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PART 1

Law reform

Part one summarises and comments on legislative developments that affect children. These include the:

- National Health Insurance Bill;
- State Liability Amendment Bill;
- Control of Tobacco Products and Electronic Delivery Systems Draft Bill;
- Control of Marketing of Alcoholic Beverages Draft Bill;
- Carbon Tax Act;
- Draft Climate Change Bill;
- Child Justice Amendment Bill;
- Customary Initiation Bill; and
- Traditional Courts Bill.

Children may not be able to vote, but they do have a voice and can be powerful advocates for health and a healthy environment.

Photo: © James Granelli

Legislative developments affecting children in 2018/19

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Introduction

This chapter describes and analyses recent developments in law that will affect the realisation of children's rights now and for generations to come.

The *National Health Insurance Bill* aims to pool finances into a single fund to enable the state to provide quality universal health care to everyone. Yet greater participation from child health experts and advocates is needed as the Bill proceeds through the Parliamentary process to ensure that it takes sufficient cognizance of children's health rights.

The *State Liability Amendment Bill* is couched as an interim measure to protect provincial health budgets from being eroded by escalating medical negligence claims, by placing restrictions on the timing and amount of compensation payable. However, human rights activists warn against this approach exacerbating the lack of accountability for poor services within the public health sector, and point out the negative consequences for individual claimants, the majority of whom are women and children with disabilities. They call instead for measures to address the root causes of poor-quality services in the public health sector, particularly within obstetrics.

The *Control of Tobacco Products and Electronic Delivery Systems Draft Bill* and the *Control of Marketing of Alcoholic Beverages Draft Bill* aim to curb the harmful effects of tobacco and alcohol, particularly for children and youth. Both have the potential to protect children from harm if legislators are guided by children's best interests instead of by powerful profit-driven industries.

South Africa is the world's 14th largest emitter of carbon dioxide, largely due to its dependency on coal for electricity. This notorious status contributes to a high burden of preventable child illness and death, particular in the areas

surrounding the biggest emitters, and is hastening the onset of climate change for all. The *Carbon Tax Act* is aimed at curbing carbon dioxide emissions by imposing a carbon tax, while the *Climate Change draft Bill* will impose emission limits. Yet both laws fall short of what is required, given the urgency of the climate change situation and the best interests of children.

The *Customary Initiation Bill* aims to reduce the high number of deaths and injuries that occur during male circumcisions, by regulating initiation schools and processes. The Bill is a product of lengthy research and extensive consultation which bodes well for effective implementation. The chapter also comments briefly on two bills that have been covered extensively in previous issues of the *South African Child Gauge*. These are the *Traditional Courts Bill* which does not allow individuals living in areas under traditional authorities to "opt out" of traditional courts and have their disputes considered by a civil court; and the *Child Justice Amendment Bill* which increases the age of criminal capacity from 10 to 12 years of age.

National Health Insurance Bill

This analysis takes a critical look at some aspects of the National Health Insurance (NHI) Bill¹ from a primary health care perspective focusing on its prospects for providing Universal Health Care in South Africa and its implications for children. The Bill was tabled in Parliament in August 2019 and is currently being considered by the Portfolio Committee on Health.

The Bill aims to establish a National Health Insurance Fund (NHIF), funded through mandatory prepayment as a means to ensure universal health coverage (UHC). The 2010 World

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Health Report defines UHC as: “financing systems ... specifically designed to provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and to] ensure that the use of these services does not expose the user to financial hardship.”²

The NHIF must collect and pool resources to procure goods and services from accredited and contracted health care service providers. It will be set up as a single strategic purchaser of goods and services. This empowers it to plan, implement, evaluate and control all procurement decisions tactically to achieve its long-term goals.

Registration and benefits

The goods and services will depend on the benefits to be covered. These will be determined by the Benefits Advisory Committee (BAC), based on the health care needs of users. The NHIF must then contract with providers to provide the necessary services.

People to be covered by the NHI must have proof of registration. Registration can only be done at an accredited provider or health establishment.³ Children born to users after the NHI commences, will be regarded as having been registered automatically at birth. Children already born will need to be registered by their parents or can register themselves from age 12 onwards. An original identity card, birth certificate and refugee identity card will be required for registration. Gaps in birth registration could result in barriers to health care for children whose births are not registered within the prescribed time of 30 days after birth. Statistics South Africa’s 2018 report on recorded live births reveals that of babies born in 2017, only 77.7% had their births registered within the prescribed time. Early birth registration was lowest in three districts in KwaZulu-Natal where fewer than half of births were registered in time: iLembe (51,8%); uMzinyathi (56,6%); and uThungulu (63,2%).⁴

People eligible for NHI include South African citizens, permanent residents, refugees, inmates, and “certain categories of individual foreigners determined by the Minister of Home Affairs, after consultation” with the Ministers of Health and Finance. Asylum seekers and illegal foreigners are entitled only to emergency medical services and services for notifiable conditions of public health concern.

All children, including children of asylum seekers or illegal migrants, are entitled to basic health care services as provided for in section 28 (1)(c) of the Constitution.⁵ This provision is to be welcomed as it suggests that all children will be entitled to the same rights as South African children. However, three

potential problems arise. Children of asylum seekers and illegal immigrants will not have the formal identity documents required to register as users. Clarity is therefore needed on how these children will gain access. Secondly, unlike most social and economic rights, the rights specified in Section 28 are not subject to availability of resources, meaning that the state has had an obligation to realise them since the ratification of the Constitution in 1996. However, the state has yet to define what “basic health care” means in practice and how it translates into a package of essential health care services for children and adolescents. It is therefore urgent to define “basic health care” for the purposes of Section 28, and to advocate for a broad package of essential services to promote not only child and adolescent’s survival but also their optimal health and development. This should extend beyond treatment to include early intervention, prevention, rehabilitation and palliative care for children with long term health conditions.

