

South African

Child Gauge

2005

Children's Institute,
University of Cape Town

Edited by Marian Jacobs,
Maylene Shung-King
and Charmaine Smith



UNIVERSITY OF CAPE TOWN



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child rights in focus
Research • Advocacy • Education

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Abbreviations

ACCESS	Alliance for Children's Entitlement to Social Security
AIDS	Acquired Immune Deficiency Syndrome
ARK	Absolute Return for Kids
ART	Antiretroviral therapy
ARV	Antiretroviral
ASSA	Actuarial Society of South Africa
CASE	Community Agency for Social Enquiry
CBO	Community-Based Organisation
CD4	Cluster of Differentiation 4
CDG	Care Dependency Grant
CRC	Convention on the Rights of the Child
CSG	Child Support Grant
DHS	Demographic Health Survey
EA	Enumerator Areas
EMIS	Education Management Information System
EPRI	Economic Policy Research Institute
FBO	Faith-Based Organisation
FCG	Foster Care Grant
GEAR	Growth, Employment and Redistribution
GER	Gross Enrolment Ratio
GHS	General Household Survey
HIV	Human Immunodeficiency Virus
IDASA	Institute for Democracy in South Africa
IDP	Integrated Development Plan
IMR	Infant Mortality Rate
MDG	Millennium Development Goals
MTCT	Mother-To-Child Transmission
NA	National Assembly
NCOP	National Council of Provinces
NER	Net Enrolment Ratio
NFCS	National Food Consumption Survey
NGO	Non-Governmental Organisation
NPA	National Programme of Action for Children
PCP	Pneumocystic Carinii Pneumonia
PMTCT	Prevention of Mother-To-Child Transmission
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RDP	Reconstruction and Development Programme
SADTU	South African Democratic Teachers Union
SALRC	South African Law Reform Commission
SOCPEN	Social Pension
TASO	The AIDS Support Organisation
TB	Tuberculosis
UCT	University of Cape Town
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Education Fund
U5MR	Under-five Mortality Rate
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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Foreword

Message from Mrs Graça Machel, Chair of the Board, Children's Institute

I am privileged to launch the first *South African Child Gauge* – a publication which will provide an annual report on progress towards meeting our national obligations to children.

The past decade has been witness to many actions on behalf of South Africa's children, in policy, law and programming. Yet in the same period, one child under the age of a year dies every ten minutes from causes which could have been prevented by known and tested measures such as immunisation, access to clean water, and prevention of mother-to-child transmission of the Human Immunodeficiency Virus. While such statistics help to measure the scale and depth of children's problems, they nevertheless hide the vast numbers of children whose deaths go unrecorded, who never get to health care, and who go to bed hungry at night. And among these numbers are boys and girls who have names, faces, families, and very different experiences. The *South African Child Gauge* illustrates the situation of children with numbers, but also tells stories of their lives, their circumstances, and the tremendous changes which children face. It also reflects the remarkable achievements for children in ten short years in South Africa. I commend the Children's Institute at the University of Cape Town for launching this important report at this time, and for promising to produce this every year from now on.

With so many South Africans, I share a tradition where children are not only regarded as our future, but especially as our present. And so I believe that it is our responsibility to ensure that children are given futures worth having, but also to make sure that they have quality lives right now. This will mean that government should strive to fulfil its obligations to children and allocate more resources to their care. It will mean that civil society organisations, communities, families and all adults should nurture and protect them. And it will mean that those who have the power to make decisions about children's



lives should listen to them, take their stories seriously, and act in whatever ways they can.

Through my work with children in armed conflict, I have learnt that despite the brutality shown towards them and the failure of adults to nurture and protect them, children are both our reason to eliminate the worst circumstances which stand in the way of their rights, and our best hope of succeeding in that charge. In short,

advocacy for children is a strong force which can unify us across the country, the continent and the globe.

This has been demonstrated effectively in the *South African Child Gauge 2005*, which represents a collaborative effort on the part of the Children's Institute to provide a snap-shot of children in South Africa, with special emphasis on children in the context of HIV/AIDS. Using the strength of the Children's Institute's academic base, the *South African Child Gauge* makes an important contribution to the discourse and action for implementing child rights in South Africa, and internationally. Most importantly, monitoring the promises made to improve the lives of children is a vital advocacy tool for advancing child rights. With the launch of the *South African Child Gauge*, the Children's Institute is making an important contribution to South Africa, and also to the larger global movement to protect and promote the rights of children.

To the Children's Institute – I extend my congratulations; and to those who read the *South African Child Gauge* – I offer my challenge that when you read this report, you consider what you can do to make a difference in the lives of our children, no matter how large or how small.

A handwritten signature in black ink, reading 'Graça Machel'. The signature is fluid and cursive, with a long horizontal line extending from the end.

Reflections on child rights and the Constitution

Justice Albie Sachs, Constitutional Court Judge



The huge progress we've made in the last decade simply underlines the huge progress we still have to make. I would say that the biggest gain has been that children are noticed and have some of a voice of their own. The idea of children's rights is powerful. Children have hope in our society. There is no longer any sense of the inevitability of injustice being done to them. Children laugh, play and dream in ways that were impossible for the majority before. They do the unimaginable. In many ways ours has become a wonderful country in which to grow up, where children have an identity, a community, a sense of being somebody, and hope.

Yet there is still abuse at a totally unacceptable level. I don't think it is any worse than it has been; we just know more about it. This makes passivity even less acceptable. We have a wonderful Constitution. The courts are far more effectively geared towards dealing with children, and more sensitively, too. Notions of restorative justice have made great strides, feeding into African traditions based on the principles

of *ubuntu*. The Child Justice Bill, which deals with children in trouble with the law, is ready for adoption by Parliament. In fact, it is more than ready:

implementation could be effected step-by-step, perhaps with pilot projects to

monitor questions of costs and management. Its adoption will show that we can simultaneously be right up there with the best in the world, and at the same time draw on the special richness of our humane culture.

Furthermore, we have to pay special attention to the conditions in which children grow up; their rights to food, clothing and shelter; their right to have healthy bodies and minds equipped to explore the wonders of the world they live in, as well as the right to travel and get to know one another and discover the joys of existence, not only its pains.

Above all, we have a lively community of social and legal activists working skilfully and confidently in this area, keeping the issues constantly before us, and looking for creative and effective solutions.



PARK

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SCHOOL

Children in South Africa

Marian Jacobs (Children's Institute)

Children have been at the forefront of concerns regarding human rights violations in South Africa since 1976, when scholars took to the streets in protest against unequal education. Since that time, there have been many reports on the situation of children – first produced by child rights advocacy groups and, in the last decade, produced by both State and civil society institutions. Yet these reports have not been produced on a regular, annual basis; nor has there been any systematic means of tracking advances with child rights over time.

The publication of the *South African Child Gauge* is an attempt by the Children's Institute, University of Cape Town, to report on the situation of children as an annual reminder of the challenges that we, as a country, still face in our efforts to promote and protect child rights.

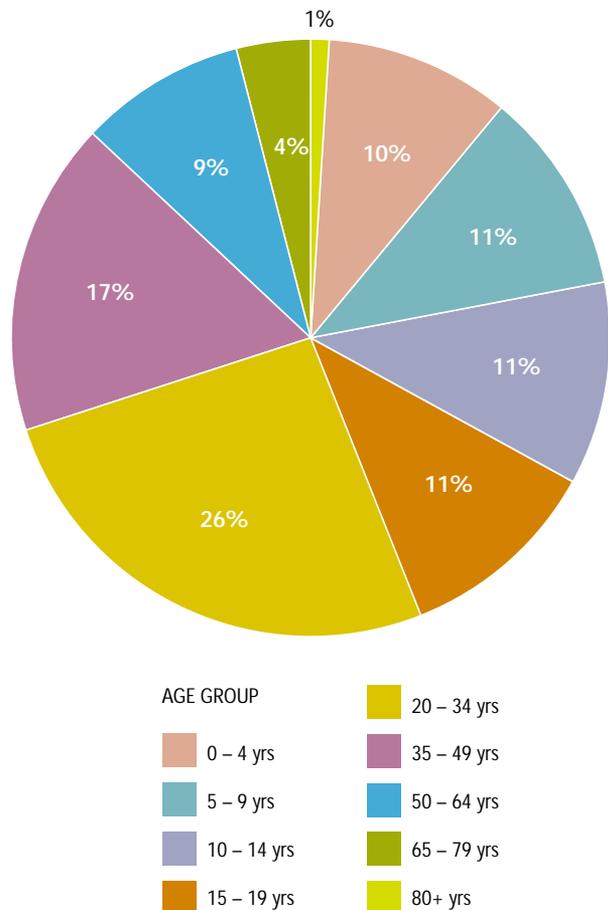
Each year, the *South African Child Gauge* will examine the links between children's reality, South Africa's commitments to child rights, and society's progress in this regard. This will be done through commentary on the country's response to different aspects of the challenge of realising children's rights, and through a set of broad-based indicators aimed at gauging improvements in the situation of children over time. This first issue focuses on children and HIV/AIDS, presented against the backdrop of a narrative and quantitative snapshot of the situation of children in South Africa.

For us at the Children's Institute, the *South African Child Gauge* is our contribution to the nation-wide efforts to advance child rights in South Africa. It is also an expression of our conviction that evidence should guide policy and practice, and should be available to all who are engaged in such efforts.

Children: A national priority

South Africa's Constitution defines children as persons aged less than 18 years. According to the 2001 Census, South Africa has just over 19 million children, making up 43% of the total population. Children thus represent a significant proportion of the country's citizens and therefore constitute a group worthy of special consideration.

Population of South Africa:
Distribution of adults and children in 2001



Source: Statistics South Africa (2003) *Census 2001 database*.

Throughout the apartheid years, children in South Africa carried a large burden of discrimination and violation of their rights to survival, development, protection and participation. In an attempt to address this legacy, children have received priority attention since 1994, and have been made new promises by those charged with bearing duty for them – namely government and civil society.

Duty-bearers: Regarded by the United Nations Convention on the Rights of the Child (CRC) as those organs of the State and civil society – institutions and individuals, including parents and caregivers – with duties and responsibilities for translating the rights in the CRC into tangible benefits in order to make them meaningful.

In its first few years of democratic rule, the new South African government adopted a framework for a comprehensive national plan of action for children, with the principles of the CRC and the Constitution forming the core of this framework. The plan identified all duty-bearers across government and civil society sectors with specific responsibility for ensuring the realisation of child rights.

But despite the adoption of the plan of action by the government, and its wide endorsement by civil society, the plan has yet to be implemented in a comprehensive way. And notwithstanding the foundation of a progressive and child-friendly Constitution, the pace of the legislative and policy reform required for the implementation of the plan has been slow.

“Every child has a right to ... a name and nationality ... care ... basic nutrition, shelter, services ... be protected ... not to work ... not to be detained ... to have a legal practitioner in civil proceedings ... not to be used ... and to be protected in times of armed conflict. A child’s best interests are of paramount importance in every matter concerning the child.”

Section 28, South African Constitution

A decade of progress with promises

Much progress has been made with child rights in South Africa. In compliance with the requirements of the CRC and the Bill of Rights in the Constitution, duty-bearers for child rights in the past decade have moved from promises to action in different ways. The government has initiated a range of child-sensitive legislative reforms, policies and programmes, while civil society has also played an important role in advocacy and action for advancing child rights. A significant civil society contribution has been to restore alliances on advocacy issues through organised responses to legislative reform; through the establishment of non-governmental organisations (NGOs); and through setting up formal and informal networks aimed at complementing the government’s social services for children. In addition, several academic and research initiatives were established to inform interventions for children.

Although the ‘children first’ approach is widely supported in the political arena, this has not been realised in law, in policy, or, especially, in the national budget.

***‘Children first’ or ‘first call for children’:
According to the United Nations World Summit for Children, which took place in 1990, this call represents a political and moral commitment by States and parties to put children first when allocating resources, particularly when it comes to socio-economic rights and children’s basic needs. States and parties must commit themselves to implement the CRC, and in particular its four principles:***

- The right to non-discrimination.
- The right of a child to have his or her best interests taken account of as a primary consideration.
- The right to survival and development.
- The right of the child to have his or her views respected.

Legislation

The government has drafted important legislation in the fields of juvenile justice, social security and health. However, while the social security laws make reference to children, the health laws are almost silent on children's special needs and requirements. In this context, civil society made a strong call for a comprehensive piece of legislation for children – the Children's Bill which, after more than a decade of widespread dialogue and debate, is now reaching finalisation. Paula Proudlock provides a more detailed account of the progress of this important law in *Part 1: Legislative developments 2004 and 2005*.

Policies

While there have been many specific sectoral policy and programme interventions for children, macro-development policies have not always been made in the best interests of children. While the government is committed to addressing the immediate realities of poverty and its consequences, its focus in recent years on the long-term economic development of the country has taken precedence, which has direct implications for child policies and programmes.

On the one hand, the principles of the Reconstruction and Development Programme (RDP) provided a framework for taking action in the interests of children. For example, the recommendations of the 2002 report of the government-appointed Committee of Inquiry into a Comprehensive System of Social Security emphasised a response to poverty through social development measures. These included universal cash grants; a package of services to enable everyone – including children – to live and function in society; strategies to ensure access to food and income generation; and consideration for children and adults with special needs. On the other hand, the macro-economic policy for Growth, Employment and Redistribution (GEAR), which evolved from the RDP, has given greater prominence to strategies towards long-term economic growth, with much less attention to the immediate challenges of addressing the dire situation of children, especially those living in poverty.

Since 1994, many policies in support of child rights have been drafted in the fields of health, education and other basic social services. Interventions by various government departments, such as justice, social development, health, education, sport and recreation, have resulted in the implementation of many child-oriented policies and programmes, such as the Child Support Grant (CSG), free

primary health care, the National School Nutrition Programme and the School Fee Exemption Policy. All these have been well received, while the success of their implementation has been variable across the provinces.

A major achievement in the past decade has been the favourable progress with coverage of some social services for children. In 2005, based on the *General Household Survey 2004*, 67% of eligible children under the age of 14 years are receiving the Child Support Grant. (More detailed information is provided in *Part 3: Children Count – The numbers*). While the CSG helps to provide a minimal means of financial support to children, the fate of the universal Basic Income Grant, recommended as a more pervasive approach to addressing income poverty across the nation, remains in dispute.

Despite the above achievements of greater social security measures for children, children's access to a full range of basic services, as prescribed in the Bill of Rights, remains fraught with problems. The complex bureaucracy involved in accessing basic nutrition, shelter, basic health care services and social services, coupled with inequity in the provision and distribution of such services of quality, constrain the good intentions in support of child rights. And the lack of a clear definition of what such services entail limits the capacity of civil society to make appropriate demands for their constitutional rights.

Failure to locate all child-sensitive policies in a comprehensive rights-based framework has therefore not only resulted in missed opportunities for closer collaboration between government departments, but also between all the duty-bearers – State and civil society – working towards advancing child rights.

The budget

The notion of the 'first call for children' implies that this call should also be reflected in resource distribution. In supporting this notion, the Children's Budget Project of the Institute for Democracy in South Africa (IDASA) is tracking the allocation of monetary resources to children in government budgets, and their advocacy efforts in this regard have extended to countries across the globe, with variable success. In South Africa, this tracking of pro-child budget allocations has proved extremely challenging because of limited available data, and also because of the way in which government budgets are arranged. Despite these constraints, the IDASA project's efforts have demonstrated inequities in the distribution of resources between children and adults, and have highlighted the challenges which countries face in trying to achieve socio-economic rights for children in the spirit of 'children first'.

What progress has been made with advancing child rights?

Right to survival

Children's survival, which is a central right for children, is under threat. According to the Medical Research Council of South Africa, 40% of deaths of children under the age of five years are directly attributable to HIV/AIDS, and common, preventable poverty-related conditions, such as diarrhoea, pneumonia and trauma, remain major child killers.

On the one end of the spectrum of childhood, causes of death of very young children are also related to poor maternal health and inadequate provision of services. On the other end, deaths of older children and adolescents are caused by accidents, homicide and suicide, much of which is related to risk-taking behaviour. Currently the system for collecting and reporting on child deaths is sub-optimal. However, the Children's Institute has initiated research towards hosting a national enquiry into child deaths with a view to developing a systematic approach to this national crisis.

Every child has a right to survival, development, protection, and participation.

Section 28, South African Constitution

Right to development

In the past decade, the government and civil society have achieved much to ensure the child's right to development. For example, the State has committed itself to ensuring access to basic education for all. However, the delivery of quality education remains unfulfilled. And while it is well known that the early years represent the critical period during which stimulation and care of the very young are vital in terms of ensuring their survival, nutrition and development, this area of responsibility falls between several government departments, with no over-arching co-ordinating framework of policies, norms and standards for the provision of education. In this setting, the major responsibility for delivery of early childhood development programmes and services is left in the hands of NGOs and community-based organisations (CBOs), many of which are inadequately resourced.

Right to protection

Children's rights to protection from physical, emotional, social and environmental assaults are still under threat despite some positive developments in this area. For example, South Africa is a world leader in tobacco control, resulting in stringent legislation to protect children from both active and passive forms of smoking. This is one example of the extent to which the right of children to be protected from adverse environmental conditions has been implemented.

Yet children remain vulnerable to other forms of abuse, and the violence pervading South African society manifests in injury and death of children. The Medical Research Council of South Africa has found that injury by firearms or other blunt objects to children under 15 years resulted in 10% of deaths in 2003. Carol Bower, director of the Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN), estimates that 400 – 500 thousand children are sexually abused every year (personal communication to the author). This violation of children's rights to protection occurs in a setting of poverty, endemic violence and fragile family dynamics. A lack of safe care for young children and of recreational care for those of school-going age result in children being exposed to preventable injury. And, while corporal punishment in schools has been outlawed, there is no protection for children in their own homes where violence against them is perpetrated by adult caregivers due to inadequate preparation for parenthood and a failure to understand children's developmental needs and capabilities.

Right to participation

So far, children's rights to participation have received least attention globally, although these rights address the very heart of the notion of children's citizenship. The CRC acknowledges a child's evolving developmental capabilities, and also emphasises the child's right to have a voice, to be heard and – most importantly – to be taken seriously.

South Africa has been at the forefront of action regarding children's rights to participation. More than a decade ago, NGOs convened a children's summit where children from across the country expressed their concerns about rights violations and made a series of suggestions for redress. More recently, children were given the opportunity to make presentations in Parliament. (See *Part 2: Heroes in the context of vulnerability: The participation of children in the Children's Bill.*) While these efforts towards greater child participation in decision-making are commendable, the responsibility for

giving children a voice extends all the way from Parliament into the home, where traditional practices, the interpretation of religious texts and power relations often mitigate against the realisation of this right.

Children's realities: The unfinished agenda

Eleven years is a short time in which to reverse the legacy of decades of inequity and uneven distribution of wealth and resources. During this time, several factors in the national and global environments further aggravated the circumstances of children and diluted efforts to address their realities.

The HIV/AIDS pandemic is first among these factors that are standing in the way of the realisation of child rights. This is well illustrated in *Part 2: Children and antiretroviral roll-out: Towards a comprehensive approach*, which reflects on the health needs of children infected with HIV and the related challenges of prevention and treatment. It also shows us that the pandemic extends way beyond infections as it impacts on the vast number of children who are affected by the ill health of their caregivers, whose ability to care for them is compromised. In this setting, roles are reversed as children become caregivers of those sick and dying adults who are normally charged with their care, with serious consequences. The end result is that huge responsibilities are placed on a range of duty-bearers who must make adequate provision for these children's needs while the caregivers are alive, and also after they have died.

Of equal concern is the second major obstacle to the realisation of child rights, which is the on-going income inequality and widespread poverty that prevail in South Africa. Unemployment remains a barrier to the development of all South Africans. Statistics South Africa, in using the expanded definition of unemployment, estimates that 41% of the economically active population were unemployed in 2004. In her paper, *Earnings inequality in South Africa, 1995 – 1998*, Budlender points out the stark racial inequalities in the distribution of individual and household income, with half of all Black individuals living in households with no income, compared to 36% of White individuals. This is confirmed in the *Human Development Report 2005*, published by the United Nations Development Programme, which reports a Gini coefficient of 57.8% in 2003, which indicates an unacceptably high income inequality.

The Gini coefficient reflects the gap between the rich and the poor. It is a measure of income or other forms of inequality, where 0 represents perfect equality and 1 represents perfect inequality. The number is expressed as a percentage.

The impact of poverty is disastrous for children. Statistics for 2004 show that 11,905,147 (66%) children were living in poverty in South Africa, and that this number is increasing. The effect of this on children manifests in malnutrition, poor growth and increased vulnerability to diseases, all of which compromise children's capacity to develop their full potential.

The State has established a number of poverty alleviation strategies aimed at addressing income, household security and access to basic services. The State's intentions for children, complemented by the efforts of NGOs, faith-based organisations (FBOs) and CBOs, are admirable. Yet, despite these measures, there is a long way to go before the socio-economic rights of children who live in poverty are realised.

The road ahead

The promises of the last decade have had many positive impacts on children and much has been achieved, but there is still a long road to the full realisation of their rights. Decades of inequity have left us with a range of child circumstances on which all duty-bearers are obliged to act. Our journey has been paved with good intentions and we have made significant progress in relation to our commitments to children. But there are several factors which will influence both the pace and the direction of future plans and actions, and progress is likely to be slow.

South Africa's entry into the global community has placed an obligation on the country to comply with the requirements of several international treaties, such as the CRC, and with global plans, such as the Millennium Development Goals (MDGs). This has helped to fast track the formal adoption of some of these treaties, such as the CRC, which the government ratified in the first year of democracy. Yet there are also some disadvantages to entering the global community. For example, while the Millennium Development Goals embody a vision linking poverty reduction, development, rights, peace and security, its goals are a technical formulation to address

issues which are fundamentally political. While all of the goals are child-related, they are time bound, not framed in equity-sensitive terms, and emphasise health and development without taking a comprehensive, sector-wide approach to the full spectrum of child rights.

Millennium Development Goals

- **Eradicate extreme poverty and hunger**
- **Achieve universal primary education**
- **Promote gender equality**
- **Reduce child mortality**
- **Improve maternal health**
- **Combat HIV/AIDS, malaria and other diseases**
- **Ensure environmental sustainability**
- **Develop a global partnership for development**

At a national level, the task of redressing decades of economic and social inequity cannot be accomplished overnight. Over the next decade Parliament plans to shift its focus from legislation to increasing opportunities for public participation. This is complemented by the government's commitment to pay greater attention to the implementation of services.

This shift holds tremendous promise for on-the-ground actions in favour of children and provides an even greater opportunity for all duty-bearers to accelerate their efforts to honour the 'first call' for South Africa's children. And, in recognition of children as an important constituency in South African civil society and, with very explicit socio-economic and political rights, it gives children a chance to engage with seats of power to make their voices heard – and be taken seriously.

The *South African Child Gauge* is one channel through which this journey towards the comprehensive realisation of children's rights will be documented in future. It will also serve as a platform for the monitoring of the policy environment and the status of children in terms of their health, living conditions and access to services, and therefore, their dignity.

