BORDER JUSTICE

Migration, Access to Justice and the Experiences of Unaccompanied Minors and Survivors of Sexual and Gender-Based Violence in Musina

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Acronyms

CPC	Centre for Positive Care
CRFSS	Criminal Record and Forensic Science Service
CWM	Christian Women's Ministries
CWSA	Child Welfare South Africa
CYCC	Child and Youth Care Centre
DHA	Department of Home Affairs
DoH	Department of Health
DoJ	Department of Justice
DSD	Department of Social Development
FCS	Family Violence, Child Protection and Sexual Offences Unit
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
LHR	Lawyers for Human Rights
MSF	Médecins Sans Frontières
NPA	National Prosecuting Authority
NGO	Non-Governmental Organisation
PEP	Post-Exposure Prophylaxis
RRO	Refugee Reception Office
RSDO	Refugee Status Determination Officer
SANDF	South African National Defence Force
SAPS	South African Police Service
SARC	South African Red Cross Society
SCUK	Save the Children (United Kingdom)
SGBV	Sexual and Gender-Based Violence
SMG	Souptsanberg Military Grounds Detention Centre
STD	Sexually Transmitted Disease
TCC	Thuthuzela Care Centre
UAM	Unaccompanied Minor
UNHCR	United Nations High Commissioner for Refugees
VEC	Victim Empowerment Centre
VCT	Voluntary Counseling and Testing (HIV)

Executive Summary

Introduction

Located just eighteen kilometres south of the border post between South Africa and Zimbabwe, the town of Musina has become host to a large population of newly-arrived migrants. These migrants are predominantly Zimbabwean, but there are also significant populations from the Democratic Republic of Congo, Ethiopia, Mozambique, Somalia, and Malawi. Some of these migrants have unique needs that are not linked to their status as migrants alone. This study focuses on the situation and experiences of two such groups that are particularly prominent in Musina: unaccompanied minors (UAMs) and survivors of sexual and gender-based violence (SGBV). It examines the barriers these migrant groups face in realising their rights and the challenges around their particular circumstances.

Unaccompanied minors are children under the age of eighteen who have crossed an international border and are not in the care of a parent or guardian. Some of these children are asylum seekers, while others have fled abusive family situations. Many also come in search of work or educational opportunities. Migrants, including UAMs, experience high levels of sexual and gender-based violence during the border crossing and once they have arrived in Musina.

Musina: A town adapting to migration

In response to the increased migration flows that accompanied the growing humanitarian crisis in Zimbabwe in the early 2000s, the Department of Home Affairs opened a refugee reception office in Musina in 2008 to process asylum claims. As a result, migrants began staying in Musina for longer periods while they waited for asylum documentation. The availability of documentation also enabled some to extend their stays so that they could gather the resources to travel to other destinations inside South Africa.

Initially ill-equipped to deal with the growing migrant population, Musina gradually became a base for a number of non-governmental (NGO) and international non-governmental organisations (INGOs) that opened local offices. The United Nations High Commissioner for Refugees (UNHCR) established a field office there in 2008. Existing local organisations also began serving migrants. These organisations have continued to provide a range of legal, humanitarian and medical assistance to migrants.

Border crossing

South Africa's restrictive border entry requirements, combined with a lack of information and/or documentation, force many migrants to cross the border informally. Informal border

crossers must traverse a poorly monitored 'bush' area. Their lack of familiarity with this area makes these migrants easy prey for both smugglers offering to lead them into South Africa, and for criminal gangs that target migrants in this 'no man's land.' Migrants are frequently robbed, assaulted, and sometime raped during this border crossing. The SGBV attacks may include gang rape and compelled rape between companions or family members. Children and men are not immune from these attacks.

Inside Musina

Once inside Musina, migrants continue to experience various forms of SGBV. Many women end up being abused by men offering them work, transport, food, or shelter. Due to their often insecure immigration status, migrant women are often reluctant to report this abuse to the police. Some female migrants turn to sex work to support themselves. These women are at heightened risk of abuse from strangers who exploit their vulnerability: foreign sex workers are reluctant to report these attacks to the police both because of their tenuous immigration status and because they are engaged in illegal work. Street children have also reported being sexually assaulted either by other street children or by adults promising them work or other remuneration. Some of these children do not report their attacks because they do not want to risk being placed in the more structured formal child care system or because they are afraid of their attackers.

Many of Musina's migrants, including UAMs and survivors of SGBV, stay in one of four shelters open to migrants, two of which house children. These shelters have only limited support from the Department of Social Development (DSD). They receive additional support from the International Organisation for Migration (IOM), UNHCR, and other organisations, but they are heavily dependent on donations. The shelters suffer from resource constraints, a lack of trained staff, and inadequate facilities. As a result, the shelters are unable to meet the needs of UAMs, many of whom chose to leave and live on the streets. The shelters are also unable to provide adequate psychological support and counselling services for UAMs and survivors of SGBV.

The two shelters housing children in Musina face an additional challenge; they must upgrade staff, resources, and infrastructure in order to meet the requirements for registration as child and youth care centres under the Children's Act (No. 38, 2005) before the 2014 deadline. Both shelters currently lack the resources needed to make the necessary changes to bring them into compliance with the norms and standards required for the registration process. If they do not make these changes, these shelters will no longer be able to house children, leaving Musina without any child and youth care facilities.

Outside of the shelters, migrants in Musina have access to a range of service providers, including local and international NGOs, faith-based organisations, legal service providers, local civil society organisations, humanitarian organisations, health care providers, and governmental and inter-governmental organisations. In July 2011, the National Prosecuting

Authority (NPA) opened a Thuthuzela Care Centre (TCC) in Musina, a one-stop care facility for survivors of SGBV. In February 2012, the South African Police Service (SAPS) established a Family Violence, Child Protection, and Sexual Offences Unit (FCS) in Musina. The establishment of dedicated units to deal with the health care, psychosocial, and justice needs of these two groups have brought about significant improvements, as have the coordinated efforts of local government and civil society. However, significant challenges remain.

Access to justice barriers for UAMs

South Africa's Children's Act sets out a range of protections and prescribed procedures for children in need of care and protection, including UAMs. Although DSD has the primary responsibility for implementing this act, other government departments also have an obligation to implement the protections found in the Act. In Musina, UAMs are not being afforded many of the protections found in the Act or in other international and domestic laws protecting children.

Some of the key challenges compromising access to justice for UAMs in Musina include the following:

South Africa Police Services

- Inadequate and subjective identification procedures leading to the illegal detention of UAMs.
- Summary deportations of children without the legally required court order.
- Legislative and SAPS' departmental procedures for handling UAM cases are not put into practice.

Department of Social Development

- No child and youth care centres (CYCCs) in Musina, and no support for the shelters to enable them to meet the requirements for registration as CYCCs.
- Limited counselling services for UAMs, particularly those with special needs or those who have suffered abuse.
- Limited alternative education options for children in the shelters.
- DSD resource constraints and unavailability of social workers after hours.
- Lack of diverse language skills amongst social workers, which compromises the services UAMs receive.
- Lengthy and often improper placement procedures for children in need of care and protection that limit their access to needed services.

- No interventions for street children who are by definition children in need of care and protection.
- Failure to assess or to inform shelters of the health status of children, resulting in failures to treat chronic, communicable, or serious health issues.
- Foster care not effectively available as an alternative to institutional care.
- Limited cross-border coordination of cases.
- Lack of durable solutions for minors to regularise their immigration status and prepare them for independence once they turn eighteen.

Department of Home Affairs

- Failure to refer UAMs who approach the refugee reception office to DSD.
- Failure to prioritise UAM asylum applications or to conduct status determination interviews.
- No effective mechanisms for documenting UAMs.
- Refusal of entry to UAMs at the border without any provision for their care.

Department of Education

- Barriers to school registration, particularly for UAMs who arrive in the middle of the school year.

Department of Health

- Barriers to obtaining the health clearance certificates that ensure that the child's health care needs are adequately addressed in his or her placement and help manage the spread of communicable diseases.

Department of Justice

- Children's court proceedings are only held once a month, leaving many UAMs without lawful placements for long periods.
- Children's court proceedings and best interest determinations are conducted without the presence of the child, in violation of the Children's Act.

Access to justice barriers for SGBV survivors

The situation for SGBV survivors in Musina has improved significantly since the opening of the Thuthuzela Care Centre and the FCS unit and the closure of SMG. Survivors now have

improved access to medical care and police assistance with less risk of secondary victimisation. Counselling and treatment services are centralised at the TCC, which has also improved evidence collection and strengthened legal cases. But high sexual assaults rates combined with low reporting and conviction rates remain a problem.

Some of the key challenges around access to justice for SGBV survivors include the following:

Department of Home Affairs

- Refusal of entry practices that are increasing informal border crossings and exposure to SGBV.
- Detentions and deportations of SGBV survivors without medical treatment.

South African National Defence Force

- Inability to curb violence along the border.

Department of Social Development

- No outreach efforts to identify and assist SGBV survivors.

South African Police Service

- Low rate of reported cases.
- High case withdrawal rates.
- Failure to investigate cases because of assumption that attacks are being committed by Zimbabwean nationals who are based in Zimbabwe.
- Police detentions and deportations of SGBV survivors in need of medical care.
- Failure to open cases.
- Long waiting periods for forensic evidence.
- Compromised evidence as a result of victim delays in reporting cases and preserving evidence.

Department of Justice

- Low convictions rates for SGBV cases.
- No measures to protect against victim intimidation.
- Non-appearance of complainants at trial.

Department of Health and the Musina Hospital

- No comprehensive care available to SGBV survivors after hours.

- Poor survivor compliance with follow-up care.
- No urgent medical care for SGBV survivors in detention.
- Healthcare systems not integrated across the country.
- No public abortion services available in Musina.
- No regular medical services available to rural populations.

Conclusion and recommendations

Initially unprepared for the large numbers of migrants that began streaming into Musina in the early 2000s, local government and civil society have worked to develop appropriate responses to the migrant population there. In the case of UAMs, social workers now work with the children's court to make lawful placements for children in need of care and protection. But many of the needs of UAMs in Musina continue to go unmet. With respect to SGBV, survivors now receive comprehensive care in one location. They are able to report their cases to the police in a confidential and therapeutic environment and have their cases handled by health care workers, counsellors, and police officers who have been trained to deal with the effects of sexual abuse and are sensitive to the needs of SGBV survivors. At the same time, the rate of sexual assaults remains high, while reporting and conviction rates remain low.

Many of the continuing problems stem from resource constraints, insufficient support at the national level and inadequate training around the procedures set out in the law. Greater coordination between the national and local level as well as improved coordination between government departments is needed to ensure that the rights of UAMs and SGBV survivors are fully realised.

To that end, ACMS makes the following recommendations:

UAMs

To the South African Police Service:

- Do not detain minors in police cells. In cases where an age determination is necessary, establish an alternative procedure in collaboration with DSD that does not require that individuals who may be minors be detained with adults.
- If minors or possible minors are detained, ensure that DSD is notified immediately.
- Halt all deportations of minors without first obtaining a children's court order.
- Ensure that all UAMs are taken directly to the shelters and that both shelter staff and DSD are notified.
- Make sure that officers are aware of their duty to remove all UAMs they encounter to places of safety, including those they encounter on the streets.

- Ensure that officers are adequately trained on the procedures they must follow in carrying out these removals, including the immediate notification of a social worker.

To the Department of Social Development:

At the national and provincial level

- The Minister and the MEC for Social Development should ensure the provision of adequate funding to establish child and youth care centres in Musina. This may include providing financial support to the existing shelters housing children to enable them to make the necessary transformations to become registered as CYCCs.
- The Minister and the MEC for Social Development should allocate greater resources to social workers working with UAMs in Musina to ensure that they are able to meet their obligations under the Children's Act.
- The Minister should engage with her counterpart in Zimbabwe to improve coordination with the Department of Social Services there and facilitate more timely responses to DSD requests around investigations into the best interests of Zimbabwean UAMs.
- The Provincial Head of Social Development needs to ensure that the therapeutic needs of UAMs in Musina are being met, including:
  - » Evaluating the therapeutic needs of UAMs in Musina;
  - » Providing interpreter services; and
  - » Ensuring that there are CYCCs in Musina that comply with the national norms and standards, and that these CYCCs have residential and therapeutic programmes tailored to the specific needs of UAMs in Musina, with a particular focus on the needs of children living and working on the streets.

At the local level

- Tailor the provision of services to the needs of the individual child.
- Make social workers available after hours.
- Provide children with appropriate counselling upon initial placement at a shelter to reduce the risk that they will leave the shelter before the formal placement procedure is complete.
- Ensure that there are trained interpreters who can communicate effectively with UAMs in Musina
- Engage in outreach to street children, who are by definition children in need of care and protection under the Children's Act.
- Develop placement options that better serve the needs of street children to minimize the risk that they will return to the street.

- Establish procedures for dealing with children who leave the shelters before the placement procedure is complete. This includes mechanisms for tracing the child, such as collecting photographs and other details.
- Institute a programme to assist children in transitioning from life on the streets to a more structured care environment.
- Identify children living in informal foster care, investigate their situation, and formalize their care in accordance with the best interest standard.
- Conduct and share the results of medical certifications with shelter staff so that they can adequately address the specific medical needs of children and take appropriate measures against communicable diseases.
- Train social workers on the documentation options available to UAMs, particularly those who risk becoming stateless. Social workers must also receive training on when particular documentation options, such as asylum and refugee protection, are appropriate.
- Make sure that only children who may have asylum claims are documented as asylum seekers.
- Make directed efforts to document UAMs before they turn eighteen.
- Train social workers in how to develop durable solutions for UAMs who are about to turn eighteen, including applying for an extension of the court order for children who will still be in school when they turn eighteen.
- Engage in active interventions when UAMs are not allowed to enrol in schools.
- Provide informal schooling and vocational training at the shelters to ensure that the educational and therapeutic needs of minors are being met when formal schooling is either not appropriate or not possible.

To the Department of Home Affairs:

- Prohibit immigration officers from refusing entry to UAMs at the border without a procedure for ensuring their care and protection.
- Establish a procedure for identifying UAMs at the border and ensuring that they are placed in the care of a social worker.
- Make sure that all staff at the refugee reception office are aware of their obligation to contact DSD if a UAM approaches the office.
- Prioritise the asylum claims of UAMs, which includes conducting status determination interviews in the company of a social worker or guardian.
- Develop mechanisms to document UAMs who do not qualify for asylum.

To the Department of Education:

- Engage with public schools in Musina to make them aware that they are not entitled to turn UAMs away and that UAMs must be allowed to enrol at any point during the school year.

To the Department of Health:

- Develop a procedure in collaboration with DSD for providing UAMs with medical certifications within 24 hours. This could include allocating a DoH staff member to conduct these certifications at a particular time every day.

To the Department of Justice/Children's Court:

- Hold children's court proceedings more than once a month to ensure that the placement needs of UAMs are being met in accordance with the requirements of the Children's Act.
- Provide the child with an opportunity to participate in the children's court proceedings to determine his or her best interest. Do not hold these proceedings in the absence of the child, which is a violation of the Children's Act.

SGBV survivors

To the Department of Home Affairs:

- Stop the practice of denying entry to asylum seekers at the border, which forces them to cross the border informally and increases the likelihood of abuse.
- Screen detainees prior to deportation to ensure that no person requiring urgent medical care is deported.
- Provide information at the border about the services available in Musina for survivors of SGBV.

To the South African National Defence Force:

- Increase patrols in the 'no man's land' between South Africa and Zimbabwe to reduce incidences of sexual and gender-based violence in this area.
- Establish a procedure to determine if an arrested individual is in need of medical care before transferring him or her to SAPS or DHA. Transport individuals in need of medical services to the TCC or the Musina hospital.

To the Department of Social Development:

- Engage in active outreach work at the shelters, farms, and the refugee reception office to ensure that SGBV survivors—both male and female—are aware of their rights and the services available to them, as well as the procedures around collecting evidence and the importance of seeking care as soon as possible.
- Make social workers available after hours for SGBV survivors who report to the police station or the hospital on evenings and weekends.

To the South African Police Service:

- Establish a procedure for determining if detainees in police cells are in need of medical care and for transporting these individuals immediately to the TCC or to the hospital when the TCC is not open.
- Ensure that these procedures apply equally to survivors of all forms of sexual and gender-based violence and not only rape and apply equally to men and women.
- Make sure that police officers do not prematurely close cases or refuse to open cases before a proper investigation has been conducted by a member of the FCS unit. Officers must be informed that they cannot turn away any individuals who report any form of SGBV.
- Maintain regular communication with complainants to keep them informed of the progress of the case, both to make sure that they are available during the court process and to ensure that they are aware that their cases are continuing. Such efforts could include:
    - » Encouraging complainants to make use of the VEC until they have become established and are able to provide contact details.
    - » Providing complainants with contact details for an officer with whom they have a relationship to encourage them to remain in contact.
    - » Inquiring as to the complainant's ultimate destination in South Africa and arranging for the complainant to be in contact with an officer in that destination.
    - » Ensuring that complainants understand the importance of maintaining contact with the police for the success of the case.
    - » Informing complainants that their transport and accommodation will be covered if the trial takes place after they have left Musina.
- Consider providing statistics on reported SGBV case to stakeholders in order to provide them with better information with which to identify where the barriers to justice are located and how to address these barriers more effectively.

To the Department of Justice:

- Maintain regular contact with complainants and witnesses to keep them informed on the status of their cases and keep them invested in the process.
- Make sure that complainants understand the importance of keeping police and prosecutors informed of their contact details.
- Ensure that complainants are aware of the fact that their travel and accommodation costs will be covered if they need to return to Musina for the court case.
- Establish a separate waiting area for survivors so that they will not risk encountering their attackers while waiting outside the court room.
- Explain the court process to the complainant and ensure that he or she is emotionally and mentally prepared to testify in court, as this will involve recounting the attack and confronting the attacker. Make sure that the complainant has access to counselling when necessary.
- Take measures to protect witnesses/survivors from pre-trial intimidation where necessary, including revoking bail and providing police protection.

To the Department of Health:

- Make available the full range of SGBV services during the hours that the TCC is closed, including trauma counselling, VCT, and access to the full course of PEP.
- Train all health care workers at the Musina hospital in the administration of VCT so that this can be provided as soon as a survivor reports to the hospital.
- Train all health care workers at the Musina hospital on how to examine and treat SGBV survivors to ensure that the examination is done in an appropriately sensitive manner that avoids secondary victimisation and exacerbating the trauma experienced by the survivor.
- Ensure that patients who receive PEP at the hospital are fully informed about the importance of follow-up treatment and completing the full course of medication.
- Make abortion services available to SGBV survivors in Musina, either by providing these services at the Musina hospital, or by providing subsidies so that SGBV survivors may reach a hospital where abortion services are available or may access these services at a private hospital.
- Provide for daily visits by DoH staff to the police cells to monitor and address the health care needs of individuals in detention.
- Establish a referral letter mechanism for migrant patients so that their treatment can be continued in any hospital or clinic in the country.
- Make sure that the mobile DoH clinics are adequately resourced so that they can visit the rural areas on a weekly basis to provide health care services and ensure that patients relying on these clinics for chronic medication do not have their treatments interrupted.

Introduction

> *I came here because I did not like what my mother does. She took us to the streets in Harare every day for begging and it was disturbing my schooling. If you deny going for begging she will beat you and you will sleep outside the house… At least here I am going to school, I will go back after finishing school…but I do not know if I will succeed because I heard they want to close the shelter.*[1]

> *[A]fter the rape incident in the bush, at the border, when more than five men raped me, I kept it to myself because I did not want my sister in law to know, because that was going to be an end to my marriage. I could not go to the hospital because I did not even have a passport or asylum to be legal here and I was scared that they can arrest me. After a month, I realised that I had an STI and pregnancy that is when I went to MSF.*[2]

Located just eighteen kilometres south of the border post between South Africa and Zimbabwe, the town of Musina has become host to a large population of newly-arrived migrants who began arriving in significant numbers in 2000. While predominantly Zimbabwean, recent years have seen growing numbers of migrants from other countries, including the Democratic Republic of Congo, Congo Brazzaville, Ethiopia, Mozambique, Rwanda, Somalia, Uganda, Nigeria, Malawi and Burundi. Some have also come from as far as Bangladesh and Pakistan. Given its relatively small population and distance from major urban centres, the town was initially ill-equipped to deal with the presence of these migrants, many of whom face particular challenges as highlighted in the excerpts above.

In response to increased migration into Musina, the Department of Home Affairs (DHA) opened a refugee reception office there in 2008 to process asylum claims. While the town remains a transit point for most migrants heading to urban areas, the availability of documents has enabled many newly-arrived migrants to remain in the town until they can gather enough funds to travel to other cities without risk of arrest. As a result of the growing migrant population and the lack of government assistance, the United Nations High Commissioner for Refugees (UNHCR) as well as numerous non-governmental organisations (NGOs), international non-governmental organisations (INGOs), and local faith-based organisations began providing assistance to the migrant population. Much of this assistance began during the height of Zimbabwean migration in 2008.

Among the migrant population are groups whose circumstances give rise to specific needs that are not linked to their status as migrants alone. This report identifies the obstacles that two such categories of migrants in Musina encounter in accessing their rights:

[1] UAM, URC Shelter, 5 November 2010.

[2] SGBV survivor, Musina, 15 December 2010.

unaccompanied minors (UAMs) and survivors of sexual and gender-based violence (SGBV). Within these two groups, there are subcategories of migrants with still greater needs, such as UAM survivors of SGBV, pregnant UAMs, or disabled or mentally incapacitated UAMs or SGBV survivors. The additional challenges faced by these subcategories are outside of the scope of this research, but many of the general observations and recommendations apply to them as well.

Although there are no accurate numbers, Musina is home to a large number of unaccompanied minors—migrants under the age of eighteen who are not in the care of a parent or guardian. Many of these children, together with other migrants, cross the border informally to reach Musina. Informal border crossers must traverse the ineffectively monitored 'bush' area, where they are susceptible to a range of crimes including sexual attacks. As a result, Musina also hosts a number of migrants who have experienced sexual and gender-based violence, encompassing any sort of sexual assault or abusive sexual contact.

The findings below explore the socio-legal situation of unaccompanied minors and survivors of sexual and gender-based violence, examining the legal framework, the institutional actors who are involved, and the practical challenges around implementing the policies, laws, and safeguards established to protect these groups. The findings highlight:

- The experiences of migrants in accessing justice and realizing their legally guaranteed rights, including the key obstacles they encounter;
- Institutional challenges in implementing the law and addressing the protection needs of particular migrant populations at the border; and
- Survival strategies of UAMs and SGBV survivors.

Regional migration

Zimbabweans make up the largest population of migrants in Musina. The land redistribution programme that began in 2000 ushered in a period of political and economic instability in the country, with migration reaching a number of peak points as political developments heightened the country's humanitarian and human rights crisis. Food shortages, unemployment, rampant inflation, growing HIV and cholera rates, declining health care services, political violence, and human rights violations all contributed to increased migration flows, which peaked in 2008.[3] Migration declined as conditions in Zimbabwe began to improve, but many Zimbabweans continue to come to South Africa for a combination of political, humanitarian, and economic reasons. Many also regularly travel back and forth between Zimbabwe and South Africa as cross-border traders and farm-workers or to visit family.

[3] See, e.g., Human Rights Watch, 'Crisis without Limits: Human Rights and Humanitarian Consequences of Political Repression in Zimbabwe,' January 2009, available at http://www.hrw.org/sites/default/files/reports/zimbabwe0109web.pdf

In order to qualify for refugee status in South Africa, an individual must be fleeing individual persecution or general conditions of instability. Many Zimbabweans do not fall clearly under this definition. Although the South African government is quick to label all Zimbabweans as economic migrants, the reality of the situation is far more complex. Zimbabwean migration is made up of mixed migration flows that stem from the many dimensions of the socio-political crisis. While a number of Zimbabweans are fleeing the effects of the economic crisis—including economic deprivation and food scarcity—these effects cannot easily be divorced from the underlying political causes, making it hard to distinctly categorise them as either economic migrants or as asylum seekers. South Africa, however, categorises most migrants who do not fall unequivocally into the category of refugees as economic migrants. Since legal avenues of migration for economic migrants—particularly those who are relatively unskilled—are highly restricted, many Zimbabwean migrants are left with no means to regularise their status in South Africa.

Migrants from other countries, including the DRC, Sudan, Ethiopia and Somalia, also use the Beitbridge border post to enter South Africa. Many of these migrants point to political violence and civil war as the cause of their flight. Smaller numbers of migrants from Malawi and Mozambique are also present in Musina, and generally come in search of economic or educational opportunity.

Border crossings

Many migrants, particularly those who are poorer and less skilled, often lack information about conditions at the border post and the options that are open to them for formal entry. This lack of information has given rise to a large smuggling enterprise that includes both professional and amateur smugglers who operate along the border to facilitate the informal entry of migrants into South Africa.[4] Informal border crossings, both with and without the assistance of smugglers, have also increased as a result of recent measures restricting formal entry such as new documentation requirements and the denial of transit permits.

Informal border crossings take a variety of forms. At the formal border post, migrants either bribe officials at the entry gate or are smuggled through the border in trucks and other vehicles. Some migrants avoid the formal border post altogether by crawling under the bridge and crossing underneath the entry gate. Many opt to cross through the Limpopo River at any point where it marks the border with South Africa. Although a fence has been erected along the banks of the river on the South African side to prevent the informal migration of both people and animals between Zimbabwe and South Africa, this structure is extremely porous, with many holes and openings that allow for a relatively easy flow of migration. Corruption also plays a role in facilitating passage.

[4] T. Araia, 'Report on Human Smuggling across the South Africa/Zimbabwe Border,' FMSP Research Report, May 2009.

