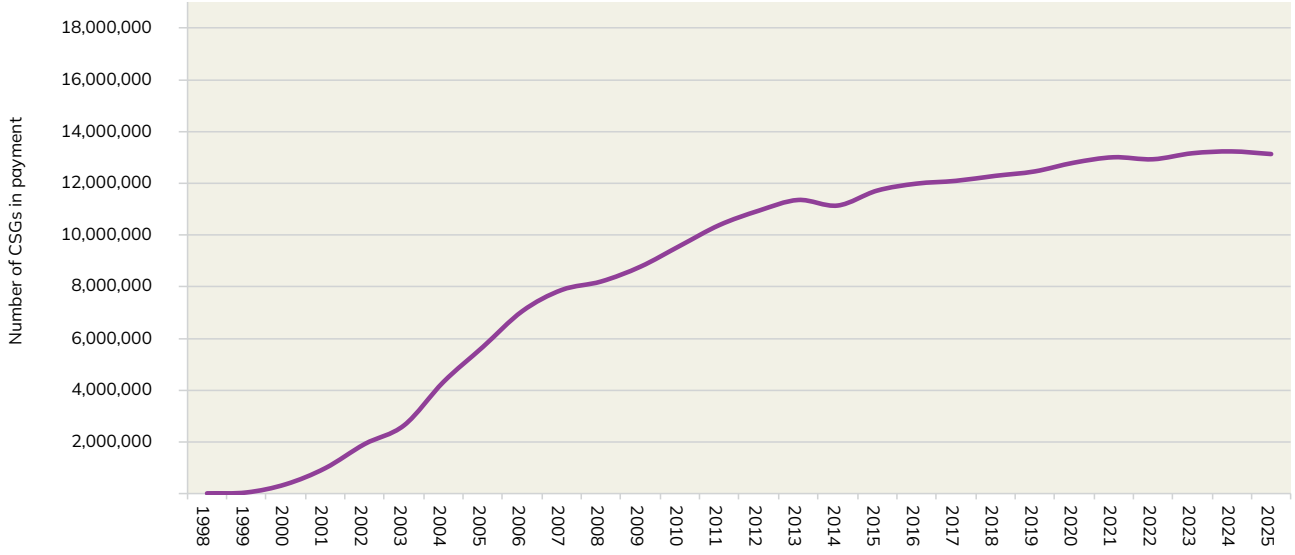
Because the CSG is targeted to poor children, a simple means test is used to determine eligibility. The income threshold is set at 10 times the amount of the grant. This means that every time the grant is increased, the means test also increases. From April 2025, the income threshold was R5 600 per month for a single caregiver and double that if the caregiver is married (R11 200 per month for the joint income of the caregiver and spouse).

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, eligible children can receive the grant until they turn 18. Take-up of the CSG increased dramatically over the first 15 years, after which the numbers started levelling off. The slight dip in grant access in 2014 was probably the result of the introduction of a biometric system which led to the identification and suspension of grants to beneficiaries who were not verified biometrically. Most were reinstated the following year, although without backpay. From 2014, the numbers increased again gradually until 2021, then stabilised.

In March 2022, nearly 80,000 fewer CSGs were in payment than in March the previous year. Although the overall numbers picked up again subsequently, it is worrying that the number of infants (under one year of age) receiving the CSG has continued to fall each year, while at the same time poverty rates have risen. In March 2020, just before lockdown, 658,000 infants were receiving the CSG. This number dropped by over 100,000 to 550,000 in March 2021. The substantial drop between 2020 and 2021 was almost certainly the result of delays in birth registration and grant applications in the context of lockdown. Although birth registration rates recovered after 2021, the number of infants receiving the CSG continued to fall – to 543,000 in 2022 then to 509,000 in 2023 and to 469,000 in 2024 and 420,000 in 2025. This has reversed improvements in uptake by caregivers of infants by 10 years – taking us back to 2014 levels. It is not clear what is causing the further decline in CSG access for infants. Possible reasons may include staff shortages, the introduction of rotating days for grant applications and the impacts of load-shedding on the systems at SASSA offices. It is also possible that birth rates are falling faster than projected in the population models, but it is unlikely that they would be falling at a rate that could account for the sharp fall in the number of infants receiving the grant – a decrease of 36% when comparing 2025 grant payments for infants with the pre-lockdown figure for the same age group.

There is substantial evidence that social grants are being spent on food, education and basic goods and services. The

Figure 2c: Children receiving the Child Support Grant, 1998 – 2025



Sources: 1998 – 2007: National Treasury Intergovernmental Fiscal Reviews.
2008 – 2025: South African Social Security Agency SOCPEN monthly statistical reports.

Table 2a: Children receiving the Child Support Grant, by province and age group, 2025

Province	Number of child beneficiaries at end March 2025			
	0 – 5 years	6 – 11 years	12 – 17 years	TOTAL
Eastern Cape	594,451	654,641	679,908	1,929,000
Free State	216,354	236,099	248,737	701,190
Gauteng	614,251	719,799	701,540	2,035,590
KwaZulu-Natal	958,992	1,013,478	1,007,583	2,980,053
Limpopo	663,751	686,848	637,628	1,988,227
Mpumalanga	400,017	408,900	390,406	1,199,323
North West	296,189	313,146	308,181	917,516
Northern Cape	110,401	116,808	109,877	337,086
Western Cape	275,508	372,860	380,640	1,029,008
South Africa	4,129,914	4,522,579	4,464,500	13,116,993

Source: South African Social Security Agency (2025) *Twelfth Statistical Report 2024/25: Social Assistance.* Pretoria: SASSA.

evidence shows that the CSG not only helps to alleviate income poverty but is also associated with improved nutritional, health and education outcomes, especially if the grant is accessed soon after birth and received continuously.[10-19] Recent research among children with young mothers has also identified an association between CSG access and improved child cognitive development.[20]

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 by caregivers of young children. An analysis found that exclusion rates for eligible infants were as high as 43% in 2014. The total rate of exclusion for all ages was estimated at 17.5% (more than 1.8 million children).[21] Infant exclusion rates dropped to 35% from 2017 to 2019, but increased again to 48% in 2020.[22] Exclusion rates are consistently found to be highest in the Western Cape and Gauteng. 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).

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 SASSA's administrative data.

The FCG is available to foster parents who have a child placed in their care by an order of the court. Foster care was designed for children who are placed with another family because they are in need of care and protection due to abuse, neglect or abandonment. Unlike the CSG, the FCG is not means-tested but is automatically paid to foster parents. The monthly value of the grant was R1 250 from April 2025.

The absence of a means test and the relatively large value of the grant compared to the CSG is justified on the basis that the child is a ward of the state because a court has placed them in alternative care, and the state is therefore directly responsible for ensuring that all the child's needs are provided for.

The number of children in foster care remained stable at around 50,000 nationally for many years when foster care was used primarily for children who were in need of care and protection or were awaiting adoption. However, from 2003, as HIV-related orphan rates rose sharply, the Department of Social Development and its social workers started encouraging family members to apply for foster care placements. They particularly encouraged grandmothers who were caring for orphaned children to apply for foster care placements because the value of the FCG was nearly three times that of the CSG.

Over the next decade, the FCG was increasingly used to provide poverty alleviation for orphaned children 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 anyway, whether or not their parents are alive. In 2022, for example, four million children – a fifth of the child population – did not live with either of their parents. Of these, 97% lived with relatives, mainly in households that included a grandparent. Less than one third were orphans. Nevertheless, with over half a million double orphans living with relatives, there were concerns that increasing demand for foster care placements would overwhelm the child protection system, which was not designed or resourced to process such large numbers of children.[23, 24]

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 strict checks and balances required by law. These included initial investigations and reports by social workers, newspaper adverts, court-ordered placements, and additional two-yearly social worker reviews and court-ordered extensions of placements. SASSA is not allowed to pay the FCG without a valid court order or extension order, and it stopped paying more than 110,000 FCGs between April 2009 and March 2011 because of backlogs in the extensions of court orders.[25-27]

In 2011, a High 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.[28] No legal policy solution had been developed by the 2014 cut-off date. The Department of Social Development sought (and received) an urgent High Court order extending the date to the end of 2017, which was then extended until the end of November 2019, then to November 2020, then November 2022, and finally to November 2023.

Two laws needed to be amended to enable a comprehensive legal solution. This process took over a decade to be completed. An amendment to the Social Assistance Act was passed by Parliament in 2020 to provide for a new CSG Top-Up (instead of the FCG) for orphaned children living with relatives.

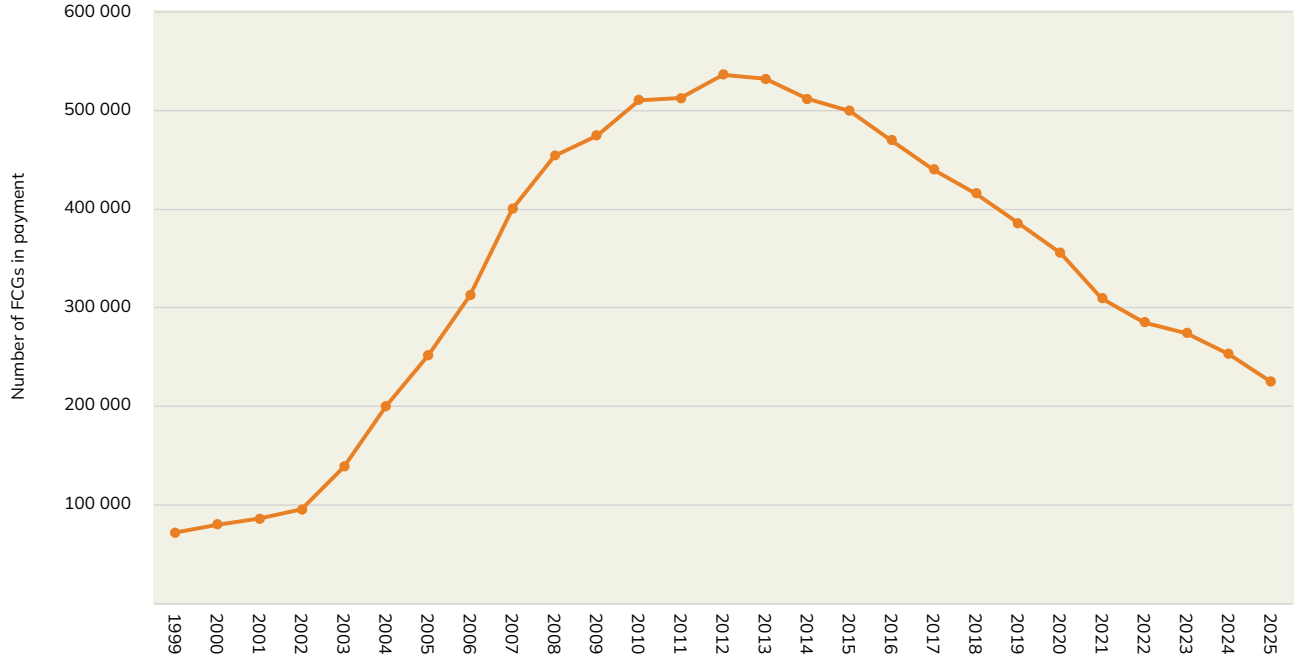
The CSG Top-Up is more easily accessible than the FCG because the caregiver can apply directly at SASSA without first having to go through a social worker investigation and court placement. It also gives access to a grant that, although lower than the FCG, is close to the food poverty line – enough to cover the basic food needs for a child. Importantly, it is not at risk of being stopped every two years. The CSG Top-Up is set at one-and-a-half times the value of the CSG, so that for example when the CSG is R500 per month, the CSG Top-Up is R750. Implementation of the top-up started in mid-2022. By March 2023 there were 37,000 children receiving the top-up, and by March 2025 the number had increased to nearly 90,000.[29] But the uptake of the CSG Top-Up has not been sufficient to offset the declining numbers of FCGs, and it is likely that many more orphans are excluded from these higher value grant amounts.

The Children's Act also needed to be amended to clarify that orphaned children in the care of relatives should be referred to the CSG Top-Up, and that only those who are in need of supervised care and protection should be placed in foster care. The Children's Amendment Bill was finally passed by Parliament and signed by the President at the end of 2022.[30] The Amendment Act came into effect a year later in December 2023. It clarifies that an orphaned child who is in the care of family members is not automatically in need of state care and protection, but like all other children, whether or not they live with their parents, they are entitled to care and protection services if needed.

This means that all new cases of orphans who are in the care of relatives can go directly to SASSA to apply for the CSG Top-Up and do not need to go via social workers or the courts to access an adequate grant. Orphans in the care of relatives who were already in foster care and receiving the FCG in December 2023 are exempted from the effect of this change and should remain on the FCG until they turn 18 (or 21 if still in education). The Amendment Act also devolves jurisdiction for guardianship orders to the children's courts (previously only accessible at the High Court) to make it easier for relatives caring for orphans to secure parental responsibilities and rights orders.

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.[31] Those grants remained in payment only because the High Court order mentioned above prevented them from lapsing. In March 2025, 225,000 FCGs were paid to caregivers of children in foster care, a 58% reduction since 2012. The most dramatic drop has been in KwaZulu-Natal, where the number of FCGs fell by 74%, from 142,000 to 36,000. Over the same period, the number of children receiving FCGs fell by over 60% in the Free State, Mpumalanga and North West, and by 59% in the Eastern Cape. 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 grant income for orphans living with relatives. Rural provinces have tended to bear the main burden of caring for orphans so, for example, many children who are orphaned in the Western Cape may be sent to live with relatives in Eastern Cape, and so are counted there.

Figure 2d: Children receiving the Foster Child Grant, 1999 – 2025



Sources: 1999 – 2007: National Treasury Intergovernmental Fiscal Reviews.
2008 – 2025: South African Social Security Agency monthly statistical reports.

Table 2b: Children receiving the Foster Child Grant, by province, 2012 & 2025

Province	2012	2025	Difference	% difference
Eastern Cape	116,826	47,650	-69,176	-59%
Free State	43,311	14,390	-28,921	-67%
Gauteng	56,451	30,562	-25,889	-46%
KwaZulu-Natal	142,114	36,457	-105,657	-74%
Limpopo	56,066	27,570	-28,496	-51%
Mpumalanga	32,886	11,923	-20,963	-64%
North West	45,634	17,426	-28,208	-62%
Northern Cape	14,456	7,574	-6,882	-48%
Western Cape	29,003	31,210	2,207	8%
South Africa	536,747	224,762	-311,985	-58%
FCG amount	R770	R1 250		

Source: South African Social Security Agency (2012; 2025) social grant statistics.

The rapid decline in the number of children in foster care over the past decade cannot be attributed only to the introduction of the comprehensive legal solution described above, as it was only partially in place by mid-2022 and fully in place from December 2023. Rather, declining numbers were due to lower rates of foster care placement and enrolment onto the grant, along with an increase in the numbers of grants terminating at the end of each year when children turn 18. This is because the beneficiaries of the FCG are still mainly orphans, who are typically older children.

In 2024, only 11% of FCGs reported in the General Household Survey (GHS) went to children who were not orphaned, while approximately 4% went to paternal orphans, 20% to maternal orphans and 65% to double orphans.[24] The GHS is not a reliable source of data on FCG uptake because the grant is under-reported in the survey (possibly because of confusion with the CSG). Nevertheless, the distributions indicate that the FCG is still mainly used for orphans. Another indicator is the number of FCGs that lapse at the end of the year when a child turns 18. It is often younger children who need to be placed in foster care because of abuse or neglect or because they are awaiting adoption, while older children are more likely to be in foster care because of orphaning. The share of FCGs lapsing at year end is mainly a reflection of children ageing out of the system. Back in the mid-2000s less than 10% of FCGs lapsed at the end of each year because children aged out of the system. But the share of FCGs lapsing continued to rise at each year end, reaching 20% in 2015 and still increasing to an all-time high of 29% at the end of 2024. Some (but not all) of the lapsed grants are reinstated the following year, as the FCG can continue until the dependant turns 21, if the family makes the effort to approach SASSA and prove that the child is still in school.

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. Until the Children's Amendment Act was put into effect in December 2023, the majority of orphans in the care of relatives were legally eligible to be placed in foster care and receive the FCG,[i] but only a small portion of these children were accessing it.

The introduction of the CSG Top-Up in June 2022 has helped reverse this trend with 90,000 orphans accessing the CSG Top-Up by March 2025. More attention needs to be paid to promoting awareness about the availability of the CSG Top-Up among the public and government personnel at SASSA, the Department of Social Development, and the children's courts.

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 children who are cared for in state institutions because the purpose of the grant is to cover the additional costs (including opportunity costs) that parents or caregivers might incur due to 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.

