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Children living with HIV/AIDS

in South Africa

A Rapid Appraisal

Researched and written by:

Rose Smart
HIV/AIDS Consultant

For the NACTT
(Interim National HIV/AIDS Care and Support Task Team)

Funded by:
Save the Children (UK)

Acknowledgements

Firstly, I would like to thank the Interim National HIV/AIDS Care and Support Task Team (NACTT) for their guidance throughout the Rapid Appraisal; Maria Mabetoa and Johanna de Beer (Department of Welfare), Cornelius Lebeloe and Liz Dartnall (Department of Health), Ros Halkett (SA National Council for Child Welfare), Karin Seydlitz (UNICEF), Stephen Morgan (Save the Children UK) and Linda Aadnesgaard (CINDI).

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And finally, to all the children living with HIV/AIDS in South Africa, to whom this work is dedicated. May it truly make a difference to your lives.

Foreword

The AIDS pandemic represents an enormous threat to South Africa, one that demands an effective and coordinated response from all sectors of society. It touches all of our lives and increasingly casts a shadow over the country's future. Moreover, it is glaringly apparent that the inheritors of this future, South African children, are particularly vulnerable. In particular, the frightening growth in the numbers of orphans constitutes nothing less than a national emergency, undermining many of the hard-earned gains of South African society in the past few years. It was precisely this fear of what the future may hold for the next generation of South Africans that encouraged the National Task Team for children infected and affected by HIV/AIDS, a coalition of Government Ministries, NGOs and donor agencies, to commission this research.

Whilst looking at all children living with AIDS, the document's principal focus is on affected children. It shares the salient lessons learnt from the experiences of selected models of care and support that are already in the front line of the national response against the pandemic. The information accrued provides the data for a series of recommendations that will, we hope, provide a framework for action for both Government and civil society. It emphasises the need for a multisectoral approach to HIV/AIDS, calling upon the private and public sectors, NGOs, families and communities to work together to develop responses that mitigate the worst of the pandemic's impact on children.

The recommendations will additionally provide core input for the National Strategic Framework for Children and HIV/AIDS. This is a process led by National Government, which will address the immediate and urgent needs of children at the present time and also develop a longer-term strategy that will prepare South Africa adequately for future challenges. The need to develop such a response is, of course, paramount. South Africa already has suffered one "lost generation". It can ill afford to lose another.

Finally, on behalf of the Task Team, we would like to thank the researcher, Rose Smart, for her excellent work. Save the Children Fund (UK) is honoured to have had the opportunity of working with South African partners in this field and to have supported such valuable research.

Stephen Morgan
Programme Director
SCF (UK) South Africa

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DEFINITIONS

The study found a lack of consistency in the definitions which are used in the literature on children and HIV/AIDS. For the purposes of this report specific definitions have been selected, which, as far as possible, are consistent with South African usage of terms

A child is a person under 18, unless by law majority is attained at an earlier age (CRC)

CINDI (children in distress)

- a child who is orphaned, abandoned or displaced
- a child, under the age of 15 who has lost his/her mother (or primary caregiver) or who will lose his/her mother within a relatively short period

Youth - the Youth Commission Act defines *youth* as anyone between the ages of 16 and 35¹

An orphan is a child under the age of 15 who has lost his or her mother

An infected child is a child, under the age of 18, who is infected with HIV

An affected child is a child living in a family in which there are, or have been, one or more HIV infected family members

Duty bearer – a parent, relative, community worker, government official etc who has duties which they 'owe' to a child

Claim holder is a child who can claim rights – the right holder

Age of consent – at 14 years, a child is competent to decide about medical treatment, but the parent or guardian retains the right to give consent, except in the case of choice on termination of pregnancy where a 14 year old female may give consent to the procedure

Child labour – the minimum age of employment of children is 15

Compulsory schooling – 15 years, or the completion of grade 9, is school-leaving age. There is provision for compulsory education between the ages of 7 and 15 years

¹ The White Paper on Social Welfare (1997) defines a young person as between 16 and 30

HOW TO READ THE REPORT

The report is intended to be an accessible reference on children living with HIV/AIDS in South Africa. Each chapter may be used as a stand-alone source of information on specific topics. For easy reference, a summary of key points appears at the end of Chapters Two to Nine.

The following is a simple guide to what is covered in the chapters.

Chapter One describes the origin, focus and methodologies of the Rapid Appraisal. The context within which the Rapid Appraisal took place is summarised.

Chapter Two sets the scene by describing the situation regarding South Africa's children and the goals for children for the new millennium.

Chapter Three describes the global HIV/AIDS epidemic, the individual, household and societal impact and the emerging epidemic in South Africa.

Chapter Four describes the basic facts about children infected with or affected by HIV/AIDS.

Chapter Five explores interventions and models of care for children infected with or affected by HIV/AIDS.

Chapter Six develops the concept of a children's rights framework and proposes a rights approach to services and interventions for children infected with or affected by HIV/AIDS.

Chapter Seven summarises the Rapid Appraisal of the perceived priorities, the needs of children, the services available and the gaps.

Chapter Eight describes selected model projects and identifies lessons for implementation.

Chapter Nine proposes a framework for a national strategy on children and HIV/AIDS based on common themes which emerged from the Rapid Appraisal.

Chapter Ten makes recommendations, for the national strategy and for projects, based on the findings of the Rapid Appraisal, and poses key research questions.



EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Background

There are 16.3 million children in South Africa, 61% of whom live in poverty. Examination of their status (health, welfare, education etc) reveals severe shortcomings in all areas. With the advent of the HIV/AIDS epidemic the situation is worsening and any hard won gains for infants and children are threatened. In recognition of this, Government has called for a **national strategy** on children and HIV/AIDS.