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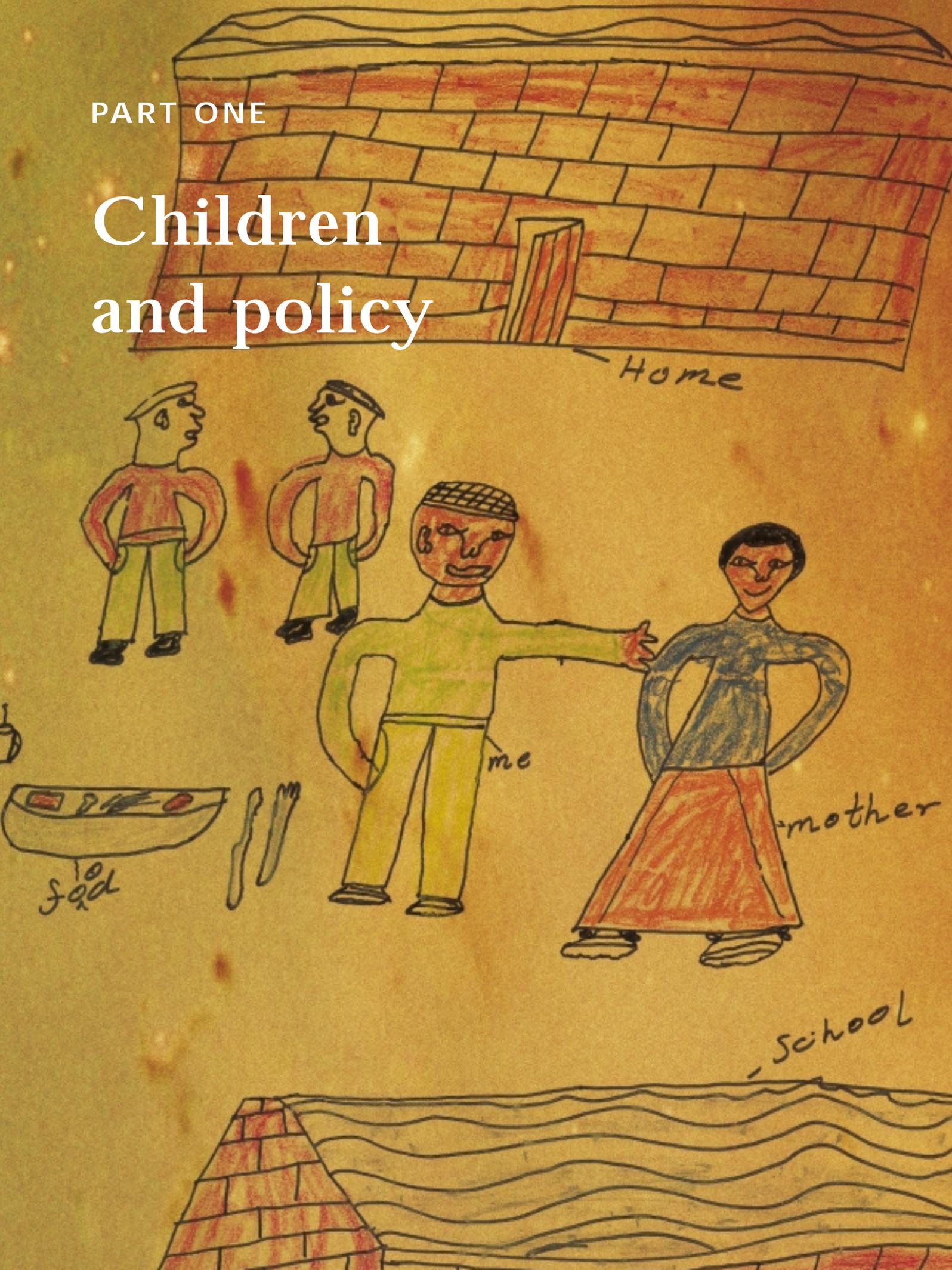
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PART ONE

Children and policy



Legislative developments 2004 and 2005

Paula Proudlock (Children's Institute)



In reflecting on recent child law reform developments, there is no doubt that the Children's Bill dominated the agenda during 2004 and 2005. This Bill is aimed at providing a legal framework for the realisation of children's rights in terms of family care, protection from abuse and neglect, social services, and legal representation in civil matters. It is also concerned with elaborating on the principle of the 'best interests of the child' and with promoting substantive equality for groups of children in especially difficult circumstances, such as children with disabilities. Apart from the Children's Bill, there has also recently been much other activity in the area of law reform that affects children.

This section focuses on the following questions:

- What is the current status of the Children's Bill?
- What does the Children's Bill focus on?
- What problem areas should still be addressed by the Children's Bill?
- What other new laws have major implications for children?
- What are our conclusions?

What is the current status of the Children's Bill?

The process of drafting a new Children's Act began in 1996 and it is now in its final stages. The first part of the Children's Bill, which was passed by the National Assembly (NA) in June 2005, deals with areas over which the national government has exclusive competence. It introduces provisions and systems that will greatly advance South Africa's capacity to care for and protect children. Thus, the Children's Bill Working Group, a national network of umbrella organisations working with children, celebrated when the NA passed the first part of the Bill, as it was seen as a major milestone for South Africa in the struggle to protect children from abuse and neglect.

This first part of the Bill is now being debated by the National Council of Provinces (NCOP). Once the NCOP has finished its deliberations on this part of the Bill, the second part of the Bill will be tabled in Parliament. This second part deals with issues where the national and provincial governments share competency. The earliest we can expect the second part of the Bill to be tabled in Parliament is March 2006 and it will take Parliament another year from the date of tabling to complete its deliberations on it. We can anticipate that the new law will be put into effect in late 2007 or early in 2008.

What does the Children's Bill focus on?

It is aimed at giving effect to constitutional rights to protection, social services and family care

To give effect to rights, the government needs to adopt laws, policies and programmes. To ensure their full realisation, each right in the Constitution needs to be supported by a law. All the chapters in the Children's Bill are aimed at giving effect to and realising the following three very important children's rights:

- The right to family care, parental care or appropriate alternative care.
- The right to social services.
- The right to protection from abuse, neglect, maltreatment and degradation.

All the chapters in the Children's Bill also emphasise the core international and constitutional principle that, in every matter affecting a child, the child's best interests should be the main consideration. This is an important development because the Children's Bill will eventually replace the 1983 Child Care Act, which was not written from a child rights perspective. It was written by the apartheid government at a time when South Africa did not have a Bill of Rights, or a democracy. It therefore did not take into account key concepts such as equality for all children, equality for parents regardless of their gender, and the principle of the best interests of the child.

It promotes equal opportunity and protection for children with disability

Children with disability are more likely to be abused and neglected than other children. This is, firstly, because of their increased vulnerability to abuse as a result of their disability. Secondly, this is because the child protection system has many barriers restricting equal access for children with disability and so does not adequately protect children. The Children's Bill says that these barriers must be removed and that the necessary support services must be provided to enable children with disability to have equal opportunities and equal access to protection.

It obliges all government departments to deliver services to children in an integrated, co-ordinated and uniform manner

Protecting children from abuse and neglect is a task that involves at least seven different government departments at the national, provincial and local spheres of government. At present, a major problem affecting the protection system is the lack of co-ordination between all the different departments and spheres of government. As a result, many children are not protected and many suffer secondary trauma when they are placed in the system. Recently, two High Court judgments ordered the different government departments involved to sit down together and jointly plan their services for children.

In recognising this problem of a lack of co-ordination between different departments and spheres of government, the Bill contains two clauses that strongly oblige all role players to co-ordinate their services to ensure integrated service delivery to children and to co-operate with one another. Although the actual mechanism to ensure co-ordination is not stipulated in the Bill, it could be set out in the regulations.

It obliges all departments to “take reasonable measures to the maximum extent of their available resources to achieve the realisation of the Act”

In Section 4 of the Bill the words ‘maximum extent’ have been included before ‘available resources’. This is a major victory for children. It means that all departments need to prioritise children when they are making decisions about budgets and the allocation of resources. These words come from Article 4 of the United Nations Convention on the Rights of the Child and are aimed at ensuring that children’s issues are prioritised in budget decisions.

It carefully regulates adoption and inter-country adoption

The Bill closes the loophole on backdoor inter-country adoptions. It streamlines adoption processes and provides adequate protection for children involved. Now any application for guardianship or the right to remove a child from the country will be regarded as an inter-country adoption and will have to go through a well-regulated procedure.

This is a particularly important provision as it protects orphaned children and those living in unregistered children’s homes from being removed from the country without the proper procedures being followed. Many of these children have relatives who are available to care for them. However, these relatives are not approached or supported with financial aid to enable them to care for these children. With this support these children would not have to be removed from their place of birth, cultural identity and family ties.

The Bill also makes it clear that the adopting parents may not pay the biological mother compensation for loss of earnings. This removes a possible form of unfair incentive that could be used to put pressure on the mother to give her consent to the adoption of her child.

What problem areas should still be addressed by the Children’s Bill?

On the whole, the Children’s Bill is a major step forward for children in South Africa, but there are still a few problem areas that should be addressed. One of these areas is protecting the property rights of orphans. When children’s parents or

caregivers die, leaving them with a house or a shack, the children need assistance to protect their property rights from unscrupulous people. Children cannot own a house or conclude contracts related to house ownership because of their age. Therefore, they need an adult to represent them and protect their property rights. If the children have a living parent, the parent normally provides this protection. If the children have been orphaned and are living with a relative, such as a granny or an aunt, it is important that the relative has the necessary legal status to protect the children’s property.

Unfortunately, the Bill does not allow magistrates’ courts to grant guardianship to relatives. This means relatives will need to go to the High Court to obtain guardianship over the children so that they can protect the children’s right to their inherited property. The High Court is inaccessible to most families, as it is located far away from most people, and the process involves a considerable amount of expenses. An accessible solution still needs to be found in this regard.

What other new laws have major implications for children?

Sexual Offences Bill and Child Justice Bill

Other new laws that are in draft form and waiting for tabling in Parliament are the Sexual Offences and Child Justice Bills. Public hearings on these two Bills were held in 2003 in Parliament shortly before the 2004 general elections. However, both Bills were withdrawn from Parliament in 2004 and taken back to Cabinet for revisions. The current Parliament will need to call for a second round of parliamentary hearings before deliberating and passing the Bills. Both these Bills are way overdue and need to be prioritised.

Social Assistance Act and the National Health Act

The new Social Assistance Act 13 of 2004 and the National Health Act 61 of 2003 were both passed in late 2003 and signed and assented to by the President. However, neither of the laws have been put into effect as their regulations are still being finalised.

The 2004 Social Assistance Act replaces the Social Assistance Act of 1992 and provides a new legislative framework for the realisation of the right to social security. It stipulates the

eligibility criteria and procedures for gaining access to social grants for the elderly (Old Age Pension), children living in poverty (Child Support Grant), people with disabilities (Care Dependency Grant and Disability Grant), children in need of foster care (Foster Care Grant), and people in social distress (Social Relief of Distress Grant).

None of these grants are new. They were all present under the 1992 Social Assistance Act and there are no substantive changes to the eligibility criteria. The main reason for the amendment to the 1992 Act was to remove the social security function from the provinces and allocate it to the national government. This was done to improve implementation and financial control over the State's biggest poverty alleviation programme. We will only be able to evaluate whether this shift has achieved the desired improvements in the administration of these grants once the new law is fully in effect and the new Social Security Agency has begun its operations.

In its preamble and in its objects clause, the National Health Act says that it is aimed at giving effect to children's rights to basic health care and basic nutrition. However, this intention is not followed through in the rest of the Act as it does not entrench an approach that gives priority to children within the health system. The Children's Bill does not contain any provisions on nutrition and health care either, other than stipulating ages of consent for medical treatment. In light of South Africa's unacceptably high infant mortality and child death rates we need a focused approach to children's health care services. Many child health providers and policy experts are now calling for a new law on child health services in order to prioritise child health.

What are our conclusions?

It is now over 10 years since South Africa became a democracy, which is underwritten by a Bill of Rights that demands priority attention for children. Legislative reform for children is now on the agenda. However, the 'honeymoon' period of the new democracy is over and a concern about insufficient budget is dominating many of the child law reform debates. It is therefore a pity that, compared to other areas of law reform, child law reform has taken so long to get off the ground.

However, on the positive side, there is a strong and vocal children's sector within civil society and a growing awareness amongst government decision-makers of the extent and nature of the challenges facing children. The result is a committed drive from both government and civil society for efficient solutions that can be implemented.

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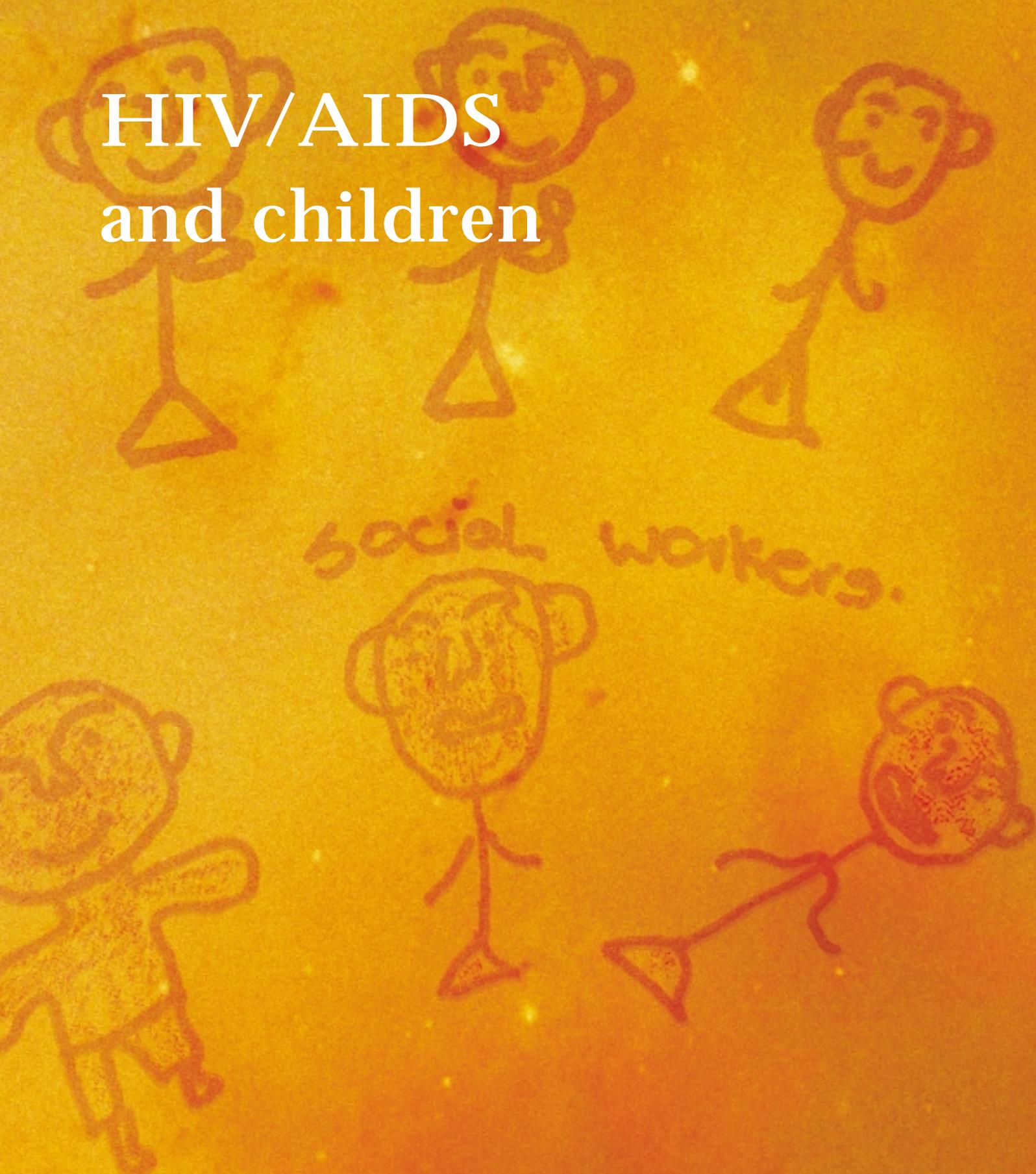
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PART TWO

hospice

HIV/AIDS and children

social workers.



Introduction



According to the *General Household Survey 2004*, there are just over 18 million children living in South Africa. Of these, 260,000 children under the age of 15 years are HIV infected, making it the fastest growing chronic infectious disease amongst children. Research indicates that this figure is growing. The Actuarial Society of South Africa estimates that, in 2000, the rate of HIV infection amongst children was 1.0% and it almost doubled to 1.7% in 2005. The infection rate, as well as the infection growth, is much higher in children under five compared to older children – thus requiring greater efforts to reduce the transmission of HIV from mothers to their children. While these statistics only focus on infected children, many more are affected by the HIV/AIDS pandemic – therefore highlighting the need for a holistic and comprehensive response across all levels of government and civil society.

It is against this background that the emphasis of this first edition of the *South African Child Gauge* is on children in the context of the HIV/AIDS pandemic in South Africa. While there are numerous critical issues that could have been highlighted, the issues featured in this edition are those that have most recently received significant attention from both the government and civil society. These issues are also the focus of research at the Children's Institute, which has enabled us to draw on the most recent data and work in these areas. The four issues discussed in this section are: antiretroviral (ARV) roll-out for children; social security for children in the context of HIV/AIDS; the transformation of schools to be nodes of care and support for vulnerable children; and the involvement of children as active participants in law-making processes that affect them.

The first section, *Children and antiretroviral roll-out: Towards a comprehensive approach*, critically analyses the South African government's *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*. It is

argued in this section that firstly, the plan does not adequately address children's general health rights and needs; and secondly, it does not meet the specific health needs of children with HIV. The authors call for the implementation of a more holistic and comprehensive approach for children infected with HIV (beyond simply administering ARVs) and for the widening of the parameters of care at policy, service delivery and advocacy levels.

The second section, *Social security for children in the time of HIV/AIDS: The (mis)use of foster care?* argues that the most equitable, accessible and appropriate mechanism for supporting children in the context of the AIDS pandemic would be through the extension of the Child Support Grant to all children and for the removal of the means test that restricts children's access to grants. The authors recommend that more children be brought into the social security 'safety net' not only on the basis of their orphan status but rather on the basis of their poverty levels and need.

Schools as nodes of care and support for children affected by HIV, AIDS and poverty examines the role that schools can play as a vehicle of service delivery to vulnerable children. This section calls for increased collaboration between different sectors and service providers; the mainstreaming of services to meet the needs of those most affected; and the integration of service delivery at the school site.

The final section, *Heroes in the context of vulnerability: The participation of children in the Children's Bill*, reminds us of the importance of facilitating children's rights to participate in processes that affect them, especially in the context of poverty and HIV/AIDS. The lessons learnt from the *Dikwankwetla* project reinforce children's agency and their abilities to participate in law-making processes, and show how this, in turn, assists law-makers to make informed decisions.

Children and antiretroviral roll-out: Towards a comprehensive approach

Maylene Shung-King (Children's Institute) and Paul Roux (School of Child and Adolescent Health, University of Cape Town)



In November 2003 the South African government, represented by the Department of Health, approved an *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*. This plan addresses a range of health issues for adults and children living with HIV and/or AIDS, including implementing the roll-out of antiretrovirals (ARVs) to those who meet certain criteria.

An ideal plan for the comprehensive care, management and treatment of HIV and AIDS must meet all the needs of affected persons. In order to assess whether the South African plan satisfies this onerous requirement, we first need to consider the world in which HIV-positive and HIV-affected children live. This section starts by briefly describing the circumstances of children – worldwide, in Africa and in South Africa. We show the close linkage between poverty and ill-health in general and indicate the specific interrelationships between poverty, malnutrition, HIV and AIDS. We consider lessons learnt from the ARV roll-out elsewhere in Africa. We then examine the South African government's national plan and make certain recommendations for action.

This section focuses on the following questions:

- What do we know about children, poverty and HIV infection?
- What constitutes the vicious cycle of poverty and HIV/AIDS?
- How do we reduce the occurrence of HIV infection in young children?
- What are the specific health needs of children with HIV infection?
- What are the considerations for ensuring adequate access to ARVs?
- What are some obstacles to accessing ARV treatment?
- What is the South African government's response to the health care needs of children with HIV infection?
- What key areas in the comprehensive plan need review?
- What is currently happening in South Africa with the ARV roll-out as it relates to children?
- What are the key concerns regarding current ARV provision to children?
- What are our recommendations?

What do we know about children, poverty and HIV infection?

Poverty throughout the world

There are about 2.2 billion children in the world. About 1 billion of these children live in poverty:

- 640 million children do not have adequate shelter;
- 500 million children do not have access to sanitation;
- 400 million children do not have access to safe water;
- 90 million children are severely deprived of food;
- 270 million children do not have access to health care services, or have access to ineffective services.

HIV/AIDS throughout the world and in Africa

By 2004:

- 42 million people throughout the world were living with HIV; 6.3 million of these people were newly infected;
- 20 million people had died of AIDS; 4 million of these were children.

During 2004, half a million children throughout the world became infected with HIV. Currently, 2.2 million African children are living with HIV and/or AIDS.

HIV/AIDS in South Africa

According to a 2004 report by the Medical Research Council of South Africa:

- Just over 5 million South Africans out of a total of 46 million were HIV positive. It is estimated that 500,000 of these people were sick and in need of ARVs.
- About 245,000 children were infected with HIV. It is estimated that 50,000 of these children were sick and needed access to treatment.
- Some 37,000 children were infected with HIV at or around birth (this is called vertical transmission) and 26,000 were infected through breastfeeding.
- Between a quarter to a third of those children who were vertically infected died before they reached one year of age.
- Only about two-thirds of HIV-infected infants survive into early childhood.

What constitutes the vicious cycle of poverty and HIV/AIDS?

There are many factors that result in, and complicate, the HIV pandemic and its consequences. One of the most critical factors is poverty.

Poverty deepens the effects of HIV/AIDS on households and HIV/AIDS in turn aggravates already existing poverty. In urban areas, affected households with at least one person living with HIV or AIDS experience a serious drop in household income. In rural communities, agricultural activity and output decrease. In general, households directly affected by the pandemic are poorer than those not directly affected.

In South Africa we have a double crisis because the rate of HIV infection is rising alongside a rising unemployment rate. There is a growing gap between the employed and the unemployed. Research by Professor Nicoli Nattrass at the University of Cape Town shows that, in certain areas, 73% of adults in HIV-affected households receive a Disability Grant. These grants make up 56% of the total income of these households. HIV-positive adults qualify for a Disability Grant when their CD4+ counts fall below 200 (established through a blood test that indicates the extent to which HIV has damaged the body's immune system).

With the national ARV roll-out, more and more adults will gain access to ARVs and their health status will improve. This will result in their Disability Grants being cancelled because the current system of grants assumes that adults will gain employment once their illness is under control. This is of course not true in a situation where unemployment figures are so high and, therefore, improved health does not guarantee that the HIV-positive adult will find work. Thus, the adult with access to ARVs faces a future of poverty. This is a disincentive to adherence to ARVs and, should the person lose the grant, future poverty is likely to lead to future disease.

Malnutrition and HIV/AIDS: A further spiral in the vicious cycle

Poverty and malnutrition are intertwined and both affect child survival. In developing countries, improved nutrition is both a humanitarian and an economic priority. A sustainable reduction in poverty requires political will, stability and economic policies that focus on creating employment. This is a long, slow process and there is no guarantee that it will adequately improve the income of the poorest. So there is also a need for other, more

immediate interventions which focus on living conditions and which specifically take children into account.

Throughout Africa the following short-term strategies are being trialed:

- School-based feeding programmes which target school-age children.
- Subsidies on basic commodities, like food and services, including the provision of clean water, power supply and agricultural inputs.
- Providing children with nutritional supplements, such as Vitamin A, selenium, zinc and other 'alternative' food supplements.
- Creating employment opportunities, which is particularly important for women who bear much of the burden of food provision and for the care of orphans and HIV-affected family members.

Generally, the most effective strategies and policies are those which help individual families to access food and financial aid, preferably through job creation.