Table 2c: Children receiving the Care Dependency Grant, by province, 2012 & 2025

Province	2012	2025	Difference	% difference
Eastern Cape	18,235	25,869	7,634	42%
Free State	5,419	10,378	4,959	92%
Gauteng	14,170	25,147	10,977	77%
KwaZulu-Natal	34,969	42,735	7,766	22%
Limpopo	11,318	19,216	7,898	70%
Mpumalanga	7,950	13,205	5,255	66%
North West	8,736	11,563	2,827	32%
Northern Cape	4,236	6,419	2,183	52%
Western Cape	9,960	18,868	8,908	89%
South Africa	114,993	175,425	58,407	51%
CDG amount	R1 200	R2 310		

Source: South African Social Security Agency (2012; 2025) social grant statistics.

i In terms of section 150 (1)(a) of the Children's Act No 38 of 2005.

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 chronic illness, who are in need of permanent care or support services. At the end of March 2025, there were 175,000 children receiving the CDG, and from the beginning of April 2025, the grant was valued at R2 310 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, Gauteng, the Eastern Cape and Limpopo – receive the largest share of CDGs. There has been a gradual but consistent increase in access to the CDG each year since 1998, when only 8,000 CDGs were disbursed.

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Child health and nutrition

Katharine Hall & Sumaiyah Hendricks (Children's Institute, University of Cape Town)

Section 27 of the Constitution of South Africa provides that everyone has the right to have access to healthcare services. In addition, section 28 (1)(c) gives children "the right to basic nutrition and basic healthcare 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) says that States Parties shall take measures "to ensure the provision of adequate nutrition…".[2]

Article 24 of the United Nations (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]

Infant, under-five and neonatal mortality

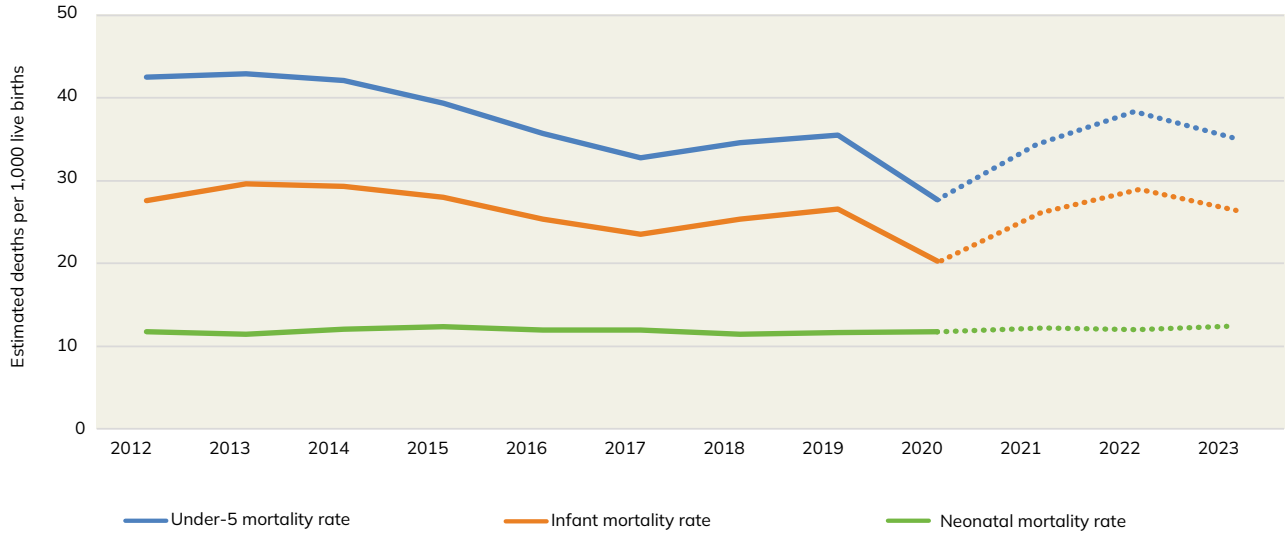
Nadine Nannan (Burden of Disease Research Unit, South African Medical Research Council)

The infant and under-five mortality rates are key indicators of heath and development. They are associated with a broad range of bio-demographic, health and environmental factors which are not only important determinants of child health but are also informative about the health status of the broader population.

The infant mortality rate (IMR) is defined as the probability of dying within the first year of life and is estimated by the number of deaths of infants aged less than one year at death per 1,000 of births in that year. The under-five mortality rate (U5MR) is defined as the probability of a child dying before their fifth birthday.

Ideally this information is obtained from vital registration systems. However, as in many middle- and lower-income countries, the under-reporting of births and deaths renders the South African system inadequate for monitoring directly. South Africa is therefore reliant on alternative methods, such as survey and census data, and modelling (particularly given the

Figure 3a: Child mortality rates, 2012 – 2023



Source: UN Inter-agency Group for Child Mortality Estimation (IGME) https://childmortality.org/all-cause-mortality/data?refArea=ZAF&indicator=MRY0T4.

Notes:
1. U5MR and IMR from Rapid Mortality Surveillance Estimates (2023 series, preliminary) as published by the UN-IGME. RMS estimates are provided to the UN-IGME by the Burden of Disease Research Unit, SA Medical Research Council.
2. Neonatal mortality estimates are referenced on the UN-IGME site as "DHIS direct" but are also those provided by the MRC RMS team. They are published on UN-IGME without a decimal place. To provide a more realistic progression of the rate over time, the estimates used in the figure include a further significant digit provided directly by the RMS team.
3. The estimates represented by dotted lines are preliminary, given absence of survey and vital registration data.

lateness in release of registration data), to determine the extent of the deficiency in the registered deaths. Unfortunately, the most recent survey data that can be used date back to 2016/7 and the most recent data on deaths released by Statistics South Africa (Stats SA) is four years out of date.[i]

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.[4]

These data have been corrected for known biases. In other words, the trends shown in Figure 3a are based on nationally representative numbers. The RMS reports vital registration data adjusted for under-reporting which allows for the evaluation of annual trends.

Trends since 2000 show that the IMR peaked in 2003 at 54 per 1,000 and decreased to 24 per 1,000 in 2017, after which the IMR rose again slightly before a sudden drop to 20 in 2020. During the same period the U5MR decreased from 81 per 1,000 in 2003 to 33 per 1,000 in 2017, rising again slightly to 36 in 2019 and then dropping to 28 in 2020.[5]

With reference to the substantial drop in infant and under-five 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".[5]

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".[5]

In other words, while the hard lockdown of 2020 was devastating for the economy and society in many ways, an unexpected benefit was that the restrictions on socialising and travel may have protected young children from infectious diseases that contribute to high mortality rates.

Preliminary estimates by the MRC suggest that infant mortality rates rose sharply in 2021 and 2022, with a corresponding increase in under-five mortality. The revised estimate for IMR in 2022 is 29 deaths per 1,000 live births. Despite slight recovery (to 26 in 2023) the estimated probability of dying in the first year of life remains above pre-COVID levels. The U5MR increased to 39 in 2022, declining slightly to 35 in 2023 – also above pre-COVID rates. The reasons for rising child mortality after lockdown are unclear as there have been long delays in the release of Causes of Death data by Stats SA. Mortality estimates beyond 2019 are extrapolations from the National Population Register (NPR), which is more prone to error because not all deaths are reported, and even if they are, they are not captured in the NPR if the birth was not registered prior to death. The NPR also does not record births and deaths for individuals who are not South African. In addition, there is quite a bit of uncertainty around the population estimates for children, and for infants in particular. This is partly due to problems with the high undercount of the 2022 census and subsequent adjustments to correct for that. In addition, administrative data on births, recorded in the Department of Health's District Health Information System (DHIS), shows an inexplicable decline to 2016 and rise to 2020 followed by an improbable decline in the number of live births from 2021 onwards, calling into question the integrity of the system.

It is partly due to these data delays, gaps and quality concerns that the MRC has not formally published its child mortality estimates since 2020, although the estimates have been shared with the United Nations Inter-agency Group for Child Mortality Estimation (UN-IGME) and inform the UN models.

Given the lack of recent data on causes of death, it is not possible to determine what is driving the estimated increase in mortality between 2020 and 2023. The leading causes of under-five mortality (other than neonatal causes) are generally diarrhoea, and lower respiratory infections, while malnutrition is often an underlying cause of death in young children.

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 taken from the UN-IGME model, which is in turn derived from neonatal deaths and live births recorded in the DHIS. The NMR estimates therefore exclude deaths that occur at home or in the many private sector health facilities that are not included in the DHIS. Unlike the live birth trend, the DHIS reflects no substantial change in neonatal deaths.

The DHIS also records the in-facility neonatal death rate – ie the number of infants aged 0 – 28 days who died during their stay in the facility, per 1,000 live births in public health facilities. The recorded rates were also around 12 in the years leading up to COVID-19 but increased after 2020, reaching 13.4 per 1,000 live births in 2023.[6]

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 2024, 14% of children in South Africa (approximately 2.9 million) lived in households that reported child hunger. Reported child hunger rates in the years 2021 to 2024 have remained slightly higher than they were in the pre-COVID lockdown year of 2019, when child hunger rates reached a low of 10%. However, the long-term trend is that reported child hunger has declined substantially since 2002 when 30% of children (5.5 million) lived in households that reported child hunger. The largest declines have been in the Eastern Cape, and Limpopo, followed by Free State, Mpumalanga and KwaZulu-Natal.

One of the main contributors to the long-term decline is the expansion of the Child Support Grant which steadily increased its coverage, reaching over 13 million children in 2024. [7] Another possible contributor to declining child hunger

i Stats SA decided the data on fertility and mortality from the most recent 2022 population census were too unreliable to be shared, even with researchers.

is the National School Nutrition Programme (NSNP), which reaches an estimated nine million learners in approximately 20,000 schools.[8] However, the NSNP only operates during the school term and does not include children who are too young to attend. Despite having the smallest child population, the Northern Cape appears to have the highest rates of hunger, with 22% of children living in households that report children going hungry. KwaZulu-Natal households report slightly lower rates of child hunger (19% of children), but because of its large child population it accounts for nearly a third (29%) of children reported to suffer hunger. The Western Cape has relatively low rates of child hunger (15%) but is also the only province where child hunger rates have not reduced in the past two decades. Given population growth, the estimated number of children reported to be hungry in that province has increased from 275,000 in 2002 to around 330,000 in 2024.[9]

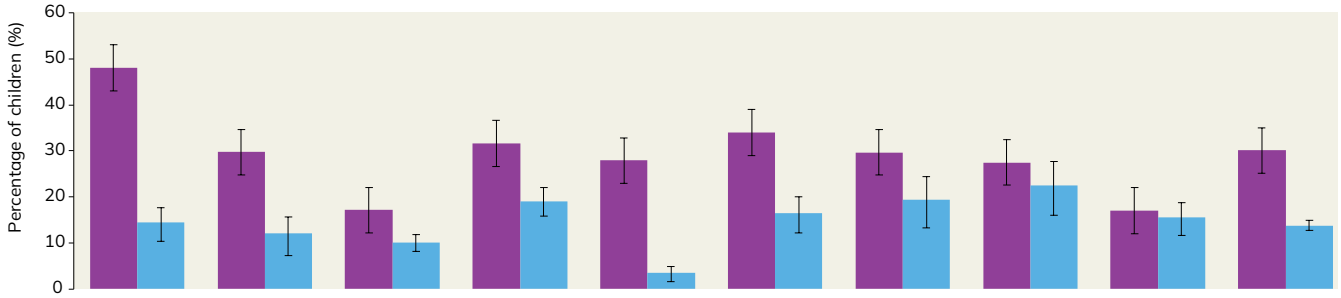
The lowest reported hunger rates were in Limpopo (4%). Despite high poverty rates, Limpopo has always reported child hunger rates well below the national average, perhaps because of the relatively fertile and productive land in rural areas where most of the population lives. However, there is no clear explanation for the dramatic decline in reported hunger in the Eastern Cape. Over the period 2002 to 2024, reported child hunger rates in that province fell from 48% (higher than any other province) to 14%, despite the Eastern Cape having the highest poverty rates in the country, with half of the children in that province living below the food poverty line.

There are no differences in reported child hunger across gender or age groups. However, as with many other indicators, child hunger is highly racialised: 15% of African children and 12% of Coloured children live in households that reported child hunger, compared with less than 3% of Indian and White children. Differences are even more pronounced across income quintiles. While one in five children living in the poorest 20% of households experienced hunger, only 1% of children in quintile 5 (the richest 20%) lived in households where child hunger was reported. Over half of all those who reported child hunger were in the poorest income quintile and nearly 90% were in the poorest two quintiles. For many years, reported hunger rates were higher in the former homelands than in urban areas, but the difference has reduced over time and in 2024 food insecurity was equally prevalent in urban and rural areas.

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 five years at 27% – a figure that has remained persistently high since the 1990s and indicates high rates of chronic undernutrition.[10] The more recent National Food and Nutrition Security Survey conducted by the Human Sciences Research Council between 2021 and 2023 found similarly high levels of malnutrition, with under-five stunting estimated at 29% nationally.[11] This suggests that chronic malnutrition has remained persistently high, and even may have worsened in the last decade.

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 living in households that do not report hunger may still not have access to sufficient nutritious food and be at risk of malnutrition. In 2024, for example, nearly 80% of children who lived in households with incomes below the food poverty line were not reported to have suffered hunger. Food poverty is an indicator that households lack the financial resources needed to meet minimum dietary requirements for children and other household members. Other measures of food insecurity also suggest a more serious challenge than the subjective hunger indicator. For example, in 2024, 22% of children lived in households that reported running out of food due to lack of money, while 27% lived in households that had been forced to cut the range of foods they could afford to buy.[12]

Figure 3b: Children living in households with reported child hunger, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	48%	30%	17%	32%	28%	34%	30%	27%	17%	30%
	1,407,000	297,000	503,000	1,314,000	675,000	518,000	346,000	109,000	275,000	5,455,000
2024	14%	12%	10%	19%	4%	17%	19%	22%	15%	14%
	361,000	126,000	483,000	830,000	91,000	296,000	280,000	99,000	331,000	2,899,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

Children living far from their health facility

This indicator reflects the distance from a child's household to the health facility that 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 classified 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 deaths of children below age five in developing countries.[13] 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, among others. Curative interventions provided through the government's Integrated Management of Childhood Illness Strategy include oral rehydration, infant resuscitation and the dispensing of medication.

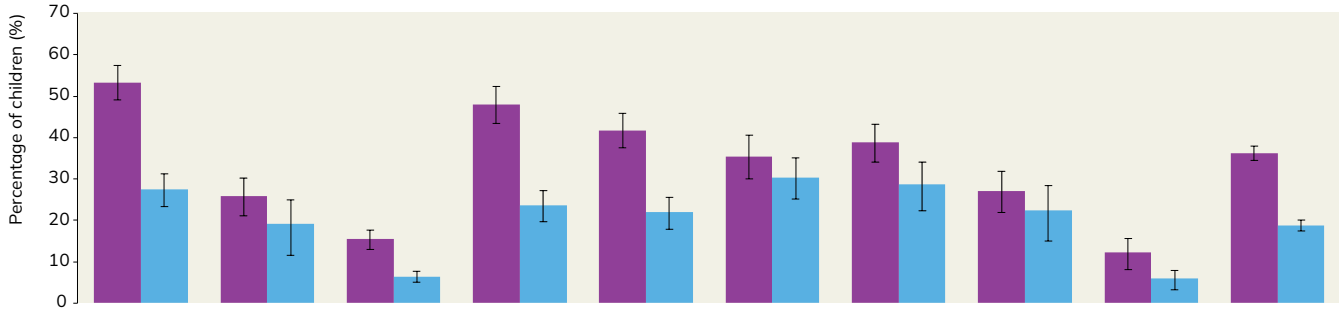
According to the UN Committee on Economic, Social and Cultural Rights, primary healthcare should be available (in sufficient supply), accessible (easily reached and affordable), acceptable and of good quality.[14] In 1996, primary level care was made free to everyone in South Africa, but the availability and physical accessibility of healthcare 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 healthcare 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.[15]

In 2024, almost 20% of South Africa's children lived far from the primary healthcare facility they normally use. Our analyses from previous years of the General Household Survey (GHS) showed that over 90% of children live in households where members attended the health facility closest to their home. Among those who do not, the main reasons for attending a more 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.[16] Unfortunately these questions were dropped from the GHS in 2020 and were not reinstated in more recent years.

In total, four million children (one in five children) travel more than 30 minutes to reach their usual healthcare service provider. This is a significant improvement since 2002, when 36% (or 6.6 million children) lived far from their nearest health facility. Improvements in the accessibility of health services are probably related both to the roll out of additional facilities since 2002, and to increased urbanisation and greater population density in the areas around existing health infrastructure. While it is easier to deliver services in areas of greater population density, it may lead to greater pressure on health facilities if their capacity is not increased alongside a growing client population.