Informal border crossers traverse a poorly monitored 'no man's land' area, making them easy prey for both smugglers and criminal gangs seeking to exploit the vulnerability of their situation. These actors target migrants for robberies, beatings, extortion, and sexual assault. Those who cross through the crocodile-infested Limpopo River also risk drowning, particularly during the rainy season.

Many informal border crossers rely on smugglers, such as the informal transport operators known as 'malayitshas.' These smugglers, both professional and amateur, often coordinate with partners on both sides of the border and arrange taxis or pick-up trucks to transport individuals. Although the smugglers offer safe passage across the border, in many cases they themselves will rob or assault their clients, or exploit their situation to extract additional money. They also collude with the amagumagumas—gangsters who target informal border crossers travelling both with and without the assistance of smugglers. NGOs have also received reports of women who travel with truckers being forced into sex work to compensate the drivers when they are unable to pay for the journey, or being raped by drivers during the journey.[5]

The rise in informal border crossings

In March 2011, the Department of Home Affairs began denying entry to Zimbabweans who did not have valid travel documents, although both international and domestic law entitle asylum seekers to enter a country without documentation. Around the same time, DHA also began applying the first safe country principle at the border as a means of refusing entry to individuals who transited another country en route to South Africa. This principle requires asylum seekers to apply for asylum in the first safe country through which they transit. Although the principle is not found in international law, states have begun employing the practice as a burden sharing method that enables them to send asylum seekers to other countries. In order to be consistent with international obligations under refugee law, states may not simply deny entry to an asylum seeker, as is South Africa's practice, but must ensure that the returned asylum seeker will be guaranteed a fair asylum procedure in the receiving country.[6] Although DHA has not consistently applied the first safe country principle, both of these restrictions have left many asylum seekers both from Zimbabwe and from non-neighbouring countries with little option but to cross the border informally.

Inside Musina

Migrants who are not detained generally stay in one of four areas inside Musina: 1) near the border post; 2) on the streets; 3) in rented shacks in the Nancefield suburb; or 4) in one of

[5] Legal counsellor, LHR Musina, 27 September 2012.

[6] For more on the first safe country principle, see R. Amit, 'The First Safe Country Principle in Law and Practice,' ACMS Migration Issue Brief 7, June 2011.

the four shelters. Some migrants are also detained at the police station for several days before either being deported or heading to one of these areas.

SAPS initially began detaining individuals at detention Centre on the Souptpansberg Military Grounds (SMG) in early 2007 in response to the growing number of migrants who began arriving in Musina. Although not authorised as such under the law, the centre was initially used (by SAPS rather than DHA) as a detention facility for individuals awaiting deportation. A May 2009 ruling by the North Gauteng High Court held that the use of SMG as an unauthorised immigration detention facility was unlawful.[7] The decision also found that detention conditions at SMG were inhumane and unlawful. Nevertheless, SAPS continued to use the facility to temporarily house individuals arrested at the border until they could be taken to the refugee reception office (RRO) to apply for asylum, arguing that it was essentially a police holding cell. NGOs agreed not to enforce the court order and to allow the facility to be used as a temporary 'accommodation facility' until individuals could apply for asylum permits in order to prevent them from sleeping outside the RRO and disturbing local businesses and residents. But SMG quickly returned to its former status as a detention facility and SAPS stopped automatically releasing detainees to enable them to apply for asylum. Instead, individuals remained in detention for several days while DHA screened detainees and conducted deportations directly from the facility despite the fact that SMG was not authorised as a DHA detention and deportation facility. Conditions worsened and in December 2011, SAPS stopped using SMG in response to growing complaints from NGOs about the deteriorating conditions and the lack of medical care. Following the completion of its new police station, SAPS began detaining individuals in the regular police cells.[8]

Police detained both unaccompanied minors and victims of SGBV at SMG during the period that the facility was in use, as well as pregnant women and women with children. Medical care at SMG was inconsistent and depended on the availability of hospital ambulances. SAPS made no provision for the particular needs of either SGBV survivors or UAMs. With respect to UAMs, SAPS did not directly transfer children to the shelters; instead, it held them in detention until DSD arrived, even when this took days or even weeks. Although access to health care in detention remains a problem, the situation for both UAMs and survivors of SGBV has improved with the move to the police cells, as fewer individuals from both categories are detained. These improvements, and the remaining challenges, will be discussed below.

Methodology

The research findings described below are based on interviews with migrants, state actors, and civil society organisations, as well as direct field observations. The field researchers

[7] *Lawyers for Human Rights v The Minster of Safety and Security and Seven Others*, 2009, NGHC, 5824/09.
[8] Legal counsellor, LHR Musina, 27 September 2012.

interviewed the key civil society actors in Musina, including employees at NGOs, INGOs, and the shelters. They also interviewed representatives of the main government departments—health, social development, home affairs, and justice, as well as the National Prosecuting Authority (NPA). Finally, where possible, ACMS conducted interviews with unaccompanied minors on the street and in the shelters and with survivors of SGBV. All interviews were conducted with the informed consent of the participants and their guardians where relevant.

The field research took place in two phases. The first phase involved a pilot study between October 2010 and April 2011. This initial phase explored the situation of unaccompanied minors and survivors of sexual and gender-based violence, identified the main actors involved in addressing the needs of these groups, and documented their experiences. The research provided an initial assessment of the situation that mapped out the responses of government and civil society and pointed to some of the main barriers.

Given the fluidity of the situation at the border, including changes in migration patterns, border control practices, and service delivery, ACMS conducted follow-up research and additional field work from January – September 2012. This follow-up research assessed what effect these changes had on the situation of UAMs and SGBV survivors in Musina. Additional findings are based on the first-hand knowledge of two researchers—one who has been based in Musina since March 2011 and another who has spent significant periods over the last several years conducting field research there. Both researchers shared their knowledge around the processes and developments described below.

The research process faced two key challenges: the refusal of some government actors to provide statistics, particularly in relation to cases involving sexual and gender-based violence, and the unwillingness of some respondents to confirm information on record because of the fear that it would jeopardise the close working relationships among both government and civil society actors in Musina.

Despite these barriers in information gathering, the report's findings provide a general picture of the situation of UAMs and survivors of SGBV in Musina and point to areas where immediate interventions and long-term responses are needed, as well as highlighting areas for further research.

Service provision in Musina

Musina is home to a range of service providers dealing with the migrant population, including local and international NGOs, faith-based organisations, legal service providers, local civil society organisations, shelters, and governmental and inter-governmental organisations. This section describes these institutions and the services they provide for migrants.

Shelters

There are four shelters in Musina providing accommodation to migrants. Two of them serve children, although there is no dedicated shelter for girls. These shelters, run primarily by faith-based organisations, were previously severely under-resourced and unable to meet the needs of their populations. Food shortages, over-crowding, inadequate facilities, insufficient and inadequately trained staff, little support from government, and a lack of security were recurring problems at these non-state funded facilities. These problems have been alleviated somewhat since DSD began providing partial funding to the shelters housing children in February 2011, but the shelters continue to face resource and capacity constraints.

Apart from the manager of the two shelters housing children—who does not herself work directly with children—none of the shelters are staffed by social workers or by individuals with certified training in child care, psychosocial support, or support for SGBV survivors. Shelter staff have received only informal training from organisations such as Save the Children UK. These organisations have run short workshops on particular topics, such as identification, tracing and reunification. The shelters also lack personnel qualified to administer primary health care, and do not have transport to take residents to the hospital if assistance is needed after hours. None of the shelters housing children have yet been registered as child and youth care centres under the Children's Act.

Christian Women's Ministries (CWM)

CWM is a church-based charity organisation established in 2008 under the authority of the United Reform Church. The organisation manages both the boys' shelter and the shelter for women and girls. CWM receives funding from DSD (R40 per child per night) for the boys and girls living at the shelter, but it does not receive any funding for the women who are at the women's shelter. The CWM's project manager manages both the boys' and the women and girls' shelters. She is accredited by the National Association of Child and Youth Care Workers, but she is primarily responsible for managing day to day operations and does not directly provide care to the children.

The Catholic Women's Shelter, Nancefield

This shelter housed in an old church provides short-term food, housing and safety to newly-arrived adult women and their children. Funding from UNHCR provides a monthly stipend for the shelter manager who also works as a care giver, a salary for a night-time security guard and funds for cooking gas. UNHCR also provides assistance with food and electricity if needed.[9] Additional funding is provided by two faith-based charities: Catholic Relief Services and Thoyondou Diocese.

The shelter has a maximum capacity of 50 women, some of whom may share a bed with their children but often houses as many as 100 residents per night. A tent has been erected on the outside of the church building to allow for the overflow. Women also sometimes sleep on mats on the floor of the main building. There is no screening or segregation of residents and some residents may carry communicable diseases such as tuberculosis. There are also no services for SGBV survivors at the shelter.

Residents receive one daily meal. The shelter has shower facilities, but these showers routinely have blocked drains and are only shielded from public view by plastic sheeting. Officially, women are allowed to stay for three days—the estimated length of time it takes to obtain documentation from the refugee reception office—but this deadline is not enforced and some women have been there for up to four months.[10] The extended periods that women stay limits the shelter's ability to take in newcomers.

I Believe in Jesus Men's Shelter, Matswale

This shelter, run by the I Believe in Jesus Church, accommodates men over the age of eighteen and provides one evening meal.[11] With a capacity of 350 people, its population is generally around 100 men per night who are housed in tents.[12] Like the women's shelter, men are allowed to stay for 72 hours, but the shelter has relaxed these rules because of changes at the refugee reception offices that restrict applications to certain days based on nationality. The shelter is managed by the church pastor and runs on donations. The El Shaddai faith-based organisation provides evening meals for residents, with funding from UNHCR. UNHCR also provides the shelter with monthly stipends for three shelter managers, as well as funding for electricity and water, and in collaboration with other agencies, sleeping mats and blankets as needed.[13] The shelter has poor sanitation and is not fenced, making security a primary concern.

The United Reform Church Women's Shelter (URC), Nancefield

This shelter assists women with more long-term needs or difficult circumstances, such as those who have experienced sexual and gender-based violence. It runs primarily on donations. Because of the lack of a dedicated shelter for girls, DSD provides R40 per day for every girl under eighteen staying at the shelter. DSD gives this money to CWM, which

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[9] Musina Officer Manager, UNHCR, 17 September 2012.
[10] Shelter manager, Catholic Women's Shelter, 18 September 2012.
[11] Administrative Officer, El Shaddai, 3 September 2012.
[12] Ibid.
[13] Musina Officer Manager, UNHCR, 17 September 2012.

consolidates this funding with the overall funds it gives to the shelter to provide food and other provisions for all the shelter residents. The shelter is designed to hold up to 50 residents. In April 2012, it was housing 71 females: 48 Zimbabweans and 23 Congolese. There were 19 UAMs, including four who had children of their own.

The shelter is officially managed by the CWM's project manager, who also runs the boys' shelter. In practice, it is run by a church volunteer. It is staffed by two additional caregivers, and two security guards who also guard the boys' shelter. Other than the CWM project manager who divides her time between the two shelters housing children, none of the caregivers have any formal child care training.

Residents are generally allowed to stay for up to a month, but some categories of residents may stay longer. Survivors of SGBV, as well as women with HIV/AIDS, are allowed to stay indefinitely. Girls may stay up to the age of 21 provided that they are going to school. Pregnant women may remain in the shelter for three months following delivery.[14]

CWM Shelter for Boys, Matswale

The Christian Women's Ministries Children's Project runs a shelter for boys up to the age of eighteen, although boys who are in school are allowed to stay up to the age of 21. The shelter manager places the maximum capacity of the shelter at 200, but there are only eighteen beds and the rest of the children have to sleep on the floor or share a bed.[15] In July 2012, the shelter housed 97 boys. The Boys' Shelter is run by CWM's project manager, three care workers who see to the cleaning and cooking at the shelter, a maintenance officer and two security guards. The care workers have no formal training as child care workers.[16] The boys receive three meals a day, but children's routines are affected by the fact that these meals are not served at regular times.

NGOs

Legal services

Two NGOs in Musina provide migrants with legal assistance. Lawyers for Human Rights (LHR), a national NGO, opened a legal clinic in Musina in 2008 to assist asylum seekers and refugees. The local Musina Legal Aid Office (MLAO) also provides paralegal services to migrants and locals. Both offices monitor and challenge unlawful arrest, detention and deportation practices. They also monitor access and service provision at the refugee reception office in Musina.

[14] Staff member, URC Shelter, 2 April 2012.
[15] Project Manager, CWM, 18 September 2012.
[16] Ibid, 19 September 2012.

Social services and drop-in centres

Child Welfare South Africa (CWSA)

Child Welfare South Africa (CWSA) is a non-profit child protection and child care organisation made up of member organisations. In March 2012, it appointed three designated social workers[17] and one student social worker to work with UAMs in Musina. The Musina-based social workers work together with the Department of Social Development to ensure that all newly arrived UAMs receive court ordered care plans and are placed lawfully in one of the two shelters available to them in Musina.[18]

The South African Red Cross Society (SARCS)

The South African Red Cross Society (SARCS) runs a drop-in centre for children in Campbell, an informal settlement about eight kilometres from Musina. The centre provides basic services including food, counselling, assistance with homework, and games. There are 80 children registered with the SARCS drop-in centre and approximately 60 of them come every day. The centre employs three non-licensed counsellors and five caregivers who prepare food, oversee the games and provide homework assistance.[19]

The Musina Community Home-Based Care Project

The Musina Community Home-Based Care Project runs a drop-in centre for minors in the Harper Hill township, about five kilometres outside of central Musina. The centre provides homework assistance and lay counselling, but food provision is sporadic because of funding constraints. Attendance at the centre varies with the availability of food, ranging from 30 to 120 children per day.[20]

El Shaddai

El Shaddai, a faith-based organisation operating out of the church in the centre of Musina, received financial support from UNHCR to provide free meals for migrants[21] and serves approximately 140 migrants per day. It offers one meal a day on its premises and also provides evening meals for men staying at the I Believe in Jesus Shelter.[22]

The Centre for Positive Care

The Centre for Positive Care conducts outreach work with sex workers in Musina, many of whom are also SGBV survivors. It provides access to contraception, general counselling services, and workshops around safe sex practices, safety in working conditions, and HIV/AIDS and other sexually transmitted diseases. CPC also facilitates community-based support groups and coordinates home-based care for HIV positive individuals.

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[17] A designated social worker is a social worker in the service of DSD, a designated child protection organisation (an organisation with approval from the Director General or Head of Social Development to perform child protection services), or a municipality.

[18] Social Worker, DSD Musina, 22 July 2012

[19] Field Officer, South African Red Cross Society, 6 September 2012.

[20] Ibid.

[21] Office Manager, UNHCR Musina, 17 September 2012.

[22] Administrative Officer, El Shaddai, 3 September 2012.

Non-Governmental and International Governmental Organisations

Médecins Sans Frontières (MSF)

MSF provides both emergency and primary health care to migrants in Musina, many of whom are newly-arrived. This migrant population may have both chronic health conditions and more immediate health care needs stemming from abuse experienced during the border crossing. MSF has a mobile clinic in the town centre, as well as several mobile primary health-care clinics on surrounding farms that are run jointly with Department of Health and the Foundation for Professional Development. The clinics provide free access to primary health care and HIV/AIDS and TB care (including testing, diagnosis and treatment initiation, drug refills and follow-up with non-compliant patients).

MSF also supports the provision of direct medical and psychosocial support to survivors of SGBV in and around Musina through its operations at the Thuthuzela Care Centre (TCC)—a multi-service centre dedicated to SGBV survivors—in partnership with the Limpopo office of the Department of Health and the National Prosecuting Authority. MSF supplies a dedicated SGBV nurse and two crisis counsellors at the Thuthuzela Care Centre.

Save the Children UK (SCUK)

SCUK is an international children's charity that supports both emergency and long-term relief as well as development programmes. It began operating in Musina during the 2008 peak in migration and now implements its programmes through local partners. The organisation provides material and technical support to the shelters and drop-in centres, as well as informal child care training for care workers at the shelters. It also provides unaccompanied minors with school uniforms and learning materials. Since September 2012, SCUK has employed a social worker to support DSD's service provision to unaccompanied minors.

United Nations High Commissioner for Refugees (UNHCR)

UNHCR's field office in Musina opened in 2008, during the influx of migrants from Zimbabwe, to provide humanitarian and advocacy services. The office's main activities include: 1) financially assisting local NGOs in the provision of humanitarian assistance to the migrant community, including security services, food, sleeping mats and blankets; 2) providing training, capacity building and information on issues related to asylum, refugee status, statelessness, international protection and contingency planning to their key government and NGO partners; 3) disseminating information to asylum seekers, refugees, and undocumented persons; 4) assisting individuals requiring international protection; and 5) coordinating inter-agency humanitarian responses to resolve problems and establish best practices and standard operating procedures within Musina.

International Organisation for Migration (IOM)

IOM's Musina office provides humanitarian assistance to migrants in the Limpopo Province, with a focus on undocumented migrants, informal cross-border traders, unaccompanied minors, victims of human trafficking, survivors of sexual and gender-based violence and

migrant workers on commercial farms and mines. This includes providing food and humanitarian assistance, legal counselling, and family tracing and reunification services. IOM also carries out awareness-raising activities for migrants through individual outreach and sponsors and manages infrastructure development in the shelters. Most recently, IOM has undertaken renovations at both the boys' and women and girls' shelters to help them meet the standards necessary to be registered as child and youth care centres under the Children's Act.

Government Actors

Department of Social Development (DSD)

DSD is the primary government department responsible for the implementation of the Children's Act. It also has the primary obligation to provide for the care and protection of UAMs and must ensure that their basic needs are met, including accommodation, food, education, health care, and documentation.

Under the Children's Act, the Department is responsible for registering and monitoring shelters that house children who are not with their families as child and youth care centres. DSD began partially funding the shelters housing children in 2011, providing them with R40 per child per day. DSD also operates in partnership with CWSA in visiting the shelters to ensure that UAMs are identified as children in need of care and protection by the children's court and receive court-ordered individualised care plans.

There are four DSD social workers in Musina dealing with UAMs and SGBV survivors. To respond to the influx of UAMs there, DSD established an 'unaccompanied and separated children's program' in 2009. This unit, which operates out of the SCUK office in Musina, employs four dedicated DSD officers, although one position remained unfilled at the time of writing.[23] In 2009, DSD created the Steering Committee for UAMs, which continues to operate as a coordinating force between all stakeholders (governmental and non-governmental) to address the needs of UAMs in Musina.[24] DSD also participates in a Cross-Border Working Group together with the Zimbabwe Department of Social Services and other stakeholders to coordinate activities around UAMs and develop standard operating procedures.

DSD has a dedicated officer for the treatment of survivors of SGBV who is based at the Musina hospital.[25] DSD does not have a social worker based at the Thuthuzela Care Centre, but it does respond to referrals from there. DSD's unaccompanied and separated children's program deals with SGBV cases involving UAMs.[26]

[23] Social Worker, DSD Musina, 22 July 2012
[24] Social worker, DSD Musina, 3 July 2012.
[25] Social Worker, DSD Musina, 22 July 2012
[26] Ibid.

Department of Health (DoH)

The Department of Health is responsible for the operations of the Musina hospital and the Nancefield Clinic. The hospital treats SGBV survivors who seek care during the Thuthuzela Care Centre's non-working hours and refers individuals to the Thuthuzela at all other times. Doctors at the hospital and at the Thuthuzela conduct medical examinations of SGBV patients and complete the J88 medical evaluation forms that are used in criminal cases.[27]

Together with IOM and the Vembe District Municipality, the DoH runs the Migrant Health Forum, a group of government and civil society actors who meet regularly to discuss and plan coordinated responses to issues around health and migration in Musina.

South African National Defence Force (SANDF)

SANDF resumed patrolling the fence area that runs the length of the South African border with Zimbabwe in 2010. Its mandate is to secure the borderline, reduce incidents of violence and prevent undocumented migrants from crossing the border. It arrests persons believed to be illegally in South Africa and transfers them to the custody of SAPS or DHA.

South African Police Services (SAPS)

SAPS works in partnership with SANDF to monitor criminal activity and illegal entry from the Zimbabwe border. Under the Immigration Act, SAPS is empowered to arrest and detain illegal foreigners for up to 48 hours.[28] In Musina, these individuals are detained at the police cells—one cell for women and two cells for men—as there is no authorised detention centre for migrants. DHA processes deportations directly from these cells.

Under the Children's Act and its accompanying regulations, SAPS is responsible for the identification and placement of children in need of care and protection. If a police officer comes into contact with a UAM outside of DSD's care, he or she is obliged to remove the child to one of the two shelters in Musina and to report the placement to the children's court.[29] SAPS must also investigate all cases of sexual assault and rape.

Department of Home Affairs (DHA)

DHA is responsible for dealing with all categories of foreign migrants in South Africa. It provides documentation to regularise the status of migrants inside the country, including asylum seekers. This includes determining who is eligible to enter the country at the border posts. It also classifies illegal foreigners and oversees their detentions and deportations. DHA opened a refugee reception office (RRO) in the centre of Musina in 2008 when migration from Zimbabwe was at its peak. This office oversees the asylum application process. It issues and renews asylum seeker permits, conducts refugee status determination interviews, and determines individual eligibility for refugee protection.

[27] TCC Site Coordinator, 26 July 2012.
[28] Act No. 13, 2002, Section 141.
[29] Children's Act and Regulations (No. 38, 2005), sections 150-152, regulation 53 and form 36.

Department of Justice (DoJ)

The Department of Justice has authority over the court system in South Africa, including the magistrates' courts. Magistrates' courts operate at both the district and the regional level. Only the regional magistrates' courts have jurisdiction over rape cases.[30] Both district and regional magistrates' courts can hear cases related to sexual offences other than rape.[31] The district court may not, however, sentence a convict to imprisonment for a period exceeding three years.[32] Thus, cases of serious sexual assault must be taken to the regional court, which can impose a prison sentence of up to 15 years. For certain offences including rape, a regional court can also impose a life sentence.[33]

Under the Children's Act, the DoJ is mandated to oversee the establishment and functioning of the children's courts.[34] Every magistrate's court in the country also operates simultaneously as a children's court. In Musina, the children's court operates once a month.

National Prosecuting Authority (NPA)

The National Prosecuting Authority is tasked with instituting (and discontinuing) criminal proceedings on behalf of the state and carrying out any necessary functions incidental to the institution of criminal proceedings.[35] In Musina, the NPA employs three public prosecutors who operate out of the local and regional magistrates' courts. There is no dedicated prosecutor for SGBV cases.[36]

The NPA has also established Thuthuzela Care Centres around the country. These centres are an initiative of the NPA's Sexual Offences and Community Affairs Unit (SOCA) in partnership with various departments and donors, 'in response to the urgent need for an integrated strategy for prevention, response and support for rape victims.'[37]

Thuthuzela Care Centre (TCC)

As part of a national initiative to open a 'one-stop' care facility for survivors of SGBV, Musina's Thuthuzela Care Centre opened in July 2011. It is based at the Musina hospital, but operates out of its own building. It provides SGBV survivors with access to a range of services in one location, including a medical and forensic examination, treatment of physical injuries, treatment for sexually transmitted diseases, psychosocial care, and police services.

According to the NPA, TCCs serve a number of important purposes: avoiding 'secondary victimization' of SGBV survivors, increasing the conviction rate of perpetrators of SGBV,

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[30] Magistrates' Courts Act (No. 32, 1944), section 89.

[31] Ibid.

[32] Ibid, section 92.

[33] Ibid.

[34] Children's Act, section 42(1).

[35] Mandate of the National Prosecuting Authority, available at http://www.npa.gov.za/ReadContent381.aspx. See also the Constitution of the Republic of South Africa (No. 108, 1996), section 179 and the National Prosecuting Authority Act (No 32, 1998).

[36] Prosecutor, Musina Magistrate's Court, 6 September 2012.

[37] National Prosecuting Authority, 'Thuthuzela: Turning victims into Survivors,' available at http://www.npa.gov.za/UploadedFiles/THUTHUZELA%20Brochure%20New.pdf.

and reducing the time period for the finalisation of SGBV cases.[38] The Thuthuzela project is led by the NPA's Sexual Offences and Community Affairs Unit (SOCA), in partnership with the DOH, MSF and DSD. In Musina, the TCC collaborates with MSF, which provides the centre with an SGBV nurse and a crisis counsellor. The centre also houses one dedicated DoH counsellor and two NPA staff members (the site coordinator and a victim empowerment officer). The Musina hospital doctor on duty conducts medical examinations at the TCC when necessary. All SGBV survivors who report to the hospital during working hours are referred to the TCC. Those who come to the hospital after hours are treated by the hospital.

Victim Empowerment Centre (VEC)

Based at police stations, victim empowerment centres were established as part of the Victim Empowerment Programme under the 1996 National Crime Prevention Strategy in an effort to provide support to victims of crime. In Musina, DSD operates the VEC out of the SAPS station. It has one room with two beds.[39] The VEC offers accommodation to victims of crime who report to SAPS and who are in need of safety, shelter, food and/or referral services. The VEC is staffed by volunteer counsellors, though victims may be referred to DSD or to the Thuthuzela Care Centre. Although there is no time limit on how long individuals may stay at the centre, most of the occupants are women and children who report crimes at night and then remain at the police station overnight.[40]

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[38] TCC Site Coordinator, Musina, 26 July, 2012.
[39] SAPS stated that the VEC had two rooms with two beds each, but service providers interviewed in Musina were only aware of one room.
[40] FCS warrant officer, SAPS station, 27 September 2012.