This brings us to the third problem. Children in South Africa currently have access to a range of additional essential services in the public sector that could potentially fall outside the defined basic package, but that are likely to be included in the benefits recommended for the NHI by the Benefits Advisory Committee. This makes it unclear if the NHI Fund will cover these benefits for children of asylum seekers and illegal migrants as it will for South African children.

The NHI provides an opportunity to improve the care of one in five children with long term health conditions (LTHCs) who require comprehensive care – close to home, but only if their specific needs are explicitly addressed. The Committee on Mortality and Morbidity of Children under five (COMMIC) has developed a framework for an essential package of health care services for children that includes children with LTHCs and those requiring palliative care⁶ and this framework should be incorporated in the development of “baskets of care” under the NHI.

The NHI Board and advisory committees

The Bill establishes a Board of “not more than 11 persons appointed by the minister” to govern the NHIF in line with the Public Finance Management Act. It is not clear who the Board will be accountable to: in section 12 (1) the Bill specifies the Board is accountable to the Minister, while the memorandum to the Bill states that the Board is accountable to Parliament (see the explanations for clauses 12 and 15 in the Memorandum). This distinction is important: an independent board accountable to Parliament is more likely to face public scrutiny than one appointed by and accountable only to the Minister.

The Bill obliges the minister to appoint advisory committees:

- The Benefits Advisory Committee. Its tasks include determining and reviewing the health care service benefits and types of services that the fund will pay for at each level of care from primary to tertiary hospitals. Its members must have technical expertise in medicine, public health, health economics, epidemiology, and the rights of patients. An additional member represents the Minister. There is no representation from organised labour or user groups.
- The Health Benefits Pricing Committee, which must recommend the prices of health service benefits. Members must have expertise in actuarial science, medicines, epidemiology, health management, health economics, health financing, labour and rights of patients. One member must represent the Minister. This is the only advisory committee with a defined number of members: “not less than 16 and not more than 24”. The Bill does not say whether members with “expertise in labour and rights of patients” actually represent those constituencies.
- A Stakeholder Advisory Committee, comprising “representatives from the statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers as well as patient advocacy groups in such a manner as may be prescribed”. This seems to be the only committee with potential representation from labour, civil society and users, but since members are appointed by the Minister “in a manner as may be prescribed”, it is doubtful whether they will truly represent and be accountable to those constituencies.

None of these advisory committees require representation from the children’s sector or child health specialists, raising concerns around whether children’s and adolescents’ interests will be adequately addressed.

Rights of users

Registered users are entitled to:

- necessary quality care from accredited providers free at the point of delivery if they have proof of membership;
- access health care services within a reasonable time period;
- be treated with a professional standard of care;
- make reasonable decisions about their health care;
- access information about the NHIF and health services available;
- access information or records regarding their health;

- have their privacy and confidentiality respected, subject to Protection of Personal Information Act;
- not be refused treatment on unreasonable grounds;
- complain, or institute legal or judicial review; and
- purchase additional services not covered by NHI through private insurance.

Concerns around quality, accreditation and inequity

Some measures in the Bill may exacerbate inequity, including the process for accreditation of health care facilities and the way user registration will work. Only health facilities that are certified by the Office of Health Standards Compliance (OHSC) will qualify for accreditation.⁷ However, the most recent report of the OHSC found that only five out of the 696 public health facilities surveyed met the norms and standards required for certification.⁸ After more than two decades of public sector austerity, many public and rural health care facilities are understaffed and under-equipped and unlikely to qualify for NHI accreditation. Hospitals are more likely to be accredited than clinics and community health centres, with clinics the least likely. Lack of accredited facilities at the community level will discriminate against people most dependent on local facilities and increase the hospital centeredness of the health services.

Private facilities are not only more likely to get accreditation but are also overwhelmingly urban-based, thus increasing both urban-rural and private-public inequality. Furthermore, the fact that the Bill ignores the Certificate of Needⁱ contained in the National Health Act represents a key missed opportunity to improve equity. There is a possibility that some people – particularly those living in rural areas - will not have access to NHI-funded health care at all.

It is therefore concerning that fewer than 1% of the inspected facilities met the requirements for OHSC certification. Are all the facilities that failed so bad that they can’t deliver their required services safely and effectively? Are the inspection protocols realistic or even appropriate?

For example, the OHSC Annual Inspection Report for 2015/2016 revealed that the Red Cross War Memorial Children’s Hospital failed by some margin to meet the standards required. Examples of failures included: emergency trolleys that did not have adult oxygen masks (this was categorised as ‘extreme’); procedures for conducting and acting on risk assessment of frail and aged patients were not available, nor had risk assessment been conducted on the files of frail or aged patients (categorised as “vital”).

i The Certificate of Need is designed to regulate where private providers can open services.

While many of the other listed failures are valid, it seems inappropriate for a children's hospital to be expected to conduct risk assessments on the files of frail or aged patients, and raises concerns around the extent to which the specific needs of children and adolescents are addressed in the national norms and standards.