Figure 3c: Children living far from their health facility, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	53%	26%	15%	48%	42%	35%	39%	27%	12%	36%
	1,559,000	259,000	453,000	1,988,000	1,010,000	538,000	451,000	108,000	199,000	6,568,000
2024	27%	19%	6%	24%	22%	30%	29%	22%	6%	19%
	687,000	199,000	309,000	1,027,000	556,000	544,000	412,000	100,000	128,000	3,960,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

It is encouraging that the greatest improvements in health facility accessibility 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 2022, increasing again slightly to 27% in 2024), KwaZulu-Natal (down from 48% to 24%), and Limpopo (from 42% to 22%). Provinces with the highest rates of access are the largely metropolitan provinces of the Western Cape and Gauteng, where only 6% of children live more than 30 minutes from their usual healthcare service.

Over 20% of African children travel far to reach their usual healthcare facility, compared with between 4% and 9% of Coloured, Indian and White children. 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 14% of African children. Only 3% of the poorest children (quintile 1) travel to their health facility in a private car, while 60% walk.

Poor children tend to bear the greatest burden of disease, due to undernutrition, poorer living conditions and lower levels of access to basic services such as water and sanitation. Yet health facilities are least accessible to the poor. A quarter of children (26%) in the poorest 20% of households travel far to access healthcare, compared with 8% 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.

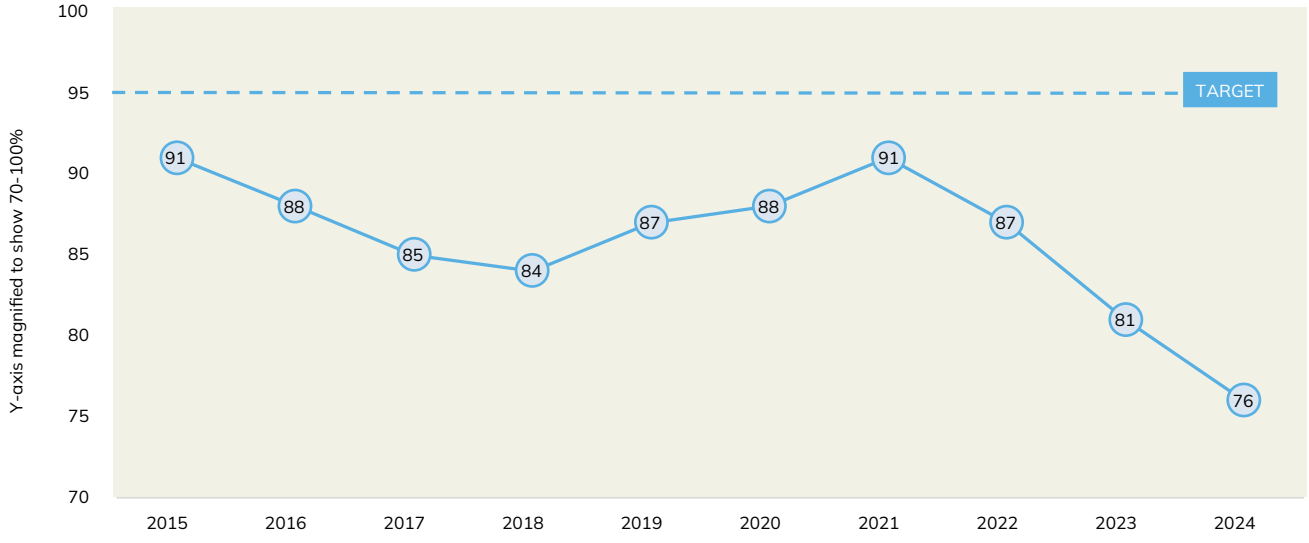
Immunisation coverage of children

This indicator reflects 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 administered in the first year of life. The primary course of immunisation in the first year includes BCG and OPV 0 (administered at birth); OPV 1; DTaP-IPVHib-HBV 1, 2 and 3; PCV 1, 2 and 3; RV 1 and 2, and the measles and rubella vaccine (usually administered at six months).

Vaccination is one of the most effective interventions to prevent serious illnesses and death in young children. It entails giving injections or drops to young children, to protect them against potentially life-threatening illnesses such as tuberculosis, polio, hepatitis and measles. Since the introduction of the Expanded Programme on Immunisation (EPI) over 50 years ago, an estimated 154 million lives have been saved globally, of which 101 million were infants. In Africa alone, the EPI has reduced infant deaths by more than 50%.[17] In keeping with world standards, South Africa has an up-to-date immunisation programme which was last revised in 2024.

The revised EPI schedule for public health facilities includes immunisation at birth, and then at six weeks, 10 weeks, 14 weeks, six months and nine months.[18] Thus, by the time of their first birthday, all babies should have visited a health facility at least five times after birth for immunisation services, and these immunisations should be recorded in the child's Road to Health Book. However, many children do not receive their scheduled immunisations. Low coverage is driven by both supply side issues, such as vaccine stockouts and a reluctance to administer multiple vaccines at once, and demand side barriers, including transport challenges, long distances to health facilities, a lack of information or fear of vaccine adverse effects. Those children are classified as 'zero-dose' – meaning that they have not received

Figure 3d: National estimates of DTP1 vaccine dose coverage in babies younger than one year, 2015 – 2024



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2024 Revision (completed 15 July 2025). Available at: https://worldhealthorg.shinyapps.io/wuenic-trends/

Notes:

1. Immunisation coverage estimates may not fully account for vaccines administered to children in the private sector, since data from the private sector are only partially collected in all provinces.
2. There has been no nationally representative household survey in the last five years to verify the reported coverage levels.

any doses of the BCG, polio, hexavalent or measles vaccines. Some children could also be classified as 'penta-zero' dose which, in a South African context, means that they haven't received the hexavalent (DTaP-IPV-Hib-HBV) vaccine – a marker of successful access to primary healthcare facilities.[19] A study using Demographic and Health Survey data of non-immunised children between 2010 and 2020 found that 5.8% of children aged 12 – 23 months were zero-dose, while 10.8% of children were penta-zero dose.[20]

In 2023, approximately 220,000 children in South Africa were considered zero-dose based on whether they had achieved access to the first dose of diphtheria, tetanus and pertussis (DTP) vaccine.[21] WHO and UNICEF estimates of National Immunisation Coverage show that coverage of DTP1 in babies younger than one year declined from 91% in 2021 to 76% in 2024. This amounts to a 15% drop in coverage of this lifesaving vaccine, far below the 95% target. The Immunisation Agenda 2030 aims to reduce the number of zero-dose children by 50%, prioritising equity in healthcare.

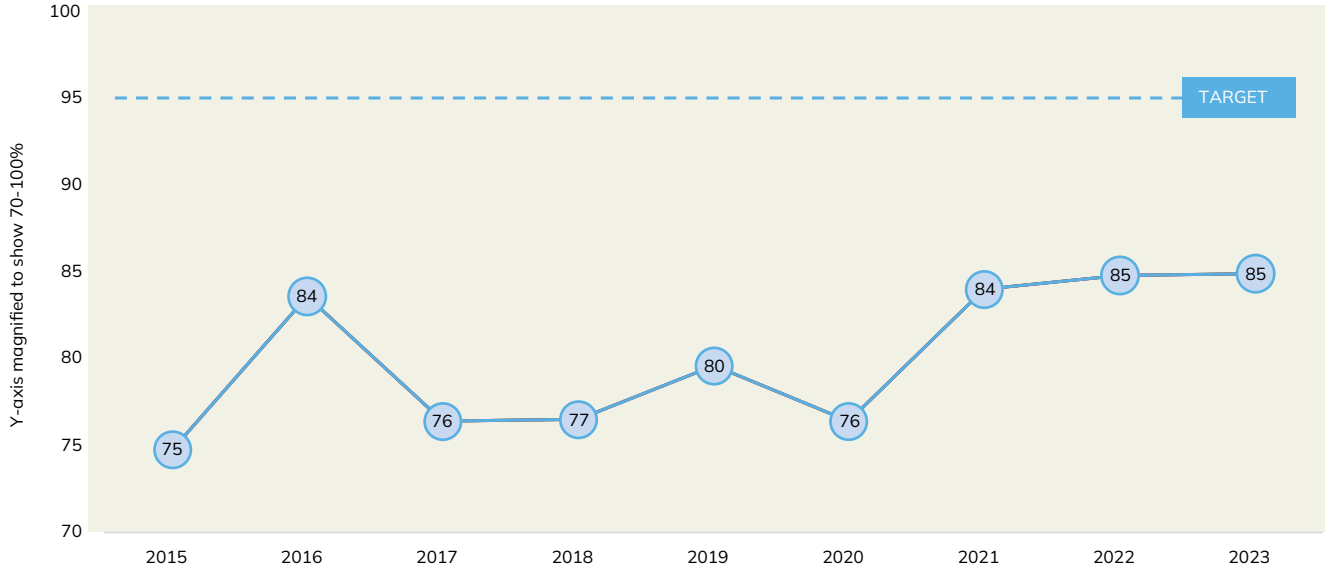
Immunisation coverage serves as a strong indicator of the extent to which young children access primary healthcare services. Immunisation coverage is also a proxy for the extent to which children access other health services, as the immunisation schedule provides a point of contact for identifying other 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 under one year who have received their complete primary course of immunisation divided by the child population under one year. Immunisation rates at district level are calculated in a similar way, by dividing immunisations administered by the infant population for a district. The percentages obtained in this way may be influenced by population movement in health seeking behaviour – for example, if children from one district or province are taken to a health facility in a neighbouring district or province. Currently, estimates of immunisation uptake are also compromised by the uncertainty around infant numbers at the national, provincial and district levels.

The 2015 immunisation rate, as reported in the 2016 District Health Barometer, reflected high levels of immunisation for infants under a year, at 89.2% [22] but the population model for the country had under-estimated the number of children. Stats SA subsequently revised its population model and released a new series of mid-year population estimates[23] and the 2015 immunisation rate was revised downwards to 79.4%. The 2016 rate dropped to 71% after retrospective adjustment to the revised population estimates. The lower immunisation rate for that year was attributed to a global shortage of Hexavalent vaccine.[18] In 2017 the immunisation rate picked up to 77%, increasing further to 82% in 2018 and 83.5% in 2019. In 2020, the immunisation rate dropped to 79.5% nationally as a result of the COVID-19 lockdown, and as low as 61% in Limpopo. These fluctuations illustrate how the immunisation programme, which generally has high levels of compliance, is highly sensitive to disruptions in vaccine supply (as in 2016) or service delivery (as in 2020).

Immunisation rates improved significantly to 85.5% in 2021, dropping back slightly to 82.2% in 2022. This increase in the year following the hard lockdown, followed by a slight decline the next year, occurred across all provinces and might have been the result of a catch-up in delayed infant immunisations. When comparing the baseline immunisation rates in 2015 with those in 2023, the overall rates are quite similar despite some volatility in the intervening years.[ii] The average rate for the

Figure 3e: National estimates of measles second vaccine dose coverage of babies younger than one year, 2015 – 2023



Source: Health Systems Trust (2025) District Health Barometer 2024 data file (derived from Department of Health District Health Information System – DHIS). Available at www.hst.org.za.

ii The immunisation rates in the District Health Barometer have not been adjusted to the revised population model before 2015, and so it is not possible to determine historical trends in immunisation uptake before 2015.

country was slightly higher in 2023 (83%) than in 2015 (79%). Underlying the overall increase between 2015 and 2023 are contrasting patterns between provinces. Immunisation rates over the period increased substantially in KwaZulu-Natal and, to a lesser extent, in the Eastern Cape, Free State, Mpumalanga and North West. At the same time, immunisation rates dropped in the Northern and Western Cape, Limpopo and Gauteng.

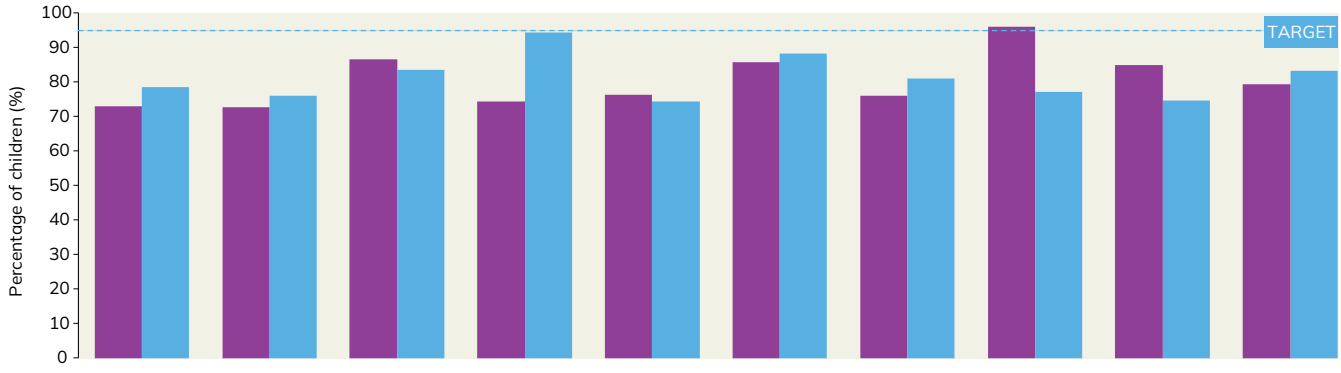
Provinces that experienced a notable increase from 2022 to 2023 were Limpopo (+6.8%) and North West (+7.1%). While provinces who experienced a significant decline in immunisation coverage were the Eastern Cape (-3.7%) and Free State (-3.5%). The highest immunisation rates for 2023 were in KwaZulu-Natal (94.5%) and Mpumalanga (88.2%), while the lowest rates were in Limpopo (74.3%), Western Cape (74.8%) and the Free State (76.2%). 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. Herd immunity depends on the disease's reproductive number: the higher the reproductive number (that is, the more people one infected person can transmit the disease to) the larger the proportion of the population that needs to be immune to achieve herd immunity. The World Health Organization recommends a target of 95% coverage to achieve herd immunity and eliminate infectious childhood diseases. While no province was able to achieve this target, KwaZulu-Natal came relatively close.

The indicator used to estimate coverage of the second dose of the measles vaccine administered at 12 months was derived from the 2025 edition of the District Health Barometer. Over the past decade, at global and national level, there have been numerous outbreaks of measles, emphasising how important it is to administer this booster dose. In South Africa, coverage of the second measles dose in children has varied between 2015 and 2023. After a peak in 2016 (83.6%), coverage dropped and stayed around 76% between 2017 and 2020 with a slight deviation of 79.6% in 2019. Coverage increased sharply to 84% in 2021 and remained at that level in 2022 and 2023. Measles coverage has consistently been the lowest in the North West and Limpopo provinces, the very same provinces that were most severely affected by the 2023 measles outbreak. To prevent outbreaks of this nature and protect children from preventable infectious diseases, we need to advocate for increased uptake of both the first and second measles dose to more than 95%.

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.[24] Internationally, vaccine sentiment and voluntary compliance is inversely correlated with socio-economic status (ie compliance is lower in wealthy countries than in poorer ones).[24] Following a campaign of misinformation about vaccines during the COVID-19 pandemic, a concerted effort needs to be made to ensure that all mothers and caregivers are educated about the importance of immunising their children.

The completion rates for 'basic immunisation' 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%.[10] This suggests that there is also an inverse correlation between socio-economic status and immunisation in South Africa, a highly unequal country.

Figure 3f: Immunisation coverage of babies younger than one year, by province, 2015 & 2023



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2015	73%	73%	87%	74%	76%	86%	76%	96%	85%	79%
2023	79%	76%	84%	95%	74%	88%	81%	77%	75%	83%

Source: Health Systems Trust (2025) District Health Barometer 2024 data file (derived from Department of Health District Health Information System – DHIS). Available at www.hst.org.za.

Notes:

1. The numerator (immunisations) comes from the NDoH's District Health Information System for April 2023 – March 2024.
2. The denominator (population under one) was derived from the 2023 mid-year population estimate.

Teenage pregnancy

This indicator shows the number and proportion of young women aged 15 – 24 who are reported to have given birth 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 (ie 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.[25-27] 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.[28]

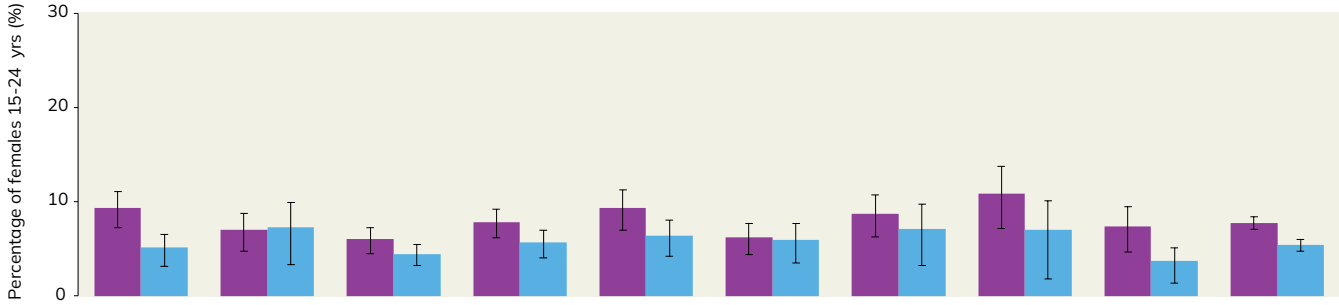
Stats SA regularly reports the number of 'recorded live births', using vital statistics data. The pattern over the past decade (from 2011) has been a decrease in adolescent births, this decrease being reflected in both the rate of current year birth registrations and late birth registrations. In 2023, out of 950,000 current-year births registered, 100,000 were registered to the mothers of adolescents aged 19 or younger.[29] The share of all births registered to teens up to 19 years was 12%, down from 16% of births that occurred a decade before.