Unaccompanied Minors in Musina

Introduction

Musina is home to large numbers of unaccompanied minors, defined as children under the age of eighteeen who have crossed an international border and are not in the care of a parent or guardian. Unaccompanied minors face a range of challenges stemming from their status both as children and as foreign migrants. Many of them also may have experienced some form of abuse or trauma either prior to leaving home or during the border crossing. In Musina, a significant proportion of UAMs opt out of the formal care framework, increasing the challenges around meeting state obligations to ensure their care and protection. This section explores the experiences and circumstances of unaccompanied foreign minors in Musina and the efforts of government and civil society to address the needs of this population in accordance with the best interest standard.

Demographic portrait of UAMs and their reasons for migration

Like other categories of migrants, unaccompanied migrants come to South Africa for a variety of reasons.[41] For many, their flight is sparked by poverty and the belief that they will have better employment or educational opportunities in South Africa. Some UAMs decide to come to South Africa following the death of a parent or guardian. In other cases, parents may encourage children to migrate, contracting smugglers to take their children over the borders and assist them in South Africa. These children are sometimes abandoned once they reach South Africa, either because the smugglers are caught by immigration or police officers, or because the parents have not paid the agreed price or cannot meet smuggler demands for additional money.[42]

While some minors left family members behind, a number were living on their own before coming to South Africa. Of the 50 UAMs interviewed in November 2010, 20 had been living on the street in Zimbabwe before coming to South Africa.[43] Some minors also come in search of relatives or parents who are in South Africa, but they are often unable to locate them because they lack contact details.[44]

According to DSD, most of the UAMs in Musina are between the ages of 10 and 17, though DSD reports serving children as young as seven. The average age is fifteen.[45] Many of the

[41] See, e.g. I. Palmary, 'For Better Implementation of Migrant Children's Rights in South Africa,' UNICEF, 2009; G. Clacherty, 'Poverty Made this Decision for Me: Children in in Musina, Experiences and Needs,' Save the Children UK, 2003; S. Mahati, 'The Representations of Unaccompanied Working Migrant Male Children Negotiating for Livelihoods in a South African Border Town,' in M Bourdillon and A. Sangare (eds.), *Negotiating Children's and Youth Livelihoods in Africa's Urban Spaces*, Dakar: CODESRIA, 2012.

[42] Staff, SCUK, Musina, 20 November 2010. Staff, Save the Children Norway, Zimbabwe, September 2010.

[43] Street children, Musina, 27 November 2010.

[44] Project Manager, CWM, 21 November 2010.

[45] Social Worker, DSD Musina, 22 July 2012

children currently receiving services from DSD and CWM came during the peak of migration from Zimbabwe between 2008 and 2009.[46] Some of these children are now approaching their late teens and will become ineligible for assistance as unaccompanied minors once they turn eighteen. Boys make up the vast majority of UAMs. At the end of July 2012, CWM was caring for 116 children at the shelters: 19 girls and 97 boys.

Minors from Zimbabwe make up the largest portion of UAMs, followed by those from Malawi and Mozambique.[47] A few also come from the DRC, Ethiopia, and Somalia. UAMs from the DRC are more likely to have fled civil war, in some instances after their parents were killed, while those from Zimbabwe, Malawi, and Mozambique more often are motivated primarily by economic or educational considerations.

As with other migrants from Zimbabwe, the politically-driven humanitarian crisis plays a role in UAM flight from the country, as does political persecution. While the political situation in Zimbabwe has been improving since the 2009 national unity government, some UAMs left to escape forced recruitment into pro-ZANU-PF youth, or as a result of politically-motivated persecution of family members or school closures due to the persecution of teachers.[48] One child described how the political situation led to his flight:

> *I am a 16-year-old boy from a rural area in Zimbabwe. My parents passed away and I was staying with an uncle who was politically active in the opposition party politics. This was the period when the violence erupted in the rural areas, when the thugs of the ruling party started attacking the people who they believed had voted for the opposition. We were left homeless after our home was burned down in flames. Me and my family escaped to the capital city were we camped at the opposition party headquarters. At the headquarters we were surrounded again by the militia in the country which took some of our friends and family members to the cells of a local police station and some of us were dumped at some outskirts farm, displaced, without care and services being provided for us. Instead, our lives were made unbearable every day by constant attacks from the ruling party supporters.*
>
> *With the others we left for the South African Embassy where we camped in the embassy yards only to be delivered again into the harsh hands of the country's militia. In this whole process I was displaced from my uncle and other older guardians who I was separated from in the whole chaos. Afraid of going back to our home area, I had no option but to skip the country and cross the border illegally and settle in South Africa. I arrived at the crowded Musina Show Ground and stayed there for a week. Later on Save the Children staff took me to the URC Shelter where I stayed for some months. Due to bullying by older boys, lack of food and not going to school at the shelter, I decided to leave and stay here in the street with my friends. I am still uncertain of where to get my next meal, sleep or where to get help from and whether I will manage to unite with my uncle and guardians.*[49]

[46] Project Manager, CWM, 23 July 2012

[47] RRO statistics provided at Interagency Working Group Meeting, October 2010.

[48] Street children, Musina, 27 November 2010.

[49] Sixteen year old Zimbabwean boy, URC Shelter, 10 November 2010.

Border Crossing

UAMs experience the same risks and challenges during informal border crossings as other migrants. Their journeys to reach the border, and their methods of crossing into South Africa, vary from child to child, but some patterns are discernible.[50]

Children use a combination of taxis, trains and/or buses to reach Musina. A small number of children travel with truck drivers and cross the border hidden from view in the truck's sleeping compartments. Some children make the journey on foot, walking distances of up to 500 kilometres.[51] Children travel both alone and in small groups. Most of them lack documentation and thus avoid the formal border post.

Under both international and domestic law, asylum seekers are entitled to enter the territory without documentation,[52] but underage migrants are rarely aware of the legal protections to which they are entitled.[53] Moreover, formal entry remains problematic as a result of DHA's practice of refusing entry,[54] particularly for Zimbabweans who do not possess passports. Some children, however, are able to negotiate their entry into the territory at the official border post despite their lack of documentation. DSD reports that immigration officials allowed most of the girls currently under their protection to enter the territory through the official port of entry.[55]

Those who enter informally generally depart Beitbridge on foot and cross the Limpopo River to enter South Africa.[56] Many children experience violence or robbery during their passage. The amagumagumas often take their clothes and give them torn clothes in return, steal their belongings and assault or rape the minors as they journey into South Africa. Many children also witness rape, or are themselves forced to rape women who are travelling with them, including relatives.[57]

Legal framework governing unaccompanied minors

Unaccompanied minors are afforded special protections under domestic and international law. Both legal frameworks provide very detailed procedures for ensuring that the best interests of the child are being met.

[50] See, e.g. T. Mahati, supra note 41.
[51] Social Worker, DSD Musina, 3 July 2012.
[52] 1951 Convention Relating to the Status of Refugees, section 31(1); Refugees Act (No. 130, 1998), section 21(4); Immigration Act, section 23.
[53] Legal counsellor, LHR Musina, 27 September 2012.
[54] Legal counsellor, LHR Musina, 27 September 2012.
[55] Social Worker, DSD Musina, 22 July 2012
[56] Social Worker, DSD, 3 July 2012.
[57] Legal counsellor, LHR Musina, 27 September 2012.

International Legal Framework

Both general and child-specific international and regional documents contain provisions recognising the unique needs of children, particularly those who are not under the care of a parent or guardian.

1948 Universal Declaration on Human Rights (UDHR)

The UDHR places special emphasis on children, entitling them to particular care and assistance. In addition, it holds that children should equally enjoy the socio-economic rights protections necessary to health and well-being (including food, clothing, housing, medical care, social services, and social security) without distinction of any kind such as race, colour, sex, language, religion, political and other opinion, national or social origin, property, birth and other status (Article 25).

1989 United Nations Convention on the Rights of the Child (CRC)

This convention is the main international treaty dealing with children, including unaccompanied minors. South Africa ratified the Convention in 1995, making its provisions legally binding. The preamble affirms that 'childhood is entitled to special care and assistance' and the Convention sets out a series of legal protections guided by the best interest of the child principle. The most relevant provisions are summarised below:

- States must respect and ensure the rights set out in the Convention of all children within their jurisdiction, regardless of nationality (Article 2).
- The best interest of the child is a primary consideration in any actions involving children (Article 3).
- States have an obligation to provide the child with the requisite protection and care necessary for his or her well-being, and to guarantee that all institutions and services dealing with the care of children meet the minimum standards of safety and health, and have sufficient, properly trained staff (Article 3).
- Children deprived of their family environment must be given special protection, including the provision of alternative care (Article 20).
- For children seeking or in need of refugee protection, states must take measures to provide appropriate protection and humanitarian assistance, and also assist with family tracing where applicable (Article 22).
- Children have the rights to health (Article 24), social security (Article 26), an adequate standard of living (Article 27), and education (Article 28).

The Committee on the Rights of the Child, General Comment No. 6: Treatment of Unaccompanied and Separated Children Outside their Country of Origin (2005)

The Committee on the Rights of the Child is a committee of independent experts established under Article 43 of the CRC. It monitors state implementation of the treaty provisions and provides authoritative interpretations of human rights provisions via its General Comments. It issued General Comment Number 6 in order to 'draw attention to the

particularly vulnerable situation of unaccompanied and separated children' and to elaborate upon state obligations toward unaccompanied minors within the CRC and the broader international human rights law framework.[58] The comment provides an authoritative set of guidelines interpreting the procedures for dealing with unaccompanied minors. The most important of these guidelines are summarised below:

General provisions

- The Convention obligations with respect to unaccompanied minors apply to all branches of government, and include positive obligations to ensure that the proper procedures are in place (para. 13).
- With respect to state obligations to undertake measures to realise economic, social and cultural rights to the extent of available resources, priority must be given to unaccompanied children in apportioning available resources (para. 16).
- States must prioritise the identification of a child as unaccompanied immediately upon arrival (para. 31).
- States should appoint a guardian or advisor as soon as the above identification takes place, together with a protection assessment of the child's needs (para. 33).
- Unaccompanied children should be registered with school authorities as soon as possible (para. 42).
- Unaccompanied children should have the same access to health care as children who are nationals (para. 46).
- Unaccompanied children should generally not be detained on the basis of their status as a migrant or as unaccompanied (para. 61).
- Where detentions are necessary, special arrangements must be made to provide detention facilities that are suitable for children (para. 63).
- Specialised training is necessary for officials working with unaccompanied minors (para. 95).
- States must develop a detailed, integrated system of data collection in order to develop effective policies to ensure the rights of unaccompanied minors (para. 98).

UAMs in the asylum system

- Unaccompanied children who are referred to asylum procedures must be provided with both a guardian and a legal representative (paras. 21, 36).
- Unaccompanied children who are deemed not to be in need of international protection should not be referred to asylum procedures, but should be protected under the relevant child protection mechanisms (para. 67).
- Asylum applications from unaccompanied minors should be given priority (para. 70).

[58] Para. 1.

- The guardian and the legal representative should be present during all interviews (para. 72).
- Refugee status determination officers dealing with the claims of unaccompanied minors should be trained to apply international and refugee law in a child, cultural and gender-sensitive manner (para. 75).

Returning the child to the home country

- Return to the home country should only be arranged if it is determined to be in the best interests of the child (para. 84).
- The child should not be returned to the country of origin if there is a 'reasonable risk' that the return would result in human rights violations, particularly where the non-refoulement principle applies. The state must investigate the safety, security, and socio-economic conditions that will be present if the child is returned (para. 84).
- The child should not be returned without advance arrangements for care in the home country (para. 84).

As these procedures make clear, the obligations toward unaccompanied minors fall on all institutions of government. States must give priority to a range of factors with respect to unaccompanied minors: 1) identifying unaccompanied minors; 2) immediately appointing a guardian following this identification; and 3) assessing asylum applications from UAMs. In addition, UAMs must be given priority in the apportionment of state resources with respect to economic, social and cultural rights.

The UNHCR Guidelines on Policies and Procedures in Dealing with Unaccompanied Children Seeking Asylum (February 1997).

The United Nations High Commissioner for Refugees (UNHCR), established by the General Assembly to protect the rights of refugees worldwide, is the authoritative body on the refugee protections found in the Refugee Convention. UNHCR's Guidelines affirm the obligations highlighted above in the General Comment, including access to the asylum system, appointment of a guardian, the adoption of measures to identify unaccompanied minors at the border, and special training for asylum officials dealing with UAMs.

African Charter on the Rights and Welfare of the Child (ACRC)

- The rights and freedoms found in the ACRC extend to all children regardless of, *inter alia*, race, nationality, and ethnic group (Article 3).
- Every child has the right to a name and nationality and should be registered immediately after birth (Article 6).
- All children have the right to free and compulsory primary education and states should encourage secondary education (Article 11).

Domestic Legal Framework

Domestically, a range of general and child-specific legislation addresses the situation of children and unaccompanied minors in South Africa.

The South African Constitution (No. 108, 1996)

Section 28 of the Bill of Rights explicitly deals with the rights of children. It protects the rights of all children, regardless of nationality. Specific rights include the right to:

- Family or parental care, or alternative care when removed from the family environment;
- Basic nutrition, shelter, basic health care services, and social services;
- Be protected from maltreatment, neglect, abuse, degradation, and exploitative labour practices;
- Not be detained except as a measure of last resort, and only for the shortest appropriate period of time; and
- Be detained separately from adults, and in a manner that takes into account the child's age.

Section 28 also makes paramount the child's best interest in all matters concerning the child.

The Children's Act (No. 38, 2005)

The amended Children's Act came into force in 2010, and is decidedly child-centred. Guided by the best interest standard, it sets out additional rights beyond those provided in the Constitution and emphasises the developmental as well as the material needs of children. The Act includes both negative state obligations to respect the rights of children, as well as more positive obligations to protect and promote their rights. Although the Act does not deal explicitly with unaccompanied minors, a court has made clear that unaccompanied foreign children fall within the Act and are seen as children in need of care and protection.[59]

General provisions

- The Act details the circumstances in which a child is deemed to be in need of care and protection, including an abandoned or orphaned child without any visible means of support, and a child who lives and works on the streets or begs for a living (Section 150).
- A child in need of protection must be referred to a social worker for investigation (Section 150).
- A social worker or police officer who encounters a child in need of care and protection may remove the child to temporary safe care with (Section 151) or without (Section 152) a court order.

[59] *Centre for Child Law and Another v Minister of Home Affairs and Others*, 2005 (6) SA 50 (T).

Child and Youth Care Centres (CYCC)

A facility that houses more than six children who are separated from their families is designated as a child and youth care centre under the Act. This includes children's homes, places of safety, and shelters.[60]

- Every CYCC 'must offer a therapeutic programme designed for the residential care of children outside the family environment,' including the care of street children, abused children, or children with psychological and behavioural difficulties (Section 191 (2)).
- The Minister of Social Development must ensure the proper national allocation of adequately resourced, coordinated, and managed CYCCs throughout the province that provide the required range of residential care programmes, while the MEC of social development must implement a provincial strategy (Section 192).
- The MEC for social development must provide and fund CYCCs (Sections 193, 195).
- CYCCs must be registered and managed in accordance with national norms and standards developed by the Minister of Social Development (Sections 193-200).
- The provincial head of social development must arrange for a quality assurance process for every CYCC (section 211(1)).

The regulations under the Child Care Act establish additional requirements for CYCCs:

- Every child placed in a child and youth care centre has the right to, *inter alia*, the following standards of care:
  - '[E] ducation and training appropriate to his or her level of maturity, aptitude and ability' (Regulation 73(k);
  - Adequate clothing, food and nurturing (regulation 73(d); and
  - Reasonable privacy (regulation 73(f)).
- Every CYCC must conduct therapeutic programs. (Part V of Annexure B, section (2)(g))
- Every child in a CYCC must have a permanency plan (outlining the needs of and permanent care plan for the child), an individual development plan and developmental program (specific to the child's individual growth and formation—including any education, professional training and other forms of personal development counselling or skills development that the child may need) (Part V of Annexure B, section (3)-(5)).
- All children in CYCCs must have access to schooling, education or other appropriate training and skills development programs. (Part V of Annexure B, section (12)).
- The premises of the CYCC must be safe. (Part V of Annexure B, section 13).

[60] Section 191 (1).

- Children should receive after care programmes providing training and education and psychosocial support, amongst other things ((Part V of Annexure B, section (10).
- The responsibility for the registration of CYCCs rests with provincial head of social development, who may appoint a social worker to a shelter in order to mentor the registration process (regulation 78).

The Children's Court Process

A children's court is a court that deals specifically with children's matters, and determines whether a child is in need of care and protection. Every magistrate's court is a children's court, and magistrates receive training on the provisions of the Children's act. The Children's Act lays out the relevant procedures under the children's court.

- Before the children's court proceedings, a designated social worker must investigate and submit a report within ninety days assessing whether the child is in need of care and protection. The child may be placed in temporary safe care during this period (Section 155).
- The court must consider the social worker's report in reaching a final decision, and make an order in accordance with the best interests of the child (Section 155-156).
- If the court finds that the child is in need of care and protection, the court can order that he or she be placed in temporary safe care until a permanent placement is made (Section 156).
- The court order lapses after two years and cannot extend beyond the child's eighteenth birthday. The court must review the order every two years and either extend it or release the child (Section 159).

The Refugees Act (130, 1998)

Section 32 of the Refugees Act addresses the situation of unaccompanied children. Specifically, it sets out the following requirements:

- Any child who appears to qualify for refugee status and qualifies as a child in need of care under the Children's Act must be brought before a children's court.
- The children's court may then order that the child be assisted in applying for asylum.

The Refugees Amendment Act (No. 33, 2008) modifies the above provision. It states that unaccompanied minors who appear to qualify for refugee status must be brought before the children's court in accordance with the Children's Act and may be assisted in applying for asylum. This differs from the current statutory position which refers broadly to a 'child in need of care' and not to unaccompanied minors specifically. The amendments to the Refugees Act have not yet come into force.

The South African Schools Act (No. 84, 1996)

Under this Act, the Minister of Education has set the age for compulsory school attendance as the last day of the school year ending when the child is fifteen, or the completion of the ninth grade. The Act also requires public schools to admit all children without unfair discrimination (Section 5).

National Education Policy Act (No. 27, 1996)

The Act requires illegal foreigners applying for school admission to prove that they have applied to DHA to legalise their stay in the country (Section 21). In the case of UAMs, this rule may exclude undocumented children who do not have the assistance of a social worker and are thus unable to approach DHA for documentation.

The Immigration Act (No. 13, 2002)

Detention of Unaccompanied Minor Children

Under the Immigration Act, the detention of an illegal foreigner is discretionary, must be weighted towards liberty, and must be based on a reasonable consideration of factors.[61] Based on these criteria, the status of UAMs as minors with special protection needs is a factor that weighs against their detention.

The minimum standards with regard to detention as contemplated in section 34(1)(e) of the Immigration Act and Regulation 28(5) are set out in Annexure B of the Regulations to the Immigration Act. These standards explicitly prohibit the detention of unaccompanied minors:

> Detained minors shall be kept separate from adults and in accommodation appropriate to their age: Provided that minors shall not be kept separate from their parents or guardians: Provided further that unaccompanied minors shall not be detained (Section 1(d)).

Both the reasoned exercise of discretion and the Regulations to the Immigration Act bar the detention of unaccompanied minors.

The scale of the problem—counting UAMs

It is difficult to accurately assess the number of UAMs in Musina because many children live informally and fall outside of the child protection system, making it hard to track them. Some children also lie about their ages so that they can more easily obtain work or documentation. DSD, SAPS, and other institutions dealing with children lack clear mechanisms for verifying a child's age and generally rely on guesswork and the age reported by the minor.

[61] See, e.g, *Ulde v Minister of Home Affairs and Another*, 2009 (4) SA 522 (SCA).

The UAM population in the shelters provides only a partial picture of the scope of the UAM problem, as many more children choose to live on the streets. The child population in the shelters has steadily decreased in the last three years, from a peak of 200 in 2009.[62] In October 2010, there were approximately 150 boys staying at the CWM shelter.[63] In July 2012, the total population was 116 (97 boys and 19 girls),[64] the lowest recorded number in the last three years. There were also approximately 30 boys sleeping at the two truck parks—areas where trucks drivers congregate at night to rest. There are two truck parks in Musina—one at the border post and one on the outskirts of the town centre.

In 2009 and 2010, DSD recorded an average of fifteen new arrivals a day.[65] However, not all of these children remained in Musina. Many continued south in search of family members or employment. Social workers generally reached four to six children a day. In 2012, new arrivals have dropped to half of their previous numbers, with DSD seeing between five and seven new arrivals per day.[66] In August 2012, DSD reported only sixteen new arrivals for the month.[67]

Meeting the needs of unaccompanied minors

UAMs are invariably children in need of care and protection under the Children's Act. Lacking a parent or guardian, they must negotiate life in a foreign country on their own. They face a variety of challenges, including risks to their physical safety, discrimination, lack of food and shelter, and problems accessing education, health care, and financial support. They also have unique psychosocial needs stemming from their experiences both prior to and during migration. Some may have fled traumatic political events in their home countries, or abusive family situations. Many were already living on the street before arriving in South Africa, while others came in search of family members. Moreover, many have been victims of crime during the border crossing and require immediate medical and psychosocial attention.

As a result of their varying backgrounds and experiences, the needs of unaccompanied minors are not uniform. Accordingly, the provision of services to UAMs must be individually tailored to the needs of the particular child following a social worker's assessment of the child's best interest in accordance with the law.[68]

Children will have varying psychosocial, medical, and social needs. Many will require counselling. Some will have urgent and/or chronic medical issues. Aside from their physical and mental health, the long-term situation of the child will vary. Some may be willing to return to their family or country of origin, necessitating family tracing and/or repatriation

[62] Social Worker, DSD Musina, 3 July 2012.
[63] Project Manager, CWM, October 2010.
[64] Project Manager, CWM 26 July 2012.
[65] Social Worker, DSD Musina, 3 July 2012.
[66] Ibid.
[67] Social Worker, DSD Musina, 22 July 2012.
[68] Children's Act, section 2. See section 7(1) for details on the best interest of the child standard.

services. In order to be compliant with the best interest obligation of the Children's Act, social workers cannot return a child to his or her family, on either side of the border, without ensuring the child's safety and well-being. This must include a plan for follow-up visits conducted either by DSD or its counterpart in the home country.[69]

UAMs who do not wish to return home require documentation to regularise their status in South Africa. There is no clear process to provide UAMs with documentation, which will vary depending on the child's circumstances. Those fleeing persecution or general conditions of instability are eligible to apply for refugee status via the asylum system. Those falling outside of the asylum system will need alternative documentation. Stateless children (children lacking a nationality) and those lacking birth certificates face additional challenges in obtaining documentation.

By definition, UAMs are children in need of care and protection under the Children's Act and must be referred to a social worker for investigation. The social worker's assessment will then be considered by the children's court, which will make a placement determination based on the best interest of the child. Children must be placed in a Child and Youth Care Centre with a therapeutic programme that meets their particular needs. The placement must also provide for access to education, particularly for those under the age of fifteen for whom education is compulsory under the Schools Act. For UAMs over fifteen, access to formal education or other forms of informal education will depend on the best interest determination.

Children living on the street have no security and are more vulnerable to crime, including sexual abuse, as well as labour exploitation stemming from their need to make a living.[70] These circumstances render them children in need of care and protection, subject to the removal and placement procedures outlined in the Children's Act.

The daily reality of UAMs in Musina

Unaccompanied minors in Musina live in a variety of circumstances. Often, their choice of living situation will be linked to their reasons for coming to South Africa, particularly for those who came either to seek work or education. Once they arrive in Musina, their experiences and whether they receive services appropriate to their needs will also affect their choices to remain in a structured care programme or to live on their own.

Children working or living on the streets

Many children come to South Africa specifically to find employment, both to support themselves and to send money back to their families in their home countries. These

[69] Social Worker, DSD Musina, 22 July 2012.
[70] Outreach Worker, El Shaddai, 3 September 2012. Legal counsellor, LHR Musina, 27 September 2012.

children often refuse to remain in the shelter, or use the shelter only as a safe place to sleep. They do not attend school or make use of the vocational training offered at the shelters. Instead, they leave the shelter during the day to seek work and return only in the evening.

Children who were living on the streets in their countries of origin experience difficulties adjusting to the more structured life in the shelter and often return to the streets. In addition, children living at the shelter sometimes bully newcomers, adding to their difficulties adjusting to shelter life.[71] DSD categorises children who return to the streets as 'absconded' children and makes no attempt to find or assist them.[72]

Musina's street children make a living through begging or informal work. Some adults use them to sell fruits, boiled eggs, nuts or other goods in the streets of the town without pay,[73] though they do sometimes receive food and accommodation.[74]

Children living on the streets do not ordinarily have access to facilities to wash themselves or their clothes.[75] The shelter provides the only alternative to sleeping on the street. The boys' shelter is six kilometres from the town centre, and many street children say that this walk is too long and they prefer to find ad hoc shelter on the streets.[76] Some street children report that they spend their nights in the bushes on the eastern edge of the town.[77] Others testify to spending their night in the doorways of shop-fronts along the town's main road, the N1.[78]

There are two drop-in centres operating in Musina but because they rely on local donations, they are not always able to provide food. Two additional drop-in centres assist children with psychosocial support and extracurricular activities on weekday afternoons, but they are based in the townships outside of Musina, several kilometres from where street children generally congregate. Within the town centre, El Shaddai provides lunch for migrants, but street children have not taken advantage of this service.[79]

According to an El Shaddai youth care worker who does outreach work with street children, there are approximately 25 children living on the streets in Musina at any given time. In the last year, he encountered sixteen girls with babies. He estimates that nine out of ten street children engage in substance abuse, largely glue sniffing and marijuana. A number of them also sell marijuana at the bus stop in Musina.[80]

[71] Social Worker, DSD Musina, 22 July 2012
[72] Outreach Worker, El Shaddai, 3 September 2012.
[73] Ibid.
[74] Interview with three street children, Musina, 17 August 2012.
[75] Outreach Worker, El Shaddai, 3 September 2012.
[76] Interview with three street children, Musina, 17 August 2012.
[77] Interview with ten street children, Musina, 29 August 2012.
[78] Ibid.
[79] Administrative Officer, El Shaddai, 3 September 2012.
[80] Outreach Worker, El Shaddai Church, 3 September 2012.