Given that HIV/AIDS is compounding the general ill-health effects of poverty, it is important to reflect on what the comprehensive health care needs are of children with HIV infection. In the light of the devastating effects of HIV/AIDS, the first priority – and the most significant response – is the prevention of childhood HIV infection. There are many mechanisms for preventing the disease in adults, but we need to look at how to prevent the disease in young children when adults have already contracted HIV.

How do we reduce the occurrence of HIV infection in young children?

Around the world, almost two-thirds of new infections that occur in children are through mother-to-child transmission (MTCT). It therefore makes sense to target MTCT as the first area of prevention. Interventions to reduce MTCT infection depend on a readily accessible health care system and an efficient and friendly prevention of mother-to-child transmission (PMTCT) programme.

In some smaller rural communities where the risk of infection amongst women runs high, women do not readily go for voluntary counselling and testing because of the fear of stigma. There is an urgent need for a focused drive to help pregnant

women counter the fear of stigma and to emphasise the benefits of PMTCT to the next generation.

Although more and more pregnant women are being tested for HIV, the rate of testing is overall not at its optimum. This means that many opportunities for prevention of MTCT are missed because HIV infection remains undetected and women and their infants do not receive PMTCT. The result is that large numbers of children will continue to be infected at the time of birth.

What are the specific health needs of children with HIV infection?

Where children do contract HIV, it is important to understand what responses are required to address their health needs best.

Children with HIV infection have the same general health needs as children without HIV infection. In addition to their general health needs, they also have a range of needs that are specific to being HIV infected. In addition, the HIV infection makes their general health needs more complex and varied.

Nutrition: The majority of children in South Africa live in extreme poverty and are malnourished. Malnutrition in HIV-infected children can speed up the progression to AIDS. Therefore an effective intervention must include food- and nutrition-based programmes for HIV-infected children and their families. It also needs to be responsive to the nutritional status of HIV-infected children, which changes as they gain access to ARVs. For example, the Paediatric HIV/AIDS Service at Groote Schuur Hospital in Cape Town has noted that, before starting ARVs, 40% of children who attended the clinic weighed far below the average for their age as opposed to those children receiving ARVs, of whom fewer than 4% were underweight for their age. They concluded that this was the result of a combination of interventions including the national feeding scheme for under-weight children, a comprehensive health care package, access to available grants (including Disability Grants), and an NGO-driven income generation project for mothers and caregivers.

Medication: Children with HIV infection need preventive and treatment medicines for HIV-related infections, including access to ARVs. Medication with ARVs requires an infrastructure to manage screening, to monitor treatment, side effects and adverse events – including the development of resistance – and to promote adherence.

Education: Adherence support requires ongoing patient and caregiver education. Life-skills programmes must be in place to support children before and after their caregivers disclose their HIV status to them.

Palliative or home-based care: Families infected and affected by HIV need support in coping with comfort care, end-of-life care, estate planning and other matters related to death and dying.

Preventive services: Pre-school children with HIV and AIDS also need routine preventive services, including vaccinations. They need ready access to dental care, as they are prone to dental caries and periodontal disease.

Psychosocial support: Children who are HIV infected have specific emotional, psychological and social needs. These include help with pre-test counselling for HIV testing, disclosure of the

diagnosis to the child, disclosure to others, and adherence support. School-going children need support in dealing with the side-effects of drugs, absence from school for health care visits and possible stigmatisation by peers. Life-skills programmes and support groups are useful adjuncts to individual counselling.

Care for children experiencing orphanhood: There is an increasing number of children who are experiencing orphanhood due to HIV/AIDS, who live with terminally ill parents, primary caregivers or elderly relatives, or who live on their own. These children need special help in accessing adequate health care services.

Bearing in mind these comprehensive health needs of children, the table below outlines a model for a comprehensive health service response that is child-specific and child-orientated, and capable of meeting the needs of children with HIV infection.

Table 1: A proposed comprehensive service for children with HIV infection

Comprehensive health care includes care that covers a range of health needs	General needs of children	Specific needs of children with HIV infection
Health promotion	This refers to all efforts to promote good health in all children and their families through health facilities, the school health system, and other interventions.	This includes: <ul style="list-style-type: none"> ■ primary prevention; ■ prevention of disease progression; ■ nutritional support and advice; ■ voluntary counselling and testing services; and ■ specially trained counsellors for children and adolescents.
Primary prevention	This refers to: <ul style="list-style-type: none"> ■ all preventive programmes aimed at young children, including immunisation, developmental screening and growth monitoring and nutritional support; and ■ specific services for adolescents that are essential, such as adolescent-friendly clinics. 	This includes interventions such as: <ul style="list-style-type: none"> ■ the prevention of MTCT; ■ post-exposure prophylaxis (ARVs for children who have been sexually abused and are at risk of HIV infection); and ■ specific adolescent-friendly services and school-based programmes relating to the prevention of HIV.

Comprehensive health care includes care that covers a range of health needs		
	General needs of children	Specific needs of children with HIV infection
Secondary prevention	This refers to measures that prevent an existing condition from getting worse.	This includes interventions such as: <ul style="list-style-type: none"> ■ access to ARVs; ■ prevention of opportunistic infections such as Pneumocystic Pneumonia, commonly known as Pneumocystic Carinii Pneumonia (PCP), TB, etc.; and ■ nutritional support.
Curative care	This includes: <ul style="list-style-type: none"> ■ intensive treatment for conditions not specifically related to their HIV infection; ■ critical care services for all children that experience life-threatening acute illnesses; ■ ongoing and continuous care services; ■ supportive services for adolescents; ■ a good referral network so that children can be referred up or down levels of care; ■ clear communication between health professionals at different facilities and levels; and ■ patient-held records detailing relevant information. 	This includes: <ul style="list-style-type: none"> ■ treatment of opportunistic infections, such as TB, pneumonia and gastroenteritis; ■ other disease-specific interventions; ■ the whole range of health services available for children with any other chronic health condition; ■ adolescent-friendly services and adult health care services that can respond to their physical, emotional and psychological needs; and ■ solid and well-structured networks that help achieve patient confidence and ensure continuity of care. Inconsistent and unreliable services will result in poor adherence to ARVs. Ideally every child on ARVs and his/her parents/caregivers should have a healthy and supportive relationship with the multidisciplinary 'team'.
Palliative or home-based care and support	This refers to care that makes children as comfortable as possible when they reach their terminal illness.	Children and their families with end-stage AIDS require ongoing terminal care and support at home.
Support to parents/caregivers of children	Parents and caregivers of children need support and information on child care, access to appropriate health care and social service support	This includes: <ul style="list-style-type: none"> ■ support in care of HIV-infected infants; ■ support regarding managing confidentiality; ■ liaison with schools; ■ management of their own disease; and ■ HIV-infected parents/caregivers also having access to the necessary treatment for themselves.
Support from other sectors	Intersectoral support from social services, education and other services for orphans, vulnerable children and children living in poverty.	This includes: <ul style="list-style-type: none"> ■ liaison between health care, education, social development, housing, NGOs and CBOs to develop comprehensive care plans for individual school-based programmes for HIV-affected children. ■ The government is still deciding on a specific grant for children that have become care-dependent – those who have reached Stage 3 or 4 of their disease.

What are the considerations for ensuring adequate access to ARVs?

So far we have highlighted the range of health needs of children with HIV infection, and have said that the sole provision of ARVs is not a sufficient response to the pandemic. It is now necessary to reflect on what is required when providing ARVs to children, given that this is an important and complex component of their total care.

The provision of ARVs is complicated. The World Health Organisation and UNAIDS proposed a package of care, prevention and support services that must be in place before ARVs can be introduced. This includes:

- HIV testing and counselling;
- trained and certified staff to prescribe ARVs and to follow up on patients;
- an uninterrupted supply of ARVs;
- a secure and confidential patient record system;
- support to ensure that the patient takes the medication; and
- community mobilisation and education on ARVs.

Although ARVs are available and are becoming more and more affordable, this treatment is often out of reach for the African child. Few African countries have accessible, free ARV programmes that run within their public service health systems. Most sub-Saharan treatment programmes rely on external funding from global agencies and other donors.

A comprehensive health care package can improve child health, prolong life and delay the need for ARVs. Where children enjoy continuous and ongoing access to appropriate health care, mothers begin to change their perceptions of their children – they no longer see them as having a terminal or life-threatening disease, but as having a chronic or long-term illness which can be appropriately managed. Researchers have noticed that mothers play differently with their children when they believe that they have the future they once thought was lost to them. This change in perception has important and holistic effects on the well-being of the child.

An inadequate health care infrastructure, which lacks a comprehensive health care package, has a critical and costly affect on the child and the family. The health of each affected child deteriorates more rapidly and children die sooner. This is the case in Africa, as already inadequate resources are being stretched to breaking point by the new, great and intensive demand imposed by the HIV/AIDS pandemic.

For children who do need ARVs, access to this medication improves their health and quality of life and reduces the need for costly in-patient hospital care. This will enable hospitals to use their resources more efficiently because children on ARVs need fewer and shorter admissions. Beds are therefore more freely available to all acutely ill children whether or not they are HIV infected.

Furthermore, treatment sites must be improved to get the best out of existing facilities, systems of care and patient flow to ARV treatment. This will ensure that the maximum number of infected children gain access to ongoing and appropriate care, closer to their homes. Many initiatives in Africa are helping treatment sites to improve their systems of care through operational research, bottom-up improvement of systems, collaborative networks, local ownership and transfer of knowledge.

What are some obstacles to accessing ARV treatment?

Screening children's need for ARV treatment

At present, in South Africa, children with HIV and AIDS are only being identified once they have already fallen seriously ill. This situation could be improved by early diagnosis of the infection in children who are suspected to have HIV, and by instituting appropriate preventative and therapeutic management early on in the course of illness. Much of this work will fall to nurses in community health centres. At present, many nurses are uncertain of their skills and abilities to perform this screening and unsure of how to refer suspected cases for further management.

Once a child is known to be HIV positive, regular CD4+ counts are necessary to monitor the child's immune status. Taking blood from a child's vein can be technically difficult. There is a need to develop technology that will permit CD4+ counts to be done on blood collected by heel- or finger-prick.

Problems with size, taste, dose of medication

Worldwide, there are obstacles to administering ARVs to children. These include calculating and administering the correct doses of medication, the taste of some ARVs and the lack of a useful range of pill sizes for children. Health workers have had to work out innovative techniques to help children swallow large pills or to help caregivers mask their unpleasant flavours. Ultimately, drug manufacturers need to produce a

range of pill sizes for each of the ARVs that will allow paediatric clinicians to prescribe increasing doses to match the needs of their growing patients.

Adhering to treatment

Adherence to ARV treatment is as good in Africa as anywhere else. The child's adherence depends on the caregiver's commitment. Adherence practices are complex and influenced by many factors. Only some of these factors can be changed through the training and education of caregivers.

It is clear that the death of the mother and joint care from surviving relatives is a threat to adherence. Comprehensive care for the child therefore requires close attention to maternal health. The fact that maternal and child health is so closely linked argues for a family medicine approach to health care for HIV and AIDS.

Poverty too contributes to poor adherence. Adherence to a regular medication schedule requires a well-regulated life. Poverty makes life difficult to regulate.

Children without adult caregivers might find themselves in a difficult position, as the current criteria require children to have at least one responsible adult who cares for them before they are put on the ARV treatment programme. In addition, good adherence in children requires that a motivated caregiver ensures that the child gets his/her medication on a daily basis and in the correct dosage. For children to take this level of responsibility for younger siblings might be difficult, depending on the age of the older children in the household, as well as their living conditions.

Creating partnerships in response to the HIV/AIDS pandemic

NGOs and faith-based organisations (FBOs) carry the bulk of the HIV-related burden in Africa. In the pre-ARV era, organisations such as The AIDS Support Organisation (TASO) in Uganda developed extensive community-based programmes, supporting tens of thousands of families. Other organisations, such as Mildmay – which established a network of hospices in sub-Saharan Africa – contributed to a network of care.

In the era of ARV access, the flexibility and creativity of NGOs have enabled them to establish original and ground-breaking treatment programmes in response to the local, 'grassroots' conditions in which they work. However, the future success of these programmes depends on efficient, sufficient and prompt partnership between these NGOs and government.

Throughout Africa, the public health clinic operates at 'grassroots' level – exactly the place where practice needs to be examined, considered and improved. These clinics can be used to provide comprehensive health care services to caregivers, children and their communities, including training, counselling, life-skills programmes, and other interventions. They can also be used as a venue for partnerships across sectors to initiate appropriate projects to deal with the burdens of poverty and disease. The clinic is also the appropriate platform for research into appropriate vaccine regimens for HIV-positive children, both before and after access to ARVs.

Treatment centres, primary health care services and NGOs need to work together with national governments and international donor organisations to address health care and poverty relief throughout Africa to treat and support children with HIV/AIDS, and to help their caregivers and communities become self-sufficient.

With this in mind, we now focus specifically on the South African government's response to children infected with HIV.

What is the South African government's response to the health care needs of children with HIV infection?

The South African Constitution guarantees all children, including children with HIV infection, the right to basic health care and basic health care services. These rights are also found in various international documents and treaties to which South Africa is a party.

The government's plan for the comprehensive care, management and treatment for HIV and AIDS focuses narrowly on the roll-out of ARV treatment. It does not particularly focus on children or consider children's comprehensive health needs. However, the government has commissioned guidelines that provide much more specific direction for the comprehensive management of HIV-infected children. These guidelines will supplement the ARV roll-out plan. The task team that developed the guidelines was co-ordinated by Dr Tammy Meyers and is referred to as the 'Meyers guidelines' for the purposes of this article. Our critique of the government's current plan thus incorporates a critique of the Meyers guidelines.

What key areas in the comprehensive plan need review?

Child-oriented counselling and testing

The government's national plan says that prevention counselling, as well as voluntary counselling and testing (VCT) should be available. The plan does not recognise that in most cases parents are not disclosing the diagnosis of HIV and AIDS to the child. The plan does not include a provision for life-skills programmes for such children to prepare them for disclosure, nor does it provide guidelines to prepare families to make the disclosure to the child. The plan does not say how the specific counselling needs of children with HIV infection should be addressed. Counselling for children needs to be age-appropriate and counsellors need specific training on how to cope with children that are old enough to understand issues related to their HIV status.

Research conducted by the Children's Institute at six sites across five provinces in South Africa found that health workers and counsellors are not comfortable in counselling and supporting children. This is a crucial part of holistic care of HIV-infected children and needs to be addressed urgently. The government needs to develop clear guidelines on when and how children should be counselled about issues such as HIV status, disclosure and confidentiality.

The national plan sets out specific directions on when to test and which tests to use for children. The complexities around HIV testing in young babies and children are inadequately covered. This is addressed more comprehensively in the Meyers guidelines, which hopefully will be taken into consideration at ARV sites.

The plan also does not give direction on how to address HIV diagnosis where children have no adult caregivers; in homeless children; or where children are in informal care where no one has the legal authority to give consent on their behalf.

ARV provision

The plan clearly outlines the different medicines available to treat children but is less clear on the specific difficulties of diagnosing HIV in children. It recommends that there must be "at least one responsible person capable of administering the child's medication", but it does not take into account how difficult this can be. No mention is made of the special considerations that need to be taken into account when preparing and providing ARVs to children. For example, no

attention is paid to trying to make medicines for children less complex to take so that adherence is easier; or to the need to develop drugs that do not rely on fridges for storage, especially in a country where large sections of the population do not have access to electricity.

Monitoring of children on ARVs

Children on ARVs need regular monitoring of varying kinds, for example monitoring of the HIV disease, of the safety of the ARVs, of their growth and development while on treatment, of how drug dosages need to be adjusted as they grow and develop, and of adverse drug side effects, amongst others. The plan does not give specific attention to these issues.

Drug availability

The plan implies that ARVs – and medicines to treat general infections, opportunistic infections and HIV-related complications – must be available at specific facilities. However it does not recognise the complexities of administering and storing some of the drugs.

Staff and human resources

One of the greatest challenges for ARV roll-out to children is to ensure that there are enough appropriately trained staff. The plan does consider the need for health workers to be trained on how to manage children on ARVs. It focuses narrowly on staff training in dealing with the medical aspects only. The Meyers guidelines, on the other hand, recommend that health workers at all levels must have more holistic knowledge and experience to ensure that children's comprehensive health care needs are met. However, both the plan and the Meyers guidelines do not adequately consider the need for other 'players' to be involved in the multidisciplinary team beyond the formal health sector – the need for CBOs and FBOs, lay counsellors, schools, amongst others.

Roles of different levels of care, referral and continuity of care

The plan clearly outlines the roles and responsibilities of the different levels of care. However it does not discuss co-ordination between ARV services for children and other relevant policies and services, such as services to children with other chronic conditions. There is an urgent need for collaboration and co-ordination within the Department of Health, between

other government departments, and between other sectors that impact on children with HIV infection.

Adherence – making sure the drugs are taken

The plan looks at the area of adherence from the point of view of the patient being able to take responsibility for his or her own adherence. It does not address children who need to rely on adults to help them with their adherence. Good adherence can be promoted by ensuring consistent support of children with HIV infection and their families/caregivers and ensuring continuity of care. Ideally, every child on ARVs and his/her caregiver should develop a healthy relationship with a specific care-providing team. This team should be led by a health worker who would be responsible for co-ordinating and monitoring the ARVs and the interdisciplinary services at all levels of health care.

From the discussion above it is clear that the plan does give consideration to children. However, this is done in a medical and technical manner and does not adequately consider the comprehensive needs of children. Two key interventions that are not adequately addressed are reducing HIV infection in adults and the prevention of mother-to-child transmissions. Both these interventions would have the greatest effect on reducing HIV in children.

What is currently happening in South Africa with the ARV roll-out as it relates to children?

ARV roll-out is taking place much slower than anticipated by the government. There are far fewer sites providing ARVs for children than for adults. Recent figures released by the Treatment Action Campaign in June 2005 indicate that close to 5,000 children are on treatment, while it is estimated that at least 50,000 children are in need of treatment. This means that only about 10% of children currently requiring treatment are getting it. This figure varies greatly from province to province, with some provinces having less than 1% and others having close to 17% of children on treatment. Most of the sites where children are on treatment are donor-funded. It seems that the major barrier to implementation is that ARVs for children are not available in some parts of the country. However, research and evaluation needs to be done to identify the exact problems with implementation.

What are the key concerns regarding current ARV provision to children?

ARV roll-out is a complex and long-term intervention which needs a well-functioning service infrastructure at all levels. At present, service providers at different levels of care have identified a number of problems at treatment sites which are creating a barrier to roll-out, such as:

General service capacity: Throughout South Africa, there are many paediatric ARV treatment sites and clinics that are trying to identify and enroll infected children and to deliver ARVs to them as fast and as efficiently as possible. Primary level facilities are currently ill-equipped. There are similar concerns about secondary level facilities. There are not enough health care professionals who are trained or skilled in screening and identifying children in need of HIV testing or in providing HIV care and ARVs. Most facilities are understaffed and cannot cope with the large number of patients requiring screening, testing and assessment for ARVs. Starting and managing large numbers of children on ARVs would require a large increase in resources.

Currently, the demand for ARVs far exceeds the supply of services. Even where care is available, it is far too centralised.

Co-ordination of services: Current services for HIV-infected children and adults are not family- or child- and caregiver-oriented. There is a need for co-ordination between different programmes in the Department of Health, between different disciplines in health facilities and across sectors. To quote one example: due to a vertical approach to care delivery, there is resistance at primary care level to the idea that ARV treatment sites should manage TB in their own patients.

Disclosure, confidentiality and consent: Current services do not address non-disclosure to children and there are few treatment sites that offer life-skills programmes or children's support groups. Children, like adults, need a lot of emotional support in dealing with the potential stigma of having HIV infection. This support is currently not available. Closely associated with this is the issue of confidentiality and consent for testing and treatment. Currently there is no agreement about how to deal with these issues.

Selecting children to receive treatment: The plan does not give any guidance on how service providers should prioritise who should be enrolled onto the programme. This means

that no clear priority is given to children above adults, or women above men. Each site uses slightly different criteria over and above the minimum requirements for enrolment. As resources are so limited it is inevitable that roll-out will initially focus on children that are very ill. As indicated above, attention should be given to a systematic approach that will screen and test children before they become ill. Children should gain programmatic access to ARVs based on the monitoring of CD4+ counts.

Adherence difficulties: Pharmaceutical companies should pay specific attention to developing child-friendly medication, with tablet and capsule sizes that permit an early switch from syrups. This would simplify treatment, reduce the number of doses and improve adherence support and monitoring.

The treatment and care of HIV-infected children in residential care facilities: Children in children's homes who have chronic health conditions such as HIV are not adequately catered for by the State. In formal residential care, no extra subsidy is given for children with chronic health conditions, even though there are additional medical and transport expenses. In informal facilities, caregivers struggle to cope with the varying needs of children and struggle to access treatment such as ARVs. This is complicated by the fact that caregivers cannot legally give consent for testing and treatment.

Material support to affected families: Poverty is a major factor in the progression of HIV and AIDS, contributing to malnutrition, poor hygiene, unsafe water, poor access to health care and non-adherence. A neglected element of comprehensive health care is the need to improve the overall public health infrastructure and social support in the form of facilitated access to grants, the development of new forms of social grants, and application for state-supported housing. Assistance in access to state-funded care and the creation of income-generating opportunities for affected families are as important as any other facet of health care.

What are our recommendations?

Our main recommendation is to reduce HIV infection in adults and to prevent mother-to-child transmissions. Both these interventions would have the greatest effect of reducing HIV infection in children.

Our other recommendations are related to policy, service delivery and advocacy.

At policy level

- All policies and plans that have implications for children must have a specific section catering for children's specific needs, and must be drawn up by child experts. In addition, different policy and planning initiatives for children must be co-ordinated within government departments and between other sectors.
- The current draft policy framework for children with chronic health conditions must be officially accepted and implemented.
- The following gaps in the plan and the Meyers guidelines must be addressed: monitoring, adherence, accessing and providing ARVs.
- The government must address the critical shortage of nurses to meet urgent needs, particularly to implement screening, diagnosis and monitoring of HIV and AIDS, at the primary health care level.
- The government must acknowledge the critical consequences of poverty that impact on HIV-affected families. It must develop policy to facilitate and support public-private income-generating projects aimed at alleviating poverty amongst HIV-affected families as part of comprehensive health care.
- The government must reassess the regulation of Disability Grants for adults and children with HIV and AIDS.

At service delivery level

- The overall health care infrastructure, especially at primary level, must be strengthened, otherwise ARVs and other HIV-specific programmes will be difficult to implement successfully. Chronic and critical care services for children are particularly neglected. Emphasis must be placed on the specific needs of children when increasing the number of ARV sites, as well as on the training of staff and providing other essential resources.
- The government must develop clear guidelines on age- and development-appropriate practices for counselling, disclosure and confidentiality in children.
- The government must develop clear guidelines on how to prioritise among eligible children and how to standardise practices across sites.
- Children living in especially difficult circumstances who require HIV treatment and support must receive special attention and support.
- Family medicine should be promoted as a model of care to sustain the health of caregivers and children alike.

- Pharmaceutical companies that develop medicines for children must pay specific attention to improvements that would enhance adherence in children.
- There should be, at clinic level, a new focus on support towards the material needs of affected families through the provision of information on and the facilitation of access to grants, state-supported housing and feeding schemes.

At advocacy level

Watchdog bodies must monitor the care and support of children with HIV infection and must advocate for and facilitate possible ways of strengthening social service provision to children.