Department of Health data between 2004 and 2019 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.[30] The share remained stable in 2022, with teens aged 15 – 19 representing 13% of participants in the antenatal survey, down from 17.5% in 2013. All of these data sources suggest that pregnancy and fertility rates among teenagers did not increase in last decade.

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 decade. However, prevalence rates are still worryingly high: of the young pregnant women surveyed in antenatal clinics in 2022, 7.6% of those aged 15 – 19 and 16.4% of those aged 20 – 24 were HIV positive.[31] For many years the majority of deaths in young mothers were caused by HIV.[32] Much of the overall decline in maternal deaths since 2011 is attributed to implementation of policies to manage and prevent HIV,[33] 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.[26, 32, 34] 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

Figure 3g: Annual childbearing rates among young women aged 15 – 24 years, by province, 2009 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2009	9,3%	7,0%	6,0%	7,8%	9,3%	6,3%	8,7%	10,9%	7,4%	7,7%
	66,000	20,000	66,000	92,000	61,000	28,000	27,000	12,000	39,000	412,000
2024	5,1%	7,3%	4,5%	5,7%	6,4%	5,9%	7,2%	7,0%	3,7%	5,4%
	26,000	18,000	61,000	59,000	34,000	27,000	24,000	8,000	23,000	281,000

Source: Statistics South Africa (2010; 2025) *General Household Survey 2009; General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

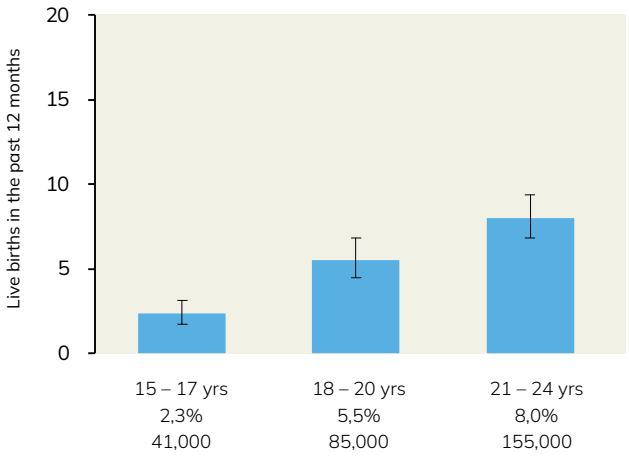
to become pregnant than those who are progressing through school at the expected rate.[35] So efforts to provide educational support for girls who are not coping at school may also help to reduce teenage pregnancies.

Poverty alleviation is important for both the mother and child, but previous studies on take-up of the Child Support Grant (CSG) among teenage mothers have found that access is low compared with older mothers.[27, 36, 37] In 2024, fewer than 1% of the 7.5 million CSG beneficiaries (caregivers) were under 20 years old.[7] 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, birth registration 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 Stats SA 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 5.4% in 2024. This is equivalent to 281,000 births to young women in this age group, out around one million births per year, according to the population models and represents a statistically significant decline since 7.7% in 2009 when the question was first asked in the survey.

Figure 3h: Childbearing rates among female youth aged 15 – 24 years, by age group, 2024



Source: Statistics South Africa (2025) *General Household Survey 2024*. Pretoria: Stats SA. Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

As would be expected, childbearing rates increase with age. Only 2% 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 6% among 18 – 20-year-olds (85,000 when weighted), and 8% in the 21 – 24 age group (155,000). This pattern has been been fairly stable over the past decade, and in the group defined as children (under 18) the childbearing rate has never risen above 3.2% (its peak in 2013).

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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 United Nations 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.

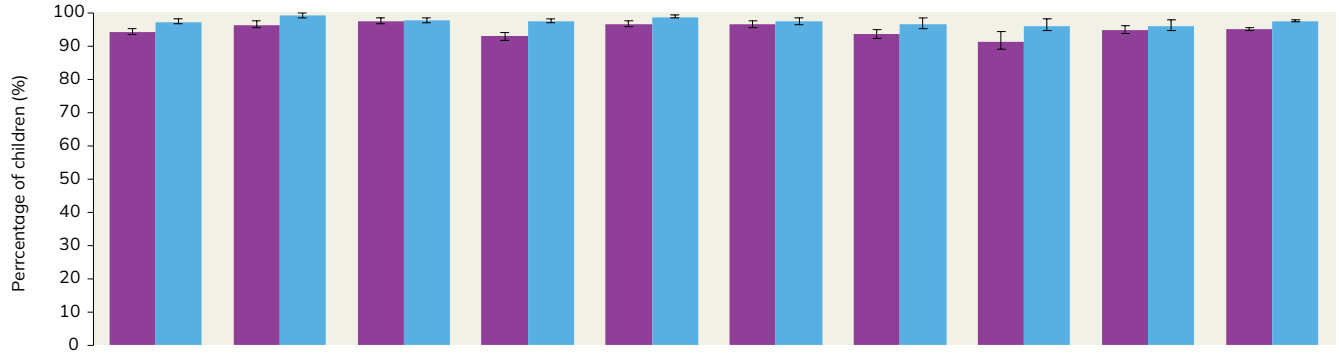
Education is a transformative socio-economic right that provides the foundation for lifelong learning and economic opportunity. All children have a right to basic education, which the Constitutional Court has ruled extends to Grade 12.[4]

Historically, basic education has been compulsory from Grade 1 (the year in which a child turns seven). The Basic Education Laws Amendment (BELA) Act was signed by the President on 13 September 2024 and came into effect on 24 December 2024.[5, 6] The BELA Act means that from 2025, Grade R has been formally integrated into the foundation phase and has become compulsory for children in the year that they turn six. Because this indicator gives a retrospective view of attendance rates, it still measures attendance against the previous compulsory starting age for children. The compulsory stage ends on completion of Grade 9 or when the child turns 15. After this, children may leave school, but the state has a responsibility to provide basic education up to the end of Grade 12 for those who want to complete school.

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.

All schools were closed between March and June 2020, due to the outbreak of COVID-19 and the resultant lockdown. From

Figure 4a: School-age children (7 – 17-year-olds) attending an educational institution, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	94,2%	96,3%	97,4%	92,9%	96,6%	96,4%	93,6%	91,2%	94,8%	95,0%
	1,811,000	603,000	1,763,000	2,470,000	1,525,000	917,000	671,000	221,000	944,000	10,926,000
2024	97,2%	99,0%	97,7%	97,5%	98,7%	97,3%	96,5%	95,9%	95,8%	97,4%
	1,507,000	645,000	2,872,000	2,609,000	1,519,000	1,073,000	829,000	249,000	1,287,000	12,590,000

Source: Statistics South Africa (2003, 2025) *General Household Survey 2002; General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

June, schools partially re-opened, but only for specific grades. Schools re-opened for all grades from late August 2020, but even then, they operated at reduced capacity with rotational timetabling of classes.

Statistics South Africa (Stats SA) ran its 2020 General Household Survey (GHS) later than usual, from September to December. 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 previous years, with just a small decrease of one percentage point from 2019, to 97%. Wave three of the National Income Dynamics Study – Coronavirus Rapid Mobile Survey (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 the 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.[7] This was due to the staggered re-opening of grades and prioritisation of those approaching the end of the primary or secondary school. Reported attendance rates remained at 97 – 98% in 2021 – 2024. Of the 12.9 million children aged 7 – 17 years in 2024, 12.6 million were reported to attend school (97%), while 330,000 were not attending. Attendance rates were similarly high across all provinces.

Overall attendance rates tend to mask dropout among older children. Analysis of attendance among discrete age groups shows that attendance remains at 95% for children aged 16, dropping to 93% among 17-year-olds. At age 18 there is a substantial drop: to around 85% among young people who have not completed Grade 12. Differences in reported school attendance rates between boys and girls are not statistically significant.

The GHS asks about reasons for non-attendance for those who are not attending an educational institution. The main reasons for non-attendance can be divided into three main categories: system failures (including exclusions and quality problems); financial barriers; and illness or disability. Together, these account for nearly two thirds of non-attendance.

Of the school-age children who were not attending any school in 2024, 11% were "unable to perform at school", 5% left because "education is useless or not interesting" while a nominal 1% dropped out because they failed their exams. Worryingly, 10% of those not attending were not accepted for enrolment, up from 4% in 2022 and suggesting that capacity constraints may be an emerging obstacle to the realisation of this important right. Together, these reasons signal failures in the education system and account for nearly 30% of all reported non-attendance.

The second main barrier to education is financial or accessibility constraints. These include the cost of schooling (the reason given for 14% of children not attending schools in 2024) and difficulties in reaching school (2% were not attending because the school is too far). Six percent of those not attending were too busy due to work or domestic responsibilities, suggesting that for some families the opportunity cost of education is a barrier. Disability is also an important reason, accounting for 8% of non-attendance in 2024 and again pointing to a failure in the education system to accommodate children with disabilities. Illness accounted for an additional 4% of the non-attendance rate.

Pregnancy accounts for 3.5% of all non-attendance, and 8.5% of non-attendance among teenage girls who are not attending school.[8-10]

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 substantially lower than those in the wealthier quintiles, although there is a statistically significant difference in reported attendance rates for children in the poorest income quintile (97%) compared with the richest income quintile (99%).

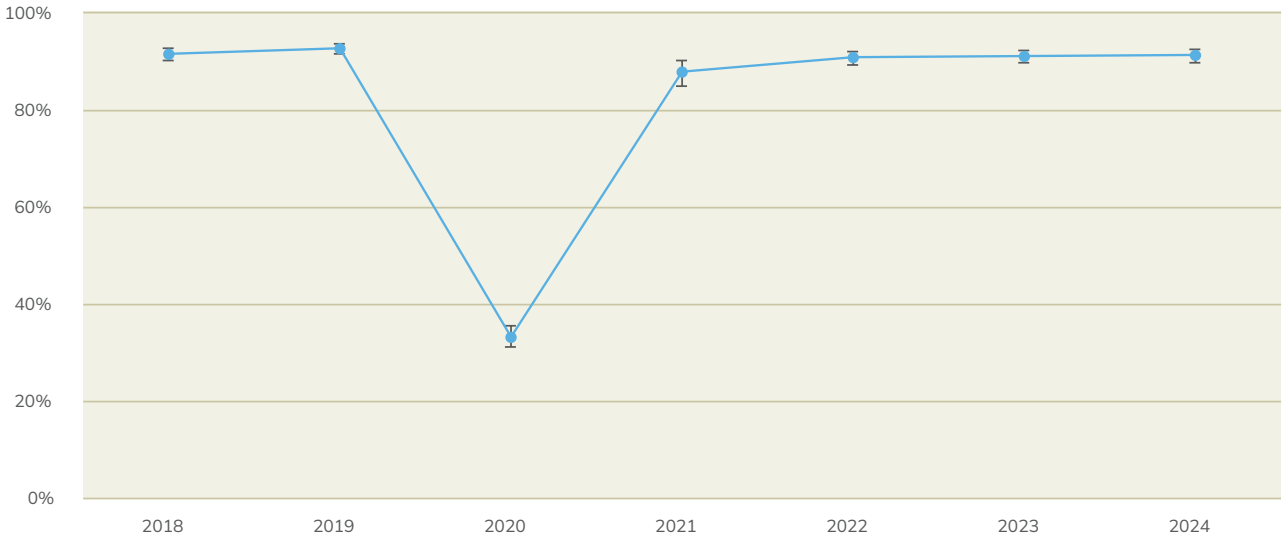
Attendance rates alone do not capture the regularity of children's school attendance or their progress through school. Research has shown that children from more disadvantaged backgrounds – with limited economic resources, lower levels of parental education, or who have lost their mother – are more prone to dropping out or progressing more slowly than their more advantaged peers. Racial inequalities in school advancement remain strong.[11, 12] Similarly, school attendance rates tell us nothing about the quality of teaching and learning.[13] Inequalities in learning outcomes are explored through standardised tests such as those used in the international SAQMEC,[14] TIMMS and PIRLS[15] studies. The DBE's controversial Annual National Assessments[16] were discontinued in 2017, meaning that the only national standardised assessment is matric.

Access to early learning programmes and Grade R

This indicator shows the number and percentage of children aged 5 – 6 who are reported to be attending Grade R or any other early learning programme (ELP) – in other words, those attending out-of-home group care and learning facilities including early childhood development (ECD) centres, pre-Grade R or Grade R. 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. Given that Grade 1 starts in the year that a child is six turning seven, the measure includes some six-year-olds who are attending Grade 1 in ordinary schools.

Educational inequalities are strongly associated with socio-economic (and therefore also racial) inequalities in South Africa.[17, 18] These inequalities are evident from the early years, even before entry into primary school.[19] They are exacerbated by an unequal schooling system,[20, 21] 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.[14, 22]

Figure 4b: Children aged 5 – 6 years attending school or ECD facility, 2018 – 2024



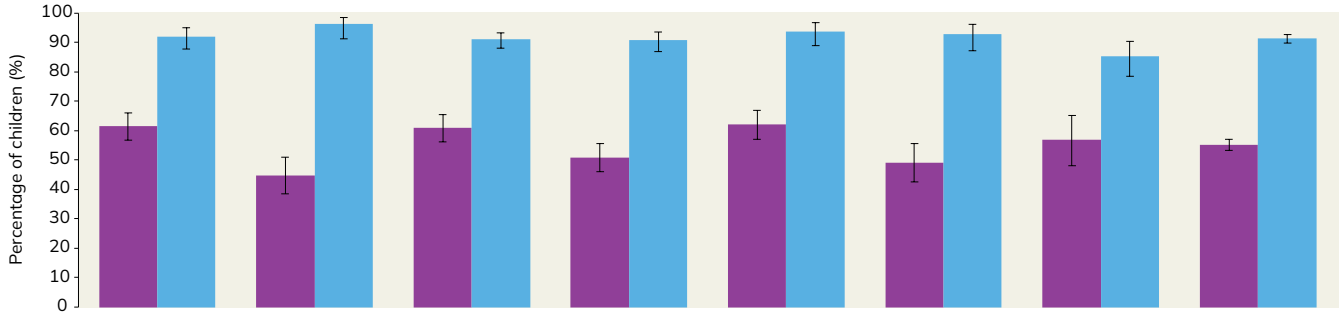
Source: Statistics South Africa (2019 – 2025) *General Household Survey 2018 – 2024;* Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Evidence suggests that quality group learning programmes are beneficial for cognitive development from about three years of age.[23] 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 National Development Plan (NDP) priorities, cited in the DBE's 2030 ECD Strategy,[24] include universal access to two years of early childhood development programmes. The DBE funds and monitors thousands of private and community-based ELPs in addition to 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.[25] It therefore makes sense to monitor enrolment in learning programmes for 5 – 6-year-olds.

According to the DBE's administrative data, 860,000 learners were attending Grade R at ordinary schools in early 2024, of whom 95% were in public (government) schools. Of the 26,000 learners attending pre-Grade R in ordinary schools, just over half (52%) were enrolled in independent schools, while 48% were at public schools.[26] These would include some private ECD centres which are registered as schools, but would exclude many other independent and unregistered facilities. Government schools are therefore providing the large bulk of education services for children in Grade R, but not for pre-Grade R.

Figure 4c: Children aged 5 – 6 years attending school or ECD facility, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	61,4%	44,7%	61,0%	50,8%	62,2%	49,1%	49,1%	34,7%	56,9%	55,2%
	194,000	49,000	188,000	220,000	158,000	80,000	63,000	16,000	97,000	1,064,000
2024	92,1%	96,5%	91,1%	90,8%	93,8%	93,0%	91,7%	86,1%	85,4%	91,3%
	261,000	101,000	498,000	458,000	293,000	178,000	136,000	46,000	186,000	2,157,000

Source: Statistics South Africa (2002; 2025) *General Household Survey 2002, 2024;* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, 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 reporting of attendance rates (for a more detailed technical explanation, see childrencount.uct.ac.za).

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, signifying substantial gains in access to ELPs over the years. Unlike many other child indicators, this measure of ECD access is not associated with significant inequalities across provinces.

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.[27] Given the inequalities in South Africa, it was also pleasing to see that as access to education increased among 5 – 6-year-olds, the inequalities in access across races and income quintiles reduced.