Children living at the Beitbridge border post truck stop

Some street children live in the truck park, an area flanking the border post. Truck drivers congregate here in order to rest and refuel. In September 2012 there were approximately fourteen children living at this truck stop. Most were male and between the ages of 15-17. They previously took shelter in either a tin shack or a container provided by SCUK.[81] Neither structure provided significant protection from the weather, with temperatures ranging from over 40 degrees Celsius in the summer to minus five in the winter. UAMs have largely been displaced from these structures by adults who are there with their families. Children at the truck stop also report forced removal at the hands of SAPS, who load the children into their vans and illegally deport them to the other side of Beitbridge border post.[82] Outreach workers report that there are also approximately 14 children at the truck park in town.[83]

These children do not attend school; they spend the day begging amongst the trucks. Occasionally, they find work cleaning the trucks, carrying bags for cross-border shoppers, and off-loading goods from delivery vans.[84] Many of them need to earn money not just for themselves but also to send home to their families.[85]A nurse working at the Musina Trucking Wellness Centre (a clinic open to the trucking community at the Beitbridge border post) reported that many of them have come to the clinic with sexually transmitted diseases, raising the possibility that they are involved in exploitative sexual relationships in exchange for money or other goods.[86]

Children living in informal foster care

The South African Red Cross Society (SARCS) reports that the majority of the 80 children who frequent its drop-in centre in Campbell are UAMs living in situations of informal foster care. Foreign and local families and individuals have unofficially taken in these children to care for them.[87] SARCS has regularly reported the informal care situation of these children to DSD, but the department has not taken any action. Although these children are not documented, most of them attend the Rixile Primary School, which accepts undocumented children. Using their primary school reports, they are then able to register with the Musina High School. They cannot write matric examinations, however, because they lack an identity number.[88]

[81] Ibid. Legal counsellor, LHR Musina, 27 September 2012.
[82] Ibid.
[83] Administrative Officer, El Shaddai, 3 September 2012.
[84] Outreach Worker, El Shaddai, 3 September 2012. Musina researcher, Johannesburg, 11 October 2012.
[85] Nurse, Musina Trucking Wellness Centre, 5 September 2012.
[86] Ibid.
[87] Programme support officer, South African Red Cross Society, 6 September 2012.
[88] Ibid.

Children living in the shelters

The children who permanently reside at the shelters in Musina receive the highest level of care from service providers. The shelters are currently undergoing significant improvements in order to meet the requirements for registration as child and youth care centres under the Children's Act, as discussed below.[89] According to DSD, children in the shelters have daily access to social workers and receive three meals a day.[90]

The CWM project manager – who is responsible for the care of the boys at the CWM Boys Shelter and of the girls at the URC shelter – provides a somewhat bleaker picture. The two shelters suffer from serious funding constraints and shortages, compromising the quality of services and training for staff. Only the CWM project manager has formal training as a youth care worker but as the manager of both shelters housing children, she does not deal directly with the children and is not able to address their psychosocial needs.[91]

Children of all age groups and categories are housed together regardless of whether they are going to school, working, or doing neither. Bullying and a general lack of discipline are common. As a result, some children feel safer on the streets than in the shelters.[92] Because of resource constraints, CWM is unable to provide life and vocational skills training. Many UAMs thus spend their time begging or doing piece jobs in the streets of the town.

Children in the shelters also face challenges in accessing health care. There is no on site medical care, and neither facility has its own transport. Children must usually walk to the Nancefield Clinic or the Musina hospital. This is a particular problem for the boys, who are housed several kilometres from the nearest healthcare facility, although at the time of writing, a mobile clinic had begun visiting the shelters once a month.[93]

The boys' shelter, which has only eighteen beds, faces significant over-crowding. In September, there were 97 boys staying there, with many boys either sharing beds or sleeping on the floor. The shelter is situated near a tavern, but lacks effective security (the fence surrounding the property is broken, leaving gaping holes of several metres). Although security guards are stationed outside every night, they are not armed and have no work phones or radios to contact the police immediately in an emergency. In the most recent security incident in September, a group of unknown men from the farms arrived around midnight, overpowered the security guards, and entered the shelter to recruit boys as farm labourers.[94]

The shelters housing children receive just R40 per youth per night from DSD. This funding is expected to cover school supplies, toiletries, clothing (casual clothing and school uniforms), bedding and three meals a day. DSD is assisting the boys' shelter to obtain

[89] Children's Amendment Act (No 41, 2007), section 194 (1), on national norms and standards for child and youth care centres.
[90] Social Worker, DSD Musina, 22 July 2012
[91] Project Manager, CWM, 26 July 2012.
[92] Interview with 10 street children, Musina, 29 August 2012.
[93] Musina researcher, Johannesburg, 11 October 2012.
[94] Project Manager, CWM, 19 September 2012.

additional beds, but is not providing any additional infrastructural support.[95] DSD will not fully fund the shelter until it becomes registered as a child and youth care facility under the Children's Act.

Children in Detention

Like other migrants, UAMs face the risk of arrest and detention as illegal foreigners. Children living at the border and on the streets undergo a cycle of arrest and release.

Detention of children at SMG

During the period that SMG was in operation, SANDF and SAPS officials who identified an undocumented foreign child would take the child to SMG and then notify DSD that a social worker was needed to take him or her to a shelter. In some instances, SAPS either failed to contact DSD or DSD did not respond. NGOs who conducted daily visits to SMG to monitor conditions and assist migrants in need of urgent care sometimes intervened in these cases by contacting DSD themselves or taking the children directly to the shelters, but they could not do so without a SAPS or DSD escort. As a result, this option was dependent on the willingness of the officer on duty to allow the removal of the children to the shelters, on the availability of an officer to accompany the child, and on the availability of transport. Many officers were also unaware of the procedures requiring the removal of children in need of care and protection.

Children who claimed to be eighteen were not assisted as minors even if they were visibly younger than their stated age. Social workers were also not available after 4:30 pm or on weekends. Children who were detained during these periods were forced to remain in SMG until a social worker was available. LHR identified an average of seven minors a week in detention during periods when social workers were unavailable.[96]

Detention of children at the Musina police station

In January 2012, following an outcry over the conditions at the detention facility coupled with the completion of the new police station building, SAPS stopped using SMG and began detaining individuals in the police cells. The police have continued to arrest and detain children and to hold them together with adults in the police cells, but the numbers of children in detention have declined.

Since moving to the cells, SAPS has stopped the practice of transferring children to the shelters in response to NGO intervention without a DSD social worker. But it has become more proactive in contacting DSD, possibly because of the presence of the FCS unit and because it is harder to argue that the police cells serve as a temporary accommodation facility as it did in the case of SMG. Increased awareness also may play a role, as NGOs conducted a number of workshops to educate police on the procedures involving UAMs and

[95] Ibid.
[96] Attorney, LHR Musina, 27 August 2012.

detention. Social workers are still not available after hours, but have become more responsive during working hours. This may be attributable to the fact that the police station is more easily accessible than SMG, particularly now that social workers have their own transport. As a result, the number of children in detention has declined. Police also sometimes take children directly to the shelters rather than detaining them.

SAPS maintains that it is not allowed to detain children at the police station and that officers take all children they encounter after hours directly to the shelters.[97] According to DSD, those children who are detained by SAPS are held for the purposes of making an age determination when they are not easily identifiable as minors.[98] As mentioned above, however, there are not established procedures or mechanisms for conducting age determinations.

Challenges, weaknesses and successes of institutional actors

The previous section highlighted some of the difficulties that UAMs encounter in Musina. This section discusses these barriers in greater detail, pointing to the role of institutional actors responsible for addressing the situation of UAMs.

According to the Committee on the Rights of the Child, all institutions of government have a positive obligation to implement the provisions relating to unaccompanied minors in the Convention on the Rights of the Child. These include providing UAMs with care and protection and ensuring that the institutions caring for children meet the minimum standards of safety, health, and properly trained staff.

South African Police Service

Identification and detention of UAMs in Musina

Although DSD has the primary responsibility for identifying children in need of care and protection, policemen are also required to remove unaccompanied minors, who are by definition deemed to be children in need of care and protection,[99] to places of safety. In Musina, many UAMs are initially detained either at the border by SANDF, who then hands them over to SAPS, or by SAPS following a raid in town. SAPS often detains these children until DSD arrives to conduct the identification process. This practice suggests that SAPS believes that only DSD is authorised to make an age determination and order the release of the child, especially in cases where a detainee is not obviously underage.[100]

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[97] Police Lieutenant, SAPS Musina, 21 March 2012.

[98] Social worker, DSD Musina, 5 August 2012.

[99] *Centre for Child Law and Another v Minister of Home Affairs and Others*, 2005 (6) SA 50 (T).

[100] Reporting officer, MLAO, 17 September 2012.

In some instances, SAPS has failed to identify and report that there are minors in detention. According to MLAO and LHR, who conduct monitoring visits, SAPS has detained some children at the police cells without contacting DSD.[101] Often, it is NGOs rather than SAPS that alert DSD to the presence of UAMs in detention.[102] Even if the detention is for identification purposes only, the detention of minors remains illegal under the Constitution,[103] the Children's Act,[104] and the Immigration Act.[105]

The numbers of children in immigration detention have declined since the beginning of 2012, but the problem has not been eliminated. The table below shows the monthly breakdown of children in immigration detention since the beginning of 2012.[106]

MONTH	MALES	FEMALES	TOTAL
January	19	-	19
February	25	4	29
April	19	3	22
May	-	1	1
June	3	-	3
July	5	-	5
August	7	8	15

These numbers show an improvement from the situation at SMG, where NGOs conducting daily visits to the facility encountered an average of seven minors per week.[107]

Conditions of detention

The legal violations around the detention of minors are exacerbated by the conditions at the holding cells. The cells are designed to hold a maximum of twelve people, but often hold much higher numbers of 40, 50 or even 70. There is only one toilet per cell and access to adequate medical care is lacking. Detainees also lack sufficient food, water, and hygiene.[108] These conditions do not meet the standards of detention required under the Constitution and the Immigration Act, as well as under international law. The Bill of Rights guarantees all detainees the right to 'conditions of detention that are consistent with human dignity,' including adequate accommodation, nutrition, and reading material.[109]

Similarly, the Immigration Act requires that the detention of a foreigner comply 'with minimum prescribed standards protecting his or her dignity and relevant human rights.'[110]

[101] Ibid.,Attorney, LHR Musina, 27 August 2012.
[102] Social Worker, DSD, 19 September 2012.
[103] Section 28(1)(g).
[104] Children's Act, section 138
[105] Regulations, Annexure B, Section 1(d).
[106] Reporting officer, MLAO, 17 September 2012.
[107] Attorney, LHR Musina, 27 August 2012.
[108] Off the record communication to ACMS.
[109] Constitution, section 35(2)(e).
[110] Immigration Act, section 34(1)(e), italics in original.

The prescribed standards are set out in annexure B of the Immigration Act regulations. They require that detention facilities have, *inter alia*, adequate space and sanitation, and access to basic health facilities.[111]

Summary deportation of children

Under the law, no unaccompanied minor child can be removed from the Republic without the consent of the children's court.[112] However, following the lifting of the moratorium and the resumption of deportations to Zimbabwe in September 2011, LHR, UNICEF and and the Jesuit Refugee Service all reported summary deportations of Zimbabwean unaccompanied children from the border regions back to Beitbridge.[113]

Although only DHA is authorised to carry out deportations under the Immigration Act, SAPS has conducted its own extra-legal deportations. Both LHR and El Shaddai continue to receive reports from returning children who were summarily deported by SAPS. These children described being picked up at the truck stop, loaded into SAPS vans and driven across the border.[114] These children almost always return to South Africa, which means they are again exposed to the dangers that accompany informal border crossings.

In December 2011—three months after the lifting of the moratorium on deportations to Zimbabwe—UNICEF encountered 86 Zimbabwean minors in Beitbridge who had been unlawfully deported from South Africa, most from the Limpopo province. Twenty-seven had been deported directly from Musina and the border area. Many of the children had been detained together with adult detainees for several days prior to their removal. None of these children were referred to a social worker prior to their deportations as required by law.[115]

Failure to follow proper procedures for handling UAM cases

International law makes clear that the obligations toward unaccompanied minors fall on all institutions of government. Similarly, although DSD bears the primary responsibility for implementing the provisions of the Children's Act, the Act places certain obligations on other state institutions as well. Police officers who encounter a child that they reasonably believe to be in need of care and protection must place the child in immediate temporary safe care without a court order and also bring the child to the attention of a social worker.[116]

The Act and regulations outline a procedure to ensure that the best interests of the child are being met following such a removal to a place of safety. Although the definition of 'removal' and its applicability to UAMs lacking a home environment is unclear in the Act, the associated prescribed form (form 36) makes clear that UAMs are included under this provision.[117] Form 36 requires the removing authority to specify the reason for removal, and

[111] Immigration Act Regulations, Annexure B, section 1(a).
[112] Children's Act, Section 139 (b)(iii).
[113] Legal Counsellor, LHR Musina, 27 September 2012.
[114] Outreach Worker, El Shaddai, 3 September 2012.
[115] Email communication from UNICEF to UAM service providers in the Limpopo region, 13 December 2012.
[116] Children's Act, Section 152.
[117] Children's Act Regulation 53, Form 36.

sets out a list of options for why the child must be removed to temporary safe care. These options include children who are not in the care of a guardian, or who are living on the streets, which would include most UAMs not already in the shelters. The procedure requires that the official removing the child notify both DSD and a designated social worker within 24 hours of the removal in order to begin the required children's court investigation.

SAPS National Instruction 3 of 2012 similarly instructs police officers that they 'have a legal duty to ensure the safety and well-being of any child that he or she comes into contact with' in the course of duty and officers must consider whether the child meets the criteria for being a child in need of care and protection, such as living on the streets or being abandoned.[118] The instruction then describes the removal procedure laid out in the Children's Act. SAPS officials regularly fail to follow these procedures or to remove children in need of care and protection that they encounter, particularly street children.

Where police do take children to the shelters, they do so in an ad hoc fashion that does not comply with their legally required obligations. The Children's Act states: 'Any person who removes a child must comply with the prescribed procedures.'[119] The main purpose of the Form 36 procedure is to document the placement of children in places of safety and to ensure that they are immediately placed under the supervision of a social worker who will ensure that their best interests are being met.[120] Most police officers are not using Form 36. Police officials sometimes drop children at the shelters as an alternative to detention, but they do not follow any set procedure around this placement. There is no consistent reporting to either the shelter staff, or to DSD indicating that they have placed a child at the shelter. In some instances the police officer simply drops the child off without any interaction with shelter staff,[121] which may delay the institution of children's court proceedings. As a result, children may spend significant time at the shelter without any procedure for ensuring that their best interests are being met.

No intervention in identification of UAMs on the streets as children in need of care and protection

As described above, SAPS is required to ensure the protection of children living on the street when they encounter them in the course of duty.[122] However, children who live on the street report that their presence there is virtually ignored by SAPS unless they are engaging in criminal activity.[123]

[118] 'The Care and Protection of Children in Terms of the Children's Act,' SAPS National Instruction 3/2010, issued under Consolidated Notice 4/2010.
[119] Children's Act, section 152 (8).
[120] See section 152(3) of the Children's Act and Form 36 of the Act's regulations.
[121] Project Manager, CWM, 19 September 2012.
[122] Children's Act, section 150.
[123] Interview with 10 street children, Musina, 29 August 2012. Confirmed by Outreach Worker, El Shaddai, 3 September 2012.

Shelters

Transformation of shelters into registered CYCCs

Under the Children's Act, all facilities that house more than six children who are separated from their families must be designated as child and youth care centres by 2014.[124] DSD must register all CYCCs after first conducting a quality assurance process that measures compliance with the prescribed minimum norms and standards for CYCCs set out in the regulations.[125]

The requirements include a broad set of standards, including, 'adequate clothing, food and nurturing,'[126] 'care programmes,'[127] 'safety,'[128] and 'reasonable privacy.'[129] In practice, this will require significant changes that may be difficult for the Musina shelters to undertake. With the assistance of IOM, CWM is working to make the necessary changes at both shelters housing children, but it lacks sufficient funding and resources to complete the transformation.[130]

According to the CWM shelter manager, DSD has communicated the following list of requirements in order for the boys' shelter to come into compliance with the CYCC requirements: 1) there must be 1-2 metres between beds and each child should have his or her own bed; 2) the centre cook must have a qualification in nutrition and must be able to produce an example of a one-week balanced menu that makes appropriate allowances for children with special dietary needs; 3) a qualified social worker must be resident at the centre; 4) the shelter must ensure that there is transport for children to get to school (children may not walk to school) and get medical care, when needed; 5) the shelter must employ one child care worker for every thirty children housed at the shelter; 6) the shelter must have a dining room that is able to pass the health and safety testing of the DSD-appointed health inspector; (7) the premises must be secured by a fence.[131] Many of these requirements will also be necessary at the women and girls' shelter.

Although the Children's Act provides for CYCC funding through the Minister and MEC for Social Development, DSD has not given the Musina shelters any financial support to meet these requirements. Instead, it has only appointed a social worker to assist with the registration process by identifying the particular improvements that are needed.

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[124] Children's Act, section 191 (1).
[125] Children's Act, section 211(1).
[126] Children's Act, regulation 73(d)
[127] Children's Act Regulations, part V of Annexure B, section 10.
[128] Children's Act Regulations, part V of Annexure B, section 13.
[129] Children's Act, regulation 73(f).
[130] Project Manager, CWM, 26 July 2012.
[131] Ibid.

Limited alternative education options provided for children in the shelters

Many of the children living in the shelters do not attend school. In June 2012, 116 children were living in the shelters—61 one of whom were officially under DSD's care (the rest had not yet lawfully been placed as the shelter). More than half (67 children) were not in school.

In order to become registered as child and youth care centres, the two shelters housing children are required to ensure that the educational needs of children are being met. For some children, formal schooling is either not appropriate (children over sixteen who did not complete primary school, for example) or not possible (in practice, children who arrive in Musina during the school year generally have to wait until the start of the following academic year to enrol in school).[132] Accordingly, there is a need for informal schooling and/or vocational training at the shelters. While vocational training is offered on an ad hoc basis, CWM does not have the resources to ensure that these services are regularly offered at the shelters. DSD is aware of the lack of services, but has only stepped in irregularly with group life skills sessions on time management, gardening and substance abuse.[133]

Department of Social Development

Resource constraints

As mentioned, DSD has the primary responsibility for implementing the provisions of the Children's Act. The department's ability to meet its obligations and promote the best interests of UAMs in Musina, however, is compromised by serious resource constraints.

The three DSD social workers tasked with managing the care of UAMs in Musina have not been provided with computers (they use their personal laptops), printers, or internet access. Until June 2012, they did not have their own car and were unable to transport children to places of safety. They have two cell phones between them, making it difficult to reach them when they are outside of the office.[134] The lack of resources has hindered the efforts of the social workers to respond to the needs of UAMs and to follow the procedures of the Children's Act for children in need of care and protection.

DSD not available after hours

DSD social workers in Musina are not available after hours, regardless of the situation. As mentioned above, this means that many UAMs remain in detention overnight or over the weekend until DSD arrives to conduct an identification and placement. At both shelters housing children, the evening staff members must address any emergency situation that may arise, despite having no formal child-care training.[135]

[132] Project Manager, CWM, 23 August 2012.
[133] Social worker, DSD Musina, 3 July 2012.
[134] Social Worker, DSD Musina, 22 July 2012
[135] Project Manager, CWM, 27 August 2012.

Many children treat the shelters as a drop-in centre, arriving late in the evenings to use it as a safe place to sleep, eat and wash. They leave the shelters during the day to work, look for work or beg in the streets.[136] As a result, they never encounter social workers, who only come to the shelters during working hours.

Lack of diverse language skills

DSD social workers are generally able to communicate with Zimbabwean migrants, but they often face language barriers in communicating with UAMs from other countries, particularly those from the DRC and Somalia.[137] In such cases, DSD is forced to enlist the services of volunteer translators—generally locals with whom they have personal relationships—because there is no budget for professional translation services.[138] Reliance on volunteer translators, however, limits the social worker's direct interaction with the child, and may limit the UAM's opportunity to actively participate in his or her best interest determination. In addition, the confidentiality of the social worker's session with the child is compromised by the presence of someone who lacks the appropriate training and qualifications.

Language barriers also make it more difficult for children to assimilate in the shelters and schools. These children do not receive any assistance tailored to their situation, despite a provision in the Children's Act calling on CYCCs, in cooperation with the provincial head of social development, to offer prescribed programs based on the needs of the children housed in a CYCC.[139]

Lengthy placement procedures

The process of obtaining an order from the children's court can take up to a month, both because of the investigation process and because of the fact that the children's court only meets once a month. Children in need of care and protection are placed in the shelter during this period. Because of the lengthy placement period, and the fact that children rarely receive active counselling during this period, many of them leave the shelters before the placement procedure is complete.

Lack of interventions for children living and working on the street

DSD does not actively identify and approach children living and working on the street. Instead, it has limited its responses to those cases that have been reported by governmental and non-governmental stakeholders. As a result, it deals only with the following categories of UAMs: 1) UAMs arrested and delivered to DSD or the shelter by SAPS or SANDF; 2) UAMs who come on their own to one of the four shelters open to migrants; 3) UAMs in detention who have been identified by either SAPS or by an NGO carrying out daily monitoring; and 4) UAMs identified by the staff at the Thuthuzela Care Centre or the hospital.

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[136] Interview with ten street children, Musina, 31 August 2012.
[137] Social Worker, DSD Musina, 22 July 2012.
[138] Social Worker, DSD Musina, 22 July 2012.
[139] Children's Act, section 191.

Street children—who make up a significant proportion of the UAM population in Musina—do not receive any assistance from DSD. These children are clearly identifiable, as they loiter in a large, discernible group outside of the shops near the refugee reception office. Despite their continued presence there, DSD has made no effort to assist these children, even in cases of girls who are pregnant. Indeed, of the thirteen street children interviewed in Musina in August 2012, only one reported having spoken with a social worker, and only after an NGO contacted DSD on the child's behalf. The child had told the NGO that he wished to return home, but he left the shelter during his first night there. In a subsequent interview with the referring NGO, the child indicated that DSD took him to the shelter but did not provide any counselling upon his placement, or any information about the importance of remaining at the shelter in order to get assistance. He left as a result of bullying.[140]

No effective response to children leaving the shelters

Many children placed in the shelters run away. Large holes in the fences around the shelters make it easy for children to come and go as they please. Children who are accustomed to the freedom of life on the streets, or who have travelled to South Africa with the purpose of finding work, often do not easily accept their placement in the shelter. No counselling is provided to ensure that shelter placements are effective, as well as to ensure that the best interests of the children are being met. Most children receive counselling only at a later stage, either upon their own request or the request of the shelter manager, or as a result of the children's court procedure. Many leave before counselling is considered.

Record-keeping involving the children living at the shelters is problematic, and the shelters do not immediately inform DSD of the children who have left. At the same time, DSD has no procedure in place for handling cases of children who leave the shelters.[141] As a result, these children are essentially no longer in the system once they leave the shelters, despite remaining in need of care and protection. Even in the cases of children who have already entered the child care system, there is no mechanism in place to trace them once they run away, such as photographs or detailed descriptions. This makes it difficult for SAPS or other officials who have not previously encountered the children to identify them.[142] Although some children voluntarily return to the shelters, those who do not are generally not sought out or located for additional assistance.[143] For example, a boy who fled during his first night at the shelter returned to the shack where he had previously been living. Two months later, he reported that DSD had not contacted him.[144]

The fact that many children either avoid the shelters entirely or treat them as drop-in centres suggests a need to redesign social services to better meet the needs of UAMs. UAMs who are unwilling to immediately accept the full package of the child care system are

[140] Street child, Musina, 17 August 2011.
[141] Social worker, DSD Musina, 19 September 2012.
[142] Legal counsellor, LHR Musina, 27 September 2012.
[143] Social Worker, DSD Musina,19 September 2012.
[144] Street child, Musina, 29 August 2012.

completely excluded from access to education, vocational training, food, water, shelter, documentation and counselling. Many stakeholders dealing with UAMs in Musina have called for the establishment of a centre that would assist children in transitioning from life on the streets to placement in alternative care. Such a facility would provide an effective bridge between the two extremes of life on the street versus life under the guardianship of the state, and would ensure that the basic needs of these children are being met.

Failure to inform shelters of the health status of the children

As part of the removal procedure, DSD must take each child for a mandatory health inspection to identify any potential health needs or concerns.[145] DSD does not always obtain these certifications. Even when it does, CWM claims that DSD does not share the outcome of these examinations with the shelter managers or caregivers.[146] As a result, the shelters are unable to guard against the spread of chronic diseases such as tuberculosis. They are also unable to ensure that the health needs of the children are being met, or to make accommodations for children with dietary needs stemming from food allergies, diabetes, or other health issues.

No registered CYCCs in Musina

Musina has no registered child and youth care centres. The existing shelters, run by faith-based organisations, are not equipped to care for children with special needs and are struggling to comply with the national norms and standards outlined in the regulations to the Children's Act before the 2014 deadline for registering all shelters housing children as CYCCs.[147] Non-registered shelters will not lawfully be able to house children after this deadline.