The requirements for user registration, which can only be done at accredited facilities is likely to further increase inequity. To apply for registration a person must provide biometrics, fingerprints, proof of residence, an original birth certificate, ID card or refugee ID card. This poses yet another risk that those already marginalised from access to care (e.g. rural populations, children, the disabled or elderly) will be further disadvantaged. Facilities that lack stable internet access, staff, medicines and equipment will not find it easy to register users as smoothly as those facilities already functioning at a much higher level of efficiency.

Strengthening primary health care

The Bill includes a commitment to strengthening Primary Health Care (PHC) services. It views the building of a high quality, effective PHC delivery platform as the foundation of the health system. This includes an emphasis on health promotion and disease prevention, and plans to make extensive use of community- and home-based services.

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

However, the Minister of Finance's mid-term budget statement⁹ promised ongoing cuts to health budgets with the only new money to be made available from Treasury being grants directly to provinces to contract private providers. In the face of austerity budgets, it will be hard to turn services around after years of neglect and promoting private sector provision will not address the critical needs in child health.

The original plans for primary health care re-engineering

also outlined the central role of District Clinical Specialist Teams (DCSTs) in providing leadership and clinical governance for maternal and child health at district level. It is therefore of concern that there is no longer any reference to the DCSTs in the NHI Bill, as this investment in clinical governance is essential to strengthen systems, improve coordination and ensure effective delivery of maternal, child and adolescent health services that are responsive to the local burden of disease. Strong leadership for child health is also needed at provincial level yet only two provinces have appointed provincial paediatricians despite such appointment being a strong recommendation from COMMIC.¹⁰

Similarly, the original plans to re-engineer rehabilitation services at district level should be revived in order to address the needs of large numbers of children with LTHCs and disability – especially in rural areas.¹¹

Conclusion

While the NHI Bill has many weaknesses, including inadequate input from child health advocates and children themselves, the concept behind it has the potential to improve access to health care. It is therefore essential that child health advocates engage in the Parliamentary deliberations on the Bill and its implementation plan to ensure it is designed and works in the best interests of children. Parliamentary public hearings have already been held in four provinces and are also likely to be held at Parliament. Thereafter the public can engage directly with individual members of parliament as the deliberations and debate proceed in 2020.¹²

State Liability Amendment Bill

Medical negligence claims lodged against provincial health departments grew from R28.6 billion in March 2015 to R80.4 billion in March 2018.¹³ Over the same period, actual payment of these claims increased from R498.7 million to R2.8 billion.

The rise in medical negligence claims and payments has been attributed to a range of factors¹⁴ including:

- Poor quality of care, especially in maternity wards
- Poor quality of clinical notes and inadequate systems for management of clinical records
- Increase in litigious behaviour by law firmsⁱⁱ
- Inadequate legal response from the state

The poor quality of clinical care is attributed to severe human resource constraints leading to increased workload on remaining staff, failure to maintain medical equipment, and poor planning and management of essential medicine

ii Due to changes in the law governing the Road Accident Fund (RAF) personal injury claims against the RAF are no longer seen as a source of income for private lawyers. Many personal injury lawyers are now choosing to focus on medico-legal claims which have much higher pay outs and contingency fees.

stock resulting in stock-outs.¹⁵ Government has committed to address these challenges in the quality of care mainly through:¹⁶

- recruiting and hiring more specialist medical personnel;
- regular inspections of public health facilities by the Office of Health Standards Compliance to promote greater adherence to the norms and standards; and
- prioritising improvements in areas with high numbers of negligence claims.

With regards to improving the state's legal response, Government has decided to:

- improve quality of clinical notes and systems for management of clinical records;
- strengthen the medico-legal units in the provincial departments of health;
- recruit national teams of experts to provide specialist support in cases; and
- amend the law so as to allow provinces to settle claims over a period of time rather than in one large lump sum.

The State Liability Amendment Bill is aimed at giving effect to the last bullet above. It aims to allow provincial health departments to pay future medical expenses claims over time according to a schedule, rather than a lump sum upfront. This amendment is particularly aimed at claims for long-term treatment for permanent incapacities or disabilities, for example, for babies born with cerebral palsy as a result of negligence by staff in the maternity and obstetric units. It proposes to do this by directing the courts to make orders for periodic payments (e.g. annually) rather than a single lump sum. If passed, this amendment will effectively amend the common law "once and for all" rule.

The Bill also allows the courts to order the provision of treatment in the public sector, rather than the payment of monetary compensation to the claimant. However, if the relevant public facility does not meet the norms and standards set by the Office for Health Standards Compliance (OHSC), then the claimant can get periodic monetary payments that would enable him or her to obtain these services at a private facility. However, the rate of compensation will be restricted to the rate charged in a public facility. The rate will increase annually based on the Consumer Price Index (CPI).

The Bill is framed as an interim measure, pending the finalisation of the South African Law Reform Commission's (SALRC) investigation into a long-term solution. The SALRC released its Issue Paper for comment in May 2017¹⁷ and the next step will be a Discussion Paper followed by a Report and a possible draft Bill.

The Bill was introduced to Parliament in May 2018 and public hearings were held in October 2018. The Bill lapsed in 7 May 2019 when the fifth Parliament dissolved and has recently (29 October) been revived by the sixth Parliament to enable its further debate and passage. If the amendment is passed, it will apply to all future medical negligence claims as well as claims already in process.