The effect of COVID-19 and lockdown on early learning was dramatic: the year 2020 saw a rapid reversal of the gains made over nearly two decades in early learning access for 5 – 6-year-olds. Young children could not attend ELPs during lockdown because of the closure of schools and ECD centres. The impacts extended later in the year due to administrative challenges in registering and funding the reopening of schools. In late 2020, when the GHS was conducted, only 33% of children aged 5 – 6 were attending any kind of educational centre, down 60 percentage points from 93% from the year before. Alongside the sharp fall in attendance was an apparent increase in racial inequality in ECD access (60% of White children aged 5 – 6 years were reported to be accessing some kind of learning facility, compared with only 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. The large numbers of young children who lost access to early learning programmes during lockdown are now among the cohort of foundation phase learners, but it is not yet known how the early learning deficit will play out in school readiness and learning outcomes in the foundation phase and beyond.

Attendance rates rose again after 2020, and by 2022 the pre-lockdown attendance rate had been regained, with 91% of 5 – 6-year-olds reported to be attending early learning programmes. The inequalities across income quintiles and races had also reduced. This level of access remained static in 2023 and 2024.

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.

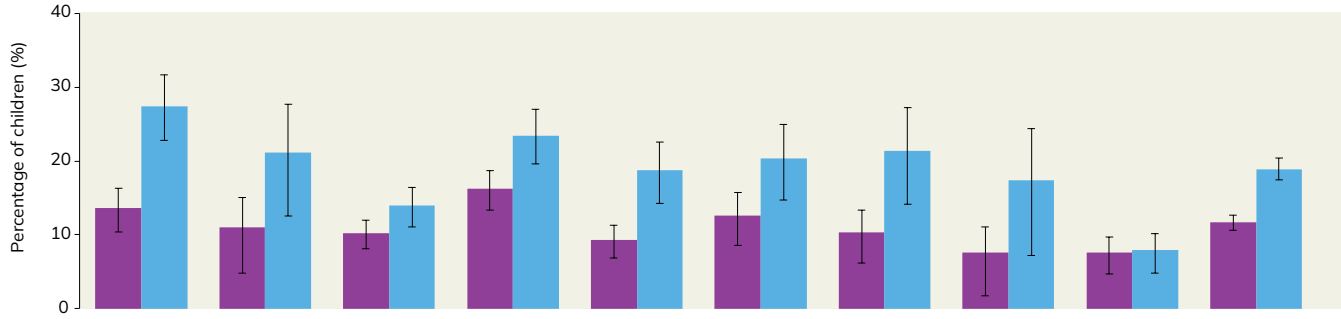
Children living far from school

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

Figure 4d: School-age children living far from school, by province, 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Primary	13,6%	11,0%	10,2%	16,2%	9,4%	12,6%	10,3%	7,7%	7,6%	11,7%
	135,000	45,000	186,000	279,000	97,000	90,000	58,000	13,000	64,000	967,000
Secondary	27,5%	21,1%	14,0%	23,5%	18,8%	20,4%	21,4%	17,4%	7,9%	18,9%
	154,000	51,000	156,000	224,000	95,000	79,000	63,000	17,000	39,000	881,000

Source: Statistics South Africa (2025) *General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

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 or 2021 GHS as the number of questions was reduced during lockdown. The question was resumed from 2022. Of the 12.6 million children who were attending school in 2024, nearly eight million (62%) walked to school, while 15% travelled in vehicles hired by a group of parents, 10% travelled in private cars and 6% used public transport (bus, minibus, taxi or train). Only 5% used school transport. The vast majority of White learners (78%) were driven to school in private or hired cars, compared with only 21% of African children. And while 66% of African children walk to school, only 6% of White children do so. These figures illustrate pronounced disparity in child mobility and mode 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 GHS. 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.

Overall, the vast majority (86%) of the 12.6 million children who attended school in 2024, travelled less than 30 minutes to reach school while nearly two million took more than 30 minutes to get to school. Children of secondary school age are more likely than primary school learners to travel far to reach school. In 2024 there were 8.3 million children of primary school age (7 – 13 years) in South Africa. A million of these children (12%) travelled more than 30 minutes to and from school every day. In KwaZulu-Natal, this percentage is significantly higher than the national average, at 16%. Of the 4.7 million children of secondary school age (14 – 17 years), 19% travel more than 30 minutes to reach school, and again children in KwaZulu-Natal are most likely to travel far (24%), along with children in the Eastern Cape (27%). The majority of these children live in rural areas: 25% of secondary school age children in the former homelands and 24% living on farms travel far to school, compared to 12% 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 were 24,850 schools in South Africa in 2024, of which 90% were public and 10% independent.[26] Over 4,000 government schools (16% of all public schools) have closed since 2002 as the DBE consolidated smaller schools and closed down underperforming and resource-poor schools as well as rural schools with low numbers of learners. While the concentration of more children into fewer schools may be an advantage from a school management perspective, the rationalisation policy and closure of 'non-viable' schools 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 more than doubled, from 1,158 to 2,469.[28]

Children's progress through school

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.

Previous systemic evaluations by the DBE have recorded very low pass rates in numeracy and literacy among both Grade 3 and Grade 6 learners,[29] and internationally comparative studies have repeatedly found South Africa's performance to be poor even when compared with other countries in the region. Both the 2016 and 2021 international PIRLS studies, which assessed literacy among Grade 4 learners, found that four out of five Grade 4 children in South Africa could not read for meaning in any language.[30, 31] 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.[32] 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.[13, 21, 33]

High rates of grade repetition have been recorded in numerous studies. An analysis of grade promotion, repetition and dropout using administrative data showed that in 2019, 12% of Grade 1 learners were not promoted to the next year and repeated the grade. In the same year 9% of Grade 2s and 7% of Grade 3s repeated their grade. Repetition rates are much higher in the senior phase, where 17% of Grade 8s and 14% of Grade 9s repeated the year.[34] Progression rates were considerably higher in 2020, perhaps because the criteria for grade promotion were relaxed in light of extensive disruption of the teaching programme during lockdown. For those who are not properly evaluated at foundation and intermediate phase, automatic promotion may lead to higher rates of repetition and dropout in the upper grades and affect matric pass rates down the line.

A study of children's progress at school, using 2008 data from the National Income Dynamics Study, found that only about 44% of young adults (age 21 – 29) had matriculated, and of these less than half had matriculated "on time".[35] In 2016, only 51% of young people aged 20 – 24 had completed a matric or matric equivalent.[36] 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 dropout.[9]

The South African schooling system is divided into three-year phases: the foundation phase (Grades 1 to 3), the

intermediate phase (Grades 4 to 6), the senior phase (Grades 7 to 9) and the further education and training phase (Grades 10 to 12). 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 and therefore provides a generous estimate of school progress: 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 2024, 94% of all children aged 10 and 11 were reported to have completed Grade 3, 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 90% in 2024), Mpumalanga (75% to 93%), Limpopo (80% to 97%), KwaZulu-Natal (75% to 97%), and Gauteng (85% to 96%). These improvements have narrowed the gap between provinces, although it is uncertain to what extent this reflects real improvements in education or arises from stricter rules limiting the number of grades that can be repeated within a school phase.

As would be expected, the rate of progression through the entire general education and training band (up to Grade 9) is lower, as there is more time for children to have repeated or dropped out by the end of Grade 9. In 2024, 78% of children aged 16 – 17 years had completed Grade 9, while 22% had not attained this level of schooling. This represents an overall improvement of nearly 30 percentage points over the two decades, from 50% in 2002. Provincial variation is slightly more pronounced than for progress through the foundation phase with Gauteng having the highest rate of Grade 9 progression (85%), followed by KwaZulu-Natal (82%). Progress was poorest in the Northern Cape, North West and the Free State, where less than 70% of children had completed Grade 9 by the expected age.

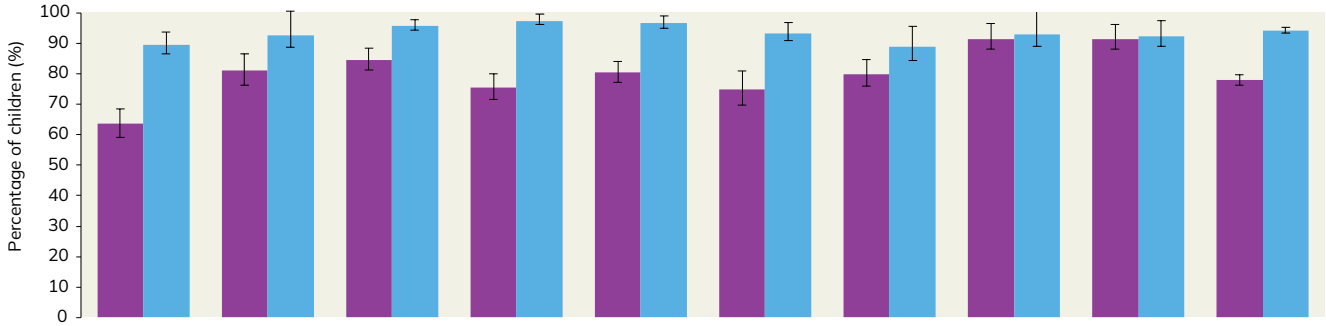
As found in other analyses of transitions through school[17, 18, 27] educational attainment (measured by progress through school) varies along socio-economic and racial lines. These differences become more pronounced as children advance through the grades. Gender differences in school progression have 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 2024, the gender difference in grade progression for Grade 3 learners was not significant (96% for girls versus 93% for boys). But in the same year, 85% of 16 – 17-year-old girls had completed Grade 9, compared with only 71% of boys in the same age cohort – a statistically significant difference. These findings are consistent with previous analyses from different data sources.[9, 37]

There are differences in grade completion across income quintiles too, especially among children who have completed Grade 9: in 2024, 73% of 16 – 17-year-olds in the poorest 20% of households had completed Grade 9, compared to 93% of those 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 stabilised since then.

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 dropout point to a range of factors. There is huge variation in the quality

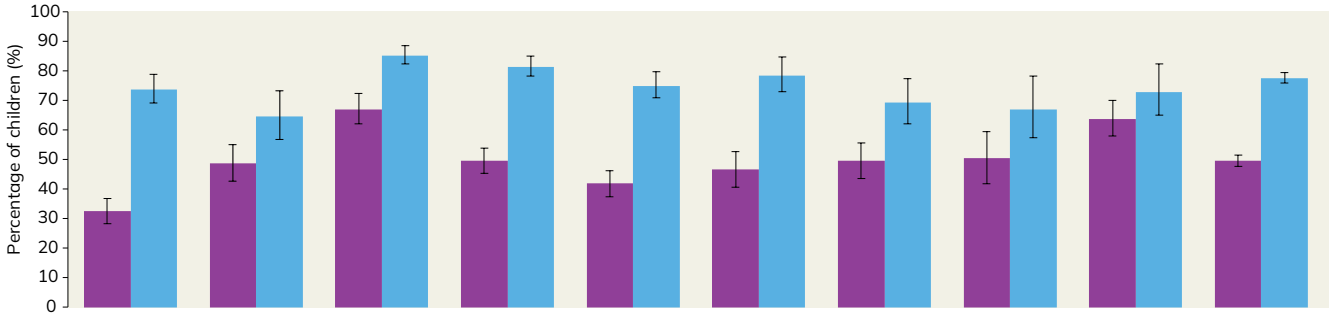
Figure 4e: Children age 10 – 11 years who passed Grade 3, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	63,7%	81,0%	84,5%	75,4%	80,5%	74,8%	79,9%	91,5%	91,3%	77,9%
	215,000	94,000	272,000	374,000	223,000	136,000	108,000	46,000	169,000	1,637,000
2024	89,5%	92,6%	95,7%	97,3%	96,5%	93,3%	88,8%	92,8%	92,3%	94,1%
	270,000	94,000	500,000	469,000	302,000	194,000	161,000	47,000	209,000	2,247,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

Figure 4f: Children age 16 – 17 who passed Grade 9, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	32,7%	48,9%	67,1%	49,6%	41,9%	46,8%	49,7%	50,7%	63,8%	49,6%
	113,000	55,000	225,000	238,000	122,000	80,000	64,000	21,000	120,000	1,037,000
2024	73,9%	64,7%	85,2%	81,6%	75,1%	78,4%	69,4%	67,2%	72,9%	77,8%
	191,000	78,000	493,000	370,000	194,000	152,000	95,000	30,000	191,000	1,795,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

of education that largely reflects 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.[35] This in turn suggests that improved educational outcomes for children will have a cumulative positive effect for each subsequent generation.

Youth not in employment, education or training (NEETs)

'NEETs' 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.[38]

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 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 people[39] and it has been argued that this unenvisaged expenditure of the grant could be addressed by extending social security to unemployed youth.[40]

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).[41] 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.[36, 41] This reduces prospects for further study or employment.[35] 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.[42, 43] The 'demand-side' driver relates to a shortage of jobs or self-employment opportunities for those who are available to work.

In 2024, there were 10.4 million young people aged 15 – 24 in South Africa, according to the GHS when population weights are applied. Of these, 36% (3.7 million) were neither working nor enrolled in any educational programme at 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 since the beginning of democracy when only two million NEETs were recorded in 1996.[44] 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 2030.[45] If anything, the number of NEETs has increased marginally.

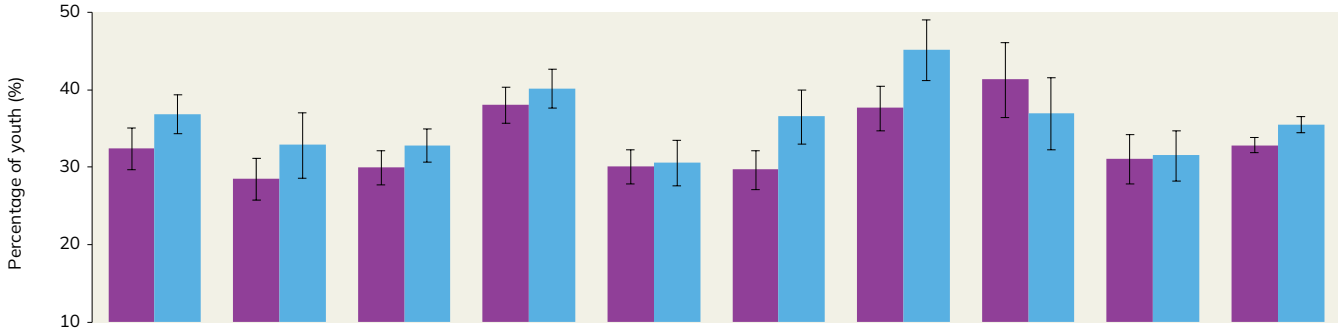
The NEET rates are quite consistent across the provinces. This is hard to interpret without further information. Limpopo, for example, is a very poor and largely rural province where one might expect high rates of unemployment. It is possible

that the slightly lower-than-average percentage of NEETs in that province is partly the result of young people migrating to cities in Gauteng or other provinces in search of work and those unemployed youth therefore being counted among the NEETs elsewhere. It is also 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 and spatial inequalities that are characteristic of many other indicators.

There is enormous variation within the broad youth group of 15 – 24 years. Only 6% of children aged 15 – 17 are classified as NEET because the majority of children in this age group are attending school. Within the 18 – 20 age band, 41% are NEETs, and more than half (58%) 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 significant. Thirty-eight percent of young women are not in employment, education or training – compared with 33% of young men.

Figure 4g: Youth (15 – 24 years) not in employment, education or training (NEETs), by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	32,4%	28,5%	30,0%	38,1%	30,1%	29,7%	37,6%	41,3%	31,1%	32,8%
	436,000	150,000	568,000	783,000	338,000	213,000	229,000	76,000	294,000	3,086,000
2024	36,8%	32,9%	32,8%	40,2%	30,6%	36,5%	45,1%	37,0%	31,5%	35,5%
	388,000	166,000	914,000	822,000	322,000	311,000	314,000	82,000	376,000	3,695,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

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Children's access to housing

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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 United Nations (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.

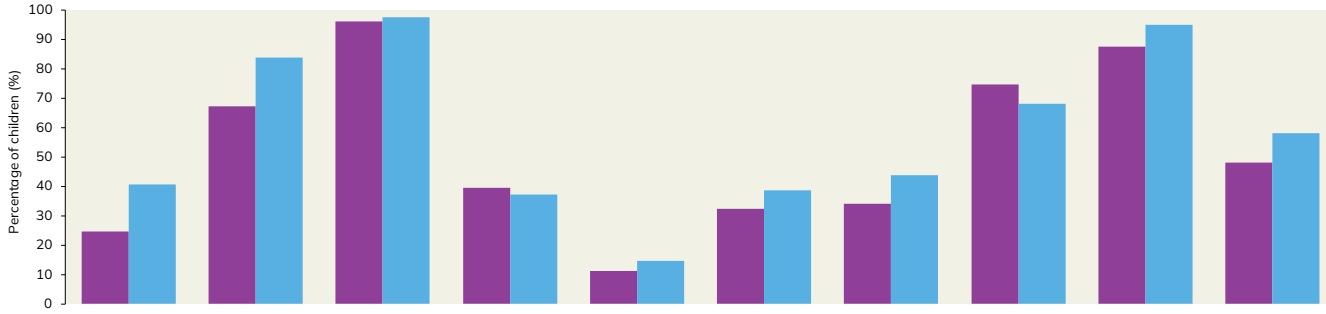
Location is one of the seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights.[3] Residential areas should ideally be situated close to work opportunities, clinics, police stations, schools and childcare facilities. In a country with a large rural population, 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.