In conclusion: Children's health rights in general and in particular the rights of children with HIV have not yet been met. Their basic general health care needs and their specific HIV-related needs have not been adequately addressed. Given the large number of children that are already HIV infected, we need to implement a comprehensive package of care for children infected with HIV. This requires political will from all government departments, careful planning, and a consciousness on the part of policy-makers, planners and implementers of the special needs of children.

Sources

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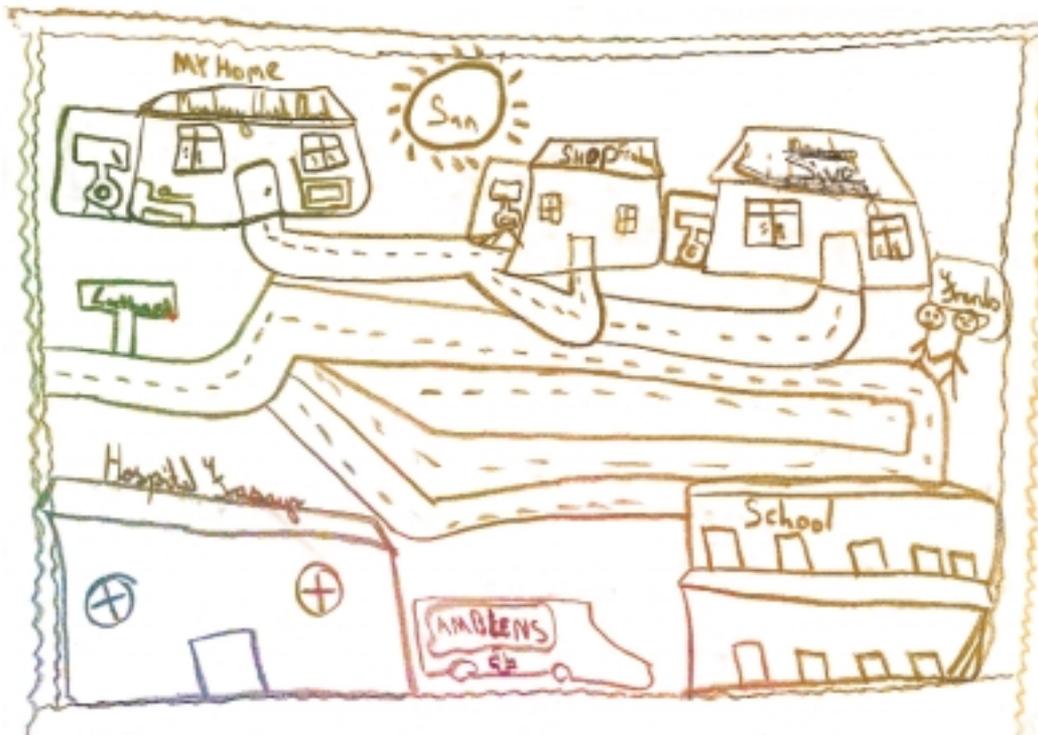
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Social security for children in the time of HIV/AIDS: The (mis)use of foster care?

Helen Meintjes (Children's Institute), Debbie Budlender (Centre for Actuarial Research),
Sonja Giese (Absolute Return for Kids) and Leigh Johnson (Centre for Actuarial Research)



It is estimated that over 10 million children under the age of 18 years in South Africa live in poverty. The AIDS pandemic can only exacerbate the circumstances of these children. In this context, appropriate social security provisioning can play a critical role in supporting poor children and their households through the pandemic.

To date, foster care placements and grants have been viewed as a key intervention in addressing the needs of children in the context of AIDS. The South African government encourages people taking care of orphans to make use of the foster care system to access financial support. This section critically considers this approach.

This section focuses on the following questions:

- What are the current and proposed social security provisions for children in South Africa?
- What are the implications of the ongoing implementation of the current provisions – how practical, effective, equitable and appropriate are they?
- What are the comparative costs of different social security scenarios?
- What are our conclusions and recommendations?

What are the current and proposed social security provisions for children in South Africa?

The current provisions

We focus on two of the cash grants that are currently legislated for children – the Child Support Grant (CSG) and the Foster Care Grant (FCG).

The Child Support Grant: The purpose of the CSG is poverty alleviation. Under the regulations to the Social Assistance Act 59 of 1992, the caregivers of poor children under the age of 14 years are, in 2005, eligible for a CSG of R180 per month. Any 'primary caregiver' of a child under 14 years old can apply to the Department of Social Development for this grant. The department will assess whether or not the caregiver qualifies in terms of a means test, which is based on income. The process is administrative and does not involve court orders or the services of social workers.

Children under the age of 14 years who have been orphaned and whose caregivers fit the above criteria are eligible for the CSG. However, the Department of Social Development, as well as non-governmental organisations (NGOs), encourage families caring for orphans to apply instead for the Foster Care Grant.

The Foster Care Grant: The two Acts that govern the FCG are the Child Care Act 74 of 1983 and the Social Assistance Act 59 of 1992.

It is crucial to note that, unlike the CSG (which is not linked to any social services), the FCG is a component of the foster care system. The foster care system was designed as a mechanism for intervening in the lives of children needing protection. In particular, it was aimed at supporting children facing abuse and neglect. It is a cornerstone of the child protection system.

The processes involved in accessing a FCG are therefore more complex than those for the CSG:

- To qualify for a FCG, the child must be placed in formal foster care. This means that the courts, with the support of social workers, must find the child to be 'in need of care' (the legal criteria are outlined in the Child Care Act). They must then place the child in the safe custody of adults who are not the child's biological parents. The foster parents are recognised as the legal custodians of the child for as long as the child is in their foster care.

- The foster parents can apply, in 2005, for a FCG of R560 per month for each fostered child who is under the age of 18 years. The FCG amount is more than three times the amount of the CSG. The foster parents do not have to pass an income-based means test to qualify for the FCG.
- Foster care placements are linked to a 'basket' of services which by law include ongoing monitoring and support of children and their families by social workers.
- Foster care placements are made for a maximum of two years at a time, at which stage a renewal process is required.

According to the Child Care Act 74 of 1983 (section 14 (4)), children who do not have any living biological parents are defined as being 'in need of care'. This makes them eligible for foster care placement and the FCG.

What role is foster care currently playing in practice?

Research shows that increasing numbers of poverty-stricken families who are caring for orphaned children are relying on foster care placements as a way to access the more substantial financial support offered by the FCG. This is understandable, considering the lack of adequate alternative cash grants, the high levels of poverty in the country, and encouragement from the government to do so.

As a result, the purpose of foster care placement is in practice being shifted away from child protection to poverty alleviation. This is likely to increase as the AIDS pandemic progresses unless a more adequate social security policy is put in place.

The new provisions proposed by the South African Law Reform Commission (SALRC)

During the process of drafting a new Children's Act, the SALRC recommended that the following cash grants (amongst others) be made available to support the care of children:

- A universal child grant aimed at providing support to all South African children up to the age of 18 years. This extends the age limits on the current CSG and removes the income-based means test.
- An Informal Kinship Care Grant for children up to 18 years of age, who live in the care of relatives (but not with their biological parents), and who have not specifically been placed there by a legal order of the court.

- A Foster Care Grant for children up to 18 years of age who the courts have found to be 'in need of care' and who have been placed in the care of foster parents to whom they are not related.
- A court-ordered Kinship Care Grant for children up to the age of 18 years whom the courts have found to be 'in need of care' and who have been placed in the care of relatives. It was suggested that relatives applying for this grant should go through an income-based means test. This approach is an attempt to provide financial support to relatives to care for children 'in need of care' but without all the administrative and monitoring procedures required by foster care placements.

The SALRC made provision for informal kinship care and court-ordered kinship care to be recognised as new legal forms of 'alternative' care. In each case, kinship caregivers are given 'parental rights and responsibilities' for children in their care.

Changes made by the Department of Social Development

The Department of Social Development made a number of substantial changes to the SALRC's draft of the Children's Bill:

- They removed the chapter providing for social security.
- They removed the provisions for the recognition of informal kinship care as a new legal form of alternative care.
- They kept the provisions for court-ordered kinship care as well as those for foster care. In other words, they have allowed for a placement which is similar to foster care, but where the court formally places the child with relatives.

All of these changes were accepted by Parliament during its deliberations on the Children's Bill in 2005.

What are the implications of the ongoing implementation of current provisions – how practical, effective, equitable and appropriate are they?

Foster Care Grants undeniably benefit the household members of the few orphaned children whose caregivers' are able to access them. But there are a number of reasons why we argue that they may not be an appropriate response to addressing children's socio-economic vulnerability in the context of the AIDS pandemic in South Africa.

Are orphan children 'in need of care' from the State?

Some children who are orphaned may indeed require the intervention of the child protection system in order to secure adult care. However, local and regional research findings show that only a small number of children find themselves living without an adult, in child-headed households. The majority of orphaned children live with relatives, without intervention or incentives from the State.

"It is quite clear that these children [orphans] are in need of money! They are not 'in need of care'." Magistrate based in KwaZulu-Natal

How will the already over-burdened and under-resourced social services system manage to meet the demand?

The administrative processes for foster care placement and for the proposed court-ordered kinship care placement are complex and impractical for the applicants, as well as for social services and court systems, which are already severely over-burdened and under-resourced.

Consider the following figures: At the end of September 2004 there were a total of 236,000 children in foster care. It was estimated that in 2004 there were about 250,000 newly orphaned children who would have qualified for foster care placement and grants. This means that the total number of

“You can imagine if we place a two-year-old, or a nine-month-old baby, in foster care; we will have to write those reports until the child has finished school. We’ve got a file open, and we’re going into Volume 2 and 3 of the file for the entire time of the child’s life ... so imagine what that means for us!”

Social worker who works in an informal settlement in KwaZulu-Natal.

children in foster care in September 2004 was less than the number of newly orphaned children who would have qualified in 2004 alone.

Research findings clearly demonstrate that in many parts of South Africa there are already far too many foster care applications for social workers to process. If we look at the predicted number of orphans in the country, it is clear that social welfare and court capacity and resources are utterly inadequate. If the State continues to provide poverty relief to these children through the child protection system, it will fail to reach vast numbers of eligible children and their families who need support.

Will the use of foster care as a poverty alleviation mechanism detract from the real purpose – that the foster care system is meant to protect particularly vulnerable children?

The huge number of applications for fostering orphans is already creating bottlenecks in the severely over-burdened system. Access to this system by those who most need protection – whether they are orphans or not – is becoming increasingly difficult. This means that the care of children who have been abused, neglected or who require temporary removal from their families is being, and will increasingly continue to be, compromised.

“I am worried about the children here. The husbands have died, and their mothers are not working, they can’t afford ... There is no foster grant for them. There’s no help from the government for them ...”

Clerk of Children’s Court, Umlazi, KwaZulu-Natal.

Is it ethical for the State to provide support to poor people caring for children who are not their own, while failing to provide adequate and equal support for poor parents caring for their biological children?

Poverty is widespread in South Africa. So why should children who live with foster parents or with relatives require special grants that are of a substantially higher value, and continue for a longer time, than grants for poor children who live with their biological parents (many of whom are also sick)? Such a system is inequitable. It fails to provide adequate support to vulnerable families and also introduces a perverse incentive for impoverished families to place their children in the care of others.

The important concept to focus on is what is meant by vulnerability in the context of the AIDS pandemic. Internationally and locally, attention has focused on children’s orphanhood as a result of the AIDS pandemic as the primary measure of their vulnerability. However, there is a need to focus more broadly on other children who also live in the context of AIDS and who are also vulnerable. For example, there are children who are living with sick caregivers who face increasing struggles as their capacity to earn an income is reduced, and much of their money is spent on health care and treatment. There are also children who live in households where the income is spread thinner and thinner because there is a need to provide for – and share the burden of illness and death with – relatives, families and neighbours. The government needs to address the poverty of all children in South Africa.

“Orphan or no orphan, it’s just the same. They are needy, all of them ...”

Teacher from KwaZulu-Natal

What are the comparative costs of different social security scenarios?

A costing study was conducted to estimate what the proposed universal CSG would cost the State in comparison to the current policy of providing the CSG to poor children up to the age of 14, with all double orphans (those who have lost both

biological parents) being eligible for foster care placement and Foster Care Grants. The findings demonstrate that, while the implementation of a universal CSG would be more costly than the current policy, the relative costs would decrease substantially over time. At the time that orphan numbers are anticipated to be at their peak, the additional cost of providing a universal CSG would be a maximum of one-third more than providing for the system that is currently legislated. It would be possible to return part of this additional cost to the fiscus through tax.

It is important to note that, while extending the CSG to all children under 18 years would cost more than implementing current policy, a universal CSG would reach far more children in need faster and would alleviate the pressure on social workers and the courts. By 2017 the current system will reach less than half of all children in need. In contrast, should a universal CSG be rolled out, roughly 125% more children would stand to be assisted within 15 years.

At first glance, the monetary value of the CSG appears to be substantially less than a FCG, and so it is difficult to appreciate that it would have the same impact for individual children as the FCG. However, research shows that the broader spread of a universal CSG would result in a greater net transfer of financial support to neighbourhoods (and in some instances households) than the more targeted scenarios which currently exist. In other words, poor neighbourhoods would in fact be better equipped to provide support to children in need of their care than is the case under the current system.

What are our conclusions and recommendations?

In order to address the needs of children adequately in the context of HIV/AIDS, including those children who have been orphaned, those who are poor, and those who are in need of protection, we recommend the following reforms to the social security system:

- Implement a universal CSG to address children's poverty. Extend the grant to 18 years of age, to every child, and adjust the amount with inflation each year. Recover some of the costs of the universal CSG through tax from those who can afford to maintain their own children.

- Strengthen the foster care system to accommodate those children who need protection and who need State intervention in their care arrangements. Discontinue the use of the foster care system for poverty alleviation. This is only feasible if the CSG is extended to all children up to 18 years.
- Keep the provisions in the Children's Bill for foster care as a placement option for children legally 'in need of care'.
- Remove the provisions in the Children's Bill for court-ordered kinship care as a placement option for children found to be legally 'in need of care'. We recommend this because:
 - These provisions are redundant if foster care provisions are legislated to protect children.
 - These provisions are based on inappropriate assumptions about children's safety in the care of relatives, as opposed to other adults.
 - These provisions will perpetuate the problems that we have already described in relation to the current foster care system.

To sum up: We recommend that more children be brought into the social security 'safety net', not on the basis only of their orphanhood, but rather on the basis of their poverty levels and their 'need'. It is only with the implementation of such social assistance that children in South Africa will be appropriately and equitably supported through the AIDS pandemic.

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Schools as nodes of care and support for children affected by HIV, AIDS and poverty

Sonja Giese (Absolute Return for Kids), Helen Meintjes and Jo Monson (Children's Institute)*



The HIV and AIDS pandemic is one of the greatest threats to the fulfilment of child rights in South Africa. The pandemic aggravates the ongoing and widespread effects of poverty, which has already significantly undermined child well-being. The impact in areas heavily affected by HIV and AIDS is felt collectively by everyone in the community and is severely straining communities' economic and social safety nets.

In responding to these tremendous challenges we need to maximise the potential of existing services and deepen collaboration at every level. In this section we explore an expanded role for schools as sites where vulnerable children can access a range of services.

This section focuses on the following questions:

- How do HIV, AIDS and poverty threaten the well-being of many children?
- What characterises current responses to the needs of children?
- How can schools operate as nodes of care and support for children?
- What are our conclusions and recommendations?

* With thanks to Norma Rudolph, Children's Institute, for comments and suggestions.

How do HIV, AIDS and poverty threaten the well-being of many children?

Between 2000 and 2003 the Children's Institute undertook extensive research and consultation on the high impact that the rate of AIDS-related sickness (morbidity) and AIDS-related death (mortality) amongst adults have on children. The research showed that children take up various caregiving roles and responsibilities. For example, following the death of her mother, 13-year-old Sindi[†] took responsibility for cooking and cleaning for her sickly father, her 76-year-old grandmother and three younger siblings.

Another child, 16-year-old Goodness, said after the death of her mother:

"... it is not the same as it was two years ago – most of the time when I am in class, teachers will be teaching but I find myself being absent-minded ... I think about the biggest problems we have. We can't find food and I have my siblings to worry about – I worry about how we are going to get food..."

Source: *Health and social services to address the needs of orphans and other vulnerable children in the context of HIV/AIDS: Research report and recommendations.*

The Actuarial Society of South Africa (ASSA) estimates that in July 2005 there were a total of 3.4 million children in South Africa who have lost one or both parents. Researchers Johnson, Bradshaw and Dorrington estimated that 250,000 of these children had lost both parents. Contrary to popular belief, the vast majority of these children currently live with, and are cared for by, extended family and neighbourhood networks. A Children's Institute working paper that investigated social security provisions for orphans in the context of the AIDS pandemic indicated that only a very small minority live without resident adult caregivers in so-called 'child-headed households'. Consequently, fewer adults care for more children, with fewer resources (including income and food). The rate of this continues to increase and makes further demands on these kinship and neighbourhood networks of care and support.

The result is that the majority of children in affected communities are feeling the effects of HIV, AIDS and poverty, and not only those who are orphaned. Many children do not

have enough food to eat, adequate clothing to wear, or uniforms and equipment to attend school. Many children struggle to access schooling and health care services. Many children (and their caregivers) do not have access to social service grants because of poor access to service sites, long delays and a lack of documentation.

What characterises current responses to the needs of children?

Some government strategies and many international funders have concentrated resources on helping so-called 'AIDS orphans'. However, this narrow focus on orphans has sometimes resulted in children being seen as 'commodities' (as goods that have monetary or resource value) and has, in some instances, also resulted in their increased stigmatisation. Given the collective effect of HIV, AIDS and poverty, it is inappropriate to focus only on orphans, or on any one category of child or need.

According to the Children's Institute-commissioned paper *Conceptualising and Addressing Vulnerability in South Africa in the Context of HIV/AIDS: A Policy Review*, it is critical that, in responding to the needs of children, there should be "caution against paying attention to only one aspect within the risk chain or addressing a single component within a complex set of vulnerabilities that are often not only interrelated but are in themselves multi-dimensional".

Over the past decade, another characteristic of the response to the needs of children affected by HIV and AIDS has been a mushrooming of, and a reliance on, non-governmental organisations and community-based services. This trend has not been adequately co-ordinated or supported by the government. There is also insufficient channelling of funds from the State to these organisations and services, with many of them relying on unpaid volunteers who are themselves poor.

"Women are not coming (to volunteer) as they used to and there are now very few left. They complain that they, and their children at home, are hungry. They are disappointed with the project as they hoped they would get jobs or be trained as a nurse."

Source: *Health and social services to address the needs of orphans and other vulnerable children in the context of HIV/AIDS: Research report and recommendations.*

[†] All names of children quoted in this section have been changed to protect their identities.

A number of national government departments have focused on developing policies on HIV and AIDS, including the Departments of Health, Education and Social Development. However, the implementation of these policies is fraught with difficulties and barriers; for example a lack of access, bureaucratic procedures and people's reluctance to disclose their HIV status because of stigma and ignorance. Where services are available, they are seldom co-ordinated and there is little departmental collaboration, despite the above-mentioned departments trying to develop a National Integrated Plan for the Social Cluster.

Programme planners need to recognise the broad impact of the HIV and AIDS pandemic, together with poverty, on children, households, communities and service providers. Interventions must be sensitive to addressing the needs of the range of vulnerable children, including orphaned children, children living with and frequently caring for sick adults and siblings, HIV-positive children, and children living in households where limited resources are stretched further as a result of supporting additional people (whether they are resident or not).

Given the scale of the challenges we face, there is a need to explore the roles that different service providers can fulfil in

terms of supporting all vulnerable children. We also need to build collaboration between all service providers, and mainstream care and support activities wherever possible.

How can schools operate as nodes of care and support for children?

Research highlights the important role that schools can play (and many already do) in providing care and support to vulnerable children through school-based services, and through assisting children to access support outside of the school. We use the term 'schools as nodes of care and support' to refer to this vision for an expanded role for schools.

Examples of good practice illustrate how schools can function as nodes of care and support by creatively using their existing resources and leveraging other resources from within government and the community. Consider the following story about Sbhongile Kuzwayo, principal of a small rural school in northern KwaZulu-Natal.

The mother to many

When Sbhongile* realised that Thabiso* was homeless and sleeping in the bushes at school because he had nowhere else to go, she spoke to the school governing body. They decided to let the boy sleep in an old classroom. Since then, other children in difficult circumstances have moved in and the school governing body built a three-roomed house on the school property to accommodate them.

Sbhongile has leapt into action as she's come to realise more and more of the difficulties that the children attending her school experience. She was alerted to the weekend-long hunger of many of the children in her school when she noticed a child who lay down, barely touching the Monday morning plate of food and clutching her stomach in pain. The child had not eaten since the previous Thursday when the school-feeding scheme last operated. Nor, it emerged, had several other children.

After meetings with her staff and with the children's caregivers (and with the financial assistance

of a local trust), Sbhongile instituted an extended feeding scheme on Fridays and over the weekends so that those children who receive no other food at home could be fed before leaving on Fridays, and return to the school on Saturdays and Sundays for a meal. "At least," says Sbhongile, "if they come to the school, we know the children get the food."

The school always grew a patch of mealies and vegetables to augment feeding scheme supplies, but this provided insufficient food for all the children. So, with an ever-increasing number of mouths to feed, Sbhongile approached the Department of Agriculture for help in learning about food production. The result is a school fish pond, and a clutch of hens that lay eggs and provide food for the fish.

Sbhongile described initiatives to identify and support vulnerable learners, including a 'postbox' to enable children to share their concerns through written letters to her and their teachers. The school also uses parent-teacher meetings as opportunities

* Names have been changed.

to inform caregivers of how to access social assistance grants and other services or support in the community.

Together with the local trust, she has organised meetings with principals at other schools in her area

and shared with them some ideas for the role that schools can play in supporting children. A principal support group has been established and the seven-day feeding scheme has been expanded to four other schools in her district, with plans afoot to do more ...

Source: Health and social services to address the needs of orphans and other vulnerable children in the context of HIV/AIDS: Research report and recommendations.

The education policy environment

Education policy, legislation and leadership, through partnerships with other sectors, make provision for schools to play a larger role than they currently do in identifying, caring for, and supporting vulnerable children. The *Education White Paper 6* provides the framework for establishing an inclusive education and training system that enables education structures, systems and learning methodologies to meet the needs of all learners.

Education White Paper 6 marks an important conceptual shift in understanding barriers to learning. Previously these were understood from a deficit or medical model, which “presupposes vulnerability and disability as inherent in the individual”. According to Baxen and Mosito, barriers to learning are now acknowledged as being the consequence of a ‘complexity of multiple factors’ and as being ‘located primarily in the environment’. *Education White Paper 6* also emphasises the critical role of intersectoral collaboration in achieving the aims and objectives of inclusive education. It emphasises, amongst other things, establishing district support teams that consist of a wide spectrum of professionals and mobilising public support.

The commitment of the Department of Education to strengthening the role of schools in the support of vulnerable learners is reflected in the following statement, which was made by the then Minister of Education in his closing address at a national education and HIV and AIDS conference in June 2002:

“Educators are not social workers. Nevertheless they can work with others to provide care and support for those affected by HIV and AIDS ...”

Minister Kader Asmal, June 2002

In 2002 the Department of Education also released their implementation plan for *Tirisano* (a Setswana word which means ‘working together’) – a response to the government’s call to improve public service delivery. Part of the *Tirisano* action plan is to, amongst other things, make schools centres

of community life, make co-operative government work, and deal urgently and purposefully with the HIV and AIDS emergency in and through the education and training system.

There are many other existing education policies and programmes which can be strengthened and expanded to support the concept of schools as nodes of care and support, for example, the inclusive education policy, the primary school nutrition programme, the safe schools programme and the life orientation/life-skills curriculum.