The strategy will cover children who are infected with HIV, children who are vulnerable to becoming infected and children who are affected, with the main emphasis being on **affected children**, including AIDS orphans.

But before South Africa can mount an effective response it is necessary to generate:

- ⌘ an awareness of the present situation regarding its children;
- ⌘ an understanding of the epidemic, both currently and the future projections;
- ⌘ an appreciation of the positions of key role-players and communities in respect of the issues of children and HIV/AIDS; and
- ⌘ an analysis of existing models of care and support for children in distress.

These, in turn will inform the national strategy, existing and planned projects and the development of appropriate, sustainable responses. A **Rapid Appraisal** of children infected with and affected by HIV/AIDS was commissioned in October 1999 by the Interim National HIV/AIDS Care and Support Task Team (NACTT), funded by Save the Children (UK). The Rapid Appraisal seeks to provide information for the national strategy and the various national, provincial and local processes emanating from it.

The context of a national strategy

There are increasing numbers of children in distress as a result of the escalating HIV/AIDS epidemic. Orphans will comprise 9 – 12% of the total population by the year 2015. Traditional models of surrogate child care are progressively less able to accommodate these children. In particular, poor communities cannot absorb children in distress into informal care and extended family structures without outside support. All these factors are compounded by the stigma associated with HIV/AIDS.

The needs and rights of affected children

All children have physical and material needs, intellectual and educational needs and psychosocial needs. Children affected by HIV/AIDS are particularly vulnerable in all these areas, as they take on adult household, parenting and caring responsibilities. Typically these children experience a lack of supervision and care, stunting and hunger, educational failure, inadequate health care, psychological problems, disruption of normal childhood and adolescence, exploitation and discrimination.

Care and support for affected children

An examination of successful models of care and support suggests that the key challenges facing South Africa are:

- ⌘ How to develop simple, effective, community-based mechanisms to identify children in need?
- ⌘ How to provide care and support that maintains the affected child within a family and within its own culture and community of origin?
- ⌘ How to mobilise and support communities in order that they, in turn, can provide support systems for children and their caregivers?
- ⌘ How to ensure that the care and support of affected children becomes an element of associated programmes such as home-based care?
- ⌘ How to increase capacity at all levels to provide care and support for affected children?

These are echoed in the nine priority areas which were identified by stakeholders who responded to a questionnaire on how South Africa should be preparing for the increasing numbers of infected and affected children. These were:

- ⌘ Policy development – national and local policy and planning leading to the assumption of responsibilities by all sectors and partnerships
- ⌘ Advocacy with an emphasis on family and community awareness, mobilisation, empowerment and involvement
- ⌘ Capacity building and training at all levels
- ⌘ Mainstreaming children's issues into other programmes such as into strategies to alleviate poverty
- ⌘ Accessing resources - financial and material
- ⌘ Co-ordination of services and the need for a database of children in need
- ⌘ Legal reform - linked to the Child Care Act
- ⌘ Research to provide relevant data
- ⌘ The development of new models

Lessons from projects

Existing projects provide many lessons for the national strategy.

- ⌘ Holistic care should include the recognition of economic security as a necessary component and should ideally provide access to a range of services at a single point.
- ⌘ Simple interventions, such as good hygiene and nutrition, have been proven to be extremely beneficial as part of a holistic care package for both adults and children.
- ⌘ Networking between organisations working for and with children facilitates the provision of material resources and information and strengthens the partner organisations in the process.

- ⌘ The best interests of the child should guide all functions and initiatives. Even in a context where the most basic needs are the priority, educating caregivers and children about their rights has had very positive consequences.
- ⌘ Home-based care programmes are the optimum vehicle for identifying children in distress and orphans and establishing programmes for them.
- ⌘ Talking to children and preparing for death is facilitated by holding family conferences and creating Memory Books.
- ⌘ Stigma and discrimination associated with HIV/AIDS are lessened when a project is not AIDS-specific.

Framework for a national strategy

A ten element framework for a national strategy is proposed:

- Multisectoral policy development
- Advocacy
- Mainstreaming HIV/AIDS and children's issues into key programme and development areas
- National and provincial capacity building
- Local and community capacity building
- Building capacity in children
- Establishing priority needs across the continuum from prevention to care and support
- Research
- Project and programme development
- Mobilising and co-ordinating the response

Recommendations from the Rapid Appraisal

The following are the key recommendations from the Rapid Appraisal:

- ⌘ ***A policy framework***
The lack of a policy framework within which to understand the whole subject of children and HIV/AIDS in South Africa was identified as a barrier to effective, co-ordinated action. The National Strategic Framework should be finalised as a matter of urgency, incorporating the findings from the Rapid Appraisal.
- ⌘ ***Database of organisations working with and for children***
Many people interviewed identified isolation from and a lack of knowledge of what was happening outside their immediate area as a real constraint. The compilation of a comprehensive database of organisations working with and for children in South Africa would greatly facilitate communication and co-operation.
- ⌘ ***Networks and co-ordination mechanisms***
The advantages of a network of organisations working together for the benefit of children in distress are obvious. A generic model of how a network can operate should be developed and training conducted with potential partners in all parts of the country on how to initiate, construct, manage and sustain a network.