In 2024, 58% of children lived in urban areas while 42% were in rural households – equivalent to 8.8 million children in the rural population. Looking back over a decade, there is a clear shift in the distribution of children towards urban areas: In 2002, 48% of children were in urban households, and the urban share increased gradually to 57% by 2017, after which it remained stable. Given population growth, the urban child population has grown by 3.5 million, from 8.7 million children in 2002 to 12.2 million in 2024. Children are consistently less urbanised than adults: in 2024, 68% of the adult population was urban, compared with 58% 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 over 70% of all rural children in South Africa. KwaZulu-Natal has the largest rural child population in numeric terms, with 2.7 million (63%) of its child population being classified as rural. The least urbanised province is Limpopo, where 85% of children live in rural areas and only 15% live in urban areas. Proportionately more children (38%) live in the former homelands, compared with adults (28%). Almost all of children living in the former homeland areas are African.

Children living in Gauteng and the Western Cape are almost entirely urban based (98% and 95% respectively). These provinces historically have large urban populations. The urban child population in Gauteng alone has grown by over 1.8 million since 2002 and the urban child population in the Western Cape has grown by over 600,000. These increases are partly the result of urban births, and partly the result of within-province movement and migration from other provinces. Other provinces

Figure 5a: Children living in urban areas, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	24,6%	67,2%	96,1%	39,5%	11,1%	32,5%	34,3%	74,8%	87,7%	48,2%
	721,000	672,000	2,825,000	1,641,000	270,000	494,000	399,000	298,000	1,411,000	8,730,000
2024	40,8%	84,0%	97,6%	37,3%	14,6%	38,8%	43,7%	68,2%	94,9%	58,1%
	1,021,000	875,000	4,660,000	1,622,000	369,000	696,000	629,000	303,000	2,027,000	12,202,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024*. Pretoria: Stats SA. Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

that have experienced a marked growth in the urban share of the child population are the Eastern Cape, Free State and North 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 2024, six out of every 10 children in the poorest income quintile lived in rural areas compared with one out of 10 in the richest quintile, and this had been a consistent trend over the previous decade. 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 inequalities remain strongly racialised. Around 90% of White, Coloured and Indian children live in urban areas, compared with 53% of African children.

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; and 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 derived from the category in the General Household Survey, 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.

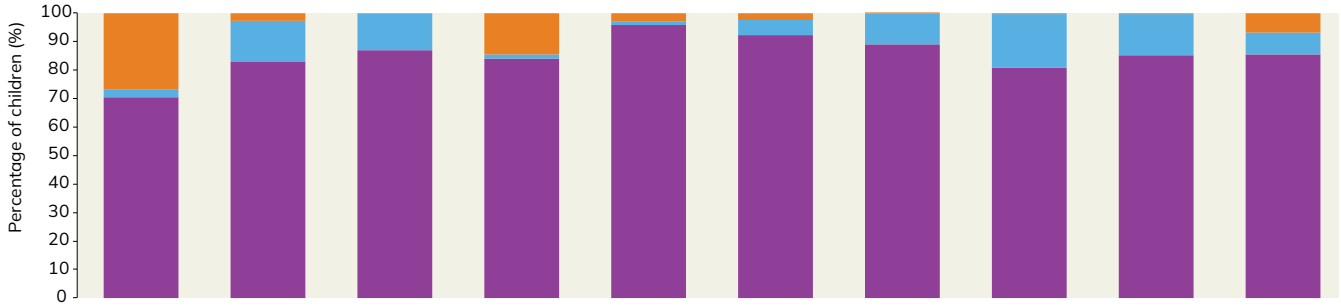
Formal brick houses that meet the state's standards for quality housing could be considered habitable, whereas informal dwellings such as shacks in informal settlements and backyards would not be considered habitable or adequate. Informal housing in backyards and informal settlements make up the bulk 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 formal dwellings in low-cost housing developments – 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 may be 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: four out of 10 children who live in informal housing are preschool age.

In 2024, nearly 1.6 million children (7% of the child population in South Africa) lived in informal housing – in backyard shacks or informal settlements. The number of children in informal housing has declined gradually from 2.3 million (13%) in 2002. The provinces with the highest shares of informally-housed

Figure 5b: Children living in formal, informal and traditional housing, by province, 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Formal	70,6%	82,9%	87,1%	84,2%	95,8%	92,3%	88,9%	80,9%	85,2%	85,6%
	1,768,000	863,000	4,161,000	3,658,000	2,423,000	1,655,000	1,279,000	359,000	1,819,000	17,985,000
Informal	2,5%	14,5%	12,9%	1,2%	1,3%	5,2%	10,9%	18,6%	14,6%	7,4%
	63,000	151,000	616,000	53,000	32,000	94,000	157,000	83,000	312,000	1,558,000
Traditional	26,9%	2,6%	0,0%	14,6%	2,9%	2,5%	0,2%	0,5%	0,2%	7,0%
	675,000	27,000	0	635,000	73,000	45,000	3,000	2,000	5,000	1,466,000

Source: Statistics South Africa (2025) *General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

children are the Western and Northern Cape, Gauteng and Free State. The Eastern Cape, KwaZulu-Natal and Limpopo have the lowest shares of children in informal housing (below 3% in each of these provinces). The vast majority of children in Limpopo (96%) are recorded as living in formal housing, while the Eastern Cape has a relatively large share of its child population living in traditional dwellings (27%). The distribution of children in formal, informal and traditional housing has remained fairly constant since 2002. But racial inequalities persist. Virtually all White children in the 2024 survey lived in formal housing, compared with 84% of African children. Access to formal housing increases with income. Nearly 100% of children in the wealthiest 20% of households live in formal dwellings, compared with 79% 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 2024, 3.7 million children lived in overcrowded households. This represents 17% of the child population – much higher than the share of adults living in crowded conditions (10%).

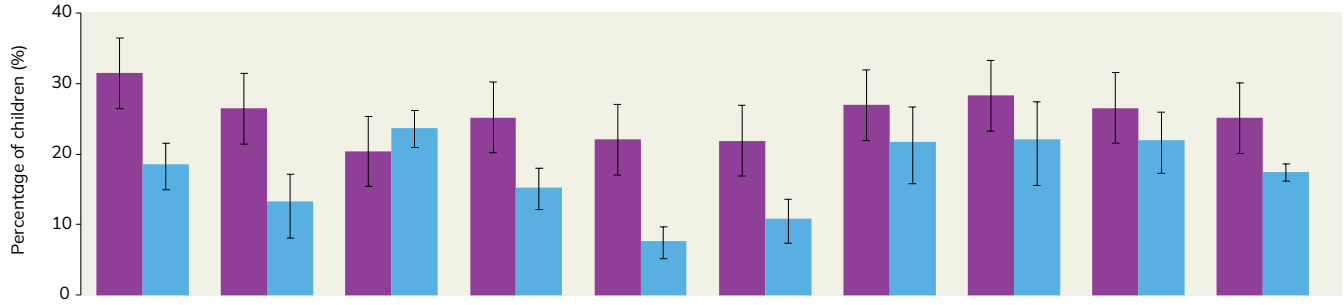
Overcrowding is associated with housing type: 42% of children who stay in informal dwellings also live in overcrowded conditions, compared with 24% of children in traditional dwellings and 15% of children in formal housing.

Young children are slightly more likely than older children to live in overcrowded conditions. Twenty-one percent of children younger than six years live in crowded households, compared to 15% of children over 12 years old.

There is a strong racial bias in children's housing conditions. While 18% of African and 22% of Coloured children live in crowded conditions, only around 1% of White children are recorded as living in overcrowded households. Children in the poorest 20% of households are more likely to be living in overcrowded conditions (23%) than children in the richest 20% of households (2%).

The average household size has decreased from 4.5 at the time of the 1996 population census, to around 3.2 in 2024.[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 declining marriage and cohabitation rates between men and women.[7] In more recent years, an important contributor to declining average household size has been the fairly rapid growth in single-person households where adults live alone.[8-10] The 2022 Census counted 18 million households in South Africa,

Figure 5c: Children living in overcrowded households, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	31,5%	26,5%	20,4%	25,2%	22,1%	21,9%	26,9%	28,3%	26,5%	25,1%
	922,000	264,000	599,000	1,046,000	534,000	333,000	314,000	113,000	427,000	4,551,000
2024	18,5%	13,3%	23,7%	15,3%	7,7%	10,9%	21,7%	22,1%	21,9%	17,4%
	464,000	138,000	1,131,000	663,000	195,000	195,000	313,000	98,000	468,000	3,665,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

double the number recorded in 1996.[4] The weighted count of households in the 2024 General Household Survey was nearly 20 million. Of these nearly 20 million households 27% (around 5.3 million) were households where one person lived alone.[11, 12] 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 2024 was 1.7 while the mean household size for households that included children was 4.7.

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Children's access to services

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

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 United Nations (UN) Convention on the Rights of the Child says that state 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]

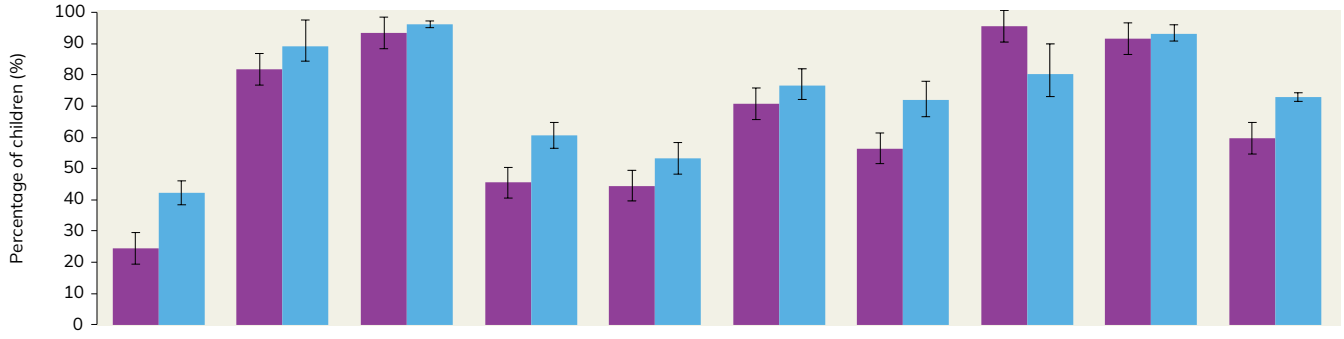
Children's access to basic water

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. Piped water 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 have had their service restricted because of inability to pay. It is therefore likely to be an over-estimation of children's access to adequate water.

Clean water is essential for human survival. The World Health Organization 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, handwashing and face washing. It does not allow for other hygiene practices like bathing showering, washing clothes or domestic cleaning. This 'basic' level of water access is still considered high risk for health outcomes. A higher 'intermediate' level of access with 'medium' risk is around 50 litres per person per day, delivered to the site or within a five-minute walk. 'Optimal' access (low risk) is defined as a minimum of 100 litres per person per day, supplied through on-site taps and continuously available.[5] Adequacy therefore refers to quantity, quality and accessibility: 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.

The Sustainable Development Goals (in 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.

Figure 6a: Children living in households with water on site, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	24,4%	81,7%	93,5%	45,5%	44,5%	70,8%	56,5%	95,6%	91,7%	59,8%
	716,000	817,000	2,747,000	1,888,000	1,077,000	1,077,000	658,000	380,000	1,476,000	10,836,000
2024	42,3%	89,3%	96,2%	60,6%	53,2%	76,7%	72,0%	80,1%	93,1%	72,9%
	1,060,000	930,000	4,596,000	2,634,000	1,345,000	1,376,000	1,036,000	356,000	1,988,000	15,319,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

Young children are particularly vulnerable to diseases associated with poor water quality. Gastro-intestinal infections with associated diarrhoea and dehydration are a significant driver of child mortality 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 set at a slightly higher standard than the definition of basic water in South Africa, as it requires a water source on site (either inside the house or in the yard of the household where the child lives).

The share of children with piped water at home increased from 60% in 2002 to 70% nationally in 2017, representing an increase of three million children. The biggest improvements over this period were in the Eastern Cape (from 24% to 40%) and KwaZulu-Natal (from 46% to 60%).

After the overall improvements in access to adequate water between 2002 and 2017, the trend levelled off, suggesting that a ceiling had been reached. In 2024, 73% of children were living in households with piped water, while over a quarter (nearly 6 million children) depended on water connections that were off-site or did not meet the adequacy standard of providing a safe, reliable supply. Adults are more likely than children to live in households with adequate water access (80% of adults compared with only 73% of children). This is because, compared with the adult population, children are more likely to live in rural households located in areas without bulk service infrastructure.

Over 90% of children living in urban areas have water on site, compared with 43% of children in the rural former homelands and 61% of children living on farms. While the majority (78%) of children in formal dwellings have access to an adequate water supply on-site, this decreases to 66% for children living in informal dwellings. Only 21% of the 1.6 million children living in traditional dwellings have water available on the property.

The vast majority of children living in the former homelands and in traditional dwellings are African, so there is also pronounced racial inequality in access to water. In 2024, 69% of African children had water on site, while levels of piped water access for all other population groups exceeded 95%. There are no significant differences in access to water across age groups.

Provincial differences are striking. Around nine out of ten children in Gauteng (96%), the Western Cape (93%) and the Free State (89%) 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 two decades. The provinces that have experienced substantial improvements in water provision are those which had the lowest levels of access to start with: the Eastern Cape (a significant improvement in the provincial share of children with water on site, from 24% in 2002 to 42% in 2024), KwaZulu-Natal (from 46% to 61%); Limpopo (a more modest improvement from 45% to 53%) and Mpumalanga (from 71% to 77%). The Eastern Cape, with its large under-serviced former homeland areas, remains the only province in which more than half of all children do not have piped water to their home, while water access in the Northern Cape seems to be declining.

Inequality in access to safe water is also pronounced when the data are disaggregated by income group. Only 57% of children in the poorest 20% of households have access to water on site, while 98% 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 (which in terms of the policy are assumed to dispose of waste safely) that are within the house or on site. Inadequate toilet facilities include pit latrines that are not ventilated, chemical toilets, bucket toilets, or no toilet facility at all.

The National Sanitation Policy 2016 defines basic sanitation as infrastructure that "considers natural resource protection, is safe (including for children), reliable, private, socially acceptable, with skills and capacity available locally for operation and maintenance, protected from the weather and ventilated, keeps smells to the 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, facilitates hand washing and enables safe and appropriate treatment and/or removal of human waste and wastewater in an environmentally sound manner".[8] This definition differs from the previous Strategic Framework for Water Services in that it includes more specific reference to environmental considerations. It also specifically mentions that sanitation should be safe for children, and that basic sanitation includes access to handwashing facilities.[9]

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.[10] 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 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 shows 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 at home – services defined as 'adequate' include a flush toilet connected to a bulk infrastructure disposal or a septic tank, or a ventilated pit latrine. By 2018, the share of children with adequate toilets had risen to 79% and the share has remained at that level since. Around 3.9 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. The majority of these children (3.6 million) use unventilated pit toilets, while 280,000 children have no sanitation facilities at all (open defecation or buckets). Children (21%) 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, over 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 2.1 million, resulting in an increase in access for 1.5 million children), KwaZulu-Natal (an increase of 7 million children) and Gauteng (an increase of 1.8 million children with adequate sanitation facilities on site). In the Free State, the share of children with sanitation improved from 53% in 2002 to 86% in 2024).

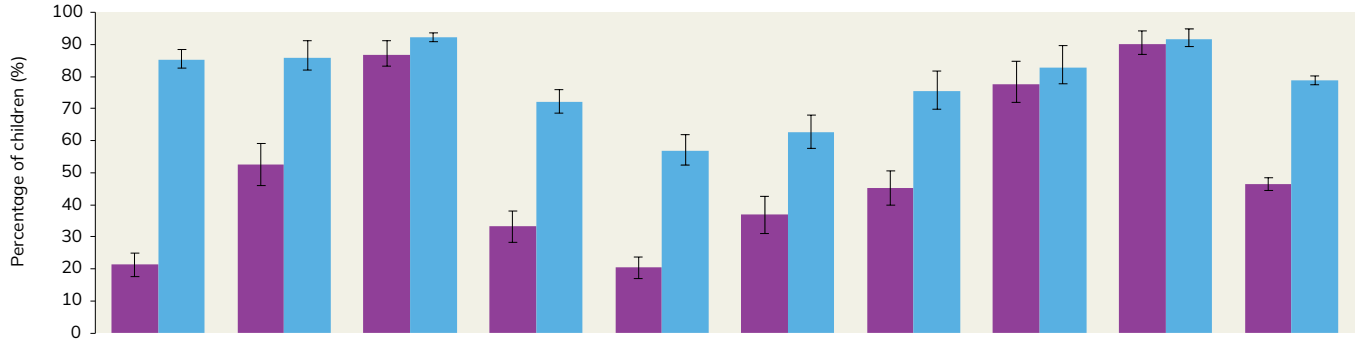
The dramatic improvement in access to sanitation from 21% in 2002 to 85% in 2024 in the Eastern Cape is largely due to increased provisioning of ventilated pit latrines, which may be provided by the state or built by households themselves. In other words, the achievements in sanitation access have not 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, 60% have pit latrines while only 40% have flush toilets. Similarly, the substantial improvements in levels of access to 'adequate' sanitation in KwaZulu-Natal and Limpopo have been achieved without corresponding expansion of bulk infrastructure to rural households but rather through increased access to ventilated pit latrines.