All parties making submissions to Parliament agreed that the escalation in claims was a challenge in need of a solution as it signalled a larger problem in terms of quality of care and it was reducing the budget available for improving quality of care. However – there was general opposition to the Bill as it was not presented with – nor based on – a root cause contextual analysis. A number of alternatives were proposed that could achieve the same aim but with less of a negative impact on individual claimants, and still ensuring public health facilities are held accountable for poor service.

SECTION27 was concerned that the state was more focussed on reducing damages pay outs and less focussed on addressing the root cause of the escalation in claims – namely poor quality of health care in the public sector.¹⁸ They called for the state to rather focus on strengthening the health system by investing in more trained health care workers, maintaining and investing in equipment, and keeping proper records. They were also concerned that due to only 0.7% of public health facilities meeting the criteria for OHSC accreditation, most claims will still be paid out in monetary amounts, and provincial hospitals are not currently in a position to reliably administer periodic monetary payments to claimants. Equipping them to do so would require significant resources and training which seems a waste of resources if the amendment Bill is viewed as an interim measure pending the SALRC's proposals. They are also concerned that payments will be restricted to public sector rates but as so few public facilities are accredited, most claimants will need to access services from the private sector where the rates are higher. Health care services will therefore be unaffordable for most claimants.

The Legal Resources Centre (LRC) and the Women's Legal Centre (WLC) pointed out that most claims arise from negligence during pregnancy and delivery.¹⁹ The amendment is therefore likely to impact mostly on women and children with disabilities. They predict that this effect will mostly be negative for the individual women and children involved and will reduce accountability that helps drive improvements in quality of care for all women and children. Women and children visiting public health facilities are mostly reliant on private lawyers to litigate on their behalf. LRC and WLC

expressed concern that if the lump-sum payments are reduced to periodic payments, contingency fee amounts for the private lawyers will be reduced and there will be less incentive for private lawyers to assist poor women and children. This will reduce the chances of women and children obtaining legal redress and reduce the accountability that these claims create for continued improvements in the public sector.

A joint submission by Total Shutdown, Black Womxn Caucus and the Sexual & Reproductive Justice Coalition made a similar argument and provided evidence of poor quality and often abusive care in state maternity wards.²⁰ They also provided a budget analysis that showed how provincial health departments lost significantly more of their annual health budgets to corruption and mismanagement than to medical negligence payouts. They therefore questioned the state's focus on reducing the amount, timing and reliability of compensation to women and children instead of addressing the root causes of poor quality care and reducing corruption and mismanagement. They were concerned that the state was placing the burden of the health system's poor quality of obstetric services and the consequences of corruption and mismanagement on poor women and children.

Other concerns raised in the public hearings include:

- The Bill aligns the inflation rate for the period payments with CPI. However, medical price inflation is much higher than CPI. The result will be that many claimants will be unable to cover the actual costs of the health care that they need.²¹
 - The amendment only addresses the challenge in the public health sector. Medical negligence claims are also a challenge in the private sector, particularly in obstetrics where the cost of insurance for obstetricians is very high and this cost is being passed onto health care users. Under the proposed NHI, the state will need to procure services from private health providers. The cost of professional liability insurance for private providers therefore needs to start being addressed.²²
 - The minimum threshold amount which would require scheduled payments rather than a lump sum is set at R1 million in the Bill. This threshold should rather be set in regulations to allow for inflation-related increases.²³
 - The proposal is delaying to future years and future generations, the negative economic effect of medical negligence payouts on the provincial budgets, rather than reducing the total cost to the state.²⁴
- Women and children who are economically disadvantaged and living in rural areas have not been given the opportunity to participate in the making of this law.²⁵

The Western Cape Department of Health²⁶ presented evidence of an alternative model already operating in the Western Cape which provides for future medical expenses payments to be paid into a trust fund that then administers payments direct to the service providers as and when the service is provided. This ensures the money is only spent on health services and, if a person dies the money is returned to the state. Furthermore, the trust is run by persons/institutions experienced in administering periodic payments, therefore ensuring no disruption in care. Other alternative proposals are being considered and developed by the SALRC through in-depth comparative research and consultation. These could include mediation as a preferred option to adversarial court-based processes, specialised health courts, and improved accountability mechanisms for negligence within the public sector.

Due to the urgency of the issue, it would be in the interests of all concerned for the SALRC process to be prioritised so that evidence-based alternatives can be considered and legislated for, rather than proceeding with the State Liability Amendment Bill in its current form.

Control of Tobacco Products and Electronic Delivery Systems Draft Bill

A draft Control of Tobacco Products and Electronic Delivery Systems Bill was published for comment in May 2018.²⁷ Once the Department of Health has considered and incorporated the comments received, the next draft will be sent to Cabinet for approval. Thereafter it can be tabled in Parliament for debate and passage.

Tobacco is highly toxic to people in all its forms. Tobacco smoke is dangerous to people who smoke and those around them ('secondary smoking') and those who enter spaces where they have been smoking ('tertiary smoking'). Nicotine, a highly addictive and toxic chemical, affects all the organs of the body and is particularly dangerous for children and adolescents who are still developing physically and emotionally.²⁸ Despite these dangers, tobacco smoking is still common in South Africa.²⁹ Over recent years, many nicotine-containing products have appeared in South Africa (such as e-cigarettes and vaping) with marketing clearly aimed at encouraging young people to try them, through flavourings, product design, retail spaces and advertising.