Why schools?

The education system has several comparative advantages over other services when it comes to the care and support of children. In addition, there are a number of factors that make schools a strategic place for children to access a range of services:

- Schools are relatively accessible and they often provide a physical infrastructure in communities where other crucial infrastructure is absent. The education system has an existing infrastructure of around 28,000 schools. The space and grounds at schools have the potential for expanded use.
- Schools represent an existing network of many components, including school staff, learners, their caregivers, school governing bodies and the broader school community. Each component is a potentially valuable resource for care and support.
- The way schools are currently clustered creates opportunities for further collaboration and provides educators and middle management with more support.
- The school environment is an inclusive environment, which focuses on children and is committed to children’s development. The education system reaches approximately 11,500,000 children, including those most affected and most at risk of HIV infection. Children spend a large amount of their time at school over many years. It is also an environment where all kinds of vulnerabilities are

exposed and it therefore has the potential to work against stigma associated with HIV and AIDS. If children feel supported within the school, they will come to school and they will remain within the school.

- The school can also reach the younger and most vulnerable age group through school-going children and their families, for example, through child-to-child programmes.
- Educators see children every day for five days of the week and are therefore ideally placed to track their well-being, to recognise change in children's lives, and to identify vulnerable children.
- In communities with inadequate service provision, schools take on an ever-increasing burden of support. The South African Democratic Teachers Union (SADTU) reports that it is inundated with requests and appeals for help from their members who are faced on a daily basis with learners dropping out of the system due to the impact of HIV and AIDS on their lives. Educators report that they lack the skills and knowledge to deal adequately with the issues as they unfold in their classrooms. This is echoed in calls by educators interviewed by the Children's Institute – for more information, for access to resources, for better support mechanisms, and for the strengthening of collaborative networks to assist them in better supporting vulnerable learners.

"All these learners, one finds that 50% come to school hungry, rape cases, they have live-in partners as young as Grade 8, a lot, a lot no money, nothing, parents passing away, HIV/AIDS, everything ... Now you need professionals to deal with those cases! But at the end of the day, you end up going (to your colleague): 'Noxolo, can you help me, this is a girl, can you deal with her in your office?'"

Source: *Health and social services to address the needs of orphans and other vulnerable children in the context of HIV/AIDS: Research report and recommendations*

Meeting the challenges

Baxen and Mosito warn that the "expectation that 'education' can bear the greatest burden of addressing social and other vulnerabilities is unrealistic and makes the education sector itself vulnerable".

Many schools and educators working in contexts of HIV, AIDS and poverty are themselves vulnerable and in need of care and support. Many educators are overburdened and also infected or affected by HIV and AIDS.

Schools in the poorest areas have poor infrastructure and

resources. Some operate in a culture of disempowerment, inertia, and cynicism, with poor or undefined leadership. Some schools and school communities are divided by organisational factions, hostile environments, power imbalances, and excessive bureaucracy.

According to Baxen and Mosito there cannot be a 'one size fits all' role for schools. We need to recognise that there are "differences among schools and they have unequal primary starting blocks". What is appropriate or possible will differ from one school to another and what could be put into operation will be very different in different contexts.

There are also challenges related to learners, for example, many of the most vulnerable children struggle to access school and sometimes schools are not the safest places for children. In many instances, the school environment actually contributes to children's vulnerability.

A full discussion on ways to meet these challenges is beyond the scope of this section. However, one critical area that we must highlight is the need to create dynamic ways in which the school, local government activities and civil society initiatives can work together. Local governments by law have to develop their own Integrated Development Plan (IDP), which can be used to co-ordinate and integrate the activities of all government and community role-players in the protection of child rights. Another critical issue is the need to build participatory management in different areas, for example, by building on ward structures as integrating mechanisms for IDPs.

So, while schools are well placed to take on an expanded role, a key consideration must be not to place a bigger burden on educators and to find ways to support schools and school communities to face the growing challenges. Schools should be used as vehicles through which services can reach children and through which children can access support; thus schools must be a site that communities and government use to integrate their service delivery.

What are our conclusions and recommendations?

The HIV and AIDS pandemic combined with poverty affects communities collectively and exposes children to a range of different vulnerabilities. There is an urgent need to increase collaboration and to mainstream services to meet the needs of those most affected. Schools should be used as nodes of care and support from which to identify those most in need and from

which to focus service delivery. However, schools and educators are themselves vulnerable and impoverished and emphasis should be placed on mobilising communities and government towards integrating service delivery at the school site.

Sources

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Heroes in the context of vulnerability: The participation of children in the Children's Bill

Namhla Mniki (Children's Institute)



The child's right to participate is entrenched in the United Nations Convention on the Rights of the Child (CRC), which South Africa has ratified. According to the government's National Programme of Action for Children (NPA), this right to participate is seen as an instrument to meet all the other rights of children in South Africa. When children participate in processes and decisions that affect them, they are better able to express what their needs are and what the best solutions to those needs can be. In the context of poverty and HIV/AIDS, the participation of children is crucial, as it enables policy-makers and other practitioners to understand what children's realities are, and how they can be supported and protected in the context of vulnerability.

The Department of Social Development has proposed a Children's Bill to replace the Child Care Act as legislation to protect children against vulnerability. The Bill covers issues such as parental rights and responsibilities, children's rights, protection from neglect and abuse, and court systems. It is divided into two parts, the section 75 Bill deals with national government competencies, while the section 76 Bill deals with issues where the national and provincial governments share competency.

As the Bill was being considered by Parliament, it was important to involve both adults who work in the children's sector and children living in the context of vulnerability in the deliberations on it. Civil society organised themselves into an adult working group made up of organisations working in the children's sector. The Children's Institute set up a parallel process of establishing a children's working group to engage with the Bill. This section presents the story of these children, who called themselves *Dikwankwetla – Children in Action*.

This section focuses on the following questions:

- What were the aims, objectives and activities of *Dikwankwetla*?
- What challenges do children face in the context of poverty and HIV/AIDS?
- What were *Dikwankwetla*'s key messages for the Children's Bill?
- What was the impact of *Dikwankwetla*'s advocacy action?
- What lessons did we learn?

What were the aims, objectives and activities of *Dikwankwetla*?

The 'Child Participation in the Children's Bill Project' began with the aim of facilitating children's participation in the adoption of the Children's Bill. Twelve children between the ages of 12 and 17 years, who are growing up in the context of HIV/AIDS, were selected to be part of the project. The children were identified through partner organisations from four provinces in South Africa. Since the children were already working with the partner organisations, they were ensured continued support throughout the project. The partner organisations were also instrumental in facilitating buy-in and obtaining consent from the children and their families.

The project was designed to go through three implementation stages, i.e. entry and buy-in (described above), the developmental stage, and the advocacy stage. During the developmental stage, the children attended a series of participatory workshops focusing on two objectives: (a) developing legislative literacy, and (b) supporting the children to become advocates. The intention was to equip the children with the capacity to engage with the provisions in the proposed Children's Bill and to articulate their opinions about it.

Developing legislative literacy

The first workshop had three main objectives:

- to introduce the children to the project and to the facilitators;
- to gain consent and buy-in from the children; and
- to explore the challenges the children faced in their everyday lives.

In this workshop, we came to understand the context in which the children live, the main challenges they face, and the ways in which they deal with these challenges. Most of the issues they raised were relevant for the Children's Bill, and these became focal points of their advocacy strategy.

Four months later a second workshop was held to inform the children about the draft provisions of the Children's Bill. A team of legal experts converted the relevant parts of the Bill into a child-friendly resource pack. This included activities to help children learn about the Bill as well as develop their opinions about the clauses in the Bill. Only those parts of the Bill that addressed the challenges that the children faced were focused on, thus deepening their ownership of the advocacy

process. Through a facilitated process the children developed their opinions about the Bill, identifying gaps and formulating key messages.

The third workshop was held two days before the parliamentary hearings. The aim was to prepare the children for their presentation in Parliament and for their meetings with decision-makers. Their views, expressed in letters, drawings and other activities, were used to compile a presentation in the format of their choice.

What challenges do children face in the context of poverty and HIV/AIDS?

In the first workshop, children were facilitated to share their life stories, focusing on the challenges that they face. Below is the broad range of issues they raised.

Neglect by adults

Many of the children had experienced neglect and not being properly taken care of. A 16-year-old girl told us:

"I am taking care of my four siblings with my old grandmother and that doesn't mean that my mother is not alive. She is very alive but the problem is that she doesn't stay at home with us and take care of us; she is always away and when she comes home she comes drunk and abuse us emotionally. These affects me mentally; I cannot cope well with my school and don't have enough time to rest and that goes to my other two sisters who come after me; they don't have time to play like other children and I think that that's abuse."

Another girl, also 16 years, stated:

"My father doesn't take good care for us. My mother struggles alone ... I don't know what kind of a human being is my father. He is aggressive. He is always shouting at us. He pushes us aside. He is always drinking."

Abuse

Some of the children also experienced conflict in their homes, as well as physical and emotional abuse in their communities. Some knew children who had experienced sexual abuse.

Below is the story of one boy:

"I am a 16-year-old boy. I have one major problem. I am abused physically by my father since my mother passed away. I am asking that everyone should respect children's rights, even our parents themselves."

And a 15-year-old girl said:

"My younger sister aged eight years was raped by a person. My mother sent her to buy cooking oil late, at about 6.30 pm, and she met the rapist. The rapist asked her for directions to another shop, and then they went together and, instead of going to the shop, he took her to the river bank and raped her ... The person who raped my sister was unknown because he gave her a wrong name when he introduced himself to her."

Poverty

Many of the children had experienced a variety of challenges related to poverty, including a lack of shelter and clothing, a lack of access to education, health and social services, and severe forms of hunger and deprivation:

"At home we don't have some shelter. At home we don't have food. At home we don't have money to buy food." (Boy, 17 years old)

"I come from Limpopo. At home, I'm living with my grandparents. My mother is not working. She is HIV positive and she can't work because she is sick. So we have nothing. No money, no clothes and even a house of our own. We are forced to live with my grandparents inside a four-roomed. Our life is too hard – no privacy and no freedom. We are slaves inside it ..." (Boy, 16 years old)

Children's rights

The children were asked if they think that children have rights. They mostly said no, because:

"Children are not taught what their rights are."

"Children don't run the world. Adults run the world, so it's easy to forget about children."

HIV/AIDS

The challenges related to HIV/AIDS that the children raised were about caring for sick parents and siblings, as well as dealing with loss and grief.

"Home is the most difficult place in my life. At home my mother is HIV positive. My father is HIV positive."

(Girl, 16 years old)

"I have one sister. And one brother. I have father only. I don't have mom. My mom died in 2000 in June 9. My sister died in 2002 May. I live at my primary school. I am in grade six. Next year I in grade 7. My hobbies are playing soccer. At home we don't have something to shelter. At home we don't have food. At home we don't have money to buying food. My brother does not learn because we don't have money ..." (Boy, 12 years old)

Peer pressure, pregnancy, drugs, eating disorders, depression

Some children raised other youth-related problems, mainly around drug use and pregnancy. Some of the children were also experiencing other problems such as depression and eating disorders.

"Waking up in the morning and not knowing what life is going to bring my way for that day is hard, but more exciting ... The toll of death is no longer an issue for me!" (Girl, 14 years old)

The Children's Bill is targeted at legislating preventative and protective measures to support vulnerable children. One of the criteria we used to choose children to participate in the project was that they had to be living in the context of vulnerability, particularly affected by HIV/AIDS. It is not surprising, then, that they raised such serious challenges. What is significant, though, is that the most dominant challenges raised were related to poverty. Even the issues related to parental neglect can be linked to the lack of employment, poverty and alcoholism rather than to intentional criminal neglect. This is an important message to heed in the South African context, especially as it relates to policy interventions. What is coming out strongly is that, even in the context of HIV/AIDS, poverty is still the key underlying cause of vulnerability. Other research by the Children's Institute supports this notion that children affected by poverty share many of the same experiences as children affected by HIV/AIDS.

However, these children are resilient despite the challenges they face. This comes through in their choice of a name for their group, *Dikwankwetla*, which means 'heroes'. And they all referred to themselves as 'heroes' because they said that they are brave; they help their parents when they are sick; they take care of their brothers and sisters; they go to school and do well; and they care about others. These children are

not helpless victims of their circumstances. They are active citizens who continuously draw on their creativity and the support structures in their communities to help them live and thrive. One girl, 16 years old, wrote:

"(I am a hero because) I respect others. I think before I act. I am responsible; I care for others; I know myself; I don't let problems take control of me; I help other children who wants to know more about HIV/AIDS. I am proud of myself."

What were *Dikwankwetla's* key messages for the Children's Bill?

We explored different advocacy strategies in the workshops, including how to engage with decision-makers and the media. The children were also facilitated to produce different advocacy outputs. In between the workshops they designed their own advocacy strategies, deciding on which activities they would engage in, and what they would advocate for. Their activities included speaking to their friends; speaking in school assemblies; presenting in council meetings and at youth rallies; holding meetings with decision-makers; and speaking on radio. However, the climax of the advocacy process was the children's presentation to Parliament. They told members of Parliament about the challenges they were facing, and the provisions to deal with those challenges that they wanted to see included in the Bill. Below are some of the key messages that they advocated for.

- **Children's rights was a key theme.** In one group discussion, the children analysed the right to information about health care. One girl, aged 14 years, asked: "What's the point of having information about health care if you don't have the health care?" They proceeded to amend this right to state that, "Children have a right to access to information and good health care." They also felt that the rights proposed in the Bill were inadequate and they in response developed a pamphlet stating all the rights that they wanted to see included in the Children's Bill.
- ***Dikwankwetla* also focused on abuse and neglect.** They discussed the appropriate punishment for perpetrators of abuse. While the Bill suggested that reported abusers should be jailed after investigation, the children strongly felt that perpetrators must be immediately taken to jail upon reporting. They added:

"The person who is abusive must be the one who is removed from home, not the child. Whatever is done must be done to the interest of the child. Children who don't live with their biological parents; the child should be removed because the caregiver can't be removed from their own homes even if they are the one who are wrong."

Later, two 16-year-old girls co-wrote a letter to the members of Parliament, stating:

"Please raise awareness about child abuse. Those who are already abused should get counselling. The government should see to it that abusers go to jail, 'cause mostly they are not arrested; they get bail and come back and they abuse children again."

- **The issue of corporal punishment was also passionately debated.** The proposed Bill suggested that children could be 'reasonably chastised' by their parents. However, the majority of children believed that corporal punishment in the home is wrong under any circumstance. Two of the children believed that only under very 'strict' circumstances should children be 'smacked', with smacking defined as "a hit on the hand not more than twice!" The rest of the children argued that when parents hit children "they create a scary environment" in the home.
- **The children also discussed parental rights and responsibilities.** They stated that all children should be taken care of by loving caregivers in a safe environment. They also highlighted the support they received from non-governmental and community-based organisations.

What was the impact of *Dikwankwetla's* advocacy action?

We have not yet conducted an impact assessment study for this project, partly because the advocacy process is not yet finished, and partly because it is difficult to measure the impact of the children's action in isolation from the broader civil society advocacy process that involved other organisations. So, we simply highlight evidence of the children's effectiveness so far.

Dikwankwetla's participation in the Children's Bill process received a considerable amount of media coverage in some newspapers, on radio and in popular journals. Most recently, Dr Maria Mabetoa, the Chief Director responsible for children

in the Department of Social Development, shared the story of *Dikwankwetla* in an interview with a popular magazine, detailing the problems the children raised. The children were frequently mentioned during the deliberations of the Portfolio Committee and their views were incorporated in the discussions of the adult working group. Most notable though, is that progressive changes were made to the section 75 Bill, which was passed by Parliament in July 2005.

This Bill has recognised and is based on children's rights as a fundamental principle. Chapter 2 of the Bill states that, "the objects of this Act are to give effect to the ... constitutional rights of children ..." and proceeds to name the relevant rights. Secondly, the Bill has progressively shifted from the concept of parental power over children to a concept of parental responsibility for children. The Bill strives to promote the best interests of the child, as well as to recognise child agency. For instance, it recognises that there is a need to make courts accessible to children, and also recognises that there is a need to regulate cultural practices that might be potentially harmful to the child.

The section 76 Bill, to be tabled in Parliament in 2006, focuses more specifically on the issues that *Dikwankwetla* raised and the children are preparing for the next phase of the project.

What lessons did we learn?

This process has given us great insight into the extent of children's daily challenges and potential solutions. We witnessed evidence of children's agency and their abilities to participate in law-making processes. The children's participation was in itself positive because they could stand up for themselves and articulate their needs. But more importantly, it helped inform some of the adult working group's debates on and proposed changes to the Bill, and it influenced the deliberations of the Portfolio Committee on Social Development. Preliminary findings of the evaluation of the Children's Bill working group suggest that members of Parliament appreciated the opportunity to interact with children so that they could make informed decisions on the final version of the Bill.

It is thus evident that children should participate in law-making processes that affect them. This not only yields positive results for the participating children as their right to participate is realised but also assists law and policy-makers in informing their decisions.

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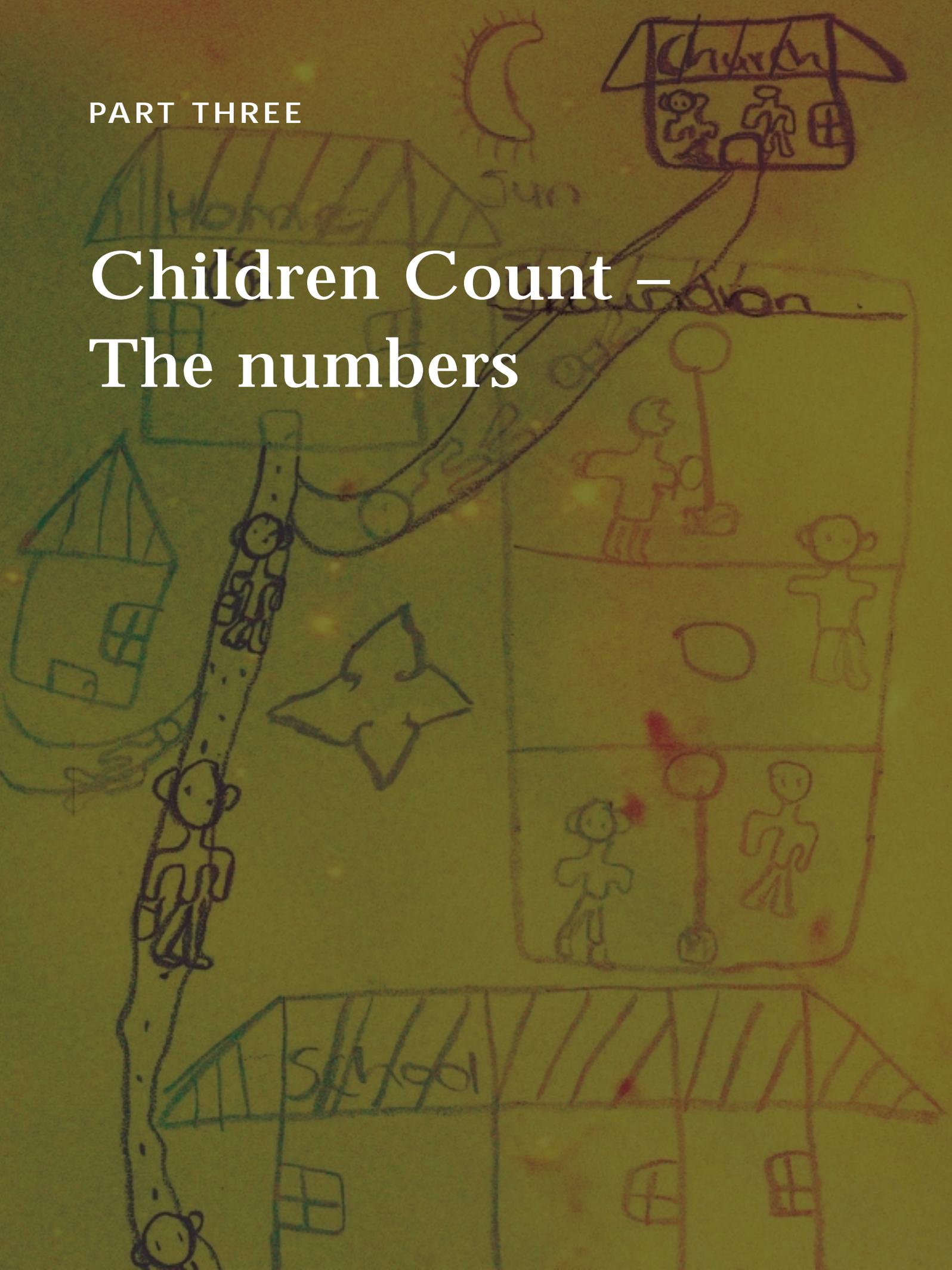
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PART THREE

Children Count – The numbers



Introducing Children Count – *Abantwana Babalulekile*

Annie Leatt and Lizette Berry (Children's Institute)



According to the South African Constitution, everyone in South Africa has a right to adequate housing, health care services, sufficient food and water, social security and basic education. Children are specifically mentioned, and every child has the right to basic nutrition, shelter, basic health care services and social services. These form part of what are collectively known as socio-economic rights. While these rights are guaranteed by the Constitution, the question is: How well are we doing as a government and as a society to make sure that these rights are realised for children?

The only way we can really answer that question is by monitoring the situation of children. Most data about the social and economic situation of South Africans does not focus on children, but instead counts people, families or households. This is standard for national data collected by central statistics organs, such as Statistics South Africa. But it is of limited use for those interested in children's rights and well-being. We need data that tells us specifically about the situation of children in South Africa, which we can then use as a tool for measuring the realisation of their rights.

Child-centred data

In 2005, the Children's Institute launched a project called *Children Count – Abantwana Babalulekile* (isiXhosa for 'children are important'). The project presents child-centred data on basic demographics and care arrangements for children, as well as on many of the areas covered under socio-economic rights. It draws on the most recent data from Statistics South Africa as well as on administrative data from relevant government departments. There is still a lot of information that is not available, but we hope that this project makes a good start towards monitoring the situation of children in South Africa and the realisation of their socio-economic rights.

Whenever new data is released, we will make it available on the *Children Count – Abantwana Babalulekile* web site at: <http://www.childrencount.ci.org.za>. As this project continues and new data is included with the release of national surveys, we will be able to track changes in the conditions of children and their access to services over time.

In this first edition of the *South African Child Gauge* we focus on a selection of indicators related to demographics and socio-economic rights. The tables on the following pages give basic information about care, health status, housing, water and basic services, social security, and education. Each table is accompanied by commentary that provides some context and gives a brief interpretation of the data. The data is presented for all South African children where possible, and by province. You can find more detailed information and a wider range of data – disaggregated by age, sex and race¹ – and accompanying web links, documents and interpretation on the *Children Count – Abantwana Babalulekile* web site.

The sources of data

There are a number of data sources that we have used for this project. Some are administrative databases used by government departments to monitor the services they deliver. The administrative sources we have used are from the Departments of Health, Education and Social Development. Some of the HIV/AIDS data we have used are from the ASSA model, a statistical model developed by the Actuarial Society of South Africa, which uses many different types of data sources to derive estimates of the incidence of HIV and treatment

needs. Most of the indicators that we present have been developed for the first time using the *General Household Survey 2004* conducted by Statistics South Africa and analysed by Debbie Budlender of the Centre for Actuarial Research at the University of Cape Town. You can find technical notes and definitions for all the indicators on pages 67 to 69, while information about data sources are displayed on pages 70.

The theme of this *South African Child Gauge* is HIV/AIDS. The footprints of income poverty and the HIV/AIDS pandemic can be seen throughout many of the indicators and rights areas presented in *Children Count – Abantwana Babalulekile*.