Expansion of waterborne sewerage systems into deep rural areas is probably not feasible given that South Africa is a water-scarce country and that the costs of installing and maintaining bulk infrastructure to remote low-density areas is prohibitive. Small urban municipalities and even well-resourced metros are struggling to maintain sanitation infrastructure and sewerage treatment works.

All sanitation infrastructure needs to be maintained to be safe and hygienic, and pit toilets need to be emptied regularly and safely to avoid health hazards and environmental contamination. Across the country, six million households still used pit toilets in 2024, and of these 88% reported that their toilets had never been emptied. Eight million children live in these households, depending on un-serviced pit toilets.

Although there have also been significant improvements in sanitation provision in Limpopo, this province still lags behind the other provinces, with only 57% 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

Figure 6b: Children living in households with basic sanitation, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	21,4%	52,5%	86,7%	33,4%	20,6%	37,0%	45,3%	77,7%	90,0%	46,5%
	626,000	525,000	2,549,000	1,384,000	499,000	562,000	528,000	309,000	1,448,000	8,427,000
2024	85,3%	85,9%	92,1%	72,1%	57,0%	62,7%	75,3%	82,9%	91,7%	78,7%
	2,136,000	895,000	4,400,000	3,133,000	1,441,000	1,125,000	1,083,000	368,000	1,959,000	16,539,000

Source: Statistics South Africa (2003;2025) *General Household Survey 2002; General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

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: 100% of Indian and White children had access to adequate toilets in 2024 and 95% of Coloured children had adequate sanitation, while only 76% 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, 98% of children have adequate sanitation, while 71% of children in the poorest 20% of households have this level of service.

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Matodzi Amisi is an evaluation practitioner. She works with NGOs and public sector institutions to develop and strengthen evaluation and evidence systems, supporting effective decision-making. Previously, she worked in the South African Public Administration, including the Commission on Gender Equality and the Department of Planning, Monitoring and Evaluation in the Presidency. She has a keen interest in monitoring and evaluation, and evidence use in the violence prevention sector, focusing on what works to prevent violence against women and children.

Lillian Artz is the director of the Gender, Health and Justice Research Unit at UCT. She has published widely on domestic violence, sexual offences, incarcerated women, and women's rights to freedom and security in Africa. Her work has also included research on female and other key populations in prisons and psychiatric settings, the epidemiology and prevalence of child sexual abuse, exposure to coercive sexual experiences among HIV testing populations, torture prevention, as well as the medico-legal management of sexual and gender-based violence in conflict-affected, post-conflict and transitional African states.

Lizette Berry is an independent researcher, with a PhD in social and behavioural sciences from the University of Amsterdam. She previously held a senior researcher position at the Children's Institute, where she managed projects on early childhood development and maternal well-being. She has 25 years of experience in child and family social policy with a particular interest in early childhood development, parenting programmes, and violence prevention. She has been involved in several consultancies with the national government, including on the development of the National Integrated Early Childhood Development Policy, and currently provides technical support to government on ECD systems.

Theresa Betancourt is the inaugural Salem Professor in Global Practice at the Boston College School of Social Work and director of the Research Programme on Children and Adversity. Her primary research interest is to understand the protective processes that contribute to risk and resilience in the mental health and development of children and adolescents facing adversity in a variety of cultures and settings. Dr Betancourt has led initiatives to adapt and test evidence-based behavioural and parenting interventions for children and families facing adversity. In recent years her work has expanded to implementation science initiatives to scale out evidence-based interventions in low resource settings both in the US and globally. She is the principal investigator of a 20-year intergenerational study of war affected youth and their children and families in post-conflict Sierra Leone.

Carla Brown has been the head of social work services at the Red Cross War Memorial Children's Hospital for over a decade. She holds a BA in social work from UCT and a postgraduate diploma in health leadership from UCT's School of Public Health. Carla has extensive experience in child protection and forms part of evaluating and developing new systems and best practice within the hospital's child protection service. Presently she is called on to consult on complex child protection matters, serving on various committees within the hospital and externally across various sectors.

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Sindisiwe Chikunga was appointed as Minister of Women, Youth and Persons with Disabilities in 2024. She has previously served as Minister of Transport, Deputy Minister of Transport, and Deputy Minister of Public Service and Administration. She has been a member of Parliament since 2004. Minister Chikunga's academic qualifications include a master's degree in curationis from the University of Pretoria, and diplomas in nursing science and midwifery from the Edenvale Nursing College. She is currently studying political science with the University of South Africa. As a member of Parliament, she has served on several portfolio committees including Correctional Services, Joint Budget, Housing and Police.

Suzanne Clulow is an applied social scientist whose work bridges research, social facilitation, and advocacy. She specialises in participatory approaches that amplify the voices of children, caregivers, and practitioners to strengthen care and protection for children. With over two decades of experience, her work focuses on child rights, social protection, violence prevention, and care reform. Her roles include programme manager at the Children in Distress Network, global ambassador for kinship care with Family for Every Child, and master trainer for the University of the Witwatersrand and UNICEF on the Caring for the Caregiver Programme.

Elizabeth Dartnall is executive director of the Sexual Violence Research Initiative (SVRI). With over 25 years of experience in health systems, mental health, and preventing violence against women and children, she has worked across government and research roles globally. Since 2006, Liz has led SVRI, guiding its transition into an independent NGO supported by multiple partners. She also serves on several international boards, technical advisory groups, and steering committees. Liz works to build a global evidence ecosystem to ensure research is survivor-centred, ethical, rigorous, and addresses the pressing problems that must be solved to end violence against women and children.

Juliana Davids is the community engagement and empowerment manager at Triangle Project and holds a master's in women's and gender studies from the University of the Western Cape. A feminist and LGBTQI+ activist with over 20 years' experience, she has advanced gender justice, inclusive governance, and democratic development across Africa. Her expertise includes grassroots movement-building, programme management, and capacity strengthening, linking development agencies with local actors. Juliana amplifies the leadership of women and youth, queer communities, and marginalised groups, ensuring their voices influence policy and practice towards more just and equitable societies in Africa and beyond.

Nicki Dawson is the research, development and training lead at the Ububele Educational and Psychotherapy Trust, and the clinical lead for Ububele's parent-infant programmes. Working as a clinician-researcher, Nicki seeks to ensure that diverse ways of being are considered in research and programme development infant mental health, parenting and first 1,000 days intervention and task shifting. She is a lecturer extraordinary for the master's in infant mental health in the Department of Psychiatry at Stellenbosch University.

Harsha Dayal is director of research at the Department of Planning, Monitoring and Evaluation in the South African Presidency. She was a public health worker before moving to the Human Sciences Research Council. She has influenced evidence to policy processes, systems and approaches nationally, through innovation in policy-relevant research and co-production methods. She developed evidence maps including diverse data sources to bridge between researchers, policymakers and citizens. Currently, she is also co-convener for research and information systems (Pillar Six) of the National

Strategic Plan on Gender-Based Violence and Femicide. She serves on several reference groups and advisory bodies nationally and internationally.

Aislinn Delany is an independent researcher with over 20 years of experience conducting applied social research in the development sector across southern Africa. Her work spans a range of social policy and development themes, including violence prevention, early childhood development, and social protection. In recent years she has increasingly focused on research and capacity building for violence prevention, including at the intersection of violence against women and children. This includes working with colleagues to develop a practical toolkit designed to help practitioners integrate these linkages into their violence prevention programming.

Gwen Dereymaeker is a policy expert with extensive experience in the fields of violence prevention, criminal justice, good governance, systems thinking, and strategic implementation. Recently, she was the director of the Violence Prevention Unit in the Department of Health and Wellness, Western Cape Government. Her passion lies in leveraging relationships, data and evidence to prioritise and implement transversal initiatives to improve the impact of government service delivery.

Wilmi Dippenaar is the director of the South African Parenting Programme Implementers Network. She has a degree in child and youth development from the University of South Africa and a master's degree in implementation research from the University of the Western Cape. She has co-authored several articles and presented on family work at numerous forums.

Kirsty Donald is a professor of paediatric neurology at the Red Cross War Memorial Children's Hospital, and deputy director of UCT's Neuroscience Institute. She is an experienced clinical academic with her research examining how early-life exposures shape brain development in African contexts, integrating MRI and EEG with longitudinal cohorts. She leads multi-country collaborations on early executive function development, low-field MRI capacity, and neurodevelopmental risk and resilience. A committed mentor and policy advisor to the World Health Organization and UNICEF, she champions contextual tools, capacity-building, and translation of neuroscience into practice, advancing child brain health in Africa.

Rowan Dunkley is a general paediatrician at the Red Cross War Memorial Children's Hospital with a special interest in child protection. He has been part of the Child Protection Team at the hospital for 11 years. His main interest is in improving the quality of medical care offered to children who have been abused and improving the quality of medico-legal documentation through teaching medical officers and registrars in paediatric training.

Chandré Gould is a senior research fellow in the justice and violence prevention programme at the Institute for Security Studies. She leads a dedicated team that works in South Africa and internationally to generate and broker knowledge and evidence; and build bridges across sectors to strengthen efforts to prevent violence. She has undertaken research on human trafficking, the life histories of repeat violent offenders, incarceration, and the impact of supporting positive parenting. Since 2015, she has convened the Violence Prevention Forum, a multi-sectoral dialogue process with the long-term goal of ensuring the scale-up of evidence-led violence prevention interventions in South Africa. She is the co-chair of the INSPIRE Implementation Working Group and co-chair of the advisory board of IGNITE Philanthropy.

Katharine Hall is a senior researcher at the Children's Institute. She has a master's in sociology from UCT, and a PhD in development theory and policy from the University of the Witwatersrand. Her research interest is mainly in child poverty, inequality, social protection and related policy. She has also undertaken policy-related research on household form, constructs of the family, gender inequality, labour migration and care strategies for children. She leads the CI's Children Count project, which monitors the situation of children in South Africa through child-centred analysis of national data.

Jill Hanass-Hancock is a chief specialist scientist at the South African Medical Research Council. Her research focuses on advancing disability-inclusive HIV and GBV responses by linking data, policy, and practice to empower women with disabilities. Her team conducts ethnographic work on disability, HIV and GBV; produces disability-disaggregated data; pioneers research approaches such as the cost of disability methods; and develops prototypes such as the Disability Awareness Toolkit for accessible healthcare and the Breaking the Silence approach for inclusive sexuality education.

Nadine Harker is a senior specialist scientist in the Mental Health, Alcohol, Substance Use and Tobacco Research Unit of the South African Medical Research Council. She is also deputy director of the substance use programme in the unit. She completed her PhD at UCT and is an associate professor at the UCT School of Public Health, and the School of Psychiatry and Mental Health. She has advised local, provincial and national government on issues related to alcohol and drug abuse prevention and policy, and has acted as a technical advisor, consultant, and reviewer to the UN Office on Drugs and Crime, the World Health Organization, the African Union and the Colombo Plan. She is currently the national head of the South African Community Epidemiology Network on Drug Use.

Sumaiyah Hendricks is a junior researcher at the Children's Institute. She holds a master's in public health specialising in epidemiology and biostatistics from UCT. Her work centres on data analysis for the Children Count project. She is interested in all aspects of maternal and child health including vaccinology, infectious and non-communicable diseases, and birth registration. With a background in biochemistry, human physiology, and public health, she brings an interdisciplinary lens to health research and data analysis.

Nancy Hornsby's research interest lies in disentangling the brain-behaviour axis and understanding substance misuse from a neurobiological basis. Her research focuses on intersecting research from the neuroscience and public health fields. She currently serves as the project manager on the South African Community Epidemiology Network on Drug Use, a national drug surveillance system.

Lucy Jamieson is a senior researcher at the Children's Institute, where she leads research focused on child rights, child protection and child participation. Lucy's work combines rigorous research with a strong commitment to social justice, emphasising the importance of children's voices in policy processes. She has played a key role in shaping child protection and social development policies in South Africa. She is recognised internationally as a leader in participatory research methodologies and currently serves on the steering committee of the International Canadian Child Rights Partnership.

Erika Jooste is the single mother of Hendrike, Jan and Annali. She is presently the gender advisor for Sesame Workshop International South Africa where she has proudly earned the Nickname "Daddy Muppet". She has a deep academic footprint in educational psychology and countless years leading innovative human-centred design initiatives. She is zealous in her pursuit of gaining new knowledge and evolving her perspectives. Her ultimate passion lies in supporting boys and girls to grow smarter, stronger and kinder.

Jane Kelly a senior research officer in the Accelerate Research Hub, Centre for Social Science Research at UCT. She has a background in psychological research and experience working in both academic and government settings. Her research has contributed to three interrelated yet standalone research areas: how young people navigate risk and resilience; the role of healthcare providers in promoting good health outcomes for adolescents and young people; and the role of an inclusive education system in supporting adolescents, including adolescent mothers.

Fatima Khan is the project coordinator of the child protection improvement project at Red Cross War Memorial Children's Hospital. She qualified as a paediatrician in 2019 and brings over a decade of experience in paediatrics and academic medicine. With a strong passion for teaching, she has been actively involved in undergraduate and postgraduate training. Her professional interests lie in community paediatrics and child protection, where she is dedicated to advancing multidisciplinary care and safeguarding vulnerable children.

Bheki Khoza is a communications and marketing professional. Currently with Sesame Workshop International South Africa as digital marketing manager, he has a BA in corporate communications from University of Johannesburg and a postgraduate diploma in business administration from Johannesburg Business School. At Sesame Workshop, he plays a pivotal role in shaping content for Takalani Sesame, focusing on early childhood development and social impact. His passion is creating engaging digital and traditional campaigns that empower children, parents and caregivers while driving collaboration with stakeholders to further educational initiatives.

Edith Kriel is a social worker who has specialised in working with traumatised children for over 30 years. She is the executive director of the Jelly Beanz Foundation. She developed the Teddy Bear Clinic into a multi-level service, initiated the Child Witness Project in the Western Cape and developed the Healing Project for children that have been sexually abused, and has co-authored several books related to child protection, trauma informed care and therapeutic support. Edith often presents multi-disciplinary workshops on a range of child trauma related topics.

Jamie Lachman is the lead principal investigator of the Global Parenting Initiative and an honorary associate professor for the Safety and Violence Initiative at the UCT Centre for Social Science Research. He is also the director of research and a senior research and teaching fellow at the University of Oxford Department of Social Policy and Intervention. He has over 20 years of experience developing, testing, and scaling up family and parenting programmes to reduce violence against children and improve child well-being. He is a co-founder, steering committee member, and master trainer of the World Health Organization and UNICEF-led initiative Parenting for Lifelong Health. The PLH digital and in-person programmes and resources that he has co-developed have reached over 210 million beneficiaries in 198 countries and territories.

Lori Lake is a communications and education specialist at the Children's Institute, where she plays a central role in the production of the annual *South African Child Gauge* and convenes the CI's child rights courses for health and allied

professionals. She specialises in making complex ideas accessible to a wider audience and is interested in engaged scholarship that harnesses the power and resources of the university to promote children's rights, survival and optimal development.

Malose Langa is a professor and senior lecturer in the School of Community and Human Development, Department of Psychology, at the University of Witwatersrand, and associate researcher at the Centre for the Study of Violence and Recompilation. His research interests include risk-taking behaviours among the youth and their role in politics, substance abuse and addiction, trauma of collective violence and the psychology of men (masculinity), fatherhood in post-apartheid South Africa. He is the author of *Becoming Men: Black masculinities in a South African Township.*

Matshidiso Lencoasa is a public finance analyst at SECTION27 and chairperson of the Budget Justice Coalition in South Africa. She holds a master's in development and education (public policy) from the University of Sussex and a BA in accounting and finance from the University of the Witwatersrand. Her research and advocacy examine the intersections of fiscal governance, gender equity, and social justice, with a focus on rights-based and gender-responsive budgeting. She contributes to national and parliamentary processes aimed at strengthening accountability and financing protections for women and children.