The Bill has two objectives. Firstly, it aims to tighten tobacco control in South Africa in the light of South Africa's commitment to the World Health Organization Framework Convention on Tobacco Control. Secondly, the Bill introduces controls on electronic delivery systems (known as e-cigarettes) including water-based delivery systems ('hubbly-bubblys'). Many of these systems deliver nicotine, yet there is currently no control on their contents, advertisement, distribution or sale. In this respect the Bill has taken a precautionary approach: Given emerging evidence that the products are dangerous and the likelihood that they are bad for human health.³⁰

For all these products, the Bill sets out stringent controls on their sale, packaging, use in public spaces, advertising and standards of manufacture:

- Displays are not allowed in any retail space.
- Distribution by postal and internet sales are banned.
- None of these products may be sold to anyone under the age of 18 years. No sale may take place in any environment in which children are educated or trained.
- Plain packaging of all products is mandated. No claims about the product may be made on the packaging e.g. flavours, 'lite' etc. The packaging must include health warnings and a prescribed leaflet in the pack that outlines its harmful constituents, the dangers of smoking and the benefits of cessation, among other messages.
- Smoking in restaurants, bars, and public transport is prohibited.
- No-one may smoke in a vehicle in which a child under the age of 18 years is present. (an extension of the current law which prohibits smoking in vehicles if a child under the age of 12 is present).
- Advertising is prohibited in any shape or form.
- The Minister is given powers to regulate the manufacture of these products and obtain information on their contents.

The Minister of Health is given wide powers to promulgate regulations governing all these areas. Should violations of this law occur then penalties including imprisonment for up to five years will be administered.

The Bill is an important step in protecting children in this country from ill health caused by chemical aerosols from cigarettes and e-cigarettes and addictive nicotine. Its many provisions provide a comprehensive approach to reducing the harmful effects of tobacco, and aim to end the marketing of e-cigarettes to young people. The Bill would be strengthened by prohibiting sale of any of these harmful products to anyone born after a certain date in order to work progressively towards a 'nicotine-free generation'.³¹

Prohibiting the sale of individual or unpackaged cigarettes would reduce access for young people, while not denying access to people who smoke. Specific regulations that prohibit sale of these products near schools and other places where children and young people congregate should be developed to further protect the next generation.

This Bill represents a valuable contribution to child and adolescent health and welfare in South Africa. It is in line with the country's commitment to the United Nations Convention on the Rights of the Child, including the Committee's General Comment 16 which outlines States' obligation to ensure that "the activities and operations of business enterprises do not adversely impact on children's rights".³² As the tobacco industry increases its lobbying against the Bill, legislators need to rely on reputable sources of evidence, rather than those funded by the industry in the interests of increasing profits.

Control of Marketing of Alcoholic Beverages Draft Bill

In 2013 the draft Control of Marketing of Alcoholic Beverages Bill, aimed at restricting alcohol advertising to the point of sale, was approved by Cabinet for public consultation. The Bill was developed over a three-year period by the National Departments of Health, Social Development, and Trade and Industry in response to the economic, health and social impact of harmful alcohol consumption.

The draft Bill is an evidence-based public health intervention that is applicable across all age groups but has specific relevance for children, by protecting children from exposure to alcohol advertising, sponsorships and promotions. Restricting advertising has been found to delay early experimentation with alcohol and subsequent risky drinking.³³ In 2011, 12% of 13-year-olds reported consuming alcohol,³⁴ and in 2016, 74% of young men and 38% of young women 15 – 19 years old reported binge drinking.³⁵

In 2009, alcohol generated approximately R97 billion in tax revenue, yet harms associated with alcohol cost the country R245 billion, much of that impacting on children through violence, abuse, foetal alcohol syndrome, loss of a breadwinner and chronic health conditions such as cancer and heart disease.

Cabinet's statement upon approval of the draft Bill in 2013, indicated political commitment to reducing alcohol-related harm:

"Alcohol is a major impediment to reaching government's outcome of a long and healthy life for all. The Bill seeks to reduce alcohol related harm

through control of marketing of alcoholic beverages. While government cannot ban alcohol it also cannot ethically permit encouragement of alcohol consumption by allowing the public and especially the youth to believe that their life will be enhanced when in fact for many it will have the opposite impact. This intervention should not be seen in isolation but as part of comprehensive measures by government to reduce alcohol-related harm."³⁶

However, six years later, the draft Bill has not yet been gazetted for public comment. This is despite several letters to the Minister of Health, media reports, a civil society submission to the UN questioning the lack of progress,³⁷ and Government citing the draft Bill as evidence of its commitment to address alcohol-related harms in its 2018 report to the UN Committee on Cultural, Economic and Social Rights.³⁸

The alcohol industry has been opposing the Bill with a concerted lobbying and advocacy campaign, using industry-funded research to warn of job losses and negative economic repercussions and questioning the legitimacy of academics and civil society organisations who support the Bill.³⁹ The industry has also proposed corporate social responsibility initiatives and industry-government partnerships as policy alternatives. These include the infamous "8 Pack Beer for Africa" and "Black Label gender-based violence/masculinity" campaigns. However, industry corporate social responsibility and education initiatives have been shown to have limited or no efficacy and are often used to stall more effective measures.⁴⁰

The Carbon Tax Act and draft Climate Change Bill

During the period 2018/2019 there were two legislative developments related to climate change mitigation and adaptation: The Carbon Tax Act⁴¹ which aims to curb industries' carbon dioxide (CO₂) emissions, came into effect on 1 June 2019, and the draft Climate Change Bill,⁴² which aims to provide a coordinated and integrated response to climate change and its impacts, was published for comment in June 2018. South Africa is the world's 14th largest CO₂ emitter, largely due to its dependency on coal.⁴³

These two instruments are therefore of crucial importance to mitigate South Africa's contribution to climate change and to uphold Government's constitutional obligations to protect the environment for present and future generations.