- ⌘ **Poverty**

HIV/AIDS precipitates families into poverty and even into destitution. An appreciation of this is fundamental to developing appropriate responses. Wherever possible poverty alleviation programmes should work hand-in-hand with projects for children and all projects should aim to have the means to provide basic necessities such as food and clothing.
- ⌘ **Identifying children in distress**

The identification of children in distress is frequently ad hoc. A standardised form for registering children in distress should be developed. This, in turn, could feed into the process of allocating grants and would provide invaluable data with which to plan for the emerging impact of increasing numbers of AIDS orphans.
- ⌘ **Using home-based care as the access point**

The issue of children affected or orphaned by AIDS is a natural extension of any home-based care programme for people with HIV/AIDS. Every home-based care programme, at whatever stage of its existence, should also cater for affected and orphaned children, not as an after-thought but as an integral part of the programme.
- ⌘ **Holistic care and support within a comprehensive continuum**

Care and support are the two terms most frequently used when considering children affected by HIV/AIDS. Traditionally, holistic care has looked at the individual as a complete person with physical, emotional, spiritual and social needs. This concept needs to be extended into the understanding of support as well, for children, extended families and communities. To translate this concept from the theoretical into the practical requires that health-focused initiatives consider a new expanded model and welfare-focused initiatives do likewise.
- ⌘ **Planning for the future of children who will be orphaned**

The stigma associated with disclosing an HIV diagnosis remains prevalent and often results in a 'silence' about a parent's impending death which becomes a barrier to making plans for his or her children's future. Whether through the means of a Memory Book, or in a family conference, there are benefits for both the parents and their children of creating a safe place to talk about the future.
- ⌘ **Supporting children as caregivers**

All projects report that children are caring for dying parents, yet, perhaps because it is so unacceptable a concept, little has been done to prepare them for this role or to support them in carrying it out. Where there is no viable alternative, children must be prepared to care for their infected parents.
- ⌘ **Promoting a rights based approach**

Training caregivers and children in understanding children's rights equips children with alternatives based on these rights. The best interests of the child should be a guiding principle in all projects and modules on children's rights should be included in all training programmes. Strategies to ensure effective participation by children and youth in all projects should be implemented.

⌘ ***Support for affected children***

There is growing consensus that ‘drop-in centres’ which could cater for support groups, counselling, supervision of homework, meals, IGAs etc for affected children would fulfil a valuable function. Community-based projects should identify the specific needs of affected children in their programmes and then consider the feasibility of establishing such centres.

⌘ ***Community mobilisation***

There is universal agreement that effective responses to HIV/AIDS must be situated in and owned by communities. Yet the reality is that AIDS is impoverishing communities and unravelling families, the very structures which constitute communities. So how can communities be *mobilised*? The starting point is to let the community identify its own concerns and what responses are possible with existing internal resources, knowledge, skills and talents. There then needs to be a process to decide on priority needs and, only at this point, should any outside capacity or resources be added that are needed to carry out the chosen activities.

⌘ ***Discrimination and stigma***

Stigma and discrimination associated with HIV/AIDS still constitute significant barriers to effective service delivery. Projects have found that not being AIDS specific, for example providing home-based care to anyone with a life limiting disease (not just people with terminal AIDS) or supporting all orphans (not only AIDS orphans) minimises this barrier.

⌘ ***Capacity building***

Critical capacity building needs have been identified at every point during the Rapid Appraisal. Across the board, projects whose primary aim was initially service delivery are being drawn into providing training, many to the extent that this is changing their focus. It is necessary to identify who requires training at national, provincial and local/community level and to share training resources.

⌘ ***Grants***

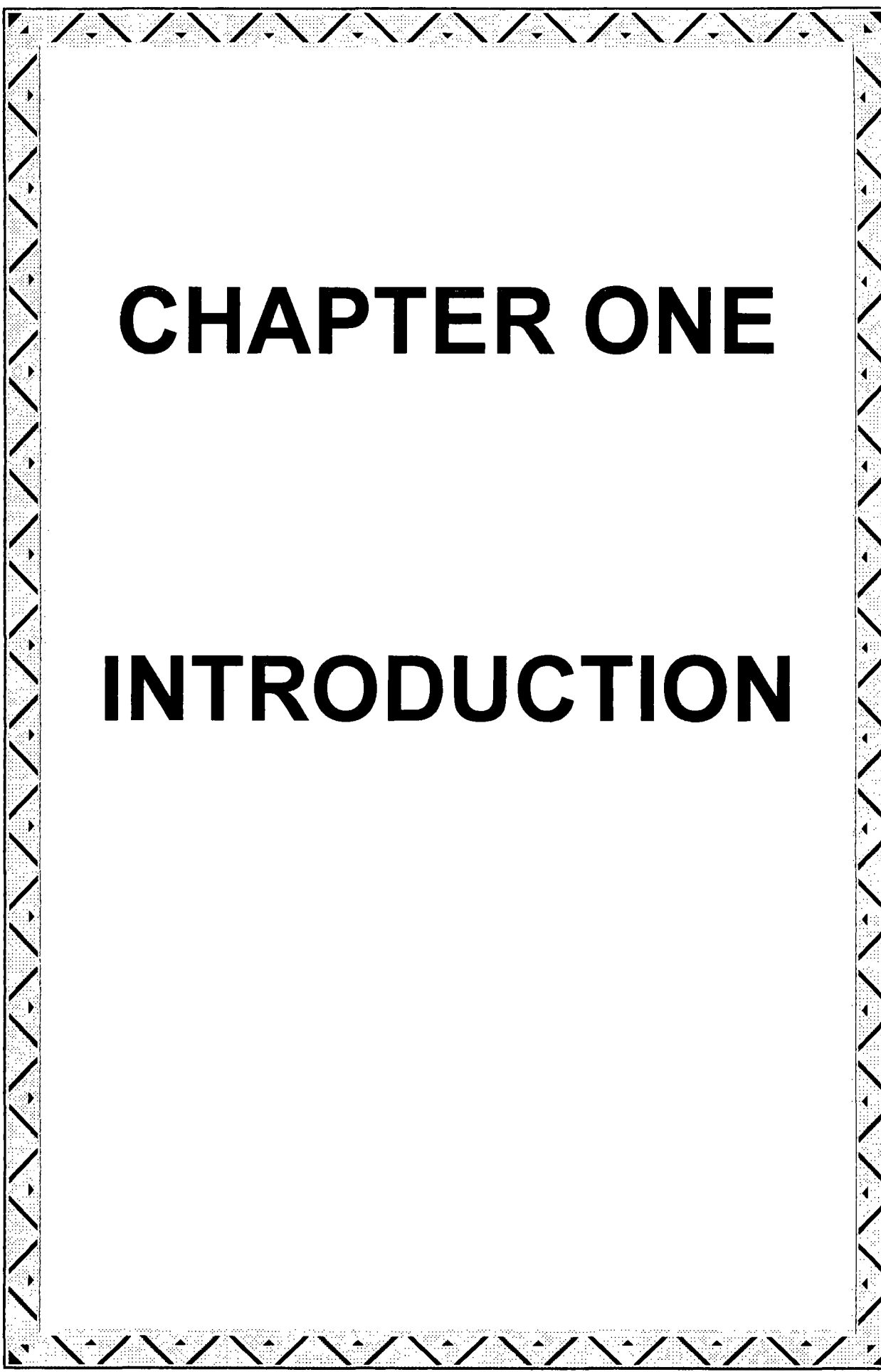
Awareness of the availability of grants is limited, the process of applying for them is fraught with difficulties, particularly where birth certificates and other identity documents are missing and processing of applications is protracted due to bureaucratic problems. Understanding the processes and supporting families to access grants will greatly alleviate poverty.