Jaco Londt is a committed public servant and experienced political leader with over 20 years in South African politics. Appointed as Western Cape Minister of Social Development in 2024, he brings deep legislative insight from his years in both the National Council of Provinces and the National Assembly. Minister Londt leads a department at the forefront of delivering hope, dignity, and essential support to the province's most vulnerable. In an era of growing social and economic pressure, he drives a bold, solutions-driven approach rooted in innovation, resilience, and inclusive partnerships across government, civil society, and the private sector, ensuring that every resident could thrive.

Phethang Mabeba is a development practitioner with a background in sustainable development and a strong focus on early childhood development (ECD), currently serving as ECD lead at Violence Prevention through Urban Upgrading. She works at the intersection of child rights, social equity, and sustainability, advocating for holistic, community-based approaches to ECD in South Africa. Her work brings a multidisciplinary lens to improving outcomes for young children, positioning ECD as a key strategy for violence prevention.

Mercilene Machisa is a senior specialist scientist at the South African Medical Research Council, an honorary associate professor at University of the Witwatersrand, a senior lecturer at University of KwaZulu-Natal, and co-director of the Global Campus Violence Prevention Network. She has over 15 years of experience researching the intersections of mental health, violence against women and children in southern Africa. She has led national surveys in six countries, evaluated systemic responses to rape, and developed campus violence prevention and mental health promotion interventions in higher education. She is associate editor for *Child Abuse Review*, editorial board member for *BMC-Women's Health* and *BMC-Global Public Health*, and co-editor of *Child Gauge 2025*.

Thokozile Madonko is a researcher and policy analyst at the Southern Centre for Inequality Studies, University of the Witwatersrand, where she manages the Public Economy Project. She holds a master's degree in political theory. She has over 20 years of experience researching public finance, with a focus on health financing, gender-responsive budgeting, and the impact of austerity. Her work advances transparency and accountability nationally and locally. She previously led initiatives with the Heinrich Böll Foundation Southern Africa, the Budget Expenditure Monitoring Forum, the People's Health Movement South Africa, and the International Budget Partnership.

Ayesha Mago is the global advocacy director for the Sexual Violence Research Initiative (SVRI). She has worked for more than two decades as a feminist researcher, activist, and trainer. Her work has focused on the rights of women, children, and adolescents in the context of discrimination, sexual and reproductive health and rights, HIV and AIDS, and access to justice in South and Southeast Asia, and in Southern Africa. More recently she has worked comprehensively on issues relating to feminist funding of women's rights, movement building and violence against women research work. At SVRI she drives the work on influencing change towards equitable and sustainable funding, practice and policy in the field.

Shanaaz Mathews is a professor in the Faculty of Health Sciences at UCT. She is also the evaluation lead for the What Works to Prevent VAWG Programme. She leads programme evaluations in Malawi, Pakistan, Eswatini and South Africa to understand the efficacy of interventions to reduce violence against women and children and how to effectively scale up proven approaches. She has worked with the women's and children's sectors for more than 30 years as a researcher and technical advisor to strengthen programmes on violence against women and children. She is a commissioner on the Lancet Commission on GBV and a founding member of

the Coalition for Good Schools. She also serves on several international advisory boards, and is the chair of the scientific committee for the World Health Organization 16th World Injury Prevention and Safety Promotion Conference 2026.

Luxolo Matomela-Kröger is a senior technical advisor for the GIZ: Violence Prevention for Peaceful and Inclusive Communities (VPPIC) programme. She has worked over 15 years across development cooperation, media, government and academia. Within development cooperation, she has a focus on violence prevention and supporting coordination of different stakeholders active in the sector for effective implementation of evidence-informed approaches.

Tarisai Mchuchu-MacMillan is the executive director of MOSAIC Training, Service and Healing Centre, and an advocate of the High Court of South Africa. She holds a BA and LLB from UCT and is a 2022 Mandela Washington Fellow with a Certificate in Leadership in Civic Engagement from Rutgers University and a Certificate in Systems Change and Social Change from the UCT Graduate School of Business. She is an experienced African feminist leader and practitioner with over 15 years of experience in designing and implementing violence prevention programmes, with a focus on youth crime prevention, children's rights, gender justice, and human rights. She is recognised for her expertise in systems change, feminist movement-building, and addressing the intersections of violence against women and children.

Franziska Meinck is an associate professor in the School of Social and Political Science at the University of Edinburgh, honorary associate professor in the School of Public Health at University of the Witwatersrand and extraordinary professor at North-West University. Her research focuses on intergenerational violence transmission, its predictors, mechanisms, and prevention in South Africa. Her research also focuses on prevalence, risk, and protective factors of violence against children in vulnerable populations; health outcomes of violence exposure in childhood; childhood violence prevention and on the development and testing of global child abuse measures.

Najat Maalla M'jid was appointed by the Secretary-General of the United Nations (UN) as his Special Representative on Violence against Children on 30 May 2019. Dr M'jid, a medical doctor in paediatrics, has over the last four decades devoted her life to the promotion and protection of children's rights. She was head of the Paediatric Department and director of the Mother-Child Polyclinic in Casablanca. She was a member of the Moroccan Council on Human Rights and founder of the pioneering NGO Bayti, addressing the protection and reintegration of children living and working in the streets of Morocco. From 2008 to 2014, she served as UN Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography.

Dr M'jid also worked as an international expert on developing and monitoring integrated child protection strategies and policies, as well as on social and development policies. She also worked as a lecturer in Moroccan and international universities on child rights protection and monitoring.

As a member of several regional and international NGOs and networks working for children's rights, Dr M'jid was also involved in the training of social workers, law enforcement, teachers, judges, and medical staff. She is the recipient of numerous awards and honors for her strong commitment to protecting children and their rights.

Benita Moolman is an associate professor in the African Feminist Studies Department at UCT. Previously, she worked as the global citizenship programme manager in the Centre for Higher Education Development at UCT, at the Human Sciences Research Council, and at Rape Crisis. She has taught, researched and published on gender-based violence, masculinities, intersectional identities, decoloniality and feminist qualitative methodologies.

Amanda Mpedi is a research assistant at the Children's Institute. Amanda holds an LLB from the University of the Western Cape and is currently reading for her LLM in international human rights law at Lund University, Sweden. Her work is related to the advancement of access to justice through legal research, drafting, and advocacy. Amanda's research interests include business and human rights, children's rights, and intersectional gender justice.

Nadine Nannan is a specialist scientist at the South African Medical Research Council. She has worked extensively in population health research, particularly in child health. A focal point of her research has been the mapping of different data sources and appropriate methods of analysis for monitoring childhood mortality in an HIV and AIDS environment. Her interests are the analysis of census and survey data, child mortality differentials and using mortality profiles to assess inequalities in health.

Xolane Ndlovu is the assistant director at the Western Cape Commissioner for Children. He is a skilled public policy professional and researcher with extensive experience in public governance and advocacy. His background includes years of service in both diplomatic and public sectors. Xolane holds a master's degree in political science from the University of the Witwatersrand.

Sebenzile Nkosi is a specialist scientist in the Mental Health, Alcohol, Substance Use and Tobacco Research Unit at the South African Medical Research Council, and a research associate in the departments of psychology at Rhodes University and the University of Johannesburg. She has a PhD in psychology from the University of South Africa and was a Fogarty post-doctoral fellow in the Launching Future Leaders in Global Health Research Training Programme. Her research focuses on boys' and men's health risks in the context of public health, including violence prevention.

Christina Nomdo is a seasoned human rights advocate with over 30 years of experience and a master's degree from UCT, specialising in child rights governance. She was South Africa's first Children's Commissioner (2020 – 2025) and a child participation rights advisor on the National Planning Commission. Christina offers expertise in leadership development, advocacy, budget analysis, child-centered policy, and youth empowerment. As former executive director of RAPCAN, she has led major initiatives promoting children's participation in governance, influencing policy at local and national levels to protect and empower vulnerable youth.

Phiwe Nota is a junior research fellow at the Children's Institute. She is a social scientist with a background in psychology and a PhD in media and cultural studies (health communications). Her research focuses on strengthening violence prevention through the health system, with a particular interest in the intersections of violence against women and children. Phiwe's work also explores how maternal and adolescent health services can serve as entry points for early identification and prevention of violence, contributing to evidence that supports more integrated and responsive health and social systems.

Thelma Oppelt holds a PhD in psychology and is the academic lead within the South African Research Chair in Human Capabilities, Social Cohesion and the Family, based at the Centre for Interdisciplinary Studies of Children, Families and Society at the University of the Western Cape. Her research explores how families' individual and collective capacities foster human capabilities and social cohesion. She focuses on early identification, family impact, and the need for community-based prevention frameworks grounded in the voices of those most affected.

Selina Palm is chair of the Working Group on Faith and Violence against Children at the Sexual Violence Research Initiative and design lead on their new course on Faith and Helping Children Thrive without Violence. She is an experienced development professional, academic, theologian and feminist researcher-activist. She holds a PhD from the University of KwaZulu-Natal and is currently affiliated with Stellenbosch University. She has over 25 years of experience working across the African continent and beyond. She addresses intergenerational cycles of violence against marginalised groups and their connections to religious and cultural systems.

Mari Payne is the deputy managing director and senior director for education and programmes at Sesame Workshop International South Africa. She has over 18 years of experience in child rights, child law, early childhood development (ECD), basic education and children's media. She has a BEd (ECD and foundation phase) and a BEd (Hons) from the University of South Africa. Her research interests are in ECD and the impact of play-based learning. She was part of the research team to map the gaps between expert, stakeholder and public understanding of ECD in South Africa with the FrameWorks Institute in Washington, DC.

Demichelle Petherbridge obtained her BCom (Law) and postgraduate LLB degree at Stellenbosch University, completing her doctorate degree at the same university. She completed her master's in international human rights law at the University of Oxford. Dr Petherbridge has worked in the field of education law in South Africa since 2015, which has included working as an attorney, later as a legal researcher at Equal Education Law Centre, and as a senior attorney in the education rights programme at SECTION27. She is currently a part-time lecturer at the Wits School of Education.

Paula Proudlock is a senior legal researcher at the Children's Institute. She holds a master's in constitutional law from UCT and specialises in research and advocacy on children's socio-economic rights. She has authored several publications on child law, and law and budget reform, and is regularly called upon by national government and civil society organisations to contribute legal opinions. She has led several civil society coalitions promoting law and budget reform that is based on evidence and children's best interests, including on the Child Support Grant and the Children's Act.

Karen Quail has a background as a school counsellor and teacher. For most of her professional life, however, she has worked independently, coaching, training, and running workshops for parents, teachers and childcare workers on non-violent discipline and related topics. She has published two papers on non-violent discipline and makes information on this topic available to the public through the Peace Discipline website peacediscipline.com and the Peace Discipline YouTube channel. In her work, she places particular emphasis on the role of attunement in effective discipline, in other words whether the intervention fits well with the needs of the child.

Marita Rademeyer is a clinical psychologist who has been working with traumatised children and their families for over 30 years. She is the chair of Jelly Beanz, an NPO that works with children and families affected by sexual abuse and harmful sexual behaviours. Marita has co-authored many resources for professionals and caregivers, including *South African Children and Pornography: A guide for professionals and caregivers interacting with children who are exposed to pornography.* She trains mental health and child protection professionals in harmful sexual behaviours and consults to organisations working in the field of online child sexual abuse and exploitation as well as harmful sexual behaviours.

Fathima Rawat is a researcher with over 15 years of experience in the NGO and public sectors. She has successfully led large-scale ECD projects in vulnerable communities across Africa, designing evidence-based programs to address barriers to children's learning, play, and development. With a passion for using research to drive social change, she combines data-driven approaches with community-based solutions to help children achieve optimal developmental outcomes. She holds a master's in early childhood intervention and is pursuing a PhD in curriculum studies. She currently serves as the monitoring, evaluation, research and learning lead for Sesame Workshop South Africa.

Wiedaad Slemming is the director of the Children's Institute, and an associate professor in the Department of Paediatrics and Child Health at UCT. She is an experienced health professional, academic and researcher, with over 20 years of experience working in a variety of settings in South Africa and abroad. She is a recognised child health, early childhood development (ECD) and child disability researcher, and currently serves on several international and national child health, nutrition, ECD and disability technical and advisory groups

Angela Stewart-Buchanan is the communications lead for the Accelerator for Children and Teens, supporting the Presidential-led National Strategy to Accelerate Action for Children and the Hold My Hand campaign. She is a social behaviour change communication specialist, health activist, and strategist, having worked on groundbreaking campaigns and projects across Africa. She is recognised for her work in HIV, primary healthcare, and child, adolescent and maternal health. Her work includes supporting government ministries with planning, implementation and systems strengthening, recently supporting COVID-19 demand acceleration efforts through her work with the DG Murray Trust.

Zeenat Sujee is an admitted attorney of the High Court of South Africa with at least 18 years of experience as a human rights and social justice lawyer. She is currently practising at SECTION27, where she holds the position of Head of the Education Rights Programme. She completed her LLB and LLM at the University of the Witwatersrand in Johannesburg. She has worked on matters relating to inclusive education, safety in schools, governance, and accountability.

Nokuzola Sisisi Tolashe is the Minister of Social Development. She was previously Deputy Minister in the Presidency for Women, Youth and Persons with Disabilities. Minister Tolashe cut her teeth in student and youth movement politics during apartheid, leading to lengthy detentions under different states of emergency. The imprisonment she suffered did not break her spirit but strengthened her resolve to fight for the liberation and empowerment of women and children.

Wessel van den Berg is senior advocacy officer at Equimundo, father of two, and co-founder of the MenCare Global Campaign and *State of South Africa's Fathers* report series. He has worked as a kindergarten teacher, counsellor, activist, and researcher, driven by a curiosity about men and care. Wessel supports global advocacy on the appreciation of care, gender-equal parenting, and children's rights, and completed a sociology doctorate at Stellenbosch University on engaging South African men in a feminist ethic of care.

Thandi van Heyningen is a senior researcher in the Justice and Violence Prevention Programme at the Institute for Security Studies. With over 15 years of experience as a health professional and public health researcher, she specialises in mental health, perinatal mental health, and violence prevention. In her current role, she focuses on developing interventions aimed at disrupting and preventing intergenerational cycles of violence within families.

Lauren-Jayne van Niekerk is a lecturer in the Department of Social Work and Social Development at UCT and the Male Engagement and Gender-Equitable Research Fellow within the Global Parenting Initiative (GPI). Her work centres on early childhood development, father involvement, and gender transformation in South Africa. Currently completing her PhD, she investigates fathers' perceptions and engagement in their children's early learning and development, reshaping narratives of fatherhood and strengthening supportive parenting environments. She contributes to gender-equitable parenting programmes and male caregiver engagement initiatives, and leads the GPI Gender-Equitable Playful Learning Group, advancing gender equality and family well-being.

Joy Ann Watson is a researcher and technical advisor with more than 20 years of experience in the field of violence against women. She has served as a policy advisor to governments

and engaged extensively in global policy processes. Her work spans research and advocacy with women's rights organisations, focusing on violence against women and children, and on advancing policy and funding reform. Her passion lies in strengthening feminist movements and driving collective action toward a more equitable world. She works as a consultant in South Africa and internationally and currently holds retainers with the Institute for Security Studies and the Sexual Violence Research Initiative. Her contribution to this *Child Gauge* was undertaken in her capacity as a consultant to the Sexual Violence Research Initiative.

Anthony Westwood has been practising paediatrics for 43 years, 32 of those as a general paediatrician in the Department of Paediatrics and Child Health at UCT. He has been registered in the new sub-speciality of community paediatrics, having spent 20 years working both as a clinician and in provincial and national child health spheres. His special interests have been in reducing child mortality, especially from preventable conditions such as acute diarrhoeal diseases and improving the outcomes and life experiences of children with long-term conditions and their families. He has been a course convener and teacher on UCT's post-graduate diploma in community and general paediatrics since its inception in 2015. He is a co-editor of *Child Health for All*, a standard child health textbook in southern Africa.

Russell Wildeman is the social policy manager at UNICEF South Africa. He is an experienced policy analyst and has worked in civil society, for the World Bank in his capacity as a consultant, and as a researcher who is interested in public finance and quantitative social science research. He is best known for his education finance research while working for the now-defunct IDASA and has continued with this work through his leadership of social policy research, evidence generation, and practical policy analysis at UNICEF South Africa.

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*:

2024: Early childhood development
2021: Child and adolescent mental health
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*® since 2005 to track progress towards the realisation of children's rights.

This eighteenth issue of the *South African Child Gauge* aims to build a shared understanding of the intersections of violence against women and children – as they co-occur in the same households, share the same risk factors and drive an intergenerational cycle of violence. Despite these intersections, the programmes, research and policies on violence against women and children have historically been siloed – with different strategies, terminologies and lead agencies. This issue of the *Child Gauge* showcases promising practices – such as gender-transformative programming – that can help promote healthier, non-violent relationships in families, schools and communities. It also identifies opportunities to strengthen systems by providing trauma-informed and family-centred services to prevent the intergenerational transmission of violence.

> 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, United Nations Committee on the Rights of the Child**

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