The right to have the environment protected for present and future generations

South Africa is extremely vulnerable and exposed to the impacts of climate change due to our socio-economic and environmental context and it is recognised that children, especially infants, are particularly susceptible to the adverse effects of climate change.⁴⁴ These impacts include: increased extreme weather events such as droughts and flooding – which may lead to an increased burden of disease, food and water scarcity; and extreme temperatures. This will also aggravate the impact of air and water pollution on children whose central nervous, immune, reproductive, and digestive systems are still developing.⁴⁵ Such impacts are at the centre of a recent legal complaint submitted to the United Nations Committee on the Rights of the Child.⁴⁶ This petition, filed by 16 young people from around the world, argues that Argentina, Brazil, France, Germany, and Turkey have known about the risks of climate change for decades, but are failing to curb emissions.⁴⁷ South Africa, as a Member State of the UN Convention on the Rights of the Child, must take heed of this landmark petition and ensure that both the Carbon Tax Act and Climate Change Bill not only uphold the right to a healthy environment for the benefit of present and future generations,⁴⁸ but also recognise that there is heightened obligation to do so in the best interests of children.⁴⁹ See the 'Deadly Air' case on page 166.

The "Polluter Pays" principle

The Carbon Tax Act adopts the "polluter pays" principle – which requires that the costs of preventing and remedying pollution, and its adverse health effects, must be paid for by those responsible for harming the environment.⁵⁰ Despite this, the Act imposes a tax rate of only R120 per ton of CO₂ equivalent (CO₂e) for the initial phase of the carbon tax's implementation.ⁱⁱⁱ This low rate combined with the tax-free allowances provided for in the Act⁵¹ could result in the effective tax rate being as low as R6 – R48 per CO₂e.⁵² It is unlikely that this rate will force industry (or at least the largest of the CO₂ emitters) to transition to low-carbon alternatives during the initial phase of the Act's implementation. In many instances, where consumers have limited alternatives available to them (as in the electricity supply sector at present), the additional cost burden of the tax will simply be passed on to consumers. This not only undermines the "polluter pays" principle, it has serious consequences for the health and constitutional rights of both present and future generations.

iii Section 1 of the Carbon Tax Act defines CO₂e ("carbon dioxide equivalent") as "the concentration of carbon dioxide that would cause the same amount of radiative forcing (the difference of sunlight absorbed by the Earth and energy radiated back to space) as a given mixture of carbon dioxide and other greenhouse gases".

The rights to life, dignity and a healthy environment

The Preamble of the Climate Change Bill highlights what's at stake and acknowledges that the rights to life, health and dignity are dependent on a healthy environment. Section 13 of the Bill envisages setting a national trajectory for the country's greenhouse gas emissions, and within that there will be emission targets for different sectors such as energy and agriculture. Entities emitting over a certain threshold would be allocated carbon budgets, which are essentially emission limits, which they may not exceed.^{iv} Although this signals a step in the right direction, if the Bill is passed in its current form this would be the only legally enforceable provision to mitigate the emission of Greenhouse Gases. The Bill does not go far enough to provide strong and clear guidance on the institutional mechanisms to monitor compliance and tackle climate change (particularly at a local level), nor does it address climate adaptation in a sufficiently coherent manner. It therefore fails, in its current form, to adequately respond to the "urgent threat to human societies" posed by climate change.⁵³ Any final Climate Change Act needs to be substantially more robust than the 2018 Bill. Despite the urgency of the situation, it is unclear when the next version of the Bill, or a final promulgated Act, can be expected.

It is critical, that the Carbon Tax Act and the Climate Change Bill are effective and lead the way toward a more comprehensive and transparent set of climate mitigation and adaptation measures, while enabling a just and inclusive transition to a low-carbon society. These measures are urgently needed to strengthen South Africa's resilience to the far-reaching impacts of climate change and to fulfil children's constitutional rights, now, and for generations to come.

Child Justice Amendment Bill

The Child Justice Amendment Bill⁵⁴ was introduced in Parliament in October 2018. The Bill was amended and then passed by the National Assembly on 27 November 2018⁵⁵ and transmitted to the National Council of Provinces (NCOP) for concurrence. When the fifth Parliament was dissolved ahead of the May 2019 general elections, the Bill lapsed.⁵⁶ It has recently been revived by the sixth Parliament⁵⁷ and is now being considered by the NCOP.

The primary purpose of the Bill is to raise the minimum age of criminal capacity.^v The Child Justice Act⁵⁸ currently sets the minimum age of criminal capacity at 10 years old. A child who commits an offence while under the age of 10 years does not have criminal capacity and therefore cannot be prosecuted for the offence.^{vi} The child should instead be placed in the care of their parents, guardian, caregiver or alternative care. A probation officer is notified about the child and assesses the child to determine the best course forward. This may include referral to a children's court, referral to counselling or therapy, or provision of support services.⁵⁹ Linking children under the age of criminal capacity to support services is important as "[m]ore often than not a young child who gets involved in crime is a child at risk and some action should be taken."⁶⁰ The Act also states that a child who is 10 years or older but under the age of 14 years is presumed to lack criminal capacity unless the state can prove that the child has criminal capacity.