The nearest CYCCs are in Polokwane, approximately 200 kilometres from Musina. While these care centres may be better equipped to meet the needs of UAMs, their location presents its own set of challenges. Under the Children's Act, the social worker who submitted the initial report maintains responsibility for monitoring the continued care and development of the child following the children's court order. Social workers based in Musina are unlikely to be able to meet this requirement, and there is only one social worker for UAMs in Polokwane.

The provincial head of social development allocated funds for a children's shelter in Musina in the 2011-2012 budget, but the municipality has for the last year failed to allocate land for the facility.[148] DSD's unused funds are not rolled over into the next year, and the 2012-2013 budget does not include funds for a DSD shelter in Musina. [149]

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[145] Social Worker, DSD Musina, 22 July 2012
[146] Project Manager, CWM, 27 July 2012.
[147] Social Worker, DSD Musina, 22 July 2012
[148] DSD indicated that it was dependent on the municipality to find land. Provincial DSD officer, Musina, 19 September 2012.
[149] Provincial DSD officer, Musina, 19 September 2012.

Lack of infrastructure support to existing shelters in Musina

Although the Children's Act requires the MEC for social development to fund CYCCs, no resources have been allocated to enable the Musina shelters to comply with the norms and standards established under the Children's Act before the 2014 registration deadline. The registration process enables DSD to monitor the quality and compliance of shelters in accordance with the newly established norms and standards.[150]

These norms and standards place stringent requirements on the shelters, with far-reaching financial implications. In order to comply with the rule that each child must have at least one to two meters between their beds, for example, the CWM Boys' Shelter would have to build three to four new blocks to house the current number of children staying at the shelter. CWM reported that it does not have the resources to make the required changes. IOM funded the building of a recently completed dining hall and kitchen and is providing funding for some of the additional changes, but the lack of resources remains a concern.[151]

Responsibility for funding CYCCs falls upon both the Minister of Social Development and the MEC for social development. The provincial head of social development, through implementation of a quality assurance process, must ensure that the CYCCs fulfil their obligations in accordance with the national norms and standards and is required to keep track of the programmes that each centre offers. The provincial head of social development for Limpopo has failed to comply with the obligations laid out in the Children's Act to ensure the adequate provision of CYCCs that meet the national norms and standards. As mentioned previously, DSD will only fund shelters that comply with these norms and standards, but Musina's shelters will be unable to comply without additional funding.

Improper placement procedures in violation of the Children's Act

The Children's Act describes placement in a CYCC as a last resort, to be used where no other option is appropriate for the child.[152] Moreover, under the children's court process, if a court decides to place a child in a CYCC, it must determine the residential care programme that is appropriate for the child and tailor the order accordingly. The provincial head of social development is then responsible for implementing the order and placing the child at a centre offering the appropriate programme.[153] In Musina, all children are placed in the two CWM shelters, which, as the previous section highlighted, lack appropriate therapeutic programmes.

Foster care not available as an effective alternative to institutional care

At the time of writing, DSD had placed two children for a trial period with prospective foster families in Musina, but it had yet to successfully place any children in official, court-endorsed foster care.[154] The limits of foster care stem both from the unwillingness of some

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[150] Children's Act, section 194.
[151] CWM Shelter Manager, 23 July 2012.
[152] Children's Act, section 158 (1).
[153] Ibid.
[154] Social Worker, DSD Musina, 22 July 2012

UAMs to enter foster care, and from the lack of available foster families for those who are willing.

Some UAMs find it difficult to assimilate into a new family and prefer life in the shelters or on the street, particularly if they suffer from trauma stemming from their experiences in their country of origin or during their journey to South Africa. Of the few children who have been placed with potential foster parents, most have run away and returned to the shelters before the process was completed.[155] DSD's efforts to counsel children during their best interest determination interviews to encourage them into foster care have proven unsuccessful.

Challenges around finding suitable and willing families also limit the availability of foster care as an effective alternative for children who desire this option. Many families do not fully understand foster care and the legal implications for their biological children. Some children may have parents outside of South Africa, which complicates the fostering process. Finally, many families do not meet the financial requirements necessary for eligibility as foster parents. As a result, DSD's ability to provide alternatives to institutionalisation is severely limited.[156]

Limits of cross-border coordination of cases

Some UAMs decide that they want to return to their countries of origin. In order to facilitate repatriation, DSD must make a determination that this is in the best interest of the child. This requires investigating the family background and circumstances of the child in his or her country of origin, including the nature of the relationship between parent and child and the ability of the parents to provide adequate care.[157] This assessment requires DSD to coordinate with its partner organisation in the country of origin to perform home visits and evaluate the family's ability to care for the child. In Zimbabwe, this task falls upon the Zimbabwean Department of Social Services (DSS). DSD reports frequently being frustrated in this process because of the length of time it takes for their Zimbabwean counterparts to respond to DSD's requests for information. Children often lose patience with this lengthy process and return home on their own, at great risk to their personal security.[158] ACMS was not able to interview DSS in Zimbabwe to obtain its views on the challenges of cross-border coordination.

Without the assistance of their foreign counterparts in the child's country of origin, DSD is forced to rely exclusively on the information provided by the child without any way to verify this information to make a balanced assessment of the child's best interest. A child claiming to be an orphan, for example, may in fact have living parents. DSD can only make an accurate determination as to whether repatriation is a possibility and whether the child's version of events is true if it can conduct an independent investigation, which depends on

[155] Social worker, DSD Musina, 5 August 2012. DSD did not indicate what happened with the other children, but did say that there have been no successful placements.
[156] Social worker, DSD Musina, 5 August 2012.
[157] Children's Act, section 7(1); Regulations, form 38.
[158] Social Worker, DSD Musina, 22 July 2012

assistance from the home country. DSD may engage the assistance of International Social Services, an INGO that coordinates cross-border investigations into the child's circumstances, but only if repatriation has been requested or determined to be in the child's best interest.[159] In the case of a child claiming to be orphaned, neither possibility applies.

Lack of durable solutions for minors

Children are no longer eligible for assistance once they turn eighteen, and their children's court orders lapse. Social workers, as part of the best interest standard, should prepare the child for this deadline by working out an exit plan with them.[160] However, DSD social workers in Musina expressed some bewilderment over how to implement this requirement, stating that 'it is not clear what has to happen to them' and 'there is nothing much in the legislation to deal and protect them when they reach eighteen.'[161]

South African legislation does provide some options for assisting UAMs after they turn eighteen. For children who have been in the territory for long periods of time and/or have compelling reasons why they should be allowed to remain in South Africa, DSD could assist them with an application to the Minister of Home Affairs for an exemption under Section 31(2)(b) of the Immigration Act. For those children who wish to return to their countries of origin, DSD could assist the child in accessing repatriation services either through the state or IOM, without having to meet the more burdensome requirements involved with repatriating children under eighteen. Some children may still be attending school after they turn eighteen. In these cases, DSD can apply to extend the court order for up to three years in order to protect the child from removal from the territory. DSD is not employing any of these options for UAMs in Musina.[162]

Lack of access to birth registration

Social workers in Musina do not investigate the documentation of UAMs in their countries of origin. DSD generally asks a child if his or her birth was ever registered—a question to which most children will not have an informed response—but does not take any further action. The Department does not contact the relevant consulate, and only involves International Social Services in tracing the nationality of the child in cases of voluntary repatriation.[163] As a result, UAMs are at a high risk of becoming stateless. Many of them come to South Africa at a very young age and lose ties with their home countries. If their internationally recognised right to a name and a nationality was not protected during this period, they may be unable to prove their origins once they turn eighteen.

[159] Ibid.
[160] Ibid.
[161] Ibid.
[162] Project Manager, CWM, 23 July 2012
[163] Social Worker, DSD Musina, 22 July 2012

Department of Home Affairs

Failure to refer UAMs to DSD

Refugee status determination officers are required to contact DSD when they encounter a UAM at the refugee reception office, but some staff are unaware of this requirement. Instead, they turn the child away on the basis that they are not allowed to assist minors without the presence of a guardian.[164]

Difficulty in accessing asylum seeker permits

Before the 2010 establishment of the children's court order procedure under the Children's Act, UAMs who approached the RRO together with a social worker were given asylum permits. DHA treated these social workers as the children's guardians for the purposes of obtaining documentation, although many UAMs were nonetheless left undocumented under this system.

Since the implementation of the Children's Act, DHA has required a court order from the children's court and the assistance of a social worker in order to issue an asylum permit.[165] Social workers, however, do not receive adequate training on the Refugees Act and are unable to determine whether the asylum system is appropriate for the child. As a result, children who may have valid asylum claims are not being directed to the refugee reception office, while others who do not have asylum claims are directed into the asylum system.

No status determination interviews for UAMs

DHA issues asylum seeker permits to all UAMs who have a court order and are assisted by DSD, but it does not conduct refugee status determination interviews for this population. Instead, the office simply extends the asylum seeker permit until the child turns eighteen. This manner of documenting children fails to serve the best interests of all UAMs, both those with valid asylum claims and those who do not qualify for asylum. Under international law, the asylum applications of UAMs should be prioritised.[166] Several potentially damaging consequences result from delaying the status determination until the child turns eighteen: 1) the country situation from which the child fled may have changed; 2) the permanent residency option that is open to persons who have enjoyed refugee status for five years will be delayed; and 3) the child's memories of his or her reasons for leaving the country of origin may have faded by the time the status determination interview takes place.

At the same time, those UAMs who do not have a valid claim will be rejected and face deportation as soon as they turn eighteen. The Committee on the Rights of the Child has stated that children who are not in need of international protection should not be referred to the asylum system, but should instead be protected under the relevant child protection

[164] Off the record communication to ACMS.
[165] Refugees Act, section 32.
[166] Committee on the Rights of the Child, General Comment No. 6: Treatment of Unaccompanied and Separated Children Outside their Country of Origin (2005), para. 70.

mechanisms.[167] The failure to address the needs of these children as UAMs will leave them in limbo once they turn eighteen, without any means for obtaining documentation regardless of how long they have been in the country.

Documentation challenges

DHA and DSD have made no provision for dealing with the immigration status of UAMs. Reliance on the asylum system provides only a temporary solution to the documentation needs of the majority of children, who do not in fact qualify for refugee protection under the law.

For many UAMs who do not qualify for refugee status, repatriation is either impossible (the professed country of origin of the child does not recognise the child) or not in the best interests of the child. Foreign children who have been abandoned or orphaned by migrant parents are at particular risk of falling into this category, as they may not have identifiable ties to any state and thus may not be returnable.

For this category of children (for whom a determination is made that repatriation is not in the best interests of the child and who do not qualify as asylum seekers), a court-issued 'Permanency Plan' will protect them from removal from the territory as long as they are minors. Once they turn eighteen, this protection is removed and the child (now an adult) will be left without any form of documentation: neither a document demonstrating their right to return to their country of origin (a birth certificate) nor a document upholding their right to remain in South Africa.

The asylum seeker permit does not address this danger for non-refugee children. Once the permit is withdrawn, the child will lack any basis to remain in the country and will still be unable to prove his or her identity or nationality. Upon turning eighteen, the UAM will be deported, often to a country with which he or she lacks any ties. Many former UAMs may be unable to return because they cannot prove their nationality, either through documentation (e.g., a birth certificate) or through other means (e.g., knowledge of the local language, culture, land or familial ties). These individuals may become stateless. Upon reaching adulthood, they can neither return to their countries or origin nor regularise their status in South Africa. Their status as illegal foreigners may also subject them to indefinite periods of immigration detention if they are arrested.

The African Charter on the Rights and Welfare of the Child guarantees every child the right to a name and a nationality.[168] This duty mandates the state to take preventative measures for groups that are at risk of statelessness. Section 31(2)(b) of the Immigration Act provides one such mechanism for regularising the status of UAMs and avoiding the statelessness outcome. It empowers the Minister to grant permanent residence to a category of foreigners who do not otherwise qualify under the Immigration Act when circumstances justify the

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[167] Ibid, para. 67.

[168] Article 6.

decision. Applying this provision to UAMs would allow them to apply for naturalisation after five years.

Individuals may apply to the minister for this exemption, but former UAMs and social workers are often unaware of this option. UAMs and former UAMs who approach the DHA office in Musina for assistance are turned away as foreigners. According to LHR, DHA has spoken of a referral mechanism for 'difficult cases,' but there is no evidence that it has ever been used.[169]

Refusal of entry

Since June 2011, LHR and MSF have been collecting testimonies from Zimbabwean asylum seekers who were refused entry into South Africa because they did not have passports. In addition to being illegal, this practice forces migrants, including UAMs, to cross informally into the territory and increases their exposure to crime and abuse. Some UAMs, however, are able to negotiate entry at the border post without producing documentation.[170]

Department of Education

School registration

Many UAMs in Musina do not attend school. In the past, schools did not allow UAMs to register both because they were undocumented and because the schools were full. Many schools officials were unaware of the fact that unaccompanied minors were entitled to education regardless of their documentation status.[171]

School admission requirements excluded undocumented and unaccompanied children. Children were required to produce an identification document in the form of either a birth certificate or an asylum seeker permit. Without the assistance of a social worker, UAMs could not obtain an asylum seeker permit and lacked any other form of documentation. The schools also required children to be supported by a parent or legal guardian in order to be admitted. In the case of UAMs, only a social worker or foster parent whose guardianship of the child has been endorsed by a court order is permitted to sign for the child in this capacity. These administrative requirements prevented UAMs from realising their right to education.

At the end of 2011, following a successful intervention by Lawyers for Human Rights and DSD, these barriers were removed. After meeting with the headmasters of schools in an around Musina, these organisations successfully negotiated the admission of students who

[169] Legal counsellor, LHR Musina, 27 September 2012.
[170] S. Mahati, 'Children Learning Life Skills through Work: Evidence from the Lives of Unaccompanied Migrant Children in a South African Border Town,' in G. Spittler and M Bourdillon (eds.), *African Children at Work: Working and Learning in Growing up for Life*, Munster: LIT Verlag, 2012.
[171] Legal Counsellor, LHR Musina, 21 August 2012. The Constitution guarantees the right to education to everyone, regardless of citizenship (Section 29).

are undocumented and/or have no legal guardian. Although a court order is no longer a strict requirement for school enrolment, it nonetheless makes the registration process easier and faster. UAMs who have not yet obtained a court order are admitted conditionally with a letter from a social worker and must provide the court order after their placement is completed.[172]

This situation marks a significant improvement for UAMs seeking to enter school, but its effects are limited to those children who were in Musina at the beginning of the school year. Those children who arrive after the academic year is underway are not able to enrol in school until the beginning of the following year, leaving them with no access to education during this period.[173] These children often grow frustrated with this situation and leave the shelter to find work on the streets. According to DSD, UAMs in other regions of the country are admitted to schools regardless of the time of the year and collaboration with the provincial Department of Education is needed to ensure that the same policy is implemented in Musina.[174]

Department of Health

Health clearance certificates

According to DSD, social workers are required to obtain a health clearance certificate from the Musina hospital before approaching the children's court for a temporary placement order. These certificates can take up to 48 hours to obtain.[175] Although social workers are prioritised over non-emergencies, they still wait for long periods because of hospital staffing shortages (the hospital has only two doctors) that leave little time for the doctor on duty to examine UAMs while dealing with medical emergencies.

In cases where the child has been removed to a place of safety, the law requires that a court order be sought within 24 hours, which includes obtaining the medical certificate.[176] Delays of 48 hours in accessing the health clearance certificate forces the social workers to allow children to remain in temporary safe care unlawfully. The inability to obtain these certificates after hours exacerbates this problem.

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[172] Social worker, DSD Musina, 3 July 2012.
[173] Ibid.
[174]Social Worker, DSD Musina, 22 July 2012
[175] Ibid.
[176] Children's Act, section 152(2)(b)

Department of Justice

Children's court

Magistrates at the Justice College (the official training institution of the Department of Justice and Constitutional Development) train local magistrates on the Children's Act and their role in administering the children's court. Recognising the prevalence of the issue in Limpopo, the training for magistrates there specifically addresses the situation of unaccompanied minors.[177]

Despite the coming into force of the Children's Act in 2010, the children's court in Musina did not deal with UAMs until January 2011, when the magistrate returned from a four-month leave. Before that, the court's operations were limited and it did not deal with UAMs at all.[178] The situation has improved significantly with the implementation of children's court proceedings, but problems remain. The magistrate convenes the children's court on only one day per month. As a result, there are long delays in accessing court orders for the removal of children to places of safety (the Children's Act dictates that the application for the court's endorsement of the removal of a child to temporary safe care must be lodged within 24 hours of the child's removal). According to DSD, the magistrate does not perceive these cases as emergencies,[179] although the time periods specified in the legislation suggest that these cases should be treated as urgent.

Because of the good working relationship between DSD and the magistrate, the latter has begun issuing court orders for the temporary and permanent care of children without the child being present at the hearing, in violation of Children's Act.[180] The magistrate makes his determination solely on the basis of the DSD report and follow-up questions.[181] As a result, the information that the magistrate receives from DSD is not verified and no independent investigation into the best interests of the child is conducted. Sources reported that the children's court has never refused to endorse DSD's recommendations.[182] The court process thus simply rubber stamps the recommendations of DSD, which negates the purpose of the children's court proceedings.

Conclusion and recommendations

Despite significant efforts by civil society and local government, the discussion above demonstrates that the needs of UAMs in Musina are going largely unmet. Many of the gaps in service provision stem from inadequate funding for social workers and child and youth care centres in Musina, an issue that urgently needs to be resolved at the national level. Outside of DSD, members of other departments lack sufficient knowledge of their duties

[177] Legal counsellor, LHR, 27 September 2012.
[178] Off the record communication to ACMS.
[179] Social Worker, DSD Musina, 22 July 2012.
[180] Children's Act, section 155(5).
[181] Social Worker, DSD Musina, 22 July 2012.
[182] Off the record communication to ACMS.

under the Children's Act and are failing to fulfil their obligations. Social workers are also not fully aware of the options available to UAMs. As a result, the rights of UAMs are being violated and many of their specific needs are not addressed.

In light of the findings detailed above, ACMS makes the following recommendations:

To the South African Police Service:

- Do not detain minors in police cells. In cases where an age determination is necessary, establish an alternative procedure in collaboration with DSD that does not require that individuals who may be minors be detained with adults.
- If minors or possible minors are detained, ensure that DSD is notified immediately.
- Halt all deportations of minors without first obtaining a children's court order.
- Ensure that all UAMs are taken directly to the shelters and that both shelter staff and DSD are notified.
- Make sure that officers are aware of their duty to remove all UAMs they encounter to places of safety, including those they encounter on the streets.
- Ensure that officers are adequately trained on the procedures they must follow in carrying out these removals, including the immediate notification of a social worker.

To the Department of Social Development:

At the national and provincial level

- The Minister and the MEC for Social Development should ensure the provision of adequate funding to establish child and youth care centres in Musina. This may include providing financial support to the existing shelters housing children to enable them to make the necessary transformations to become registered as CYCCs.
- The Minister and the MEC for Social Development should allocate greater resources to social workers working with UAMs in Musina to ensure that they are able to meet their obligations under the Children's Act.
- The Minister should engage with her counterpart in Zimbabwe to improve coordination with the Department of Social Services there and facilitate more timely responses to DSD requests around investigations into the best interests of Zimbabwean UAMs.
- The Provincial Head of Social Development needs to ensure that the therapeutic needs of UAMs in Musina are being met, including:
  - » Evaluating the therapeutic needs of UAMs in Musina;
  - » Providing interpreter services; and
  - » Ensuring that there are CYCCs in Musina that comply with the national norms and standards, and that these CYCCs have residential and therapeutic

programmes tailored to the specific needs of UAMs in Musina, with a particular focus on the needs of children living and working on the streets.

At the local level

- Tailor the provision of services to the needs of the individual child.
- Make social workers available after hours.
- Provide children with appropriate counselling upon initial placement at a shelter to reduce the risk that they will leave the shelter before the formal placement procedure is complete.
- Ensure that there are trained interpreters who can communicate effectively with UAMs in Musina
- Engage in outreach to street children, who are by definition children in need of care and protection under the Children's Act.
- Develop placement options that better serve the needs of street children to minimize the risk that they will return to the street.
- Establish procedures for dealing with children who leave the shelters before the placement procedure is complete. This includes mechanisms for tracing the child, such as collecting photographs and other details.
- Institute a programme to assist children in transitioning from life on the streets to a more structured care environment.
- Identify children living in informal foster care, investigate their situation, and formalize their care in accordance with the best interest standard.
- Conduct and share the results of medical certifications with shelter staff so that they can adequately address the specific medical needs of children and take appropriate measures against communicable diseases.
- Train social workers on the documentation options available to UAMs, particularly those who risk becoming stateless. Social workers must also receive training on when particular documentation options, such as asylum and refugee protection, are appropriate.
- Make sure that only children who may have asylum claims are documented as asylum seekers.
- Make directed efforts to document UAMs before they turn eighteen.
- Train social workers in how to develop durable solutions for UAMs who are about to turn eighteen, including applying for an extension of the court order for children who will still be in school when they turn eighteen.
- Engage in active interventions when UAMs are not allowed to enrol in schools.
- Provide informal schooling and vocational training at the shelters to ensure that the educational and therapeutic needs of minors are being met when formal schooling is either not appropriate or not possible.

To the Department of Home Affairs:

- Prohibit immigration officers from refusing entry to UAMs at the border without a procedure for ensuring their care and protection.
- Establish a procedure for identifying UAMs at the border and ensuring that they are placed in the care of a social worker.
- Make sure that all staff at the refugee reception office are aware of their obligation to contact DSD if a UAM approaches the office.
- Prioritise the asylum claims of UAMs, which includes conducting status determination interviews in the company of a social worker or guardian.
- Develop mechanisms to document UAMs who do not qualify for asylum.

To the Department of Education:

- Engage with public schools in Musina to make them aware that they are not entitled to turn UAMs away and that UAMs must be allowed to enrol at any point during the school year.

To the Department of Health:

- Develop a procedure in collaboration with DSD for providing UAMs with medical certifications within 24 hours. This could include allocating a DoH staff member to conduct these certifications at a particular time every day.

To the Department of Justice/Children's Court:

- Hold children's court proceedings more than once a month to ensure that the placement needs of UAMs are being met in accordance with the requirements of the Children's Act.
- Provide the child with an opportunity to participate in the children's court proceedings to determine his or her best interest. Do not hold these proceedings in the absence of the child, which is a violation of the Children's Act.

Survivors of Sexual and Gender-Based Violence in Musina

Introduction

The nature and circumstances of sexual and gender-based violence often make these crimes difficult to report, investigate and prosecute. These challenges are exacerbated for foreign migrants who are both unfamiliar with and likely to be afraid of approaching state institutions for assistance. Attacks that occur in the 'no man's land' between Zimbabwe and South Africa pose still greater jurisdictional and investigatory challenges.

In Musina, service providers and state institutions have made significant progress in addressing the justice and physical and emotional health needs of SGBV survivors. But many migrants who have experienced SGBV still face obstacles at various stages of the process, including accessing treatment, opening police investigations, and pursuing successful prosecutions. This section explores these barriers, as well as the factors that deter victims from reporting cases of sexual and gender-based violence. The challenges around accessing treatment and justice for SGBV are not unique to migrants, but are linked to broader limitations within the justice system. While cognizant of this broader context, this report seeks to explore the particular added challenges migrants face.

Background on sexual and gender-based violence

According to the World Health Organisation (WHO), sexual violence involves 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm, or physical force by any person regardless of their relationship to the survivor, in any setting.'[183] In addition to physical violence, this definition includes the use of psychological pressure to induce participation in a sexual act, even if the act is not consummated.[184] Sexual violence may also include 'inappropriate touching, by force or under unequal or coercive conditions.'[185] Gender-based violence is not specific to women; men and children of both genders also experience SGBV.

Incidents of sexual violence are largely underreported, particularly where the victims are male.[186] In addition to the shame that often inhibits survivors from disclosing the attacks, other relevant factors include fear, cultural stigma, and a lack of trust in the institutions of

[183] World Health Organisation, 'Guidelines for medico-legal care for victims of sexual violence,' 2003, p. 6, available at http://whqlibdoc.who.int/publications/2004/924154628X.pdf.
[184] Population Council, 'Sexual and Gender Based Violence in Africa: Literature Review,' February 2008, p. 4, available at http://www.popcouncil.org/pdfs/AfricaSGBV_LitReview.pdf.
[185] UNICEF, *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons (2003)*, available at http://www.unicef.org/emerg/files/gl_sgbv03.pdf.
[186] World Health Organisation, note 183, p. 9.

justice. For migrants, a lack of knowledge regarding their rights and how to seek treatment, report cases to the police, and obtain legal assistance further inhibit disclosure, as does fear of interacting with state authorities.[187]

Survivors of SGBV may suffer a range of short-term and long-term physical and psychological health consequences that may include physical injuries, gynaecological disorders, sexually transmitted diseases (STIs) including HIV/AIDS, depression, eating disorders, anxiety, a tendency to engage in high-risk sexual behaviours, and post-traumatic stress disorder.[188] An effective treatment programme involves a range of treatment elements: treatment of physical injuries; pregnancy testing and emergency contraception; prophylaxis for STIs; HIV testing, counselling, and post-exposure prophylaxis (PEP); forensic examination; and trauma counselling, as well as follow-up care and counselling.[189]

It is important that survivors receive appropriate medical treatment and counselling; yet, as the Population Council has pointed out, most programmatic interventions are designed for women survivors, while many of those seeking services are in fact males and female children.[190] There is thus a need to tailor services to meet the particular needs of children, who may face more long-term physical and psychological effects, including a tendency to commit abuse against others and to engage in high-risk sexual behaviours. Programmes must also be designed to meet the specific health needs of male survivors of SGBV.[191] The availability of appropriate health care and referral programmes is also essential to ensure the collection of forensic evidence for use in trial within the 72-hour window of opportunity.[192]

From a justice system perspective, the lack of effective sanctions against perpetrators has been identified as a contributing factor to higher rates of sexual and gender-based violence.[193] From the survivor's side, a number of barriers prevent them from seeking care and engaging with the justice system. These include:

- No knowledge of where and how to access medical and legal services;
- Distrust of the police and judicial institutions;
- Fear of stigma and discrimination;
- Fear of abusers;
- Desire to leave Musina and proceed with their journey into South Africa;
- Inadequate training and sensitivity among the police and the judiciary;
- Reluctance of police and prosecutors to pursue the case;
- Low prosecution rates;

[187] Ibid at p. 29.
[188] Population Council, supra note 184, pp. 7-8.
[189] Ibid, p. 16.
[190] Ibid, p. 10.
[191] Ibid, pp. 10-14.
[192] Ibid, p. 26.
[193] Ibid, p. 9.