⌘ ***Guidelines for projects***

Many projects arise as an emotional response to an observed need. Proper planning which anticipates the demands on the project and locating the necessary expertise, for example by ensuring that people with suitable qualifications are represented on management structures, will assist.

⌘ ***Research questions***

It is necessary to generate a research agenda, as there are multiple areas where research is required to provide information to guide the implementation of the national strategy.



CHAPTER ONE

INTRODUCTION

CHAPTER ONE: INTRODUCTION

Chapter One describes the origin, focus and methodologies of the Rapid Appraisal. The context within which the Rapid Appraisal took place is summarised.

WHY WAS THE RAPID APPRAISAL COMMISSIONED?

Following the regional CINDI Conference held in Pietermaritzburg in June 1998, an Interim National HIV/AIDS Care and Support Task Team (NACTT) was established to co-ordinate the development of a **national strategy on children and HIV/AIDS**. To inform the strategy, the NACTT retained a consultant to conduct a Rapid Appraisal of children infected with or affected by HIV/AIDS in South Africa.

The terms of reference were to describe:

- What is known about children infected with and affected by HIV/AIDS in South Africa currently, and the projections for their future status?
- What are the needs of infected and affected children and children vulnerable to HIV infection?
- Where are the gaps in understanding of the issues and in the provision of services for children?
- What lessons can be learned from selected models?
- What are the recommendations for the national strategy?

WHAT IS THE FOCUS OF THE RAPID APPRAISAL?

The term *children living with HIV/AIDS* was adopted by the NACTT to encompass all children, namely:

- Those from 'uninfected' households who are affected due to the societal impact of the epidemic (reduced access to services and reduced quality of services);
- Abandoned children;
- Those from 'infected' households who are affected in a range of ways both before and after the deaths of their parents;
- Those who are vulnerable to HIV infection; and
- Those who are infected

Recognising that the scope of the Rapid Appraisal would be very broad, encompassing all children, it was agreed that the primary focus should be on **care and support for affected children**. In addition, due to the global move to define children's issues in terms of their rights, the Rapid Appraisal sought to identify a process to move from a needs-based framework to a rights-based framework.

WHAT METHODOLOGIES WERE USED?

The components of the Rapid Appraisal included:

- A desk review of relevant literature
- Stakeholder questionnaires and interviews
- An in-depth analysis of selected models of care and support

The NACTT wished to complement the rapid appraisal with additional elements, namely:

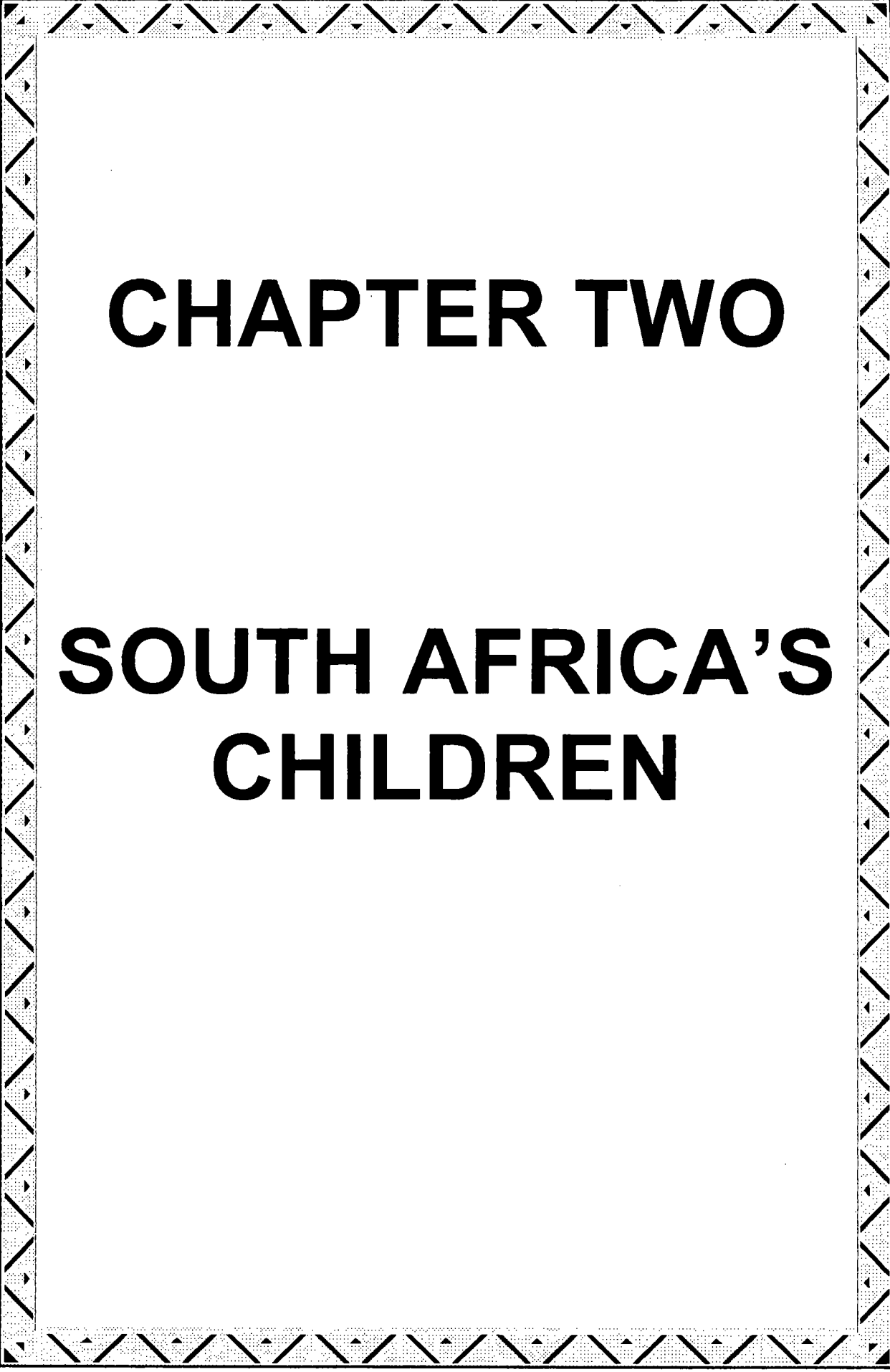
- Interviews with community leaders;
- Focus groups with service providers; and
- Focus groups with users (children)

Due to time and other constraints, it was not possible to pursue this and it is acknowledged that this is a limitation of the rapid appraisal.

WHAT OTHER PROCESSES WERE ALSO TAKING PLACE?

The original time frame for the rapid appraisal was five months, from October 1999 to February 2000. A number of events related to the development of a national strategy on children and HIV/AIDS occurred during that time which impacted on the Rapid Appraisal. These are summarised below:

October 1999	The Inter-Ministerial Committee (IMC) on HIV/AIDS instructed that an implementation strategy be developed to ensure effective and efficient services to children affected by and infected with HIV (lead Department: Welfare)
2 November 1999	Draft National Strategic Framework (NSF) for affected and infected children developed and circulated
9&10 November 1999	Consultative meeting held to finalise a NSF for affected and infected children; identify community-based models for immediate implementation; develop a four-year implementation plan (2000-2003), identify sites where implementation will commence; determine financial implications; and determine institutional arrangements for implementation and monitoring
16 November 1999	Workshop report circulated
30 November 1999	First draft of NSF
4 January 2000	Second draft of NSF
17 January 2000	Third draft of NSF
25 January 2000	NSF submitted to IMC. Resolution that the NSF be incorporated into the Five-year National AIDS Plan (lead Department: Health)
Feb – March 2000	Meetings in all Provinces to present the NSF; obtain commitment; clarify roles; identify pilot sites; develop a business plan; and set up local forums
16&17 March 2000	National meeting to establish structures
1 April 2000	Implementation to commence



CHAPTER TWO

SOUTH AFRICA'S CHILDREN

CHAPTER TWO: SOUTH AFRICA'S CHILDREN

Chapter Two sets the scene by describing the situation regarding South Africa's children and the goals for children for the new millennium.

FACTS ABOUT SOUTH AFRICA'S CHILDREN^{1 2}

In South Africa there are 16,3 million children, almost half of the total population of 38,8 million.³ There are 6 million children under the age of 6, many of whom live in under-resourced rural areas. It is estimated that 61% of children live in poverty. The first South African supplementary report on the UN Convention on the Rights of the Child (May 1999) described the context for South Africa's children as a '*racially divided, traumatised, dehumanised and child welfare negligent society*'. The following facts describe this reality.