The Bill proposes to raise the minimum age of criminal capacity to 12 years old. The Bill also proposes that children 12 years old or older but under the age of 14 years are presumed to lack criminal capacity. The Bill retains the provision requiring a review of the minimum age of criminal capacity no later than five years after the commencement of the amendment.

Raising the minimum age of criminal capacity to 12 years old ensures that South Africa aligns with recommendations from the United Nations Committee on the Rights of the Child to increase the minimum age to at least 12 years and to continue increasing the age.⁶¹ Commentary linked to Rule 4 of the United Nations Standard Minimum Rules for the Administration of Juvenile Justice⁶² provides that the following must be considered when a minimum age of criminal capacity is being determined and discourages states from fixing the age at too low a level:

"The modern approach would be to consider whether a child can live up to the moral and psychological components of criminal responsibility; that is, whether a child, by virtue of her or his individual discernment and understanding, can be held responsible for essentially antisocial behaviour."

iv Six greenhouse gases were declared priority air pollutants by the then-Minister of Environmental Affairs in July 2017: carbon dioxide ("CO₂"), methane ("CH₄"), nitrous oxide ("N₂O"), hydrofluorocarbons ("HFCs"), perfluorocarbons ("PFCs") and sulphur hexafluoride ("SF₆").

v Section 8 of the Act provides for a review of the minimum age of criminal capacity in order to determine whether it should be raised. This section requires the Minister of Justice and Correctional Services (previously the Minister of Justice and Constitutional Development) to, not later than five years after the commencement of the Act, submit a report to Parliament dealing with the question of the review of the minimum age of criminal capacity. The report was submitted to Parliament in March 2016: Department of Justice and Constitutional Development "Report on the Review of the Minimum Age of Criminal Capacity" (2016).

vi The child is taken through procedures set out in Section 9 of the Act titled "Manner of dealing with child under the age of 10 years".

The Bill further proposes a number of consequential amendments. These include, amongst others, amendments that:

- recognise that prosecutors are not in a position to determine the cognitive capacity of a child (for purposes of prosecution) or the criminal capacity of a child (for diversion);^{vii}
- refer the issue of determining criminal capacity to plea and trial in order to unclog the child justice system and prevent children being pathologised during pre-plea and trial processes; and
- give prosecutors and child justice courts the ability to refer children to a probation officer to be dealt with as children that lack criminal capacity if there is a belief that the children will not benefit from diversion or diversion is not appropriate

Traditional Courts Bill

The Traditional Courts Bill continues to be contentious. Many civil society and community-based organisations have raised serious concerns with various versions of the Bill on the basis that provisions violate constitutionally protected rights of communities in general, and women and children in particular.⁶³ Concerns with the latest version that was passed by the National Assembly in March 2019⁶⁴ include, that the Bill:

- preserves patriarchal norms;
- does not accurately reflect the nature of customary law;
- does not contain an 'opt-out' clause that gives people the choice of whether or not to have their dispute heard by either a traditional court or a civil court; and
- fails to align with systems established to protect and promote children's rights and well-being.⁶⁵

The Bill lapsed in May 2019 when the fifth Parliament was dissolved and has only recently been revived, enabling it to now proceed to the National Council of Provinces. This will provide another opportunity for advocacy on issues of concern for women and children.

Customary Initiation Bill

Every year the media reports on deaths, serious health issues and rescues from "illegal" initiation schools, raising concerns about the poor regulation of initiation schools. The Customary Initiation Bill (CIB)⁶⁶ aims to provide such effective

regulation through the establishment of oversight and coordinating structures for the protection of life, prevention of injuries and all forms of physical and mental abuse related to customary initiation. Furthermore, the CIB aims to provide guidance on governance and the responsibilities of different role-players to ensure that initiation is practiced in line with Constitutional and other legal prescripts.

It is important to note, in the discussions that follow, that the Bill differentiates between circumcision and initiation. Circumcision relates to the surgical removal of the foreskin or clitoris, while a person goes through initiation when they attend an initiation school for the purposes of undergoing customary or cultural practices, rituals or ceremonies which may include teachings relating to ideals, values, aspirations and respect that mark a person's transition into adulthood.

A number of provisions relate to the protection of children undergoing customary initiation practices, including the following:

- Initiation is a voluntary practice and no person may be forced or coerced into undergoing initiation practices or going to an initiation school.
- Parents, legal or customary guardians^{viii} must decide together with the child whether the child should participate in customary initiation or not. If male circumcision forms part of the initiation process then the parents, legal or customary guardians must decide together with the child whether he will be circumcised medically or traditionally or not at all.
- The Bill provides that no person under the age of 16 years may attend an initiation school for the purposes of being initiated.
- Circumcision of a male child under the age of 16 years is prohibited except if performed for religious or medical purposes.
- A child between 16 and 18 years may not attend an initiation school for purposes of being initiated unless such child and his or her parents or customary or legal guardian have given written consent.
- Circumcision of a male child between the ages of 16 and 18 years is subject to the provisions of the Children's Act⁶⁷ and regulations. The Children's Act states that the child must give consent after proper counselling⁶⁸ and taking into consideration the child's age, maturity and stage of development. Every male child has the right to refuse circumcision.⁶⁹

vii The prosecutors are only called on to consider a child's educational level, domestic and environmental circumstances, age and maturity of the child.

viii The Bill defines a 'customary guardian' as any person other than a parent or legal guardian who, in terms of the customs of a particular community, accepts parental responsibility for a child, including the responsibilities referred to in section 18 of the Children's Act. Section 18 of the Children's Act sets out what parental responsibilities and rights entail.