Demography of South Africa's children (pages 52 – 54)

The section on demography details the number of children, orphans, and children living in child-headed households in South Africa. While many of these orphans have lost a parent – particularly a father – through accidents, violence, or other types of illness, HIV/AIDS is one of the main causes of the increase in the number of orphans. As the pandemic proceeds, it is possible that more child-headed households may occur, though often as a temporary living arrangement. While the number of children living in these circumstances is relatively small, it is a heavy burden for children to be primarily responsible for one another.

In addition, the majority of children in South Africa experience severe poverty. Some 66% of children are living in income poverty, which is defined here as children living in households that have less than R1,200 per month to spend on the needs of all their members.

Children's access to social assistance (pages 55 – 56)

The impact of the HIV/AIDS pandemic has made many children more vulnerable and in need of extra care and support – in particular financial support. One way in which the South African government has responded to the needs of children and families is by making social assistance, in the form of cash grants, available to adults and children. There are three social grants for children, namely the Child Support Grant

¹ The terms for race groups used in this part are 'Black', 'Coloured', 'Indian' and 'White'. The term 'Black' refers to the 'African' population group exclusively.

(CSG), the Care Dependency Grant (CDG), and the Foster Care Grant (FCG).

The CSG is the primary poverty alleviation mechanism for children. To date, some 67% of poor children are accessing the grant, although a large number of eligible children have yet to gain access.

The CDG is available to children with special care needs. It is aimed at children with severe disabilities. In June 2005, just over 85,000 children were receiving the CDG.

The FCG is available to parents who have a child who has been removed from his or her original family and placed in their care by an order of the court. This grant is increasingly being used to provide financial support to children who have been orphaned because of the HIV/AIDS pandemic or other causes. In June 2005, nearly 272,000 children were in receipt of a FCG.

These grants assist households to meet the basic needs of their members and contribute toward living expenses. However, many children and families cannot access these grants due to eligibility criteria and administrative requirements that often act as barriers to access.

Child health and HIV/AIDS (pages 57 – 60)

The health sections present data that shows that South Africa has a high infant mortality (death) rate. This data reflects both the poor socio-economic conditions that children live in, as well as issues related to people's access to perinatal care and maternal health. Fifty-nine out of every 1,000 children die within a year of their birth, and 95 out of every 1,000 children die before they turn five years old. Of those who do not live to their fifth birthday, 40% die as a direct consequence of HIV/AIDS. In this same age group (0 – 5 years), 3.4% of children were HIV positive in 2005, and some 260,000 children under the age of 15 years (1.7%) were estimated to be HIV positive. The data in this section also shows that few of the children in need of antiretroviral therapy necessary for their survival are able to access it.

Children's access to water, sanitation and electricity (pages 61 – 62)

Aside from the direct measures of HIV/AIDS, many children in South Africa are living in substantially less than ideal circumstances. While there has been improved access to water,

sanitation and electricity in some areas, the data points to a number of areas that still require improvement. In the Eastern Cape alone, nearly 2.5 million children live in areas where there is no proper water supply, and where they have to fetch water from rivers or distant communal taps.

Children's access to housing (pages 63 – 64)

More than 4.5 million children live in overcrowded houses and approximately 2 million live in informal dwellings and backyard shacks on the periphery of cities and towns. In addition, more than half of South Africa's children (54%) live in rural areas. A strong racial bias is evident, as 96% of rural children are Black, while only 62% of Black children live in formal housing.

Children's access to education (pages 65 – 66)

South Africa has a high enrolment rate in schools, but there is evidence that attendance is low, and that many children are not enrolled at an age-appropriate level. The gradual reduction in the learner:educator ratio at schools is positive. However, the ratio remains high for public schools, especially at primary school level. And many children are travelling long distances or walking for a long time to get to schools.

In conclusion: What is striking in many of these indicators is the great disparities between the provinces. The poorer children live in the poorer and rural provinces which are less well-served in terms of clinics and schools, housing and basic services. And in every indicator, the racist legacy of apartheid is evident in the heavy burdens of poverty and inequitable access to assets and services by the majority of Black children.

This data and this publication will provide benchmarks against which we can monitor the improvements in children's living conditions. We hope that it will serve as a useful information resource for those tasked with developing policy, laws and programmes that shape the lives of children in South Africa.

Demography of South Africa's children

Helen Meintjes, Annie Leatt and Lizette Berry (Children's Institute)

The United Nations General Guidelines for Periodic Reports on the Convention on the Rights of the Child, paragraph 7, says that reports made by States should be accompanied by "detailed statistical information ... Quantitative information should indicate variations between various areas of the country ... and between groups of children ..."

The number and proportion of children living in South Africa in 2004

In 2004, there were just over 18 million children in South Africa. They make up almost half (49%) of the country's population. The most children living in either KwaZulu-Natal (21%) or the Eastern Cape (18%). A further 15% live in Gauteng and 14% in Limpopo. Most children are Black. Only in the Western and Northern Cape provinces are Coloured children in the majority. Girl and boy

populations are almost equal. Of all children, 40% are currently aged between 6 and 12 years old, with one-third (33%) of all children being younger than this. These gender and age patterns apply nationally, as well as provincially. (For more details about this indicator refer to page 67.)

Table 1a: The number and proportion of children living in South Africa in 2004 by province

Province	Number	%
Eastern Cape	3,215,847	18
Free State	1,063,842	6
Gauteng	2,641,736	15
KwaZulu-Natal	3,792,375	21
Limpopo	2,615,606	14
Mpumalanga	1,307,865	7
Northern Cape	337,192	2
North West	1,488,646	8
Western Cape	1,558,708	9
South Africa	18,021,817	100

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, University of Cape Town (UCT).

Table 1b: The number and proportion of children living in South Africa in 2004 by population group

Population group	Number	%
Black	15,070,505	84
Coloured	1,533,497	8
Indian	310,163	2
White	1,098,908	6
Other	6,610	0
Unspecified	2,134	0
South Africa	18,021,817	100

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

Table 1c: The number and proportion of children living in South Africa in 2004 by age group

Age group	Number	%
0 – 5 years	5,949,840	33
6 – 12 years	7,124,436	40
13– 17 years	4,947,541	27
Total	18,021,817	100

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

Table 1d: The number and proportion of children living in South Africa in 2004 by sex

Sex	Number	%
Male	9,495,371	53
Female	8,525,503	47
Unspecified	943	0
Total	18,021,817	100

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

The number and proportion of orphans living in South Africa in 2004

In South Africa in 2004, there were approximately 3.3 million 'orphans' – children who had lost a biological mother, father or both parents. This is equal to 18% of all children in South Africa. In 2004, 827,755 (25%) of all orphans were resident in KwaZulu-Natal; and a further 715,713 (22%) were resident in the Eastern Cape.

The death of one parent can have different implications for children to the death of both parents, as can the death of a mother relative to the death of a father. Research suggests that the absence

of a mother in particular may have greater impact on children than the absence of a father (Case & Ardington 2004). In 2004, 12% of all children had lost a biological father only, whereas 3% of all children had lost only their mother. A further 3% of all children were documented to be 'double orphans', having lost both biological parents. It is important to note that the majority of all orphans in South Africa – 68% – are paternal orphans, having lost a biological father. (For more details about this indicator refer to page 67.)

Table 2: The number and proportion of orphans living in South Africa in 2004

Province	Maternal		Paternal		Double		Total orphans	
	Number	%	Number	%	Number	%	Number	%
Eastern Cape	97,878	14	516,778	72	101,057	14	715,713	22
Free State	40,938	20	121,996	59	42,628	21	205,562	6
Gauteng	62,319	17	262,623	71	47,231	13	372,173	11
KwaZulu-Natal	165,125	20	515,584	62	147,046	18	827,755	25
Limpopo	47,016	12	304,330	75	56,042	14	407,388	12
Mpumalanga	45,853	20	145,875	64	37,904	17	229,632	7
Northern Cape	9,556	18	33,595	65	8,593	17	51,744	2
North West	37,588	12	213,956	69	58,281	19	309,825	10
Western Cape	27,473	16	125,171	75	13,902	8	166,546	5
South Africa	533,746	16	2,239,908	68	512,684	16	3,286,338	100

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

The number and proportion of children living in child-headed households in South Africa in 2004

There is much concern that the number of children living in child-headed households will rapidly increase due to the HIV/AIDS pandemic, and that extended family networks will no longer be able to support orphaned children. While there is little evidence to support this notion, it is nonetheless important to monitor the prevalence and nature of child-headed households (Meintjes & Giese 2004). It seems likely that many child-headed households exist only temporarily (Meintjes & Giese 2004; Hill, Ardington & Hosegood 2005).

According to an analysis of the *General Household Survey 2004*

by Debbie Budlender, there were 106,741 (0.6%) children living in 53,000 (0.4%) child-headed households. The proportion of children living in child-headed households relative to those living in adult-headed households is therefore very small: 99% of children live in households where adults are resident. Almost two-thirds of children living in child-headed households were 13 years and older. More than 60% of all children living in child-headed households in July 2004 were located in Limpopo (38,754) and the Eastern Cape (28,718). (For more details about this indicator refer to page 67.)

Table 3: The number and proportion of children living in child-headed households in South Africa in 2004

Province	Adult-headed household		Child-headed household		Total
	Number	%	Number	%	Number
Eastern Cape	3,187,129	99.1	28,718	0.9	3,215,847
Free State	1,060,069	99.6	3,773	0.4	1,063,842
Gauteng	2,639,886	99.9	1,850	0.1	2,641,736
KwaZulu-Natal	3,781,330	99.7	11,044	0.3	3,792,375
Limpopo	2,576,852	98.5	38,754	1.5	2,615,606
Mpumalanga	1,300,668	99.4	7,197	0.6	1,307,865
Northern Cape	337,094	100.0	98	0.0	337,192
North West	1,473,965	99.0	14,681	1.0	1,488,646
Western Cape	1,558,082	100.0	626	0.0	1,558,708
South Africa	17,915,075	99.4	106,741	0.6	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

The number and proportion of children living in income poverty in South Africa in 2004

Children have a right to financial support through social assistance when their families do not have enough money to care for them adequately. Levels of income poverty are important because they tell us how many children may not be able to have their basic needs met; and this indicates how many children are living with severely constrained resources. Income poverty is often closely related to poor health, education, physical environments and personal safety.

Child poverty is very high in South Africa. Two-thirds (11.9 million) of children in South Africa live in households that have R1,200 per month or less. Rates of child poverty differ across the country. Limpopo has the highest rate of child poverty, at 81%. The Eastern Cape, Mpumalanga, KwaZulu-Natal and the Free State provinces have higher rates of child poverty than the national average. Nearly all poor children (95%) in South Africa are Black. (For more details about this indicator refer to page 67.)

Table 4: The number and proportion of children living in income poverty in South Africa in 2004

Province	Poor household		Non-poor household		Total
	Number	%	Number	%	Number
Eastern Cape	2,533,770	79	682,077	21	3,215,847
Free State	721,868	68	341,974	32	1,063,842
Gauteng	1,170,640	44	1,471,096	56	2,641,736
KwaZulu-Natal	2,623,460	69	1,168,915	31	3,792,375
Limpopo	2,118,486	81	497,120	19	2,615,606
Mpumalanga	910,901	70	396,964	30	1,307,865
Northern Cape	212,735	63	124,457	37	337,192
North West	1,071,098	72	417,548	28	1,488,646
Western Cape	542,192	35	1,016,516	65	1,558,708
South Africa	11,905,150	66	6,116,667	34	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

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Children's access to social assistance¹

Annie Leatt, Helen Meintjes and Lizette Berry (Children's Institute)

The Constitution of South Africa, Section 27 (1) (c), says that, "everyone has the right to have access to social security including, if they are unable to support themselves and their dependants, appropriate social assistance". The United Nations Convention on the Rights of the Child states that every child has the right to a standard of living adequate for his or her development (Article 27).

The number and proportion of children aged 0 – 14 years receiving the Child Support Grant (CSG) in South Africa in June 2005

The government is obliged to support children directly when their parents or caregivers are not able to support them adequately due to poverty. This is done primarily through social assistance programmes such as the CSG. The fundamental purpose of the right to social assistance is to ensure that persons living in poverty are able to access a minimum level of income sufficient to meet basic subsistence needs so that they do not have to live below minimum acceptable standards. The CSG is a cash grant to the value of R180 per month per child. In June 2005, the CSG went to nearly 6 million children from 0 – 14 years old. Using the *General Household Survey 2004*, Budlender calculated that some 8.8 million children are eligible for the CSG. This is 65% of all children in the eligible age group.

Using these eligibility rates, it is estimated that 67% of eligible children are able to access the Child Support Grants across the

country. The extension to the age of 14 years began in April 2005; so there is still room for improvement in the uptake rates. By these calculations, a little more than 2.5 million eligible children had yet to access the financial support of the CSG. In order to access the grant, children's caregivers make an application and pass an income test. Children are eligible for this grant if their primary caregiver and his/her spouse have R800 per month or less in income and live in an urban area and formal house. Those who live in rural areas or informal housing in urban areas must earn R1,100 per month or less in order to qualify for this grant. There is substantial evidence that grants, including the CSG, are being spent on food, education and basic goods and services. (Samson, Lee, Ndlebe, Mac Quene, Van Niekerk, Gandhi, Harigaya & Abrahams 2004). (For more details about this indicator refer to page 67.)

Table 5: The number and proportion of children aged 0 – 14 years receiving the Child Support Grant (CSG) in South Africa in June 2005

Province	Child population		Children eligible for the CSG		Children receiving the CSG		Uptake rate	
	Number		Number	%	Number	%		
Eastern Cape	2,205,694		1,616,774	73	1,078,442		67	
Free State	725,750		511,654	71	361,318		71	
Gauteng	2,137,682		1,006,848	47	723,432		72	
KwaZulu-Natal	2,905,733		2,057,259	71	1,338,045		65	
Limpopo	1,890,829		1,353,834	72	990,194		73	
Mpumalanga	999,662		681,769	68	489,663		72	
Northern Cape	240,585		156,621	65	101,728		65	
North West	1,131,625		804,585	71	465,242		58	
Western Cape	1,227,683		605,248	49	365,655		60	
South Africa	13,465,243		8,792,804²	65	5,913,719		67	

SOURCE: Department of Social Development (2005) *SOCPEN database*. Pretoria: Department of Social Development. Eligibility analysis by Debbie Budlender, Centre for Actuarial Research, UCT, using Statistics South Africa (2005) *General Household Survey 2004*. Pretoria: Statistics South Africa.

¹ Social assistance is made up of non-contributory social grants to adults and children, funded as part of the South African national budget.

² Due to rounding-off error, this figure does not reflect the exact sum of the provincial estimates.

The number of children receiving the Care Dependency Grant (CDG) in South Africa for June 2004 and June 2005

Social assistance is available to children with special care needs in the form of a cash grant called the Care Dependency Grant (CDG). This grant is provided to caregivers of children who require permanent home care because of severe disability. We are not able to develop an uptake rate of the CDG because there is little data on the number of children living with disability in South Africa, and none on children who are severely disabled and in need of 24-hour care. Although the grant is targeted at children with severe disabilities, children with chronic illnesses are eligible for the grant once the illness becomes disabling.

In the context of AIDS, the grant can assist caregivers to care for children who are very sick. In June 2005, 85,698 children were receiving the CDG. This figure is up by 7% from 2004, when just over 80,000 children were receiving this sort of support. From April 2005, the value of the grant was R760 per month. (For more details about this indicator refer to page 67.)

Table 6: The number of children receiving the Care Dependency Grant (CDG) in South Africa for June 2004 and June 2005

Province	June 2004	June 2005
Eastern Cape	18,246	19,925
Free State	3,210	3,401
Gauteng	10,522	11,468
KwaZulu-Natal	20,510	20,994
Limpopo	8,844	9,609
Mpumalanga	4,188	4,273
Northern Cape	1,853	2,186
North West	6,424	6,961
Western Cape	6,290	6,881
South Africa	80,087	85,698

Source: Department of Social Development (2005) *SOCPEN database*.
Pretoria: Department of Social Development.

The number of children receiving the Foster Care Grant (FCG) in South Africa for June 2004 and June 2005

The Foster Care Grant (FCG) is a non-contributory cash grant to the value of R560 per child per month. It is available to foster parents who have had a child placed in their care by an order of the court. The grant was initially intended as financial support for children who had been removed from their families and placed in foster care for protection against situations of abuse or neglect. However, it is increasingly being used to provide financial support to children who have lost parents because of the HIV/AIDS pandemic or other causes.

At the end of June 2005, nearly 272,000 children from birth to the age of 18 years were receiving a FCG. This is 56,000 more than in June 2004 – a 26% increase. It is not possible to calculate an uptake rate for the FCG. If we compare the 272,000 children receiving the grant with only the orphan figures for example, it is clear that only a small proportion of children who under current policy would be eligible on their orphan status alone are receiving this grant, as more than half a million children had lost both parents in 2004. (For more details about this indicator refer to page 67.)

Table 7: The number of children receiving the Foster Care Grant (FCG) in South Africa for June 2004 and June 2005

Province	June 2004	June 2005
Eastern Cape	39,772	53,383
Free State	25,140	33,653
Gauteng	28,281	34,647
KwaZulu-Natal	49,462	57,351
Limpopo	18,718	25,615
Mpumalanga	7,642	12,662
Northern Cape	8,693	9,480
North West	14,154	19,000
Western Cape	23,903	26,026
South Africa	215,765	271,817

Source: Department of Social Development (2005) *SOCPEN database*.
Pretoria: Department of Social Development.

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Child health: The general context

Kashifa Abrahams and Lizette Berry (Children's Institute) and Michael Hendricks (Child Health Unit, University of Cape Town)

Section 28 (1) (c) of the Constitution of South Africa gives children “the right to basic nutrition, shelter, basic health care services, and social services”. Article 24 of the United Nations Convention on the Rights of the Child says that State Parties should recognise “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”.

The infant mortality rate and under-five mortality rate in South Africa for 2000

Infant mortality rate (IMR)

The infant mortality rate provides a key indication of how a country is progressing with its plan to realise children's rights, in particular their right to life, survival and development, and health care services.

The IMR reflects access to perinatal care, as the majority of deaths under the age of one year occur in the perinatal period – in the first 28 days of life. Mothers' health is linked to the health of their babies, and therefore pregnancy, childbirth, breastfeeding and caregiving are all important aspects that impact on the IMR. The IMR is thus a sensitive indicator of the availability, utilisation and effectiveness of health care, in particular of perinatal care. The IMR also serves as a good indication of the socio-economic conditions under which people live. The IMR is therefore important for monitoring inequalities in socio-economic conditions and access to services. In the context of HIV/AIDS, this indicator provides information on HIV-related infant deaths and the impact of prevention and treatment programmes.

In 2000, the infant mortality levels differed across South Africa's nine provinces. The Western Cape (32 per 1,000 live births) and Gauteng (44 per 1,000 live births) provinces fared better in comparison to the Eastern Cape (71 per 1,000 live births) and KwaZulu-Natal (68 per 1,000 live births). Overall, the mortality for young boys was higher than for girls (Bradshaw, Nannan, Laubscher, Groenewald, Joubert, Nojilana, Norman, Desiree & Schneider 2004). (For more details about this indicator refer to page 68.)

Under-five mortality rate (U5MR)

This indicator is linked to internationally recognised goals which countries strive towards in order to fulfil children's rights. The under-five mortality rate is an indication of how young children, including babies, are progressing in terms of survival and development. Similar to the IMR, the U5MR reflects the socio-economic status of this

population and is an indicator of health status and health care in general, with particular reference to the impact of HIV/AIDS on the South African population.

The U5MR varied considerably between provinces. The Western Cape province ranked the lowest, with an U5MR of 46.3 per 1,000 live births. According to these estimates, the Western Cape, Gauteng and the Northern Cape were the only provinces that met the 'Health for All' target of 80 per 1,000 live births for under-five child mortality. Boys under five years old seemed to have slightly higher rates of mortality than girls (Bradshaw, Nannan, Laubscher, Groenewald, Joubert, Nojilana, Norman, Desiree & Schneider 2004). (For more details about this indicator refer to page 68.)

Table 8: The infant mortality rate and under-five mortality rate in South Africa for 2000

Province	Infant mortality rate	Under-five mortality rate
	Deaths per 1,000 live births	Deaths per 1,000 live births
Eastern Cape	71.0	105.0
Free State	62.0	99.0
Gauteng	44.0	74.6
KwaZulu-Natal	68.0	116.4
Limpopo	52.0	80.7
Mpumalanga	59.0	99.8
Northern Cape	46.0	68.1
North West	55.0	88.5
Western Cape	32.0	46.3
South Africa¹	59.0	95.0

Source: Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, Norman R, Pieterse D & Schneider M (2004) *South African National Burden of Disease Study 2000 – Estimates of Provincial Mortality*. Cape Town: Medical Research Council of South Africa, Burden of Disease Unit.

¹ The national estimates do not correspond exactly with the provincial estimates.

The proportion of children aged 1 – 9 years who are underweight and severely underweight in South Africa in 2000

Children's access to nutritious food is a major factor influencing their health status. Due to the high levels of poverty in South Africa, caregivers are often unable to access adequate nutritious food for their dependants. Children who are underweight generally lack essential nutrients in their diet. Mild to moderate and severe forms of under-nutrition in children are closely related to childhood death, a higher risk of infection and impaired development. Under-nutrition also affects children's physical growth. One of the easiest ways of determining this is by weighing a child regularly.

Nationally, one out of every 10 children (10.3%) was found to be underweight, while 1.4% of children were severely underweight. The 1 – 3-year age group had the highest proportion of children who were underweight in comparison to the 7 – 9-year age group (Labadarios 1999). Provincially, the Northern Cape had the highest proportion of children who were underweight (23.7%) and severely underweight (8.9%). The prevalence of underweight in the Northern Cape is much higher than for the other provinces. (For more details about this indicator refer to page 68.)

Table 9: The proportion of children aged 1 – 9 years who are underweight and severely underweight in South Africa in 2000

Province	Underweight children	Severely underweight children
	%	%
Eastern Cape	7.1	1.0
Free State	14.3	1.0
Gauteng	8.8	0.5
KwaZulu-Natal	6.0	0.6
Limpopo	15.0	1.6
Mpumalanga	4.2	2.1
Northern Cape	23.7	8.9
North West	15.3	1.3
Western Cape	8.3	0.9
South Africa	10.3	1.4

Source: Labadarios D (ed) (1999) *The National Food Consumption Survey (NFCS): Children aged 1 – 9 years, South Africa, 1999*. Pretoria: Department of Health, Directorate: Nutrition.

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Child health: HIV/AIDS

Maylene Shung-King, Kashifa Abrahams and Lizette Berry (Children's Institute)

The Constitution of South Africa, Section 28 (1) (c), gives children “the right to basic nutrition, shelter, basic health care services, and social services”. The United Nations Convention on the Rights of the Child says that State Parties should recognise “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health” (Article 24).

The leading causes of deaths among children under five years of age in South Africa for 2000

Monitoring the deaths of children is crucial if we are truly committed to ensuring children's right to life, survival and development. The majority of causes of children's death in the country are preventable. HIV/AIDS remains the leading cause of deaths among children under-five years of age, nationally and across all provinces, primarily due to transmission before and during the birth process. Diseases of poverty account for at least 30% of all under-five child deaths. Injury-related causes rise in number for children older than five

years old (Bradshaw, Bourne & Nannan 2003).