Health status

- The infant mortality rate (IMR) was 45 per 1 000 in 1998
- Of the 1.2 million children born annually in South Africa, 85 000 die before their 5th birthday (U5MR). The child mortality rate is 15 per 1 000 live births
- Only 63% of one-year olds have complete immunisation cover and only 56% of children have a Road to Health card
- 36% of all child deaths are due to treatable conditions - diarrhoeal diseases (25%) and acute respiratory infections (11%)
- 23% of children under 5 are stunted due to long-term malnutrition (1994) One in three children have marginal Vitamin A status and 50% of pregnant women suffer from iron deficiency
- 32% of African households are dependent on river water and 16% have no toilet facilities at all
- The maternal mortality rate was 150 per 100 000 births in 1998, reflecting weaknesses in the delivery of health care

Welfare status

- 20% of children do not live with their mothers
- Only 49% of children have a birth certificate (which has implications for accessing welfare grants)
- 47% of households contain more than 6 people
- 40% of poor households are dependent on a social pension
- 39% of households are headed by women and the poverty rate in these households is double the rate in male-headed households
- 29 000 children are currently in residential care⁴ and 73 000 in foster care⁵
- During 1997, about 3 000 adoption orders were issued

¹ Robinson, S and Biersteker, L (eds); *First Call: The South African Children's Budget* (1997)

² UNDP; *HIV/AIDS Human Development South Africa* (1998)

³ The SA National Council for Child Welfare's publication *HIV/AIDS and the Care of Children* uses a figure of 19 775 600 children under the age of 18 in 1997

⁴ SA Law Commission; Issue Paper 13; *The Review of the Child Care Act* (1998)

⁵ President's report on the state of the nation's children (December 1999)

- In 1997, Child Protection Units investigated 35 000 cases of child abuse. Rape was the most prevalent crime. Given the low levels of reporting, these are conservative estimates of the number of children who have experienced or continue to experience some form of abuse. Thorpe (1994) estimates that 500 000 female children are sexually victimised annually
- The number of children in dysfunctional families is high. In 1995 there were 31 592 divorces affecting 40 156 children
- In 1993, the number of street children in South Africa was estimated to be about 10 000

Education

- Only 1 in 10 pre-school children are in early childhood development programmes
- An estimated 1.6 million children of school-going age are out of school
- For every 100 African girls and boys who started Sub A in 1983, 51 girls and 35 boys reached Standard 10 in 1994
- 22% of girls and 16% of boys aged between 14 and 35 can be considered to be functionally illiterate
- Average teacher-pupil ratios in 1995 were 1:33
- Teenage pregnancy is one of the major reasons why girls leave school; 1 in every 8 girls is forced out of the education system as a result of pregnancy

Justice

- In 1995, between 65 000 and 160 000 children under the age of 18 were arrested. At any time there are 1 700 children awaiting trial. 4 000 children were sentenced in 1998, over 90% of whom were boys⁶

Labour

- It is estimated that 200 000 children between the ages of 10 and 14 and another 200 000 between the ages of 15 and 18 are engaged in various forms of paid labour⁷

WHAT WILL MAKE A DIFFERENCE?

Clearly there is a great need to improve the situation for South Africa's children. There are both global goals as well as goals for South Africa which represent the vision for children which was developed within the past ten years. With the arrival of the 21st century it is necessary to review these goals and to take account of the toll which the epidemic is exacting.

⁶ Personal communication, Ann Skelton, Department of Justice

⁷ SA National Council for Child and Family Welfare; *Children and Poverty* (1998)

At the 1990 World Summit for Children, the following Year 2000 goals were adopted:⁸

1. Reduction of infant and under-5 child mortality rates by one-third of the 1990 levels or to 50 and 70 per 1 000 live births, respectively, whichever is less
2. Reduction of the 1990 maternal mortality rates by half
3. Reduction of severe and moderate malnutrition among under 5 children by half of the 1990 levels
4. Universal access to safe drinking water and to sanitary means of excreta disposal
5. Universal access to basic education and completion of primary education by at least 80% of primary school age children
6. Reduction of the adult illiteracy rate to not more than half of its 1990 level, with emphasis on female literacy
7. Improved protection of children in especially difficult circumstances

In South Africa, policy priorities have been identified by the National Programme of Action for Children. These are:

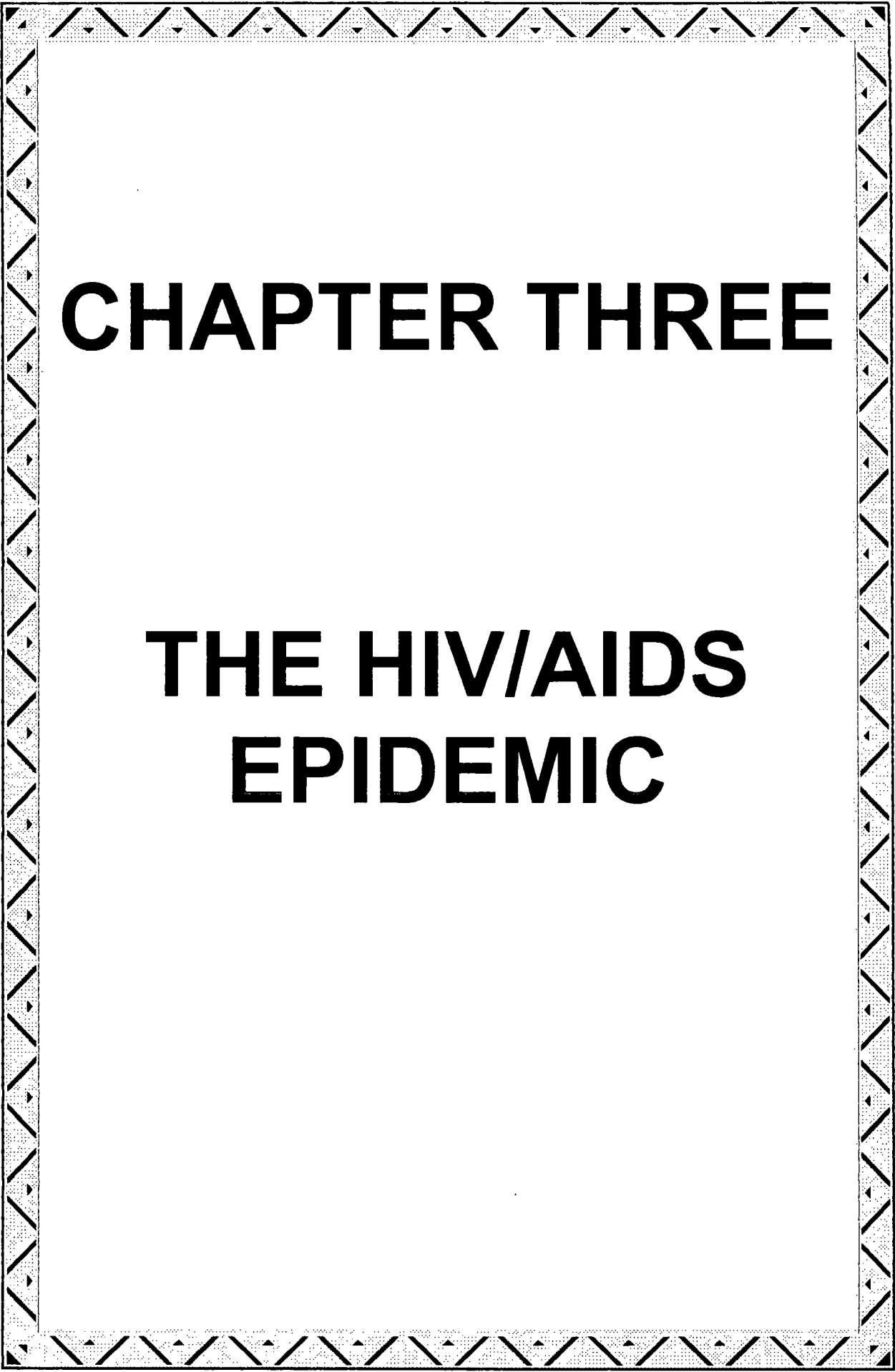
- Nutrition
- Child health
- Water and sanitation
- Early childhood development and basic education
- Social welfare development (family environment, out-of-home care and social security)
- Leisure and cultural activities
- Child protection measures

For each of these policy areas, goals have been identified and checked against the relevant articles of the UN Convention on the Rights of the Child (CRC). Those sectors with responsibility for leading responses in each area have been identified and regular reports are submitted to an Inter-Ministerial Committee appointed by Cabinet. The framework is therefore in place and the commitment to 'make a difference' articulated. But how will the HIV/AIDS epidemic impact on these targets?

SUMMARY OF KEY POINTS

- ✘ 61% of South Africa's children live in poverty.
- ✘ In 1998, the infant mortality rate was 45 per 1 000.
- ✘ Only 49% of children have a birth certificate.
- ✘ An estimated 1.6 million children of school-going age are out of school.
- ✘ 1 in every 8 girls is forced out the education system as a result of pregnancy.
- ✘ The 1990 World Summit for Children adopted global goals, and in South Africa the NPA has identified policy priorities and mechanisms to improve the situation for children.

⁸ UNICEF; *The progress of Nations* (1999)



CHAPTER THREE

THE HIV/AIDS EPIDEMIC

CHAPTER THREE: THE HIV/AIDS EPIDEMIC

Chapter Three describes the global HIV/AIDS epidemic, the individual, household and societal impact and the emerging epidemic in South Africa.

THE PRESENT AND FUTURE AIDS EPIDEMIC

*Globally and in Sub-Saharan Africa*⁹

Almost 13 million adults and more than three and a half million children have died of AIDS worldwide since the beginning of the epidemic. In 1999 alone, over two and a half million people died of AIDS, including 510 000 children under 15. In Africa, AIDS is now the leading cause of death. Five million adults and 570 000 children (under the age of 15) were newly infected with HIV in 1999, foreshadowing even greater losses in the future. Since the epidemic began, 4 million children under the age of 15 have been infected with HIV. More than 90% of them were infants born to HIV infected mothers.

The major demographic sequelae of the HIV/AIDS epidemic include changing population growth rates, age distribution and dependency ratios. **AIDS is eroding precious and hard-won infant and child survival gains.** In the world's nine most severely-affected countries (all of them located in Africa) where at least one-tenth of the adult population has HIV, life expectancy for a child born in 2000-2005 will drop to 43 years from the pre-AIDS expectation of 60 years of life.¹⁰ The US Bureau of the Census estimates that by the year 2010, AIDS may increase the infant mortality rate (IMR) by 76% and the under-5 mortality rate (U5MR) by more than 100% in those regions most affected.

EXPECTED DEMOGRAPHIC CHANGES IN THE AVERAGE SUB-SAHARAN COUNTRY ¹¹			
	1985	2010 – no AIDS	2010 – with AIDS
Crude birth rate	50	40	32
Crude death rate	15,8	10,2	16,4
Growth rate	3,5	3	2,4
IMR	106	61,3	104,7
U5MR	166	92	215,3
Life expectancy	51,5	61,4	47,1

⁹ UNAIDS report on the global epidemic (1999)

¹⁰ The UNDP Human Development report projects a fall in life expectancy from 68,2 years (in the absence of AIDS) to 48 years by the year 2010

¹¹ SALC, Project Committee on the Review of the Child Care Act; *Consultative Paper on Children infected and affected by HIV/AIDS* (1999)

Sub-Saharan Africa is the area of the world worst affected by the epidemic. Infection levels are *highest*, access to care is *lowest*, and social and economic safety nets that might help families cope with the impact of the epidemic are *badly frayed*.