- Low conviction rates;
- Inadequate measures to protect survivors during the court process;
- Unavailability of legal assistance;
- Harmful practices such as detaining women for their protection; and
- Improper forensic procedures and preservation of the chain of evidence that increase distrust of the institutions of justice.[194]

The provision of timely and adequate health care and legal support ensures the well-being of the survivor and increases the likelihood of successful prosecutions. These effects contribute to the overall well-being of the community by minimising potential health effects that may extend beyond the victim, while also contributing to a potential reduction in crimes of sexual and gender-based violence through the imposition of effective sanctions.

Legal framework governing survivors of sexual and gender-based violence

Survivors of sexual and gender-based violence face a number of barriers in accessing justice at various levels, from inhibitions stemming from their own trauma to barriers in evidence gathering at the investigatory stage to discrimination by the institutions of justice.

International Legal Protections

Although a number of international conventions contain provisions relating to the rights of survivors of SGBV, the main protections are found in the United Nations Convention on the Elimination of All Forms of Discrimination against Women and the authoritative interpretations provided by the Committee created to oversee implementation of the Convention.

The United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

This Convention prohibits all forms of discrimination against women including discrimination in accessing justice. South Africa ratified the Convention in 1995.

Committee on the Elimination of Discrimination Against Women, General Comment No. 19: Violence Against Women

The CEDAW convention establishes a Committee on the Elimination of Discrimination Against Women to monitor the progress of state implementation of the Convention. The

[194] Ibid, pp. 30-31.

Committee also issues authoritative interpretations of the treaty obligations. General Comment No. 19 deals specifically with gender-based violence:

- The Committee defines gender-based violence as a form of discrimination (para. 1) and notes that such violence violates the fundamental human rights and freedoms of women (para. 7).
- It notes that states are responsible both for violence perpetrated by public actors (para. 8), and for private acts where the state has failed to exercise due diligence to prevent such acts from occurring, or to adequately investigate and punish such acts (para. 9).
- It calls on states to ensure that laws against gender-based violence provide adequate protection to all women while respecting their integrity and dignity. States should also make protective and support services available, and provide gender-sensitive training to judicial and law enforcement officers and other public officials (para. 24(b)).

Domestic Legal Framework

The South African Constitution (No. 108, 1996)

The Constitution does not deal specifically with SGBV. But it guarantees the fundamental right to human dignity, which requires that survivors of SGBV, regardless of nationality, be treated in a dignified manner by the authorities when they seek treatment or take part in the investigatory and judicial process. Other relevant provisions include:

- The Constitution protects the freedom and security of every individual, regardless of nationality. This includes the right to be free from all forms of violence from both public and private actors (Section 12).
- It ensures that everyone has the right to equality (Section 9), dignity (Section 10), and privacy (Section 14).
- It guarantees the right to access to health care services to everyone and prohibits the refusal of emergency health care to anyone (Section 27).

Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32, 2007)

This Act, which amended the Sexual Offences Act (No. 23, 1957) provides a comprehensive revision of the laws relating to sexual offences. Noting that existing common and statutory law do not deal 'adequately, effectively, and in a non-discriminatory manner' with sexual offences and the protection provided to victims, the Act replaces several common law offences with new statutory offences.[195] The preamble also references the obligations found in the CEDAW Convention and the Convention on the Rights of the Child to protect women

[195] Preamble.

and children from violence, and recognises the Constitutional rights mentioned above. Some of the most relevant provisions include:

- The Act expands the definition of rape from vaginal penetration alone to include anal and oral penetration with any object, which allows for the possibility of male victims (section 3).
- The Act outlaws sexual assault (section 5), compelled sexual assault (section 6) and compelled rape (section 4).
- The Act entitles victims to Post Exposure Prophylaxis (PEP) at a designated public health institution, but links this provision to the victim either laying a charge with the police or reporting the incident in a prescribed manner at the designated public health institution (Section 28).
- The Act provides for extra-territorial jurisdiction under certain conditions, including if the accused or the victim is South African or ordinarily resident in South Africa, or if the accused was arrested on South African territory (Section 61). This provision may be relevant for offences committed in the 'no man's land' between Zimbabwe and South Africa.

The Criminal Procedure Act (No. 51, 1977)

- This Act provides for certain protective measures, such as allowing for witness testimony behind closed doors where necessary (Section 153) or prohibiting publication of the court transcript (Section 154).

National Policy Guidelines for Victims of Sexual Offences (1998)

In 1996, the Justice Department launched a public campaign to prevent violence against women. At the time, only one-third of reported rapes made it to court and the conviction rate for those cases stood at 50 percent. Police also estimated that less than three percent of rapes were reported. The Department of Justice convened a task team to develop uniform national guidelines for all those involved in rape and sexual offence cases, including SAPS, and the Departments of Health, Welfare, Justice, and Correctional Service.[196] Some of the most relevant provisions of these guidelines are summarised below.

South African Police Services (SAPS): Support to victims of sexual offences

- 'SAPS must treat very victim with the necessary respect, empathy and professionalism' (Chapter 1).
- When a victim approaches a police station that is outside of the jurisdiction of either his/her home, or of where the attack occurred, the station where the offence is reported must deal with the case and treat it as if it had happened in their area. The station must open a docket that will subsequently be sent to the victim's home station (Chapter 2: Sexual Offence Reported in Person).

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[196] National Policy Guidelines for Victims of Sexual Offences, Introduction, available at http://www.justice.gov.za/policy/guide_sexoff/sexoff_guidelines1998.htm

- The guidelines set out certain steps for dealing with a victim who arrives at a police station. The policeman must:
  - » Introduce him/herself, explain his/her role in the investigation, and take the victim to a quiet area away from the main desk.
  - » Determine if the victim requires medical assistance and ensure that it is provided immediately.
  - » Contact the investigating officer as soon as possible, and remain with the victim until he or she arrives.
  - » Prioritise the medical examination over taking a statement because of the necessity of medical evidence.
  - » Ensure that the statement is taken only by the investigating officer, and only after the victim has recovered enough to be able to provide one (Chapter 2: Sexual Offence Reported in Person).
- In the case of a victim under the age of eighteen, SAPS must contact the Child Protection Unit/Specialised worker (Chapter 2: Extra Care and Assistance).
- The guidelines set out a range of procedures for the first officer and the investigating officer, which include: listening to and comforting the victim, explaining police procedures (including the confidentiality of the case), explaining the medical examination, staying with the victim until another person arrives to continue the investigation, and earning the victim's trust (Chapter 3).
- The guidelines also establish procedures for conducting the medical examination (Chapter 4) and taking the victim's statement (Chapter 5).
- SAPS must keep a list of all organisations in the area providing counselling, inform the victim of the available services, and help the victim to get counselling (Chapter 9).
- SAPS should keep the victim regularly informed of the status of the case and take certain steps to prepare the victim for court to lessen the possible trauma of the court process (Chapter 10).

SAPS has also adopted binding national instructions for its officers on sexual offences. These instructions provide comprehensive guidelines on how to provide support to survivors and conduct investigations.[197] The instructions also prohibit the police from turning any victim away.[198]

[197] SAPS National Instruction No 22/1998, 'Sexual Offence: support to victims and crucial aspects of the investigation.' see also, South African Law Commission, Discussion Paper 102, Project 107, *Sexual Offences: Process and Procedure (*2002), available online at http://www.justice.gov.za/salrc/dpapers/dp102.pdf.

[198] Ibid, section 3(1).

Department of Justice: National Guidelines for Prosecutors in Sexual Offence Cases

- Prosecutions of sexual offences should ideally be conducted by a specialist prosecutor, and all prosecutors must treat these cases with the appropriate sensitivity and interest.
- The prosecutor should consult with the victim, the health care provider, and the police.
- Sexual offence cases should be finalised as soon as possible, and the victim should be able to contact the prosecutor to be informed about the case.

The National Prosecuting Authority has issued binding policy directives on sexual offences that require, among other things, that specialist prosecutors prosecute sexual offences and that prosecutors consult with SGBV survivors.[199]

Department of Welfare: Procedural Guidelines to Social Welfare Agencies and Appropriate NGOs in Assisting Victims of Rape and Sexual Offences

- Social workers should receive appropriate training in trauma counselling.
- The guidelines set out a range of procedures that must be followed in opening a case file and interacting with the victim.

Department of Health: Uniform National Health Guidelines for Dealing with Survivors of Rape and Other Sexual Offences

- The guidelines establish a protocol for dealing with the survivor and detail the optimal allocation of health resources.
- The process should both provide physical and psychological support for the victim and ensure that adequate medical evidence is obtained to support the prosecution.

The Service Charter for Victims of Crime in South Africa

The Service Charter, approved by Cabinet in 2004, sets out the rights and services provided to victims under the existing legal framework.

- Victims have the right to be treated fairly and with dignity and privacy.
- Victims have the right to receive information, including information on all relevant services that are available.
- Victims have the right to protection, including from intimidation, harassment, tampering, bribery, corruption and abuse.
- Victims have the right to assistance, including access to social, health, and counselling services.
    - » The prosecutor must ensure that special measures are adopted in relation to sexual offences, *inter alia*, and such cases should be heard in specialised courts where available.

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[199] National Prosecuting Authority Policy Directive Part 27: Sexual Offences, 1999.

The nature of SGBV incidents in Musina

Sexual and gender-based violence takes a variety of forms, and occurs both during the border crossing and after migrants have crossed into South Africa and are based in Musina.

SGBV during the migration journey

> *My wife and I did not know where we were going and what to do when we reached the border post. A man approached us as we were walking from the bus stop toward the bridge, telling us not to go that way or we would be arrested and beaten by the police. He said it would be much better for us to travel through the bush and that he would show us the way. We went with him, and three of his friends joined us. They showed us to a hole in the fence and said that we should climb through it and then we would be in South Africa. But first, he said, they needed to collect payment for showing us the way. They made me give him all the money I had on me. Now we have nothing. He also took my wife's cell phone. Then each of the men took their turn raping my wife. They made me watch and they laughed at us when we cried out. I don't feel like a man anymore and I can't even look my wife in the eye. She has not stopped crying since. She was pregnant, but now she is worried about losing the baby after being attacked like that. I don't know where we will go from here.*[200]

Migrants often have little or no knowledge about procedures at the border post and the possibilities for formal entry. A large smuggling enterprise exploits this lack of information, with smugglers promising to facilitate migrants' informal entry into South Africa.[201] Recent measures restricting formal entry at the Beitbridge border post have further exacerbated the problem. By the time migrants have reached Beitbridge, they are fixed in their plans to travel to South Africa and refusal of entry at the formal border post does not typically deter them but only redirects them to informal means of entry.

Migrants who cross informally into South Africa have to traverse a poorly monitored 'bush' area between Zimbabwe and South Africa that is more than 20 kilometres wide and stretches along either side of the Limpopo River. Incidents of SGBV are common along this route. Criminal gangs or 'amagumagumas' target migrants traveling both with and without smugglers or guides. They also sometimes pose as guides promising to show the way into South Africa for a fee, and then rob, assault, and sometime rape their clients once inside the bush.

[200] Zimbabwean migrant outside the LHR office, Musina, 7 December 2011.
[201] T. Araia, 'Report on Human Smuggling across the South Africa/Zimbabwe Border,' FMSP Research Report, May 2009.

The SGBV attacks include threats of sexual violence, gang rape, or compelled rape between companions or even family members. Pregnant woman are not spared from these sexual attacks. In some cases, children and partners have been forced to watch the rape of a relative or spouse. In addition, men are forced to rape sisters, mothers, or other family members, or face being raped by the amagumagumas if they do not comply.[202] Men have also been sodomised or been forced to sodomise other migrants. Condoms are generally not used, resulting in pregnancies and increased risk of HIV/AIDS infection.

SGBV inside Musina

Once they reach Musina, migrants remain vulnerable to SGBV.[203] Sexual violence in Musina takes a variety of forms, including violence from persons promising to assist newly arrived migrants, violence by employers, violence experienced during sex work, and violence against street children, either from their companions or from persons promising work.

Newly arrived migrants often do not know what services are available to them to secure food and shelter. Some of them, mostly women and girls, decide to accompany men who promise to provide food, shelter, or other assistance. Some of these men later become abusive, but the women may remain with them because they are dependent on these men for survival.[204] The public prosecutor dealing with SGBV cases in Musina reported that the majority of the SGBV cases he deals with fit this description, although he did not provide any specific numbers.[205]

Street children also experience sexual abuse and rape. Some of these abuses are committed by other street children. In other cases, street children are targeted by persons promising work or remuneration of some kind.[206] These children often do not report their attack because they do not want to come into contact with DSD and risk institutionalisation or because they are afraid of their attackers.[207]

Migrant women in Musina sometimes turn to sex work to support themselves. Their work places them at heightened risk for abuse as they enter private places with little protection from violent clients.[208] The Centre for Positive Care (CPC), which conducts outreach work with local sex workers, reports that over half of the sex workers it encounters are migrants.[209] These women primarily come from Zimbabwe, DRC, Nigeria and Zambia. CPC deals with approximately five rape cases a month among sex workers. The attackers often exploit the tenuous legal situation of these women—not only are they engaged in illegal work, but they also may be in the country without any legal status. The victims are thus

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[202] MSF Briefing Paper, May 12, 2010.
[203] SGBV nurse, TCC, 29 August 2012
[204] Off the record communication to ACMS.
[205] Prosecutor, Musina Regional Magistrate'sCourt, 6 September 2012.
[206] Outreach Worker, El Shaddai, 3 September 2012.
[207] Interview with three street children, Musina, 17 August 2012.
[208] Outreach worker, Centre for Positive Care, 5 September 2012.
[209] Ibid.

reluctant to report the attacks to the police. In response to the high levels of violence, CPC has distributed whistles to sex workers to enable them to alert other sex workers in the area when they are in danger.[210]

Although not unique to migrants, the survival strategies many migrants adopt place them at a higher risk of sexual and gender-based violence. Often lacking support structures and knowledge of their rights and the assistance that is available to them, they may remain in abusive relationships. These individuals may not perceive themselves as victims of SGBV because their attacks stem from work or private relationships.[211] As a result, they do not report the attacks to the police. Many of these women do, however, approach the magistrate's court to obtain a protection order. Indeed, the NPA reports that the majority of SGBV cases dealt with by the local judicial authority revolve around cases of domestic violence, and that over half of these cases involved migrants.[212]

The reliance on protection orders may reflect reluctance on the part of victims to report these crimes to the police. Alternatively, they may indicate reluctance by the police to open cases of sexual assault, particularly since SAPS performance targets aim to decrease the rate of contact crimes, a factor that works against the recording of sexual offences.[213]

Assessing the numbers of SGBV cases in Musina

As mentioned above, many SGBV cases go unreported, making it difficult to provide a comprehensive picture of the scope of the problem. The fact that perpetrators often rape every member of a group of individuals travelling together suggests that for every reported case, there are several additional cases from the same incident that go unreported. MSF estimates that as many as two-thirds of cases go unreported.[214]

Migrants are reluctant to report sexual violence for a variety of reasons: the social stigma attached to rape, a lack of knowledge about their rights, and a fear of arrest due to their undocumented status.[215] Others do not want their spouses to find out or are anxious to proceed with their journeys into South Africa. Some have also normalised rape as an expected consequence of the border crossing.[216]

Undocumented migrants who have just arrived on the territory are often afraid of reporting their attack to state authorities for fear of arrest and deportation.[217] Some survivors wait months to seek medical or psychosocial support, and may no longer be in Musina by the

[210] Ibid.
[211] Off the record discussion with person involved in these cases.
[212] Prosecutor, Musina Magistrate's Court, 2 April 2012.
[213] S. Waterhouse, 'The Impact of Changing Criminal Justice Responses to Child Victims of Sexual Abuse,' Open Society Foundation Criminal Justice Initiative Occasional Paper 4, 2008, pp. 18-19.
[214] Email communication to ACMS, 17 April 2012.
[215] Site Coordinator, TCC, 27 September 2012.
[216] Musina researcher, Johannesburg, 11 October 2012.
[217] Nurse, Musina Trucking Wellness Centre, 5 September 2012.

time they do seek assistance.[218] In 2009, MSF treated more than 140 SGBV victims in Johannesburg, more than half of whom had been abused while crossing the border.[219] The delays in seeking treatment mean that these SGBV survivors are not receiving PEP and are at an increased risk of contracting HIV/AIDS.

In July 2011, the government opened a Thuthuzela Care Centre (TCC) in Musina to centralise services for survivors of SGBV. Cases recorded there provide a partial picture of the scope of SGBV incidents in the area, but may be limited by underreporting. In addition, it is unclear whether these numbers reflect rape cases exclusively or also include other forms of SGBV. Although the TCC officially treats all cases of SGBV, off the record interviews suggested that this was not always true in practice.

In the first year that it was open, the TCC in Musina recorded 134 cases of rape. These numbers include cases that were treated at the hospital during hours that the TCC was closed. The highest number of cases was reported in February 2012 (16 cases) and the lowest number in September 2011 (7 cases).[220] Of the reported cases, 64 percent of the victims were migrants. The TCC deals with an average of ten cases a month, an apparent decline from the peak period of 2008, when MSF reported dealing with 20-30 cases a month.[221] MSF also reported 253 cases in 2010, an average of 21 cases a month.[222] The NPA received more than ten cases of SGBV per month in 2008 and 2009, but this number has dropped to a reported three to four cases per month in 2012.[223]

The prosecutor attributes this decline to effective patrolling of the border by SAPS and SANDF.[224] MSF does not believe that the rate of sexual violence along the border has decreased and believes the lower numbers are more likely the result of overall decreases in migration rates, as the peak in reported cases coincided with the peak of Zimbabwean migration to South Africa in 2008 and 2009.[225] The TCC coordinator also indicated that the numbers were not necessarily reflective of the extent of sexual violence along the border or inside Musina because of underreporting.[226]

[218] SGBV nurse, TCC, 29 August 2012
[219] MSF, *South Africa*, available at http://www.msf.org.za/countries/south-africa.
[220] These numbers may reflect patterns of border crossings, as many people cross in January and February following the holiday period. Border crossing numbers are lower in September.
[221] SGBV nurse, TCC, 29 August 2012
[222] Email communication to ACMS, 17 April 2012.
[223] Prosecutor, Musina Magistrate's Court, 2 April 2012.
[224] Ibid.
[225] Field office coordinator, MSF Musina, 27 September 2012.
[226] Site Coordinator, TCC, 27 September 2012.

STATISTICS FROM THE THUTHUZELA CARE CENTRE

Year	Month	Total SGBV cases reported	Cases reported by Migrants	Gender		Cases reported by Minors		Organisation that referred individualto TCC[227]			
				M	F	Migrant	Local	Self	SAPS	MSF	Other
2011	July	10	6	-	10	1	-				
	Aug	12	5	1	11	-	3				
	Sept	7	1	1	6	-	1	3	2	1	1 (IOM)
	Oct	9	6	3	6	1	2	3	2	2	1 (clinic)
	Nov	7	4	1	6	1	2	-	5	2	-
	Dec	11	10	1	10	2	-	3	6	3	-
2012	Jan	8	6	6	2	1	1	1	2	5	-
	Feb	16	13	3	13	-	2	7	5	4	-
	March	9	7	4	5	1	-	3	4	1	1 (clinic)
	April	11	8	2	9	1	2	2	4	4	1 (unknown)
	May	14	8	-	14	2	4	4	6	4	
	June	13	8	2	11	1	5	3	7	3	
	July	7	4	3	4		1		4	3	
Total		134	86	27	107	11	23	29	47	32	4

The TCC does not record statistics on cases that are referred to the police, but IOM has reported that through March 2012, 38 TCC cases were referred to the police.[228]

Although perpetrators of SGBV target both males and females, particularly during the border crossing, 79.8 percent of cases reported to the TCC in the last year involved females. Most of these rapes occurred during the border crossing between Zimbabwe and South Africa and involved Zimbabwean and Congolese victims.[229] Yet, while 64 percent of these cases involved migrants, migrants make up only 40 to 50 percent of the cases that make it to the prosecutor.[230]

Services for SGBV survivors in Musina

The needs of survivors of SGBV are distinct from those of other violent crimes. Sexual attacks affect not only affect physical well-being, but also may have psychological effects

[227] Numbers in this category are lower than the overall total because this information is not provided for all cases.
[228] Staff member, IOM Pretoria, 26 July 2012.
[229] Site Coordinator, TCC, 26 July, 2012.
[230] Prosecutor, Musina Magistrate's Court, 2 April 2012.

and may influence future sexual activity.[231] As a result, SGBV survivors have a range of medical and psychological needs.

Past practice involving SGBV cases in Musina

The services for SGBV survivors in Musina have improved significantly since the opening of the Thuthuzela care centre in July 2011 and the closure of SMG in January 2012. Survivors now have improved access to medical care and police assistance. The number of reported rapes along the border has also decreased, although as mentioned earlier, this decrease may be the result of decreased migration. As such, it does not necessarily mean that the scale of attacks against those crossing the border informally has decreased. Police have also been increasingly sensitised to the needs of SGBV survivors as a result of workshops sponsored by IOM and the arrival of a specialised unit for SGBV cases.

In the past, SGBV survivors who were held at SMG generally did not receive any medical or police assistance without NGO intervention. Although some women did try to open cases with the police, SAPS officers generally took the attitude that it was not worthwhile to open a case because survivors could not identify the assailant or the scene of the crime and often left Musina before the investigation could be completed.[232] One woman who tried to open a case complained that questioning by the police was inappropriate and that the police suggested that it was her fault, increasing the trauma of the rape.[233] SAPS also often assumed that the sexual assaults took place on the Zimbabwean side of the border and told SGBV survivors that they had to return to Zimbabwe to report the attacks.[234] Finally, only one officer was allocated to investigate crimes involving SGBV.

The lack of an effective response to SGBV cases led to the development of standard operating procedures (SOPs) in Musina spearheaded by the NGO People Opposing Women Abuse (POWA) in 2009.[235] Under these SOPs, the SGBV survivor, identified by an NGO or a shelter, was first referred to DSD, who interviewed the survivor and then, if the individual did not wish to open a case, accompanied him or her to the hospital. If the survivor did wish to open a case, DSD first took him or her to SAPS. A SAPS officer took a statement and then referred him or her to the hospital.

The past situation in Musina was problematic for many reasons. First, under the National Policy Guidelines for Victims of Sexual Offences, police must treat SGBV survivors with respect and dignity, and be sensitive to the trauma of their situation. Second, the National Instructions deny individual officers the authority to turn the survivor away and to refuse to open a case. Third, in contrast to the SOPs developed in Musina, the guidelines make clear that the medical examination should be prioritised before the taking of a police statement.

[231] Population Council, supra note 184, p. 8.
[232] Police officer, SAPS Musina, 12 February 2011.
[233] Fifteen year old girl, Women's Shelter, 10 November 2010.
[234] MSF field coordinator, Musina, February 2011.
[235] POWA Workshop on the Standard Operating Procedure for SGBV in Musina, November 2009.

With respect to medical care, some SGBV survivors were asked to pay a fee for treatment or were turned away from the hospital if they did not come equipped with a sexual assault report kit provided by SAPS, a situation that prioritised the collection of forensic evidence over the health needs of the survivor. The need to report the assault at multiple locations—the police, DSD, the hospital—also increased the risk of secondary victimisation from repeatedly recounting the attack. Treatment was similarly decentralised, with survivors reporting to the hospital for follow-up medical care, and to DSD for continued psychosocial care. The Department of Health also had no trauma counsellor in Musina.

Current Practice in Musina

This situation has dramatically improved with the opening of the TCC. Both the hospital and the TCC now stock evidence kits and administer treatment regardless of whether the survivor intends to report the incident to the police. Counselling and treatment services are centralised at the TCC, and women who seek treatment at the hospital no longer report being asked to pay fees.

According to the NPA, although the number of rape cases has dropped since the peak in 2008, more cases are making it onto the court roll since the TCC opened.[236] The NPA also noted an improvement in the quality of investigative work since the TCC opened.[237] The provision of rape kits and counselling at the TCC has contributed to the collection of forensic evidence. At the same time, the establishment of a Family Violence, Child Protection, and Sexual Offences Unit (FCS) in February of 2012, with four SAPS officers dedicated to SGBV work, has also improved the quality of evidence. Previously, all SGBV cases were referred to the FCS unit in Makhado, approximately 95 kilometres from Musina. Officers there would retrieve files opened in Musina but conduct their investigations from Makhado.[238] While it is clear that the situation has improved, SAPS' unwillingness to share the number of rape cases reported to the police makes it difficult to measure the effects that the TCC and the FCS unit are having on the successful prosecution of these cases.

The various dimensions in service provision and related improvements are described below.