Social determinants of health make children living in impoverished conditions more vulnerable to becoming ill more frequently, which could lead to their death. Thus health interventions alone would be insufficient – economic and environmental changes would also be required to ensure long-term improvements in the health status of children and the prevention of such deaths. (For more details about this indicator refer to page 68.)

Table 10: The percentage of leading causes of deaths among children under five years of age in South Africa for 2000

Province	HIV/AIDS		Diarrhoeal diseases		Lower respiratory infections		Low birth weight	
	% Male	% Female	% Male	% Female	% Male	% Female	% Male	% Female
Eastern Cape	27	30	15	17	7	7	5	6
Free State	40	43	11	10	8	8	7	7
Gauteng	46	49	5	6	5	5	5	5
KwaZulu-Natal	49	52	10	10	6	5	5	4
Limpopo	37	40	16	15	6	5	7	6
Mpumalanga	47	50	11	11	6	6	7	4
Northern Cape	25	28	17	15	5	8	10	9
North West	40	43	11	13	8	9	7	6
Western Cape	20	23	10	11	7	6	11	6
South Africa¹	40		10		6		11	

Source: Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, Norman R, Pieterse D & Schneider M (2004) *South African National Burden of Disease Study 2000: Estimates of Provincial Mortality*. Cape Town: Medical Research Council of South Africa, Burden of Disease Unit.

¹ The national estimates do not correspond exactly with the provincial estimates.

The HIV-prevalence rate among children in South Africa from 2000 to 2005

The HIV-prevalence rate refers to the proportion of children, at a given period, who have HIV infection. South Africa is currently experiencing an overwhelming HIV pandemic. Many children are infected with HIV or have become ill and died due to AIDS. The majority of children are infected before and during the birth process. Children may also become infected through being sexually abused by an HIV-positive person or through sexual intercourse. It is of critical importance to know the numbers of children that are infected with HIV.

Current estimates from the Actuarial Society of South Africa (ASSA) model suggests a prevalence rate of 1% in 2000, almost doubling to 1.7% in 2005 for children under the age of 15. For children aged 0 – 5 years, the rate increased from 2.1% in 2000 to 3.4% in 2005. For children aged 6 – 12 years, the rate increased from 0.1% to 0.8% between 2000 and 2005. These figures bear out that the greater proportion of children with HIV are those younger than five years of age. A total number of 260,000 children under the age of 15 years are estimated to be living with HIV infection (ASSA 2004). (For more details about this indicator refer to page 68.)

Table 11: The HIV-prevalence rate among children in South Africa from 2000 to 2005

Age group	2000	2001	2002	2003	2004	2005
	%	%	%	%	%	%
0 – 5 years	2.1	2.6	3.0	3.2	3.4	3.4
6 – 12 years	0.1	0.2	0.3	0.4	0.6	0.8
0 – 14 years	1.0	1.2	1.4	1.5	1.6	1.7

Source: Actuarial Society of South Africa (2004) *ASSA2002 AIDS and Demographic Model*. Available: <http://www.assa.org.za>

The proportion of children receiving antiretroviral therapy (ART) in South Africa from 2000 to 2004

The HIV pandemic is currently one of the largest and most serious infectious diseases affecting children in South Africa. Many children themselves are infected, as described previously. Children that become infected can progress to getting AIDS. They thus need antiretroviral (ARV) medication to delay the onset of AIDS, as it invariably leads to death. In November 2003, the government released an *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*. Children are an important group of people infected with HIV/AIDS and therefore the monitoring of the extent to which children are prioritised in the ARV roll-out is a critical child rights issue. This indicator tells us how many children that should be accessing ARV treatment do in fact manage to do so.

It is difficult to comment on trends, as the ARV roll-out has only been in place for one-and-a-half years. The roll-out also began later in some provinces than in others. However, it is already clear that sites that provide ARVs to children are far fewer than those servicing adults. Whilst the current coverage for children, as a proportion of all people receiving ARVs, is 10% on average nationally, the inter-provincial variations range from less than 1% in Mpumalanga to nearly 17% in the Western Cape (Treatment Action Campaign 2005). The modelled data suggests that the average national proportion of children receiving ARVs has steadily increased from 2% in 2002 to 17% in 2004. (For more details about this indicator refer to page 68.)

Table 12: The proportion of children receiving antiretroviral therapy (ART) in South Africa from 2000 to 2004

Age group	2000	2001	2002	2003	2004
	%	%	%	%	%
0 – 18 years	2.0	4.0	6.0	8.0	17.0

Source: Actuarial Society of South Africa (2004) *ASSA2002 AIDS and Demographic Model*. Available: <http://www.assa.org.za>

Sources

Actuarial Society of South Africa (2004) *ASSA2002 AIDS and Demographic Model*. Available: <http://www.assa.org.za/default.asp?id=1000000050>.

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Children’s access to water, sanitation and electricity

Annie Leatt and Lizette Berry (Children’s Institute)

Section 28 (1) (c) of the Constitution of South Africa gives children “the right to basic nutrition, shelter, basic health care services, and social services”. Article 24 (1) (2) (c) of the United Nations Convention on the Rights of the Child states that States Parties should “recognise the right to the enjoyment of the highest attainable standard of health ... through the provision of clean drinking-water”.

The number and proportion of children living in households with adequate water in South Africa in 2004

Across South Africa, there are some 7.7 million children whose families rely on unsafe or distant water sources. They make up 43% of all children in South Africa. There is a significant racial bias in the distribution of adequate water as 99% of children without access to water on site are Black.

Some areas are performing well in delivering water to children. The Western Cape, Northern Cape and Gauteng provinces all have more than 90% of their child populations able to access water on site. In contrast, some provinces have well over half of their children

exposed to inadequate water sources. This means that they are exposed to health risks or are responsible for fetching and carrying water to their homes. The Eastern Cape is home to nearly 2.5 million children (76%) living under such circumstances. In Limpopo, 60% of children are living without water on site, and 58% in KwaZulu-Natal are living in similar conditions. Lack of access to adequate water is also closely related to poor sanitation and hygiene. (For more details about this indicator refer to page 69.)

Table 13: The number and proportion of children living in households with adequate water in South Africa in 2004

Province	Adequate		Inadequate		Total
	Number	%	Number	%	Number
Eastern Cape	782,685	24	2,433,162	76	3,215,847
Free State	902,396	85	161,446	15	1,063,842
Gauteng	2,435,458	92	206,278	8	2,641,736
KwaZulu-Natal	1,608,636	42	2,183,739	58	3,792,375
Limpopo	1,047,299	40	1,568,307	60	2,615,606
Mpumalanga	877,356	67	430,509	33	1,307,865
Northern Cape	307,641	91	29,551	9	337,192
North West	841,374	57	647,272	43	1,488,646
Western Cape	1,456,965	93	101,743	7	1,558,708
South Africa	10,259,810	57	7,762,007	43	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

The number and proportion of children living in households with adequate sanitation in South Africa in 2004

Good sanitation is essential for safe and healthy childhoods. There are a number of negative consequences for children and youths who are not able to access good toilets. It is very difficult to maintain good hygiene without water and toilets, and children are exposed to worms and bacterial infection. Public toilets and open bush can be dangerous and girls are especially likely to need clean and private toilet facilities. The use of buckets and open *veldt* (fields) is also likely to have consequences for water quality in the area, and can lead to the spread of disease.

There are large numbers of South Africans under the age of 18 years without access to adequate sanitation. Just over half of South African children have access to adequate toilet facilities, while the other 8.75 million are using inadequate facilities. More than two-thirds of all children in the Eastern Cape (73%) and Limpopo (71%) are reliant on inadequate sanitation. According to an analysis of the *General Household Survey 2004* by Debbie Budlender, nearly all children using inadequate sanitation facilities are Black and only 43% of Black children live in households with access to flush toilets or improved ventilated pit toilets. (For more details about this indicator refer to page 69.)

Table 14: The number and proportion of children living in households with adequate sanitation in South Africa in 2004

Province	Adequate		Inadequate		Total
	Number	%	Number	%	Number
Eastern Cape	869,424	27	2,346,423	73	3,215,847
Free State	644,280	61	419,562	39	1,063,842
Gauteng	2,357,434	89	284,302	11	2,641,736
KwaZulu-Natal	1,555,960	41	2,236,415	59	3,792,375
Limpopo	755,390	29	1,860,216	71	2,615,606
Mpumalanga	570,765	44	737,100	56	1,307,865
Northern Cape	268,431	80	68,761	20	337,192
North West	783,443	53	705,203	47	1,488,646
Western Cape	1,462,033	94	96,675	6	1,558,708
South Africa	9,267,160	51	8,754,657	49	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

The number and proportion of children living in households with an electricity connection in South Africa in 2004

Access to electricity in the physical structure of the house is important for a range of reasons. Where there is no electricity, families use fuels for heating and cooking. These pose health hazards. Wood or dung fires can result in chest infections. Where families do not have access to fridges, they are also less likely to be able to keep food fresh.

There are a number of time-use consequences to not having electricity. It is usually women and children who collect wood and other fuels, and more effort is required in cooking and heating.

Also, the lack of adequate electric lighting is a contributing factor in children not being able to study after dark.

In June 2004, 76% of children in South Africa lived in households that were connected to electricity. There are some provinces, however, where an electricity connection is still difficult to access. In the Eastern Cape, 1.5 million children (47%) do not have electricity connections on site. Another 1.4 million children (38%) in KwaZulu-Natal are in the same situation. (For more details about this indicator refer to page 69.)

Table 15: The number and proportion of children living in households with an electricity connection in South Africa in 2004

Province	Connected		Not connected		Unspecified		Total
	Number	%	Number	%	Number	%	Number
Eastern Cape	1,688,944	53	1,525,637	47	1,266	0	3,215,847
Free State	919,071	86	143,541	13	1,230	0	1,063,842
Gauteng	2,392,998	91	242,742	9	5,996	0	2,641,736
KwaZulu-Natal	2,364,592	62	1,427,783	38	0	0	3,792,375
Limpopo	2,054,565	79	560,393	21	648	0	2,615,606
Mpumalanga	1,092,455	84	213,525	16	1,885	0	1,307,865
Northern Cape	297,030	88	40,162	12	0	0	337,192
North West	1,374,988	92	113,658	8	0	0	1,488,646
Western Cape	1,450,041	93	106,761	7	1,906	0	1,558,708
South Africa	13,634,684	76	4,374,202	24	12,931	0	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

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Children's access to housing

Katharine Hall and Lizette Berry (Children's Institute)

Section 28 (1) (c) of the Constitution of South Africa gives children "the right to basic nutrition, shelter, basic health care services, and social services". Article 27 of the United Nations Convention on the Rights of the Child states that every child has the right to a standard of living adequate for his/her development.

The number and proportion of children relative to their area of residence in South Africa in 2004

It is useful to know where children are living because the type of area is closely related to services and facilities available and accessible to them. In addition, the location of children in urban or rural areas directly influences their access to formal housing. More than half of South Africa's children (54%) live in rural areas. Furthermore, 96% of rural children are Black.

There are marked provincial differences in the rural and urban distribution of the population. The Limpopo, Eastern Cape and KwaZulu-Natal provinces are home to about three-quarters (74%) of all rural children in South Africa. Gauteng is almost entirely urban and the Western Cape is 87% urbanised.

Adults living in rural areas often move to urban centres in search of work, while their children remain in rural areas. Babies younger than one year are more likely to be living in urban areas than older children, suggesting that babies born in urban areas initially remain with their mothers. According to an analysis of the *General Household Survey 2004* by Debbie Budlender, after one year of age, the proportion of babies in urban areas drops from 53% to 49%. (For more details about this indicator refer to page 69.)

Table 16: The number and proportion of children relative to their area of residence in South Africa in 2004

Province	Urban		Rural		Total
	Number	%	Number	%	Number
Eastern Cape	753,285	23	2,462,562	77	3,215,847
Free State	718,994	68	344,848	32	1,063,842
Gauteng	2,547,854	96	93,882	4	2,641,736
KwaZulu-Natal	1,386,456	37	2,405,919	63	3,792,375
Limpopo	302,005	12	2,313,601	88	2,615,606
Mpumalanga	454,836	35	853,029	65	1,307,865
Northern Cape	254,097	75	83,095	25	337,192
North West	497,297	33	991,349	67	1,488,646
Western Cape	1,348,411	87	210,297	13	1,558,708
South Africa	8,263,235	46	9,758,582	54	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

The number and proportion of children relative to their type of housing in South Africa in 2004

Children have a right to adequate housing. This means that they should not have to live in informal dwellings. In South Africa, almost 2 million children live in backyard dwellings or shacks in informal settlements. Children in formal areas are likely to have better access to facilities than those in informal settlements, who are also more exposed to hazards such as shack fires and paraffin poisoning.

Housing provides the context for family life. Since migrant labour often leads to children living apart from their parents in rural areas, access to formal housing enables children to live with their parents in urban areas. Nevertheless, the greatest proportions of inadequately

housed children are in the provinces with large metropolitan centres, since it is in these areas that rapid urbanisation leads to the growth of informal settlements.

About a third of all children (32%) living in informal and backyard housing are in the Gauteng province. According to an analysis of the *General Household Survey 2004* by Debbie Budlender, there is great racial inequality in children's housing: 99% of White children live in formal housing, while only 62% of Black children live in formal houses, and 12% are inadequately housed. (For more details about this indicator refer to page 69.)

Table 17: The number and proportion of children relative to their type of housing in South Africa in 2004

Province	Adequate		Inadequate		Traditional dwelling		Other/unspecified		Total
	Number	%	Number	%	Number	%	Number	%	Number
Eastern Cape	1,065,495	33	194,295	6	1,948,109	61	7,948	0	3,215,847
Free State	772,108	73	197,868	19	91,306	9	2,560	0	1,063,842
Gauteng	1,976,132	75	632,261	24	10,655	0	22,688	1	2,641,736
KwaZulu-Natal	1,970,587	52	353,776	9	1,468,012	39	0	0	3,792,375
Limpopo	2,240,499	86	78,507	3	294,887	11	1,713	0	2,615,606
Mpumalanga	1,056,842	81	145,457	11	103,507	8	2,059	0	1,307,865
Northern Cape	308,951	92	22,167	7	5,422	2	652	0	337,192
North West	1,335,874	90	119,614	8	33,158	2	0	0	1,488,646
Western Cape	1,304,895	84	236,082	15	0	0	17,731	1	1,558,708
South Africa	12,031,383	67	1,980,027	11	3,955,056	22	55,351	0	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

The number and proportion of children living in overcrowded dwellings in South Africa in 2004

Over 4.5 million children, or a quarter of all children in South Africa, live in overcrowded households. A dwelling is overcrowded when there is a ratio of more than two people per room (excluding bathrooms but including kitchens and living rooms). Overcrowding is related to a shortage of housing. Although the government has been providing new housing, this is not enough to keep up with the pace of population growth and urbanisation.

Overcrowding is a problem because it can undermine other needs, like privacy. Children in crowded households may struggle to negotiate space for their own activities. Overcrowding also places children at greater risk of sexual abuse, especially where boys and

girls have to share beds, or children have to sleep with adults. Children under the age of six years old are marginally more likely than older children to live in overcrowded households. According to an analysis of the *General Household Survey 2004* by Debbie Budlender, a strong racial bias is also evident: over 90% of all children living in overcrowded households are Black, and less than 1% are White children.

Overcrowding is also a problem when services and other programmes do not take into account the size of the household. Children who live in crowded households not only have less living space, but may also have poorer services. (For more details about this indicator refer to page 69.)

Table 18: The number and proportion of children living in overcrowded dwellings in South Africa in 2004

Province	Overcrowded dwellings		Non-crowded dwellings		Total
	Number	%	Number	%	Number
Eastern Cape	983,080	31	2,232,767	69	3,215,847
Free State	316,466	30	747,376	70	1,063,842
Gauteng	623,892	24	2,017,844	76	2,641,736
KwaZulu-Natal	880,827	23	2,911,548	77	3,792,375
Limpopo	494,894	19	2,120,712	81	2,615,606
Mpumalanga	309,242	24	998,623	76	1,307,865
Northern Cape	102,113	30	235,079	70	337,192
North West	409,174	27	1,079,472	73	1,488,646
Western Cape	442,052	28	1,116,656	72	1,558,708
South Africa	4,561,740	25	13,460,077	75	18,021,817

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

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Children's access to education

Lizette Berry and Norma Rudolph (Children's Institute)

Section 29 (1) (a) of the Constitution of South Africa states that “everyone has the right to a basic education”.

Article 28 (1) of the United Nations Convention on the Rights of the Child states that States Parties should recognise “the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity ...”.

The Gross Enrolment Ratio (GER) for children enrolled in ordinary schools in South Africa in 2001

Education is a critical socio-economic right that provides the foundation for children's lifelong learning and work opportunities. On the whole, the Gross Enrolment Ratio¹ indicates that children's participation levels in the South African schooling system are high. However, children may be enrolled in school but not necessarily attending regularly.

In 2001, the national GER for primary and secondary school stood at 103%. It was lower for secondary schools (86%) but the ratio remained high for primary schools, at 117%. Rates of over 100% indicate the proportions of under- and over-aged children

enrolled in the school system. The Net Enrolment Ratio (NER)² tells us about the proportion of age-appropriate children that are enrolled in a particular school phase, e.g. primary school phase. According to the UNESCO Institute of Statistics, the NER in South Africa in 2002/03 was 89% for the primary school phase, and an estimated 66% for the secondary school phase. It is concerning that an estimated one-third of the population of secondary school-aged children was not enrolled in secondary school in 2002/03. (For more details about this indicator refer to page 69.)

Table 19: The Gross Enrolment Ratio (GER) for children enrolled in ordinary schools in South Africa in 2001

Province	Primary school		Secondary school		Total	
	Number of learners	Ratio	Number of learners	Ratio	Number of learners	Ratio
Eastern Cape	1,421,752	125	585,998	67	2,007,750	100
Free State	433,142	117	260,474	89	693,616	105
Gauteng	963,633	112	568,178	96	1,531,811	106
KwaZulu-Natal	1,685,113	122	931,615	91	2,616,728	109
Limpopo	1,063,960	110	647,917	90	1,711,877	101
Mpumalanga	564,205	122	331,829	97	896,034	111
Northern Cape	128,277	100	63,448	66	191,725	86
North West	567,973	108	321,995	85	889,968	98
Western Cape	585,361	111	317,820	82	903,181	99
South Africa	7,413,416	117	4,029,282³	86	11,442,698⁴	103

Source: Department of Education (2003) *Education statistics in South Africa at a glance in 2001*. Pretoria: Department of Education.

¹ The GER is defined as the number of learners enrolled in a school phase regardless of age, as a proportion of the appropriate age group in the population (e.g. 7-year-olds to 18-year-olds) and is expressed as a percentage.

² This indicator is defined as the enrolment of the school age group for a level of education (e.g. primary), expressed as a percentage of the population in that age group. See: UNESCO Institute of Statistics (2005) *UNESCO Institute for Statistics. Glossary*. Viewed: 21 September 2005: http://www.uis.unesco.org/glossary/Term.aspx?name=Net_enrolment_rate&lang=en.

³ This figure does not reflect the exact sum of the provincial figures.

⁴ This figure does not reflect the exact sum of the provincial figures.

The learner-to-educator ratio for children enrolled in ordinary schools in South Africa in 2001

Educators and classroom assistants are a key resource requirement that aid in the learning process. The number of children per educator in a classroom setting is an important indicator of the individual attention a child receives from the educator. In the context of HIV/AIDS, it is necessary for educators to be in touch with individual children's circumstances and to offer care and support to children in need of assistance. This becomes increasingly difficult if an educator has large numbers of children to attend to.

South Africa has seen a gradual reduction in the learner-to-educator ratio. There are huge differences in the learner-to-educator ratio between public and independent schools. Primary school ratios tend to be higher than secondary school ratios. Provincial analyses show that only the Eastern Cape, KwaZulu-Natal and the Limpopo provinces experienced a decrease in the ratio, while the remaining provinces showed an incline between 1999 and 2001 (Department of Education 2001; Department of Education 2003). The differences between provincial ratios indicate that inequity among provinces is still cause for concern. (For more details about this indicator refer to page 69.)

Table 20: The learner-to-educator ratio for children enrolled in ordinary schools in South Africa in 2001

Province	Public and independent schools	
	Number of learners	Ratio
Eastern Cape	2,033,832	33.2
Free State	716,021	31.2
Gauteng	1,561,359	30.7
KwaZulu-Natal	2,698,453	36.3
Limpopo	1,816,189	31.6
Mpumalanga	903,997	36.9
Northern Cape	197,101	31.0
North West	893,144	30.6
Western Cape	918,030	33.7
South Africa	11,738,126	33.1

Source: Department of Education (2003) *Education statistics in South Africa at a glance in 2001*. Pretoria: Department of Education

The number and proportion of children relative to the distance travelled to school⁵ in South Africa in 2004

Access to education is essential to ensure that children are given the opportunity to develop their full potential. It is also a key socio-economic right. The location of a child's school in relation to his or her home can pose a barrier to accessing education. Influencing factors include the availability of transport, community safety and environmental factors. Young children are most vulnerable and in danger of falling victim to foul play if travelling to school by themselves. Children are also likely to be physically tired from their long journey, which has a number of effects on their ability to learn.

According to Budlender's analysis of the *General Household Survey 2004*, of the 7.4 million children of primary school-age living

in South Africa, 1.3 million attend schools that are far from their homes. The majority of these children live in the KwaZulu-Natal and the Eastern Cape provinces. Slightly fewer than 5 million children in South Africa are of secondary school-age. Exactly one-third of these children (33%) attend schools that are situated far from their homes. On the whole, one-quarter (25%) of South African school-aged children travel far distances to reach their schools. Of the nine provinces, the Eastern Cape (33%), KwaZulu-Natal (35%), North West (25%), Mpumalanga (29%) and Limpopo (25%) provinces have one-quarter or more of their children attending far-away schools. (For more details about this indicator refer to page 69.)

Table 21: The number and proportion of children relative to the distance travelled to school⁵ in South Africa in 2004

Province	School is not far from home		School is far from home		Total
	Number	%	Number	%	Number
Eastern Cape	1,482,819	67	716,455	33	2,199,274
Free State	564,293	81	129,876	19	694,169
Gauteng	1,476,898	88	198,374	12	1,675,272
KwaZulu-Natal	1,676,442	65	903,824	35	2,580,266
Limpopo	1,374,965	75	446,368	25	1,821,333
Mpumalanga	609,158	71	251,597	29	860,755
Northern Cape	164,924	80	41,469	20	206,393
North West	736,544	75	249,390	25	985,934
Western Cape	951,655	91	96,922	9	1,048,577
South Africa	9,037,698	75	3,034,275	25	12,071,973

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

Sources

Department of Education (2003) *Education statistics in South Africa at a glance in 2001*. Pretoria: Department of Education.

Department of Education (2001) *Education statistics in South Africa at a glance in 1999*. Pretoria: Department of Education.

The Constitution of the Republic of South Africa. Act 108 of 1996.

United Nations Children's Fund (1990) *First Call for Children. World Declaration and Plan of Action from the World Summit for Children*. New York: United Nations Children's Fund.

⁵ These figures refer to children travelling to primary and secondary schools.

Technical notes on the indicators and data sources

Indicators

The number and proportion of children living in South Africa

(Table 1a – 1d): This indicator refers to the number and proportion of children under the age of 18 years who were living in South Africa at the time of the *General Household Survey 2004* (GHS). The proportion is calculated by dividing the number of children per category (e.g. girl/boy) by the total number of children in the population. The provincial proportions are calculated by dividing the number of children per category (e.g. girl/boy) in a province by the total number of children in the population.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of orphans

(Table 2): An orphan is defined as a child under the age of 18 years whose mother, father or both parents have died. This indicator measures the number and percentage of children under 18 years whose parent(s) had died by July 2004.