The consent requirements for initiation and circumcision will differ if this Bill is passed in its current form. While initiation will require the consent of both the child and his parents or guardian, circumcision only requires the consent of the child after proper counselling as set out in the Children's Act. The Children's Act does not require parental or guardian consent because it acknowledges that a child aged 16 to 18 years is an autonomous being with the sufficient capacity to make a decision about whether or not to undergo circumcision once given adequate guidance. In terms of the Children's Act a parent, guardian, caregiver or social service professional can provide proper counselling to guide the child when making their decision.⁷⁰

It is commendable that the provisions of the CIB affirm the need for children to be involved in decisions about their own initiation or circumcision. These are deeply personal procedures and practices that affect a child's right to bodily and psychological integrity. However, the process outlined for consent to initiation is lacking when compared to the process set out in the Children's Act for circumcision. It is important that the requirements for initiation be aligned with the Children's Act requirements for circumcision. The Bill must be strengthened in this regard through amendments that make it clear that the decision to go through initiation should be the child's as set out in provisions in the Children's Act dealing with circumcision.^{ix} This will require removing the requirement of parental consent from the CIB and replacing it with parental guidance/counselling to assist the child in making his/her decision and clarifying that it is the child who has the right to make the decision.

The Bill aims to align with the Children's Act provisions around genital mutilation, circumcision and virginity testing. The Children's Act prohibits the genital mutilation or circumcision of female children of any age.⁷¹ It also prohibits the virginity testing of female children under the age of 16 years⁷². Virginity testing of children older than 16 years may only occur if the child consents and after proper counselling.⁷³ The CIB reinforces these provisions of the Children's Act by stating "no child ... may be forced to undergo virginity testing as part of an initiation process."⁷⁴

Provisions on discipline and teaching provide, amongst other things, that the principal of an initiation school and caregivers employed by the school, must ensure discipline among initiates at all times and must ensure that teachings discourage misconduct. Discipline must not include abuse

or assault. Prohibition of the use of corporal punishment – particularly in relation to children – is a glaring omission that needs to be addressed the Bill in order to make it clear that corporal punishment in initiation schools will not be condoned.⁷⁵

The Bill places an obligation on the principal and caregivers to ensure that initiates have at all times access to clean water, appropriate sanitation and food. Caregivers, principals and traditional surgeons all have the obligation to ensure that initiates who display symptoms of ill-health, serious injury, infection or excessive, recurring or continuous bleeding, receive immediate medical attention. The Bill, however, lacks clarity on where the child/children concerned must receive the medical attention (or that it must be from a registered health professional). It is essential that the Bill is clear on the importance of ensuring that children are taken to a doctor, clinic or hospital to receive adequate medical care.

The Bill further provides guidance on the process to be followed in the event of the death of an initiate.⁷⁶ This includes immediately informing parents and/or guardians, the South African Police Service, the relevant Provincial Initiation Coordinating Committee, traditional surgeon, where applicable medical practitioner and senior traditional leader where relevant.

The Bill provides that no person may participate in any aspect of initiation if that person is found to be unsuitable to work with children in terms of the Children's Act; if that person's name is contained in Part B of the National Child Protection Register; or if that person's details are in the National Register for Sex Offenders. The Bill further provides that principals and caregivers of initiation schools must be subject to screening to ensure that they have no history or criminal record of abuse of children. This seems to provide children with two layers of protection namely registers that aim to protect children and screening that includes a "history" of abuse and criminal record.

The content of the Bill is commendable in that it attempts to ensure that the rights and well-being of children involved in customary initiation are protected and affirmed. However, key to this will be consistent implementation of the Bill once it becomes law. Relevant duty bearers and oversight bodies will need to ensure that there is strict adherence to the provisions of the Bill, especially those that aim to protect children from illness, abuse, serious injury, death and psychological harm.

ix In addition to respecting and affirming the child's right to make a decision that may have an impact on his bodily integrity, having a clear provision will avoid conflicts that arise relating to what should be done if a parent/guardian and a child make different decisions.

The Bill was introduced in Parliament in April 2018. After engagements with stakeholders, in particular the National House of Traditional Leaders,^x and a day of parliamentary hearings, the Portfolio Committee on Cooperative Governance and Traditional Affairs proposed amendments⁷⁷ and voted to adopt the Bill in November 2018.⁷⁸ Thereafter, the National Assembly passed the Bill⁷⁹ and referred it to the NCOP for concurrence. Due to the dissolution of the fifth Parliament, the Bill lapsed in May 2019, and has only recently been revived by the sixth Parliament.⁸⁰ The next step for the Bill will be deliberations and public hearings by the NCOP.

Conclusion

The professional lobbying of profit-driven industries such as the tobacco and alcohol industries; and the powerful influence of those invested in coal production or preserving patriarchal traditional systems have the potential to dominate the law-making process, resulting in laws that preserve the vested interests of a few at the expense of children.

On the other hand, if lawmakers were to seriously consider and uphold the best interests of children, then they would be more likely to make decisions that would improve the quality of life for all, and sustain the planet for generations to come.

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