Medical care

Immediate medical care is essential to manage the possible consequences of sexual violence. The first point of contact with a survivor must thus be focused on providing for his or her urgent medical needs, which may differ depending on gender and age. Individuals may need the following collection of services:

- A medical evaluation and treatment of injuries, which may include vaginal laceration, cuts, bruises, and internal bleeding.[239]

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[236] According to numbers provided by the administrative assistant to the NPA, Musina Magistrate's Court, 14 September 2012.
[237] Prosecutor, Musina Magistrate's Court, 6 September 2012.
[238] FCS warrant officer, SAPS, 27 September 2012.
[239] SGBV nurse, TCC, 29 August 2012

- A range of prophylaxis care to prevent infection and the spread of disease, including:
    - » Emergency oral contraception to prevent pregnancy, which can be administrated up to five days after the sexual assault.[240]
    - » Treatment to address or prevent sexually transmitted infections (STIs).
    - » Post exposure prophylaxis (PEP) to prevent HIV/AIDS given the possibility of exposure as a result of the attack. The drug regimen for PEP consists of a combination of anti-retroviral drugs that are taken daily over a period of 28 days.[241] PEP is most effective if taken within 72 hours, and the Sexual Offences Act only entitles SGBV survivors to PEP within this time-frame.[242]
- In order to collect and document the maximum amount of evidence of the attack, a forensic examination of the victim must be carried out as soon as possible after the SGBV has taken place, generally within 72 hours.
- For some survivors, termination of pregnancy may be required.
- Follow-up testing is required at three month intervals for the six months after the initial consultation to confirm that the PEP has been effective.[243]
- Repeated testing and treatment of STIs is needed during this time-period.[244]

These services are available at the Thuthuzela Care Centre, which is dedicated to the treatment of rape and other forms of SGBV. It provides for survivors' medical, psychological and legal needs in a central location, and minimises the risk of secondary victimisation. SGBV survivors are treated immediately and receive free care from professionals who are trained to deal with their situation. Individuals receive needed medications free of charge, information on how to take these medications, and follow-up appointments.

The TCC is only open until 4:30 pm on week days. Survivors needing medical care over the weekend or after hours on week days receive care at the hospital.[245] Doctors at the hospital can administer the rape evidence collection kit, but additional services are limited. In order to receive PEP, an SGBV survivor must first undergo voluntary HIV counselling and testing (VCT) and test negative for HIV. The hospital does not always have a health care worker on duty who is trained to administer VCT.[246] Even when VCT is available, survivors who seek treatment after the hospital pharmacy closes at 4:30 pm will have to return to obtain the full 28 day course of pills required for PEP.[247]

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[240] SGBV nurse, TCC, 29 August 2012

[241] Centre for AIDS Development, Research and Evaluation (CADRE), for the Department of Health, South Africa (2003) *Rape and Post-Exposure Prophylaxis in South Africa: A review*, available at: http://www.cadre.org.za/files/Womens_PEP_Review_Final.pdf.

[242] Sexual Offences Act (No. 23, 1957), section 28(2).

[243] Site coordinator, TCC, 5 September 2012.

[244] Ibid.

[245] Communications Officer, Musina Hospital, 28 September 2012.

[246] Site Coordinator, TCC, 27 September 2012. Communications Officer, Musina Hospital, 28 September 2012.

[247] Off the record communication to ACMS.

Psychosocial support

SGBV survivors often require trauma counselling to manage the feelings of depression, anxiety, fear, anger, shame, insecurity, self-hate, and self-blame they may experience.[248] Counselling may also be necessary to support individuals through the process of reporting their attack to the police and going through the trial process.

The TCC has a full-time trauma counsellor. Two additional MSF trauma counsellors who are fluent in Shona (a Zimbabwean language) are based at the centre. Trauma counselling is available for all SGBV survivors who come to the centre. Those requiring more long-term counselling are referred to a dedicated DSD social worker. Individuals may also approach DSD directly to receive long-term counselling.[249]

Survivors who seek treatment after hours, however, do not have access to a trauma counsellor to provide them with emotional support as they undergo treatment at the hospital. They must return to TCC the following working day to access these services.[250] Social workers are also not available after hours. This is particularly problematic for cases of SGBV involving minors, who may receive neither counselling nor an assessment by a social worker if they do not voluntarily return to the TCC the following day.[251]

Survivors who approach the police station day or night have access to the Victim Empowerment Centre based there and run by DSD. The VEC offers women who report cases temporary safe shelter, food, informal counselling, and referral services for medical treatment and psychosocial support.

Justice

If an SGBV survivor at the TCC wishes to report the attack to the police, the TCC staff (only with the individual's consent) contact SAPS. An investigating officer comes to the TCC to take the patient's statement in a private room. The on-site nurses are trained to administer the rape evidence collection kit and will hand this evidence over to SAPS. The successful prosecution of a perpetrator of a sexual attack rests on the effective collection of forensic evidence and a reliable chain of evidence in which proper procedures for handling evidence are followed to ensure that the evidence remains admissible during trial.

The police, the prosecutor, and DSD must prepare the SGBV survivor for the court process to minimise both the trauma to the survivor and the possibility of weakening the case. This includes preparing the survivor emotionally to recount the attack and face his or her attackers. It also means ensuring that the witness is prepared to answer questions about the attack to avoid any inconsistencies that may weaken the case against the defendant, particularly in cases where there are no corroborating testimonies or physical evidence.

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[248] SGBV nurse, TCC, 29 August 2012.
[249] DSD Coordinator, Victim Empowerment Centre, 13 September 2012.
[250] Communications Officer, Musina Hospital, 28 September 2012.
[251] Off the record communication to ACMS.

Post-treatment services: Victim Empowerment Centre

In an effort to incorporate a more victim-centred approach to justice that included support services for victims of crime as part of the 1996 National Crime Prevention Strategy—an inter-departmental initiative—SAPS began opening victim empowerment centres at its police stations.[252] Although housed in the police station, the centre is run by DSD but is generally staffed by a police officer or a volunteer rather than a DSD social worker. In Musina, the VEP has a single room with two beds.

The centre most often houses survivors of SGBV—both adults and children—who have reported their cases to the police and require police protection, shelter, and counselling. There are no limits on the length of stay, but survivors ordinarily use the facility for one night after arriving at the police to report their attacks. They are overseen by either a police officer or a volunteer, as DSD does not offer on-site counselling services and only responds to referrals from SAPS, limiting survivors' access to psychosocial assistance.[253]

The justice system and SGBV cases

Conviction rates for rape and other forms of SGBV in South Africa are very low. In Musina, only thirteen cases were placed on the court roll in 2011. Six of these cases were withdrawn after the complainant failed to appear at the trial. The other seven resulted in convictions, but only two received prison sentences—one for ten years, the other for life. The remaining five were given suspended sentences. Since January 2012, seventeen cases have been brought to court with the following results: six withdrawn after the complainants did not appear at the trial, nine rape convictions, one conviction for assault, one acquittal. Eight of the convictions resulted in suspended sentences.[254] Court staff indicated that most of the complainants were Zimbabwean,[255] but they did not provide a precise breakdown.

SAPS generally does not share its crime statistics. Because ACMS could not obtain information on the number of reported rape cases, it was not possible to assess the proportion of reported cases that make it to trial and result in convictions. What is certain is that the numbers above do not reflect the true scope of SGBV crimes in Musina.

Although the justice system is open to all victims, regardless of nationality or immigration status,[256] many migrants do not approach the institutions of justice out of fear, a lack of trust, or lack faith in the efficacy of these institutions. Those who do report attacks often lose contact with the police and prosecutor during the drawn out processes of investigating and prosecuting their cases. As a result, they may assume that their cases have been abandoned or they will simply lose interest in the process and will be less likely to inform

[252] DSD Coordinator, Victim Empowerment Centre, 13 September 2012.
[253] Ibid.
[254] Administrative officer, Musina Magistrate's Court, 14 September 2012.
[255] Ibid.
[256] Warrant officer, SAPS, 19 July 2012. Prosecutor, Musina Magistrate's Court, 6 September 2012.

police and prosecutors of their updated contact information if they relocate. Many are unaware of the fact the NPA will pay for the cost of their transport to and from the trial, as well as their accommodation in Musina during the trial if necessary.[257]As one SGBV survivor explained:

> *[I]t's always difficult to stay in Musina while you know that there is a job waiting for you in Johannesburg and you have children to look after. Sometimes you just thank God, 'At least I am alive; they did not kill me,' and proceed with your journey….It's not like we do not want justice, but sometimes finding money for transport to come back for court to Musina is a problem, especially when you find it difficult to pay your rent.*[258]

The 'life-cycle' of a sexual violence case

The legal life of an SGBV case begins when it is reported to the police. In Musina, all SGBV cases are referred to the dedicated Family Violence, Child Protection and Sexual Offences (FCS) Unit. This unit is made up of four officers who are trained to deal with SGBV survivors to help avoid secondary victimisation.[259]

An officer of the FCS unit first interviews the individual, either at the police station (if the complainant reported directly to SAPS) or at the TCC. After the initial statement is taken, the officer opens a case file and ensures that an investigating officer is assigned to the case.

As part of the medical examination at the TCC, a nurse will administer a sexual assault evidence collection kit,[260] which includes a thorough examination of the body of the victim for traces of the perpetrator's saliva, seminal fluid, hair or blood. The collection of this evidence is documented and its integrity preserved using 'swab guard boxes.'[261] If the victim is wearing the same clothes that he/she was wearing at the time of the assault, the TCC collects these items. The medical provider will also note any bite marks, grazes, cuts, bruises, scratches, and vaginal or anal tears. All of the above will form part of the medical report that is submitted to the investigating officer. If an SGBV survivor approaches the police before seeking medical assistance, the investigating officer will bring him or her to the TCC for the administration of a rape kit.

If the victim knows the exact location of the assault, the police will comb the scene for any physical evidence.[262] SAPS submits its findings from the scene of the crime, as well as the evidence gathered by the medical practitioner, to its Criminal Record and Forensic Science Service (CRFSS) in Pretoria, where forensic testing will confirm the presence of any foreign

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[257] Prosecutor, Musina Magistrate's Court Musina, 2 April 2012. Prosecutor, Musina Magistrate's Court, 6 September 2012.
[258] Zimbabwean SGBV survivor, El Shaddai, February 2011.
[259] Warrant officer, SAPS, 19 July 2012.
[260] Ibid.
[261] SGBV nurse, TCC, 29 August 2012.
[262] Warrant officer, SAPS, 19 July 2012.

DNA. This testing takes at least 90 days, and the report is then sent to the investigating officer to be included in the case docket.[263]

According to SAPS, most successful cases rest on eye witness identification of the perpetrator. In all of the cases described by SAPS and the NPA, the arrest was based on an eye witness identification.[264] After arresting a suspect, SAPS will take a DNA sample for comparison with the foreign DNA identified through forensic testing.

Following an arrest, SAPS hands the case over to the NPA. Musina does not have a dedicated prosecutor for SGBV cases. A single prosecutor does deal with all the rape cases reported in Musina, but he does not deal with these cases exclusively.[265] The prosecutor reviews the evidence and assesses the survivor's credibility to decide whether to proceed with the case. If he decides to proceed, the matter is set down on the court roll.

The defendant is first brought to court for a bail hearing. The prosecutor will oppose bail if the defendant is a foreigner and has no fixed address or place of employment,[266] and he or she will be remanded into SAPS custody to await trial.

In preparation for trial, the prosecutor meets with the victim and any witnesses to the crime. He prepares them for cross-examination by reviewing their statements with them, checking for inconsistencies and informing them of the questions that he plans to ask at trial.[267]

If the victim is unavailable, the prosecutor can proceed to trial only in very special circumstances. In a rape case, the prosecutor will need sufficient circumstantial evidence to support the assertion that the sex was non-consensual.[268] In addition, if the witness is not available to confirm his or her eye witness identification at trial, the case will rest on DNA evidence.[269] If the prosecution is successful, a separate sentencing hearing is held.

Protection Orders

Cases of domestic violence offer an alternative path to accessing justice. An individual who has a relationship with his or her aggressor—e.g. employer, neighbour, boyfriend, etc.—may approach the magistrate's court for a protection order.[270] These orders are issued on the basis of an affidavit from the complainant that he or she is being sexually abused by the respondent.

[263] Ibid.
[264] Ibid. Prosecutor, Musina Magistrate's Court, 6 September 2012.
[265] Prosecutor, Musina Magistrate's Court, 6 September 2012.
[266] Prosecutor, Musina Magistrate's Court, 6 September 2012.
[267] Ibid.
[268] Ibid.
[269] Ibid.
[270] Domestic Violence Act (No. 116, 1998), sections 1(iii), 4(1).

A protection order is accompanied by a suspended warrant for the respondent's arrest. If the respondent violates any of the terms of the protection order, the complainant can approach SAPS with the order and an affidavit describing the violation and the arrest warrant will become active.[271] The Musina magistrate issues protection orders without regard to the immigration status of the complainant.[272]

On average, thirty women per month seek protection orders, and 60 percent of these cases involve migrants.[273] The high rate of protection orders (relative to the low rate of prosecutions for SGBV cases among migrants) reveals the extent to which migrants in Musina experience domestic violence. But they also may be indicative of the reluctance of the police to open cases of SGBV, pushing survivors into the protection order process to achieve some sort of justice. Further information is needed to determine the extent to which this is the case.

Challenges, weaknesses, and successes of institutional actors

The successful treatment and prosecution of SGBV cases rest on coordination between multiple actors. Proper coordination is essential to ensure both that survivors receive proper care and that forensic evidence is obtained and preserved. The experiences of SGBV survivors seeking post-assault assistance from the health system can have a significant impact on their psychological well-being. A negative post-assault experience can result in secondary traumatisation of the individual.[274] For this reason, it is essential that all institutional actors coming into contact with SGBV survivors receive adequate training that enables them to treat these individuals with the proper sensitivity and respect. Although the provision of health care and psychosocial support has improved with the arrival of the Thuthuzela Care Centre, barriers at various stages of the survivors' experience continue to prevent SGBV survivors from realising their rights and accessing justice. In addition, the shelters housing SGBV survivors are overcrowded and unable to adequately meet the physical and psychosocial needs of these survivors.

[271] Ibid, section 8.
[272] Magistrate, Musina Magistrate's Court, 23 March 2012
[273] Clerk, Musina Magistrate's Court, 21 September 2012.
[274] R. Campbell. 'The psychological impact of rape victims,' *American Psychologist*, Vol 63(8), Nov 2008, pp. 702-717.

AT THE BORDER

Department of Home Affairs

Refusal of entry and deportation

As mentioned above, the Department of Home Affairs began systematically refusing entry to Zimbabweans who were not able to produce valid travel documents in March 2011.[275] As a result, Zimbabwean asylum seekers wishing to enter South Africa are obliged to cross informally, placing them at heightened risk of violence during the border crossing, including SGBV. Asylum seekers of other nationalities who are turned away at the border post face similar risks.

In addition to engaging in border practices that increase exposure to SGBV, DHA's deportation practices once individuals reach South Africa also may jeopardise access to services for SGBV survivors and negatively affect their physical and psychological well-being. In 2012, a rape victim was deported before receiving medical care or reporting the case to SAPS.[276] ACMS was unable to obtain any additional information to establish whether this was an isolated incident or part of a broader practice.

South African National Defence Force

Inability to curb violence along the border

SANDF has deployed a significant number of troops along the Beitbridge border to combat violence and smuggling. Despite these efforts, the illegal activities of the amagumaguma—including attacks on informal border crossers—continue unchecked. Using their detailed knowledge of the area, they have largely managed to avoid detection. One SANDF official described them as 'the masters of this place.'[277]Although soldiers are deployed to patrol the bush, the amagumaguma send out their own foot soldiers to keep track of the soldiers' movements.[278]

[275] Legal counsellor, LHR Musina, 27 September 2012.
[276] SGBV nurse, TCC, 29 August 2012.
[277] SANDF Captain, Musina, cited in S. O'Toole and P. Botes, ' Porous Border is Smugglers' Paradise,' *Mail & Guardian*, 4 April 2011, available at http://mg.co.za/article/2011-04-04-porous-border-is-smugglers-paradise.
[278] Ibid.

INSIDE SOUTH AFRICA

Narrowing SGBV to rape

As described above, sexual and gender-based violence encompasses a range of acts that extend beyond rape and the associated requirement that there be penetration. In practice, many service providers in Musina have equated SGBV with rape, limiting the provision of SGBV services to rape victims. Survivors of other forms of SGBV generally lack the same level of dedicated assistance or access to services that rape victims receive despite the fact that they may suffer some of the same physical and psychological harms as rape victims. This issue will be highlighted below.

SGBV survivors

A number of factors affect the actions of SGBV survivors following an assault. The psychological effects of the attack, their status as undocumented migrants, and their lack of knowledge regarding the care that is available to them all influence their efforts to seek care and to report the case to the authorities. These factors may negatively affect the future course of an investigation if they do later decide to open a case.

Delayed reporting

The majority of SGBV survivors who come to the TCC arrive within 24 hours of their attack, but some survivors have arrived up to a week after their assault, either because they were fearful of approaching service providers without documentation or they did not know where to go for assistance.[279] Many survivors become aware of the available services as a result of the outreach activities that NGOs and other service providers conduct at the shelters. The TCC has also provided care to SGBV survivors who first sought assistance months after their attack, after they became sick or realised they were pregnant.[280]

These delays in reporting compromise the ability to collect physical evidence and significantly diminish the likelihood that SAPS will be able to gather enough evidence to support an arrest or a trial. They also increase the likelihood of contracting HIV/AIDS.

Interference with evidence

Evidence collection will be compromised if victims change or wash their clothes; wipe, bathe or shower; eat, drink, or smoke; brush their teeth or rinse their mouths; or urinate or

[279] Site coordinator, TCC, 26 July, 2012.
[280] Ibid.

defecate.[281] Any of these activities could remove the presence of foreign blood, semen, saliva, skin cells or hair on the victim's body or clothes following an attack.

In many cases, this information is not known to survivors, whose first instinct is to wash themselves as soon as possible after an attack.

Department of Social Development

DSD is the state institution responsible for providing counselling to SGBV survivors and ensuring their physical and psychological well-being. Although NGO actors provide supporting services in this area, DSD bears the primary responsibility for meeting the psychosocial needs of SGBV survivors.

No outreach efforts to SGBV survivors

The United Reform Shelter for women and girls provides shelter to survivors of SGBV. Many newly-arrived women in Musina also stay at the Catholic Women's Shelter. Some of the women at this shelter have recently experienced SGBV, generally during the border crossing.[282] DSD does not visit either shelter to identify women in need of assistance. Instead, NGOs have taken on this role. MSF, MLAO, LHR, UNHCR and IOM all visit the shelters regularly to ensure that newly arrived women are informed of their rights, including the available healthcare and psychosocial support options, and their right to access the criminal justice system without discrimination. They also describe the practicalities of dealing with rape evidence.

Other hotspot areas where there are likely to be individuals who have recently experienced SGBV include the surrounding farming area and the refugee reception office. DSD does not conduct any outreach activities in these areas either.[283]

DSD's failure to engage in outreach efforts to provide information and support to SGBV survivors has negatively affected migrants' access to justice. Newly arrived migrants are not likely to be fully aware of their rights, healthcare needs and the processes of the criminal justice system. Improved government assistance and outreach may increase rights awareness, leading to increased reporting of SGBV cases and a strengthened evidence-gathering process, as well as improving the emotional support provided to survivors.

[281] SGBV nurse, TCC, 29 August 2012.
[282] Ibid.
[283] Ibid.

South African Police Service

Victim care in the reporting process

The National Policy Guidelines for Victims of Sexual Offences set out a range of procedures that SAPS must follow to ensure that victims are treated with the necessary 'respect, empathy, and professionalism.' These include ensuring that the SGBV survivor is interviewed in a private place, that the officer listens to and comforts the victim, and that he or she explains the police procedures to the victim. It also calls on SAPS to inform the survivor of available counselling services and to ensure the immediate provision of medical assistance where necessary.

The FCS unit has significantly improved service provision to SGBV survivors in line with these guidelines. The four dedicated officers have received SAPS and DSD training on victim empowerment, child protection and family violence.[284] They wear plain clothes and drive unmarked vehicles in an effort to make themselves more approachable and to remove the stigma that SGBV survivors may feel. The TCC provides a dedicated room for FCS investigations so survivors need not ever report to the police station to make their statements.[285] Prior to the establishment of this unit in Musina, all SGBV case file were transferred to investigating officers in the Makhado FCS unit (95 kilometres away).[286] Investigations were hampered by this distance and by a lack of continuity, as the officer who took the survivor's statement and initiated the investigation did not follow it through.[287]

Low rate of reported cases

Counselling services provided at the Thuthuzelas have increased the numbers of cases that are reported to SAPS, but these reported cases still only represent a very small proportion of the cases that reach the TCC.[288] The TCC does not report cases without the victim's consent. Police do not know why reporting rates are so low: 'We don't know why some women refuse assistance. We think it may be because some of them are undocumented or are afraid of the police.'[289] Survivors described a number of reasons for not reporting their assaults: 1) they did not believe that it would help them; 2) they did not want to disclose their attacks; 3) they did not want to interrupt their migration journey.[290]

Case withdrawal because of complainant relocation

According to SAPS, many of the cases they open cannot proceed to trial because they are unable to locate the complainant.[291] Many complainants are newly arrived in the country

[284] FCS warrant officer, SAPS, 27 September 2012.
[285] Communications Officer, Musina Hospital, 28 September 2012.
[286] FCS warrant officer, SAPS, 27 September 2012
[287] Ibid.
[288] Ibid. SAPS would not provide the number of reported cases.
[289] FCS warrant officer, SAPS, 19 July 2012.
[290] Legal counsellor, LHR Musina, 27 September 2012.
[291] FCS warrant officer, SAPS, 19 July 2012.

and do not have a stable address or phone number. Many also leave Musina without providing any forwarding addresses.[292]

The National Police Guidelines for Victims of Sexual Offences call on SAPS to keep SGBV survivors regularly informed of the status of their case. In the past, SAPS adopted a passive approach toward complainants that exacerbated this problem. Officers did not maintain regular contact with survivors, which contributed both to the complainant's lack of faith in the system and to the problems in keeping track of their situation. This situation has improved with the establishment of the FCS unit, but challenges remain. Many SGBV survivors have their cell phones stolen during their attacks and are unable to provide any contact details either for themselves or for friends or relatives within South Africa, as this information was stored in their phone.[293] Officers ask these individuals to provide their contact information as soon as they are able to do so, but many do not follow through on this request. Some survivors actively avoid further contact with the investigating officer for fear of being stigmatised by their partner or family whom they have come to South Africa to join.[294]

Attacks perpetrated by foreign nationals

Although SAPS policy is to open files for all reported SGBV cases, many of these attacks occur along the border. These cases often stall either because of a lack of evidence or because the police are unable to identify or locate the suspect.[295] SAPS claims that many of the attacks that occur along the border are committed by Zimbabwean nationals who operate along both sides of the border but do not stay in South Africa,[296] making it impossible for SAPS to arrest them.[297]

Given the investigation difficulties highlighted by SAPS, it is unclear how it has been able to determine that the attackers are Zimbabwean. Without additional information, it is not possible to determine whether this is in fact the case, or whether it is simply a way for SAPS to avoid any responsibility for the fact that very few cases make it to trial. SAPS has also claimed that it has made arrests and that some of these arrests ultimately led to convictions, but it would not provide any statistics to confirm this claim.[298]

Police detentions of SGBV survivors in need of medical care

The National Policy Guidelines for Victims of Sexual Offences prioritise the medical needs of SGBV survivors, calling on officers to determine whether the victim requires medical assistance and to ensure that it is provided immediately. In cases where SGBV survivors are detained, SAPS has not consistently met this obligation.

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[292] Ibid.
[293] FCS warrant officer, SAPS, 27 September 2012.
[294] Ibid.
[295] FCS warrant officer, SAPS, 19 July 2012.
[296] Ibid.
[297] Regardless of where the offence was committed, the alleged perpetrator can only be arrested and brought to trial if found within South African territory. Sexual Offences Act, Section 61.
[298] FCS warrant officer, SAPS station, 27 September 2012.

NGOs are no longer allowed to remove detainees at the Musina police station who report rape or sexual assault to them, as was the practice at SMG. Even at SMG, however, the practice was problematic because of delays in obtaining assistance. In one instance, a woman who had been raped was detained all weekend at SMG and not taken for treatment. Following an intervention by LHR, the police took her to the hospital. As a result of the delay in treatment, she fell pregnant and later tested positive for HIV.[299]

The denial of direct NGO intervention at the Musina police station increases the risk that treatment will be delayed. Although SAPS generally transports a woman who identifies herself as a rape victim to the TCC,[300] the situation remains problematic for detentions that take place after hours or on weekends. In these cases, women are often forced to wait until the TCC reopens. In one such case, a rape survivor was deported before this took place. A SAPS officer had taken her to the TCC for treatment outside of business hours. The officer was not willing to wait with the woman so that she could receive treatment at the hospital, and she was instead returned to the police cells. She was later deported without receiving any medical assistance.[301]

The situation is also problematic for women who are not clearly identified as rape victims and thus fall outside of the protections offered to SGBV survivors. Many survivors either do not acknowledge that they have been raped or they have been sexually assaulted but not raped. SAPS does not take survivors of other forms of SGBV to either the hospital or the TCC for medical care unless they are visibly in need of emergency medical care.[302] Instead, they are treated as any other detainee with non-urgent medical concerns.

Police officers rarely take detainees with medical issues to the hospital because of the waiting periods involved for receiving treatment there. SAPS argues that it lacks the capacity to ensure medical care for individual detainees because detainees must be accompanied by a police officer throughout their entire hospital visit.[303] In some instances, SAPS has told detainees who have requested medical assistance to wait for MSF, which has an agreement with the Department of Health to provide services.[304]

These delays may harm both the physical and psychological well-being of the SGBV survivor and the prospects for arrest and prosecution. Delays in access to medical care can have a detrimental effect on the psychological well-being of an SGBV survivor. In cases of rape, both the administering of the rape kit and the provision of PEP must occur within 72 hours of the assault. This 72-hour window may close during the time that police are unwilling to take a detainee to the hospital if the TCC is closed, which may jeopardise both the collection of evidence, and the long-term health of the individual.