For the purpose of this indicator, we define different kinds of orphans as follows: a maternal orphan is a child whose mother has died but whose father is alive; a paternal orphan is a child whose father has died but whose mother is alive; a double orphan is a child whose mother and father have both died.

Orphans as a proportion of the child population is calculated by aggregating the number of children whose mother, father or both parents are dead or whose living status is unknown, and dividing this by the total child population.

The proportion of orphans by type is calculated by dividing the number of orphans for each category (maternal, paternal, double) by the total orphan population. This indicator does not include the numbers of double orphans when calculating the numbers of maternal and paternal orphans.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of children living in child-headed households

(Table 3): A child-headed household is defined as a household where everyone who lives there is under 18 years old, i.e. a child-headed household is a household consisting only of children. This indicator reflects the number and proportion of children that are living in child-headed households in South Africa in 2004.

The proportion of children living in child-headed households in South Africa is calculated by identifying the number of children living in households where the oldest resident is younger than 18, and dividing this figure by the total child population in South Africa.

The proportion of child-headed households is calculated by dividing the number of households where the oldest resident is younger than 18 by the total number of households in South Africa.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of children living in income poverty

(Table 4): One way of identifying how many children live without enough resources to meet their needs is to use a poverty line and measure how many children live under this poverty line. In this indicator, we identify children (aged 0 – 17 years) as poor when they live in households with an income of less than R1,200 per month for all the household members combined.

We used the R1,200 per month poverty line because it is the closest we could get to the R1,100¹ per month line when using the GHS. The income data in the GHS is collected in question 4.71 which asks, "What was the total household expenditure in the last month?" The bands break at R399, R799 and R1,199. Children living in households in these three bands were included as poor for the purposes of this indicator.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of children aged 0 – 14 years receiving the Child Support Grant (CSG)

(Table 5): This indicator is defined as the number and proportion of eligible children from birth to 14 years who were receiving the CSG at the end of June 2005.

Source: Department of Social Development (2005) *SOCPEN database*. (These figures are taken from the daily reports for June 2005.) The eligibility figures were calculated by Budlender using the 2004 GHS (Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa). The eligibility calculations were sourced from: Budlender D, Rosa S & Hall K (2005) *At all costs? Applying the means test for the Child Support Grant*. Cape Town: Children's Institute and the Centre for Actuarial Research, University of Cape Town.

The number of children receiving the Care Dependency Grant (CDG)

(Table 6): This indicator reflects the number of children (aged 0 – 17 years) who are accessing the CDG. The Department of Social Development's SOCPEN database records the CDGs paid out per month according to the number of children and their caregivers (beneficiaries). Figures are taken from the last working day in June 2005 from the SOCPEN daily reports.

Source: Department of Social Development (2005) *SOCPEN database*.

The number of children receiving the Foster Care Grant (FCG)

(Table 7): This indicator reflects the number of children (aged 0 – 17 years) receiving the FCG as of the end of June 2005. The SOCPEN database records the FCGs paid out per month according to the number of children and their caregivers (beneficiaries). Figures are taken from the last working day in June 2005 from the SOCPEN daily reports.

Source: Department of Social Development (2005) *SOCPEN database*.

¹ The R1,100 line is used by the Treasury and the Department of Provincial and Local Government funding for poverty alleviation programmes. Hendricks M & Hussey G (2004) The field assessment of nutrition. In: Gershwin M, Nestel P & Keen C (eds) *Handbook of nutrition and immunity*. Tottowa: Humana Press.

Infant Mortality Rate (IMR) (Table 8): The IMR is defined as the number of children younger than one year who die before their first birthday, per 1,000 live births during that year. This indicator presents data on the probability of a child dying in the first year of his/her life, for every 1,000 live births within that given year. The ASSA2000 model was used to determine overall mortality, the population size and the number of deaths due to HIV/AIDS for each province.

Estimates of the number of deaths refer to the 12-month period that started in mid-2000 and are referred to as 2000. The estimates for South Africa are from the *South African National Burden of Disease Study 2000* and differ slightly from the sum of the provincial estimates.

Source: Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, Norman R, Pieterse D & Schneider M (2004) *South African National Burden of Disease Study 2000 – Estimates of Provincial Mortality*. Cape Town: Medical Research Council of South Africa, Burden of Disease Unit.

Under-five mortality rate (U5MR) (Table 8): This indicator refers to the number of children younger than five years old who die in a year, per 1,000 live births during that year. It is a combination of the infant mortality rate, plus the 1 – 4 years mortality rate.

This indicator presents data on the probability of a child dying between the ages of one and five years. The ASSA2000 model was used to determine overall mortality, the population size and the number of deaths due to HIV/AIDS for each province. Estimates of the number of deaths refer to the 12-month period that started in mid-2000 and are referred to as 2000. The estimates for South Africa are from the *South African National Burden of Disease Study 2000* and differ slightly from the sum of the provincial estimates.

Source: Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, Norman R, Pieterse D and Schneider M (2004) *South African National Burden of Disease Study 2000 – Estimates of Provincial Mortality*. Cape Town: Medical Research Council of South Africa, Burden of Disease Unit.

The proportion of children aged 1 – 9 years who are underweight and severely underweight (Table 9): This indicator refers to children aged 1 – 9 years whose weight is below a cut-off weight (i.e. the third percentile or Z-score < -2SD) for their age. A child whose weight falls below this cut-off is referred to as being underweight for age. The third percentile represents a 60% of expected weight-for-age growth curve. If the child's weight is below 60% of expected weight (Z-score < -3SD) the child is considered to be severely underweight.²

Weight was determined for all children using electronic scales. The average of two readings was used. If the two readings varied by more than 100g, the procedure was repeated.

Source: Labadarios D (ed) (1999) *The National Food Consumption Survey (NFCS): Children aged 1 – 9 years, South Africa, 1999*. Pretoria: Department of Health, Directorate: Nutrition.

The percentage of leading causes of deaths among children under five years of age (Table 10): This indicator shows the leading causes of death among children younger than five years old. The ASSA2000 model was used to determine overall mortality, the population size and the number of deaths due to HIV/AIDS for each province. Estimates of the number of deaths refer to the 12-month period that started in mid-2000 and is referred to as 2000.

The estimates for South Africa are from the *South African National Burden of Disease Study 2000* and differ slightly from the sum of the provincial estimates.

Source: Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, Norman R, Pieterse D & Schneider M (2004) *South African National Burden of Disease Study 2000 – Estimates of Provincial Mortality*. Cape Town: Medical Research Council of South Africa, Burden of Disease Unit.

The HIV-prevalence rate among children (Table 11): This indicator shows the proportion of children, at a given period, who have HIV infection. It is calculated by dividing the number of children from age 0 – 17 with proven HIV infection in a given time period by the total number of children in the child population (0 – 17) during that same time period.

By its very nature, updated prevalence data can only be obtained through surveys. The difficulty with doing these surveys on children is that taking blood in young children is a very difficult task, and other diagnostic tests such as tests using saliva are not effective in young children. Hence we will have to continue relying on modelled estimates, such as those produced by the ASSA, and have to ensure that the underlying model assumptions are adapted according to changes in the pandemic.

Source: Actuarial Society of South Africa (2004) *ASSA2002 AIDS and Demographic Model*. Available: <http://www.assa.org.za/default.asp?id=1000000050>.

The proportion of children receiving antiretroviral therapy (ART) (Table 12): The indicator reflects the number of children who are receiving antiretroviral therapy as a percentage of children who require, and should be on, antiretroviral therapy, but who are not yet receiving it. This indicator is calculated by dividing the number of children receiving ARV treatment by the number of children who require ARV treatment.

The difficulty with this data is that the denominator is not known. The actual number of children that are HIV positive, as well as the number of those children who are in need of ARV treatment, are not known nationally. Thus all the figures, both prevalence and need, are based on modelled estimates.

Source: Actuarial Society of South Africa (2004) *ASSA2002 AIDS and Demographic Model*. Available: <http://www.assa.org.za/default.asp?id=1000000050>.

The number and proportion of children living in households with adequate water (Table 13): For the purposes of this indicator, children (aged 0 – 17 years) have access to adequate water if they have access to a clean and reliable water supply that is at their house. All other water supplies including rivers and communal taps are considered inadequate.

The *General Household Survey* asks in question 4.19 what the household's main source of water is. There are 13 options. The first four water sources are considered adequate in this indicator and include a piped tap in the dwelling or on the site or yard, a borehole on site or a rain-water tank on site. The remaining water sources are considered inadequate because of their distance from the house or the likelihood that the water is of poor quality. These inadequate water sources include public taps or those at other houses, rivers, dams, and springs.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

² Hendricks M & Hussey G (2004) The field assessment of nutrition. In: Gershwin M, Nestel P & Keen C (eds) *Handbook of nutrition and immunity*. Tottowa: Humana Press.

The number and proportion of children living in households with adequate sanitation (Table 14): This indicator includes the number and proportion of children (aged 0 – 17 years) living in households with adequate and inadequate sanitation. Adequate sanitation includes facilities that are safe, reduce odours and are within or near a house. Inadequate sanitation includes a wide range of poor toilet facilities including pit latrines that are not ventilated, chemical toilets, buckets, or no facilities at all.

The *General Household Survey* asks about each household's sanitation facilities. The following facilities are included in the category of adequate sanitation: 'flush off-site', 'flush on-site', and 'VIP', standing for ventilated improved pit toilet. Inadequate sanitation includes the following: 'chemical' toilets, 'other pit', 'bucket', 'none' and a small number of 'unspecified'.

Source: Statistics South Africa. 2005. *General Household Survey July 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of children living in households with an electricity connection (Table 15): The number and proportion of children (aged 0 – 17 years) that live in households connected to the mains electricity supply. Question 4.39 of the GHS 2004 asks, "Does this household have a connection to the mains electricity supply?" This indicator is calculated according to the number and proportion of children in households that answered yes (connected) and no (not connected).

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of children relative to their area of residence (Table 16): This indicator shows the number and proportion of children (aged 0 – 17 years) living in urban and rural areas. The classification between urban and rural is described by Statistics South Africa as 'rather fluid', and some areas have been reclassified in the past few years. This is mostly because the 'semi-urban' category was dispensed with in the 2001 Census, resulting in a slightly more inclusive 'urban' classification.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of children relative to the type of housing they live in (Table 17): This indicator shows how many children (aged 0 – 17 years) live in adequate housing. 'Adequate' is defined as formal housing, while 'inadequate housing' includes informal dwellings in informal settlements and backyard dwellings. 'Traditional' housing in rural areas is a third category, which is not necessarily adequate, but is not always defined as 'inadequate' in official estimates of the housing need.

South African housing policy has no clear or consistent definition of adequate housing since 'adequate' includes a range of attributes. Some of these are very technical, for instance relating to the quality and size of the dwelling. There are also qualitative descriptors of 'adequate' housing. However, the main attribute used to determine the housing backlog is the type of the dwelling. This indicator provides a fairly crude measurement of adequacy, calculated purely on the basis of housing type.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The number and proportion of children living in overcrowded dwellings (Table 18): Children (aged 0 – 17 years) are defined as living in overcrowded dwellings when there is a ratio of more than two people per room (excluding bathrooms but including kitchen and living room).

There is no standard measure of overcrowding in South Africa, but there are many international definitions. The definition used here is derived from the UN-HABITAT definition, which is a maximum of two people per habitable room. 'Habitable' excludes bathroom and toilet. The data is taken from Question 4.5 in the *General Household Survey*: number of rooms occupied (excluding bathrooms and toilets). The overcrowding ratio is obtained by dividing the total number of household members by the total number of rooms occupied by the household.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

The Gross Enrolment Ratio (GER) for children enrolled in ordinary schools (Table 19): This indicator reflects the proportion of children enrolled at school in a specific school phase (e.g. primary school), regardless of age, as a percentage of the total appropriate school-age population.

The GER is thus defined as the number of learners enrolled in a school phase, regardless of age, as a proportion of the appropriate age group in the population (e.g. seven-year-olds to 18-year-olds), and expressed as a percentage.

Source: Department of Education (2003) *Education statistics in South Africa at a glance in 2001*. Pretoria: Department of Education.

The learner-to-educator ratio for children enrolled in ordinary schools (Table 20): The learner-to-educator ratio is the average number of pupils per educator at a specific level of education, or for a specific type of school, in a given school year (EduAction, 2005³). The ratio is calculated by dividing the number of learners by the number of educators for a specific school type (e.g. public schools).

Source: Department of Education (2003) *Education statistics in South Africa at a glance in 2001*. Pretoria: Department of Education.

The number and proportion of children relative to the distance travelled to school (Table 21): This indicator reflects the distance that children (aged 6 – 17 years) travel from their homes to the school that they attend. The distance is seen as far if children travel more than 30 minutes to reach their schools.

This indicator is based on the *General Household Survey* (2004:8⁴) question: "How long does it take (the child) to get to the school/educational institution where he/she attends?" Where respondents indicated that children spent more than 30 minutes travelling to their school, the distance to school was categorised as 'far'. Where children spent 30 minutes or less travelling to their school, the distance was categorised as 'not far'. The indicator was also defined by school-going age (primary or secondary) and not by school attendance.

Source: Statistics South Africa (2005) *General Household Survey 2004*. Pretoria, Cape Town: Statistics South Africa.

³ EduAction (2005) *SADC Regional EMIS Database*. Accessed 19 July 2005: <http://brilliantweb.co.za/test/sadc/overview.html>

⁴ Statistics South Africa (2004) *General Household Survey Questionnaire 2004*. Pretoria, Cape Town: Statistics South Africa.

Data Sources

General Household Survey: The *General Household Survey* is an annual survey conducted by the national statistics body, Statistics South Africa (<http://www.statssa.gov.za>). The sample used is based on the enumeration areas established during the Census demarcation phase and therefore covers all parts of the country. The sample of 30,000 dwelling units ensures as much representivity as possible by stratifying by province, and then by urban and rural area. The resulting estimates should be representative of the total population of South Africa.

However, over- and under-estimation appears to have occurred in the weighting processes. It seems that the numbers of children aged 7 – 12 has been over-estimated by 6%, as well as the numbers of persons aged 13 – 22 years. The number of very young children appears to be under-estimated. The patterns of over- and under-estimation appear to differ across population groups. For example, the number of White children appears to be over-estimated by 14%, while the number of Coloured persons within the 13 – 22 year age group appears to be 9% too low.⁵

Further error may be present due to methodology, i.e. the questionnaire is administered to only one respondent in the household who is expected to provide information about all other members of the household. Not all respondents will have accurate information about all children in the household. In instances where the respondent could not provide an answer, this was recorded as 'unspecified' (no response) or 'don't know' (the respondent stated that they didn't know the answer). The survey is conducted annually, and datasets are therefore available on a yearly basis.

SOCPEN database, Department of Social Development: There has never been a published, systematic review of the SOCPEN database, and the extent of the limitations of validity or reliability of the data has not been quantified. However, it is regularly used by the department and other government bodies to monitor grant uptake. This administrative data set is constantly updated by Department of Social Development employees when entering application and payment data. Uptake data and selected reports are available from the department on request throughout the year. Grants data will be updated every three months for the *Children Count – Abantwana Babalulekile* project.

Education statistics in South Africa at a glance, Department of Education: This data is based on the department's annual survey and SNAP (snap-shot) survey, taken on the tenth day of the school year. The data capturing and processing of these surveys are known to be problematic and erroneous. The accuracy and reliability of this data is therefore questionable.

As these surveys are conducted annually, data should be available on a yearly basis. However, data processing systems differ across the provinces, and some are more efficient than others. The most recent data set that has been released is for 2001. The department's current information management system, known as the Education Management Information System (EMIS), is presently under review.

South African National Burden of Disease Study: This study makes use of vital registration data (number of official births and deaths) but adjusts for under-registration, as large number of births and deaths of younger children in particular are unreported. A modelling approach, developed by the Actuarial Society of South Africa (ASSA), was thus used to estimate the total number of deaths since vital statistics are incomplete. The ASSA2000 model was used to

determine overall mortality, the population size, and the number of deaths due to HIV/AIDS for each province.

The basic mortality assumptions for children were as follows: "child mortality estimates from the 1996 Census and the 1998 *Demographic Health Survey* (SADHS) both show a reversal of the downward trend, although there are differences in the estimated levels (Nannan et al, 2000). Adjustments are made to both sets of estimates due to differences and inherent biases in the different methodologies. A small upward adjustment is made to the DHS and a downward adjustment to the Census data which appear too high due to the inclusion of stillbirths incorrectly classified as live births who have died (Moultrie and Timaeus, 2002)."

The ASSA modelled estimates are made available on a yearly basis.

The National Food Consumption Survey (NFCS): This was a cross-sectional survey in children aged 1 – 9 years in South Africa. A nationally representative sample with provincial representation was drawn using the Census 1996 data. The number of children included in the study was 3,120, allowing for over-representation of children from high-risk areas.

A total of 156 randomly selected Enumerator Areas (EA) was included in the survey. A qualifying household was defined as any household with at least one child aged between 1 – 9 years. A snowball sampling technique was used to establish a sampling frame in each EA of households with children in the prescribed age group. From the list of qualifying households, the required number of households for the survey in a given area was randomly selected. Five questionnaires were used in the study, and anthropometric assessments were carried out on each child in the study by trained fieldworkers. Standardised and internationally recognised methods were used for these assessments.

The results of the survey appear to be accurate, within the sampling framework used, at a national and at provincial levels.

ASSA2002 AIDS and Demographic Model: Currently the only available data on HIV-related indicators are estimates based on modelling. The underlying assumptions of the model, however, are well accepted nationally and these are thus the best estimates that we have at present.

Estimates are obtained by using mathematical models. These models give an indication of the proportion of adults and children affected by HIV/AIDS. The demographic model is based on a wide range of available empirical evidence, for example, regular survey data and vital statistics, such as the antenatal clinic survey results and number of deaths from the population register (Dorrington, Bradshaw, Johnson, & Budlender 2004). Data and modelled results are available on <http://www.assa.org.za/default.asp?id=100000050>.

Sources

Dorrington RE, Bradshaw D, Johnson L & Budlender D (2004) *The Demographic Impact of HIV/AIDS in South Africa National Indicators for 2004*. Cape Town: Centre for Actuarial Research, Medical Research Council of South Africa and Actuarial Society of South Africa.

Moultrie T & Timæus I (2002) *Trends in South African fertility between 1970 and 1998*. Cape Town: Medical Research Council of South Africa, Burden of Disease Unit.

Nannan N, Bradshaw D, Timæus & Dorrington R (2000) *The impact of HIV/AIDS on infant and child mortality in South Africa*. Abstract of poster MoPeD2507. XIIIth International AIDS Conference, Durban, South Africa, 8 – 13 July 2000.

⁵ Dorrington R & Kramer S (2004) *The 2004 mid-year estimates: Method, reliability and implications*. Paper presented at a Centre for Actuarial Research seminar, University of Cape Town.

About the contributors

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Debbie Budlender is a specialist researcher with the Community Agency for Social Enquiry (CASE). She has a BA Honours in Economics, an MA in Industrial Sociology and a BSc in Computer Science and Mathematics. She is overall co-ordinator of South Africa's Women's Budget Initiative and has served as a consultant to the Department of Finance, non-governmental organisations and other governments and donors in various countries. She serves on South Africa's Employment Conditions Commission and on the Council of the University of Cape Town. She has since 2002 been on a long-term, part-time secondment to the Centre for Actuarial Research at the University of Cape Town.

Sonja Giese, formerly with the Children's Institute, now works for the United Kingdom-based charity, Absolute Return for Kids (ARK), where she is establishing a programme to support children in heavily AIDS-affected communities in South Africa. She has a Social Science Honours (Psychology) degree and is currently registered for an interdisciplinary Masters degree. Her areas of interest include supporting children through schools, strengthening the role of home-based carers in their support of vulnerable children, and preventing and addressing the institutionalisation of children.

Katharine Hall is a senior researcher in the Child Poverty

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Michael Hendricks is a paediatrician and researcher at the Child Health Unit in the School of Child and Adolescent Health, University of Cape Town. He has an MB ChB, MMed (Paed) and MTrop (Paed DCH). His field of research includes clinical and public health nutrition. The focus of his research includes micronutrients, the impact of micronutrient deficiency on cognitive function, community-based nutrition and the evaluation of nutrition programmes/policies. He also convenes the Masters programme (M Phil) in maternal and child health and is involved in undergraduate and postgraduate training.

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Leigh Johnson is a researcher at the Centre for Actuarial Research at the University of Cape Town. He has a Bachelor of Business Science and PG Diploma Actuarial Science. His research interests are in the modelling of HIV/AIDS and other sexually transmitted diseases, and in the modelling of prevention and treatment strategies for these diseases. He is a member of the AIDS Committee of the Actuarial Society of South Africa (ASSA), and he has been closely involved in the development of the ASSA AIDS models.

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Mrs Graça Machel is the current Chancellor of the University of Cape Town and also the Chairperson of the Children's Institute Board of Advisors. Passionate about education and the problems of children in the developing world, she has been a major force in increasing literacy and schooling in Mozambique, and has spoken for the rights of children, families and communities from platforms all over the world. In the 1990s, she led a United Nations study on the impact of armed conflict on children, which resulted in the approval of a Special Representative of the UN Secretary General on Children in Armed Conflict. She is a goodwill ambassador for UNICEF, chairperson of the National Organisation of Children of Mozambique and president of the country's UNESCO commission.

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Namhla Mniki is a researcher in the HIV/AIDS Programme at the Children's Institute, University of Cape Town. She has a postgraduate degree in development studies and has lectured in the development field and in research methodology. Currently she is managing the *Dikwankwetla* project, as well as researching the capacity of schools to be nodes of care and support for vulnerable learners in South Africa.

Jo Monson is the materials developer for the HIV/AIDS Programme at the Children's Institute, University of Cape Town. She has worked extensively in the development sector across a range of communication fields including drama, radio, video and publishing. She is currently developing a range of materials in collaboration with facilitators, learners, educators and community members to support schools in ensuring child well-being.

Paula Proudlock has a BA (LLB) and a BA degree and is in the final stages of an MA in Public Law. She has nine years of experience in project and network management, children's rights and advocacy. Her particular interest is on promoting the participation of civil society in the policy and law-making process. She is a founding member of the Alliance for Children's Entitlement to Social Security (ACCESS) and currently serves on the ACCESS board. She is also the manager of the Children's Bill Working Group and the Child Rights Programme Manager at the Children's Institute, University of Cape Town.

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Justice Albie Sachs is a human rights activist and a Constitutional Court judge. He played a prominent role in the struggle for South Africa's liberation from apartheid and spent his early years as an advocate defending people charged under racist statutes and repressive security laws. He went into exile in 1966 and spent more than two decades in exile in England and Mozambique. He returned home in 1990 and, as a member of the Constitutional Committee and the National Executive of the African National Congress, he played an active part in the negotiations which led to South Africa becoming a constitutional democracy.

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The *South African Child Gauge* is produced by the Children's Institute, University of Cape Town. The aim of this annual publication is to report on the situation of children to highlight the challenges related to the promotion and protection of children's rights.

The *South African Child Gauge* examines the links between children's reality, South Africa's commitments to child rights, and society's progress in this regard. This is done through commentary on the country's response to different aspects of realising children's rights, and through a set of broad-based indicators aimed at gauging improvements in the situation of children over time. This first edition focuses on children and HIV/AIDS, presented against the backdrop of a narrative and quantitative snap-shot of the situation of children in South Africa.

The Children's Institute aims to contribute to policies, laws and interventions that promote equity and realise the rights and improve the conditions of all children in South Africa, through research, advocacy, education and technical support.

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