[299] Legal counsellor, LHR Musina, 27 September 2012.
[300] Site Coordinator, TCC, 27 September 2012.
[301] SGBV nurse, TCC, 29 August 2012.
[302] Off the record communication to ACMS.
[303] Legal counsellor, LHR Musina, 27 September 2012.
[304] Musina researcher, Johannesburg, 11 October 2012.

Failure to Open Cases

SAPS has refused to open cases in response to reports of SGBV for a variety of reasons, pointing to jurisdictional issues and insufficient claims. In many instances, they maintain that the incident occurred on the Zimbabwean side of the border. According to MSF, somewhere between 50-80 percent of the SGBV cases it handled in 2010 occurred on the South African side of the border.[305] There is little evidence to suggest this situation has changed, particularly given the admitted ineffectiveness of SANDF patrols.

SAPS has also refused to open cases on other grounds.[306] In one instance, the officer refused because the victim could not provide the PUK number for her cell phone, which had been stolen during the attack. In the second case, SAPS refused to open a case for a woman who was raped by her partner after assuming without any investigation that the woman would not be able to prove that the attack was in fact rape and not consensual sex between partners. Such a determination rests not with the police but with the prosecutor and magistrate. The first case preceded the establishment of the FCS. In the second case, the officer did not report the incident to the FCS for further investigation. The refusal to open a case violates SAPS stated instructions against turning away any SGBV survivor.[307]

Long waiting periods for forensic evidence

Forensic analysis at the Criminal Record and Forensic Science Service (CRFSS) takes a minimum of three months.[308] This makes the speedy arrest, trial and conviction of alleged perpetrators virtually impossible. While this issue is not unique to Musina, the situation of newly arrived migrants who are unlikely to stay in the area for long periods heightens the necessity for a quick process. The National Guidelines for Prosecutors in Sexual Offences Cases call for sexual offence cases to be finalised as soon as possible.

Department of Justice

Low conviction rate

The prosecutor reports a conviction rate of over 90 percent in cases that go to trial.[309] This figure is somewhat misleading, however, given the extremely low number of cases that actually make it to trial in relation to the number of cases reported to the TCC. Of the few cases that are reported to SAPS, even fewer will meet the evidentiary requirements necessary to bring a case to trial. In fact, the prosecutor dealing with rape cases reported that he had not brought a single case of rape occurring along the border to trial.[310]

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[305] Email communication to ACMS, 17 April 2012.
[306] Legal counsellor, LHR Musina, 27 September 2012.
[307] SAPS National Instruction No. 22/1998, 'Sexual Offence: support to victims and crucial aspects of the investigation,' section 3(1).
[308] Prosecutor, Musina Magistrate's Court, 2 April 2012.
[309] Prosecutor, Musina Magistrate's Court, 6 September 2012.
[310] Ibid.

The prosecutor did state that 'although there have been less reported cases of rape in the last year, we have been more successful in terms of our conviction rate related to these cases.'[311] He did not, however, provide figures to support this statement.

Victim intimidation

The Criminal Procedure Act provides for certain measures to protect witnesses and complainants during a trial.[312] The Service Charter for Victims of Crime in South Africa also calls for measures to protect victims during the court process. Despite these provisions, the DoJ does not generally make special arrangements to protect victims from facing their attackers while awaiting trial in the court's corridors. The prosecutor reports that when he is aware of the situation and is not otherwise occupied in court, he allows the victim to await the hearing in his office, but this is not always possible.[313] No institutional solution for protecting witnesses and victims from pre-trial intimidation exists, aside from the inclusion of an order preventing such intimidation in the bail conditions.[314]

In addition, aside from the one room at the Victim Empowerment Centre, there are no safe houses for SGBV survivors in Musina. Security at the shelters is lacking, and amagumagumas and malayitshas frequent these buildings.[315]

Non-appearance at trial

The NPA's major challenge in SGBV cases is the failure of victims to appear on the date of the trial.[316] In cases of rape, witness testimony is essential to prove that the sex was non-consensual. In the absence of eye witness testimony, strong circumstantial evidence—in the form of the medical practitioner's report, other witness testimony, or the testimony of the investigating officer and/or the person to whom the first report of the attack was made—is necessary.[317] Such evidence is rarely strong enough to support a case on its own. In fact, the NPA has only successfully prosecuted one rape case in Musina in the absence of the victim.[318]

As a result, the NPA has adopted the practice of not pursuing cases where the victim does not have a residential address or contact number.[319] If the victim is not contactable, the public prosecutor is forced to provisionally withdraw the case until the victim reports to SAPS with updated contact details.[320] As with the police, the guidelines for prosecutors in sexual offence cases also call for the prosecutor to consult with the victim and keep him or her informed about the case. Such communication may increase the SGBV survivor's faith

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[311] Ibid.
[312] Criminal Procedure Act (No. 51, 1977), section 154.
[313] Prosecutor, Musina Magistrate's Court , 6 September 2012.
[314] Ibid.
[315] Musina researcher, Johannesburg, 11 October 2012.
[316] PublicProsecutor, Musina Magistrate's Court, 2 April 2012.
[317] Ibid,
[318] Ibid,
[319] Ibid.
[320] Ibid.

in the system, and increase the likelihood that he or she will maintain contact with the prosecutor in the event of relocation.

The NPA in Musina has attempted to overcome the problem of victim disappearance by creating an awareness campaign on Musina FM (the local radio station) and by ensuring that the nurses and counsellors at the TCC inform the victim that any change in address must be communicated to SAPS.[321] These interventions have so far not had the intended effect.[322]

Department of Health and the Musina Hospital

The Department of Health has the primary responsibility for providing health care for SGBV survivors, which includes providing emergency medical care, administering PEP and treating other potential STIs, providing pregnancy prevention treatment and abortions, conducting voluntary testing and counselling on possible HIV infection, and making referrals to DSD for long-term counselling services. The DoH (either a doctor or nurse trained in SGBV care) is also responsible for the completion of the "J88 form" (which records medical-legal evidence that may be used to obtain a conviction in rape cases) and the medical evidence kit (containing slides, swabs, test tubes and other equipment to collect samples of blood, hair, semen, vaginal fluid and fingernail scrapings).[323]

No comprehensive care available to victims after hours

SGBV survivors who seek assistance at the Musina hospital when the TCC is closed do not receive the full range of medical services provided by the TCC.[324] The hospital does not have the necessary staff and resources to provide survivors with the comprehensive care package 24-hours a day. The lack of resources is particularly acute after hours: there is no crisis counsellor available to survivors;[325] there is not always a health care worker available who is trained to carry out voluntary HIV counselling and testing (VCT);[326] the hospital pharmacy is closed and the full 28-day cycle of PEP tablets cannot be provided; and social workers are not available.[327] Individuals who seek treatment during these hours are advised to go to the TCC on the next working day, but very few of these individuals report to the TCC for follow-up care.[328] This situation highlights the importance of ensuring that individuals receive adequate care at their first point of contact, and that provision is made for providing medical and psychosocial services when the TCC is not open.

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[321] Prosecutor, Musina Magistrate's Court, 6 September 2012.
[322] Ibid.
[323] S. Suffla, M. Seedat, and A. Nascimento, 'Evaluation of medico-legal services in Gauteng: Implications for the development of best practices in the after-care of rape survivors,' South African Medical Research Council, 2001, available at http://www.mrc.ac.za/policybriefs/polbrief5.htm.
[324] Site coordinator, TCC, 5 September 2012.
[325] Communications Officer, Musina Hospital, 28 September 2012.
[326] Ibid.
[327] Off the record communication to ACMS.
[328] Site coordinator, TCC, 5 September 2012.

Follow-up care for SGBV survivors

The provision of psychosocial support, information and monitoring is essential for the long-term well-being of the SGBV survivor, particularly with the provision of PEP. Without follow-up counselling and testing and measures to ensure patient drug compliance, the effectiveness of PEP is significantly reduced.[329] Hospital staff notify survivors that they should return to the health facility at six week, three month and six month intervals, but patients rarely return to the TCC for follow-up visits.[330]

There are several reasons for poor compliance and non-return. Rape survivors suffer trauma after the rape incident, and experience a reduced ability to assimilate vital healthcare information about the importance of compliance to the PEP regimen and the necessity of follow-up visits.[331] Denial is also a possible response to the trauma of SGBV, and could explain why victims do not regularly take their drugs.[332]

In order to combat these problems, effective counselling is required at the time that PEP is administered, which includes HIV counselling and testing (VCT). There is often no health care worker trained in VCT on staff at the hospital after hours.[333] As a result, patients will be instructed to seek treatment at the TCC in the morning and will not receive PEP at their first point of contact with DoH.[334]

Patients who do receive PEP at the hospital must nonetheless seek follow-up care at the TCC in order to receive the full 28-day course of medication because the pharmacy is generally closed after hours.[335]There is also no counsellor available after hours to explain importance of taking this medication. Patients will receive this information at the TCC, but many do not return for subsequent care and the full course of medication.[336]

No urgent medical care for SGBV survivors in detention

The Department of Health does not visit the police cells. NGO stakeholders have access to the cells between nine and eleven am, but they are not allowed to remove detainees for counselling or treatment and can only refer cases to SAPS and DoH. SAPS has generally transported cases brought to its attention to the TCC during working hours.[337] But the limits of NGO monitoring and the need to provide care after hours and on weekends point to a need for more regular DoH monitoring of and intervention at the police cells.[338]

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[329] Ibid.
[330] Ibid.
[331] Centre for AIDS Development, Research and Evaluation (CADRE), 'Rape and Post-Exposure Prophylaxis in South Africa: A review,' for the Department of Health, South Africa (2003) available at:
http://www.cadre.org.za/files/Womens_PEP_Review_Final.pdf.
[332] Ibid.
[333] Site Coordinator, TCC, 27 September 2012. Communications Officer, Musina Hospital, 28 September 2012.
[334] Site Coordinator, TCC, 27 September 2012.
[335] Communications Officer, Musina Hospital, 28 September 2012.
[336] Site Coordinator, TCC, 26 July, 2012. Communications officer, Musina Hospital, 28 September 2012.
[337] Site Coordinator, TCC, 27 September 2012.
[338] Communications officer, Musina Hospital, 28 September 2012.

Healthcare systems not integrated

More broadly, health systems in the South Africa are not adapted to ensure continuity of care for migrants. Migrant SGBV survivors are highly mobile, and although the need for continuity of care in SGBV cases is acknowledged by the DoH, no system is in place at present to cope with patients who do not return to the TCC facility for continued treatment,[339] particularly in cases where individuals require chronic medication for conditions such as HIV/AIDS.[340] There is no procedure for providing referral letters that would allow individuals to access continuous care at other health care facilities

No abortion services in Musina

Under the law, women are entitled to free abortion services at government hospitals.[341] However, SGBV survivors are currently unable to receive abortions at any state facility within the Musina district because of unwillingness by staff to perform these services.[342] Survivors are referred to hospitals in other districts such as Louis Trichardt or Siloam, but they must arrange their own transport.[343] Women seeking to terminate pregnancies resulting from rape must go to private institutions and pay for these procedures, or pay for their own transport outside of the Musina District to a state institution that does offer these services. Many SGBV survivors do not have the resources to take advantage of these options. As a result, they turn to dangerous and potentially fatal 'backstreet abortions.'[344]

Rural populations not receiving regular services

High levels of abuse on the farms surrounding Musina have been reported and levels of HIV/AIDS there are also high. Accordingly, there is a significant demand for services on the farms.[345] The rural areas surrounding Musina are served by three mobile Department of Health (DOH) clinics. According to DoH, these clinics visit the farms once a week unless transport is unavailable. Resource constraints mean that these mobile units often only reach the farms once a month.[346] As a result, SGBV survivors in more rural areas must go into town in order to access medical care, but many are unable to take a day off work, which also means a day without pay.

Conclusion and recommendations

The prevalence of SGBV remains an issue for migrants at the border, both during the border crossing and inside Musina. The coordinated response by government and civil society in

[339] Site Coordinator,TCC, 27 September 2012.
[340] MSF, *Providing antiretroviral Medication for Mobile Populations* (July 2012), available at http://www.msf.org.za/sites/default/files/publication/documents/Providing%20Antiretroviral%20Therapy%20for%20Mobile%20Populations.pdf.
[341] Choice on Termination of Pregnancy Act (No. 92, 1996).
[342] Communications Officer, Musina Hospital, 28 September 2012.
[343] Ibid.
[344] Off the record communication to ACMS.
[345] Musina researcher, Johannesburg, 11 October 2012.
[346] Ibid.

Musina, together with the opening of the Thuthuzela Care Centre and the establishment of the FCS unit at SAPS, has significantly improved the care and treatment for SGBV survivors. Survivors now receive comprehensive care in one location, are able to report their cases to the police in a confidential and therapeutic environment, and have their cases handled by health care workers, counsellors, and police officers who have been trained to deal with the effects of sexual abuse on survivors and are sensitive to their needs. The closure of SMG has also had a positive effect, improving the access to health care for those who identify themselves as SGBV survivors in detention.

Despite these improvements, challenges remain. These include the high rate of sexual assaults during the border crossing coupled with low rates of arrests and convictions for SGBV cases and the lack of comprehensive health care services on evenings and weekends. The long time periods involved with investigating and prosecuting SGBV cases also poses a challenge for migrants who are unlikely to stay in Musina during this period. All of these factors inhibit access to justice for migrant survivors of SGBV.

In light of the situation described above, ACMS makes the following recommendations:

To the Department of Home Affairs:

- Stop the practice of denying entry to asylum seekers at the border, which forces them to cross the border informally and increases the likelihood of abuse.
- Screen detainees prior to deportation to ensure that no person requiring urgent medical care is deported.
- Provide information at the border about the services available in Musina for survivors of SGBV.

To the South African National Defence Force:

- Increase patrols in the 'no man's land' between South Africa and Zimbabwe to reduce incidences of sexual and gender-based violence in this area.
- Establish a procedure to determine if an arrested individual is in need of medical care before transferring him or her to SAPS or DHA. Transport individuals in need of medical services to the TCC or the Musina hospital.

To the Department of Social Development:

- Engage in active outreach work at the shelters, farms, and the refugee reception office to ensure that SGBV survivors—both male and female—are aware of their rights and the services available to them, as well as the procedures around collecting evidence and the importance of seeking care as soon as possible.

- Make social workers available after hours for SGBV survivors who report to the police station or the hospital on evenings and weekends.

To the South African Police Service:

- Establish a procedure for determining if detainees in police cells are in need of medical care and for transporting these individuals immediately to the TCC or to the hospital when the TCC is not open.
- Ensure that these procedures apply equally to survivors of all forms of sexual and gender-based violence and not only rape and apply equally to men and women.
- Make sure that police officers do not prematurely close cases or refuse to open cases before a proper investigation has been conducted by a member of the FCS unit. Officers must be informed that they cannot turn away any individuals who report any form of SGBV.
- Maintain regular communication with complainants to keep them informed of the progress of the case, both to make sure that they are available during the court process and to ensure that they are aware that their cases are continuing. Such efforts could include:
    - » Encouraging complainants to make use of the VEC until they have become established and are able to provide contact details.
    - » Providing complainants with contact details for an officer with whom they have a relationship to encourage them to remain in contact.
    - » Inquiring as to the complainant's ultimate destination in South Africa and arranging for the complainant to be in contact with an officer in that destination.
    - » Ensuring that complainants understand the importance of maintaining contact with the police for the success of the case.
    - » Informing complainants that their transport and accommodation will be covered if the trial takes place after they have left Musina.
- Consider providing statistics on reported SGBV case to stakeholders in order to provide them with better information with which to identify where the barriers to justice are located and how to address these barriers more effectively.

To the Department of Justice:

- Maintain regular contact with complainants and witnesses to keep them informed on the status of their cases and keep them invested in the process.
- Make sure that complainants understand the importance of keeping police and prosecutors informed of their contact details.

- Ensure that complainants are aware of the fact that their travel and accommodation costs will be covered if they need to return to Musina for the court case.
- Establish a separate waiting area for survivors so that they will not risk encountering their attackers while waiting outside the court room.
- Explain the court process to the complainant and ensure that he or she is emotionally and mentally prepared to testify in court, as this will involve recounting the attack and confronting the attacker. Make sure that the complainant has access to counselling when necessary.
- Take measures to protect witnesses/survivors from pre-trial intimidation where necessary, including revoking bail and providing police protection.

To the Department of Health:

- Make available the full range of SGBV services during the hours that the TCC is closed, including trauma counselling, VCT, and access to the full course of PEP.
- Train all health care workers at the Musina hospital in the administration of VCT so that this can be provided as soon as a survivor reports to the hospital.
- Train all health care workers at the Musina hospital on how to examine and treat SGBV survivors to ensure that the examination is done in an appropriately sensitive manner that avoids secondary victimisation and exacerbating the trauma experienced by the survivor.
- Ensure that patients who receive PEP at the hospital are fully informed about the importance of follow-up treatment and completing the full course of medication.
- Make abortion services available to SGBV survivors in Musina, either by providing these services at the Musina hospital, or by providing subsidies so that SGBV survivors may reach a hospital where abortion services are available or may access these services at a private hospital.
- Provide for daily visits by DoH staff to the police cells to monitor and address the health care needs of individuals in detention.
- Establish a referral letter mechanism for migrant patients so that their treatment can be continued in any hospital or clinic in the country.
- Make sure that the mobile DoH clinics are adequately resourced so that they can visit the rural areas on a weekly basis to provide health care services and ensure that patients relying on these clinics for chronic medication do not have their treatments interrupted.

Conclusion

Initially unprepared for the large numbers of migrants that began streaming into Musina in the early 2000s, local government and civil society have worked to develop appropriate responses to the migrant population there. These efforts have been met with varying levels of success. Some of the biggest challenges have involved populations whose circumstances give rise to special needs that are not linked to their status as migrants alone. Two such populations—unaccompanied minors and survivors of sexual and gender-based violence—make up a significant proportion of the migrant community in Musina.

The establishment of dedicated units to deal with the health care, psychosocial, and justice needs of these two groups have brought about significant improvements, as have the coordinated efforts of local government and civil society. At the same time, resource constraints, insufficient support at the national level, and inadequate training around the procedures required by law have hampered these successes. Greater coordination between the national and local level as well as improved coordination between government departments is needed in order to address the remaining challenges and ensure that the rights of UAMs and SGBV survivors are fully realised.

To that end, ACMS makes the following recommendations:

UAMs

To the South African Police Service:

- Do not detain minors in police cells. In cases where an age determination is necessary, establish an alternative procedure in collaboration with DSD that does not require that individuals who may be minors be detained with adults.
- If minors or possible minors are detained, ensure that DSD is notified immediately.
- Halt all deportations of minors without first obtaining a children's court order.
- Ensure that all UAMs are taken directly to the shelters and that both shelter staff and DSD are notified.
- Make sure that officers are aware of their duty to remove all UAMs they encounter to places of safety, including those they encounter on the streets.
- Ensure that officers are adequately trained on the procedures they must follow in carrying out these removals, including the immediate notification of a social worker.

To the Department of Social Development:

At the national and provincial level

- The Minister and the MEC for Social Development should ensure the provision of adequate funding to establish child and youth care centres in Musina. This may include providing financial support to the existing shelters housing children to enable them to make the necessary transformations to become registered as CYCCs.
- The Minister and the MEC for Social Development should allocate greater resources to social workers working with UAMs in Musina to ensure that they are able to meet their obligations under the Children's Act.
- The Minister should engage with her counterpart in Zimbabwe to improve coordination with the Department of Social Services there and facilitate more timely responses to DSD requests around investigations into the best interests of Zimbabwean UAMs.
- The Provincial Head of Social Development needs to ensure that the therapeutic needs of UAMs in Musina are being met, including:
    - Evaluating the therapeutic needs of UAMs in Musina;
    - Providing interpreter services; and
    - Ensuring that there are CYCCs in Musina that comply with the national norms and standards, and that these CYCCs have residential and therapeutic programmes tailored to the specific needs of UAMs in Musina, with a particular focus on the needs of children living and working on the streets.

At the local level

- Tailor the provision of services to the needs of the individual child.
- Make social workers available after hours.
- Provide children with appropriate counselling upon initial placement at a shelter to reduce the risk that they will leave the shelter before the formal placement procedure is complete.
- Ensure that there are trained interpreters who can communicate effectively with UAMs in Musina
- Engage in outreach to street children, who are by definition children in need of care and protection under the Children's Act.
- Develop placement options that better serve the needs of street children to minimize the risk that they will return to the street.
- Establish procedures for dealing with children who leave the shelters before the placement procedure is complete. This includes mechanisms for tracing the child, such as collecting photographs and other details.
- Institute a programme to assist children in transitioning from life on the streets to a more structured care environment.

- Identify children living in informal foster care, investigate their situation, and formalize their care in accordance with the best interest standard.
- Conduct and share the results of medical certifications with shelter staff so that they can adequately address the specific medical needs of children and take appropriate measures against communicable diseases.
- Train social workers on the documentation options available to UAMs, particularly those who risk becoming stateless. Social workers must also receive training on when particular documentation options, such as asylum and refugee protection, are appropriate.
- Make sure that only children who may have asylum claims are documented as asylum seekers.
- Make directed efforts to document UAMs before they turn eighteen.
- Train social workers in how to develop durable solutions for UAMs who are about to turn eighteen, including applying for an extension of the court order for children who will still be in school when they turn eighteen.
- Engage in active interventions when UAMs are not allowed to enrol in schools.
- Provide informal schooling and vocational training at the shelters to ensure that the educational and therapeutic needs of minors are being met when formal schooling is either not appropriate or not possible.

To the Department of Home Affairs:

- Prohibit immigration officers from refusing entry to UAMs at the border without a procedure for ensuring their care and protection.
- Establish a procedure for identifying UAMs at the border and ensuring that they are placed in the care of a social worker.
- Make sure that all staff at the refugee reception office are aware of their obligation to contact DSD if a UAM approaches the office.
- Prioritise the asylum claims of UAMs, which includes conducting status determination interviews in the company of a social worker or guardian.
- Develop mechanisms to document UAMs who do not qualify for asylum.

To the Department of Education:

- Engage with public schools in Musina to make them aware that they are not entitled to turn UAMs away and that UAMs must be allowed to enrol at any point during the school year.

To the Department of Health:

- Develop a procedure in collaboration with DSD for providing UAMs with medical certifications within 24 hours. This could include allocating a DoH staff member to conduct these certifications at a particular time every day.

To the Department of Justice/Children's Court:

- Hold children's court proceedings more than once a month to ensure that the placement needs of UAMs are being met in accordance with the requirements of the Children's Act.
- Provide the child with an opportunity to participate in the children's court proceedings to determine his or her best interest. Do not hold these proceedings in the absence of the child, which is a violation of the Children's Act.

SGBV survivors

To the Department of Home Affairs:

- Stop the practice of denying entry to asylum seekers at the border, which forces them to cross the border informally and increases the likelihood of abuse.
- Screen detainees prior to deportation to ensure that no person requiring urgent medical care is deported.
- Provide information at the border about the services available in Musina for survivors of SGBV.

To the South African National Defence Force:

- Increase patrols in the 'no man's land' between South Africa and Zimbabwe to reduce incidences of sexual and gender-based violence in this area.
- Establish a procedure to determine if an arrested individual is in need of medical care before transferring him or her to SAPS or DHA. Transport individuals in need of medical services to the TCC or the Musina hospital.

To the Department of Social Development:

- Engage in active outreach work at the shelters, farms, and the refugee reception office to ensure that SGBV survivors—both male and female—are aware of their rights and the services available to them, as well as the procedures around collecting evidence and the importance of seeking care as soon as possible.

- Make social workers available after hours for SGBV survivors who report to the police station or the hospital on evenings and weekends.

To the South African Police Service:

- Establish a procedure for determining if detainees in police cells are in need of medical care and for transporting these individuals immediately to the TCC or to the hospital when the TCC is not open.
- Ensure that these procedures apply equally to survivors of all forms of sexual and gender-based violence and not only rape and apply equally to men and women.
- Make sure that police officers do not prematurely close cases or refuse to open cases before a proper investigation has been conducted by a member of the FCS unit. Officers must be informed that they cannot turn away any individuals who report any form of SGBV.
- Maintain regular communication with complainants to keep them informed of the progress of the case, both to make sure that they are available during the court process and to ensure that they are aware that their cases are continuing. Such efforts could include:
    - » Encouraging complainants to make use of the VEC until they have become established and are able to provide contact details.
    - » Providing complainants with contact details for an officer with whom they have a relationship to encourage them to remain in contact.
    - » Inquiring as to the complainant's ultimate destination in South Africa and arranging for the complainant to be in contact with an officer in that destination.
    - » Ensuring that complainants understand the importance of maintaining contact with the police for the success of the case.
    - » Informing complainants that their transport and accommodation will be covered if the trial takes place after they have left Musina.
- Consider providing statistics on reported SGBV case to stakeholders in order to provide them with better information with which to identify where the barriers to justice are located and how to address these barriers more effectively.

To the Department of Justice:

- Maintain regular contact with complainants and witnesses to keep them informed on the status of their cases and keep them invested in the process.
- Make sure that complainants understand the importance of keeping police and prosecutors informed of their contact details.

- Ensure that complainants are aware of the fact that their travel and accommodation costs will be covered if they need to return to Musina for the court case.
- Establish a separate waiting area for survivors so that they will not risk encountering their attackers while waiting outside the court room.
- Explain the court process to the complainant and ensure that he or she is emotionally and mentally prepared to testify in court, as this will involve recounting the attack and confronting the attacker. Make sure that the complainant has access to counselling when necessary.
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