The most vulnerable

All members of society are vulnerable to the impact of HIV/AIDS, but not equally so. Women, children and the elderly are most vulnerable.

Twelve to thirteen African women are infected for every ten African men. This is due to a number of reasons. HIV passes more easily from men to women during sex than from women to men. Women tend to become infected far younger than men for both biological and cultural reasons (girls aged 15-19 are five or six times more likely to be infected with HIV than boys their same age). Moreover, the vulnerability of girls is exacerbated by denial and neglect of their rights, including gender discrimination.

In women, the highest rates of HIV infection correspond with their peak reproductive years, with major implications for women themselves as well as for their children and families. HIV positive women are assumed to bear 20% fewer children once infected than they otherwise would have done. The effect of HIV/AIDS on fertility is three-fold. Firstly the number of births may be reduced if women die before reaching the end of their child-bearing years. Secondly, HIV infection and AIDS reduce fertility through physiological means. Finally, awareness of transmission risks, increased condom use and the empowerment of women may reduce fertility.

By the end of 1997, 8,2 million children had lost their mothers or both parents to AIDS. More than 95% of these children live in Sub-Saharan Africa. This figure is expected to be 13 million by the turn of the century.¹²

ORPHANS AS A PERCENTAGE OF CHILDREN UNDER 15 BY THE YEAR 2000¹³			
Botswana	23,27%	Lesotho	14,09%
Malawi	27,43%	South Africa	11,62%
Zambia	34,31%	Zimbabwe	27,44%

Amongst the elderly, the epidemic will mean the loss of social and economic support structures. When AIDS affects a family, the elderly are forced to take on parental responsibilities and, at the same time, manage the care needs of terminally ill adults. With the death of the adult, the burden of economic and domestic duties and the responsibilities of keeping the family together shift, frequently becoming concentrated on a surviving grandmother.¹⁴

¹² The Census Bureau estimates that the total number of children who will lose one or both of their parents from all causes will be 24,7 million in 2000 (*Children on the Brink*, USAID)

¹³ US Bureau of the Census (1996)

¹⁴ Marcus, T; *Wo! Zaphela izingane – it is destroying the children – living and dying with AIDS* (1999)

The household and societal impact

The effects of the epidemic will be felt throughout society, from the micro to the macro levels. At the household level, the impact will be catastrophic, particularly where nuclear households are the norm and where supportive links between and for such households are limited. Existing coping mechanisms will be hard-pressed or may simply cease to cope.¹⁵

Illness and death are likely to have a marked effect on food production and food security. This will be detrimental to the nutritional status of children, especially those who already live in poverty. Child care, make up of diet, ability to send children to school and care of orphans will also be adversely affected. Girls' education may be sacrificed to ensure that boys can attend school. Consequently many girls will grow up illiterate and with little or no job training. This ultimately makes them economically dependent on men, and robs them of independence and the power to protect themselves.

At a macro level the demands on health and welfare services will increase and education will be faced with multiple new challenges. In the workplace, the cost of labour will increase whilst productivity will decrease.

The HIV/AIDS epidemic in South Africa

South Africa has the fastest growing HIV/AIDS epidemic in the world, with more people infected than in any other country, with the exception of India. In 1999, at least 1:8 adults were estimated to be HIV infected, representing about 4 million people. The highest rates are amongst young adults, with an alarming increase observed among teenage girls. The highest rates are found in KwaZulu-Natal, Mpumalanga and Free State.

In South Africa, it is projected that AIDS will account for a 100% increase in child mortality - from an anticipated 48.5 per 100 000 births without AIDS to almost 100 per 100 000 births in the year 2010.¹⁶ In 1999, at Greys Hospital in KwaZulu-Natal, 81% of all deaths in the paediatric ward were proven AIDS related deaths – the figure is 90% for children under 3 years.¹⁷

In the 1999 Progress of Nations Report, South Africa was one of seven countries listed at the top of the scale as having a greater than 400% increase in the number of children orphaned by HIV/AIDS between 1994 and 1997. The report quotes a figure of 110 children under the age of 15 per 10 000 who have lost their mother, or both parents to HIV/AIDS. By 2015, when the epidemic should have reached its peak, orphans will comprise 9 – 12% of the total population. This equates to 3.6 – 4.8 million children under 15.¹⁸ In KwaZulu-Natal, one projection estimates that by the Year 2000 there will be between 197 000 and 278 000 children under the age of 15 orphaned in that Province as a result of AIDS (5.8 – 8.8% of all children).

¹⁵ Barnett, A; *AIDS Brief: Subsistence Agriculture* (1999)

¹⁶ UNDP; *HIV/AIDS, Human Development, South Africa* (1998)

¹⁷ Personal communication, Neil McKerrow, KwaZulu-Natal Department of Health

¹⁸ SALC, Project Committee on the Review of the Child Care Act, *Consultative Paper on Children infected and affected by HIV/AIDS* (1999)

South Africa is therefore currently confronting the reality of:¹⁹

- Increasing numbers of children in distress associated with the escalating AIDS epidemic
- The inability of traditional models of surrogate child care to accommodate the number of children in distress
- The inability of poor communities to absorb children in distress into informal care facilities without the introduction of outside support
- The stigma associated with HIV/AIDS affected families

South Africa's susceptibility

Several factors have been defined as responsible for South Africa's severe epidemic.²⁰ These are:

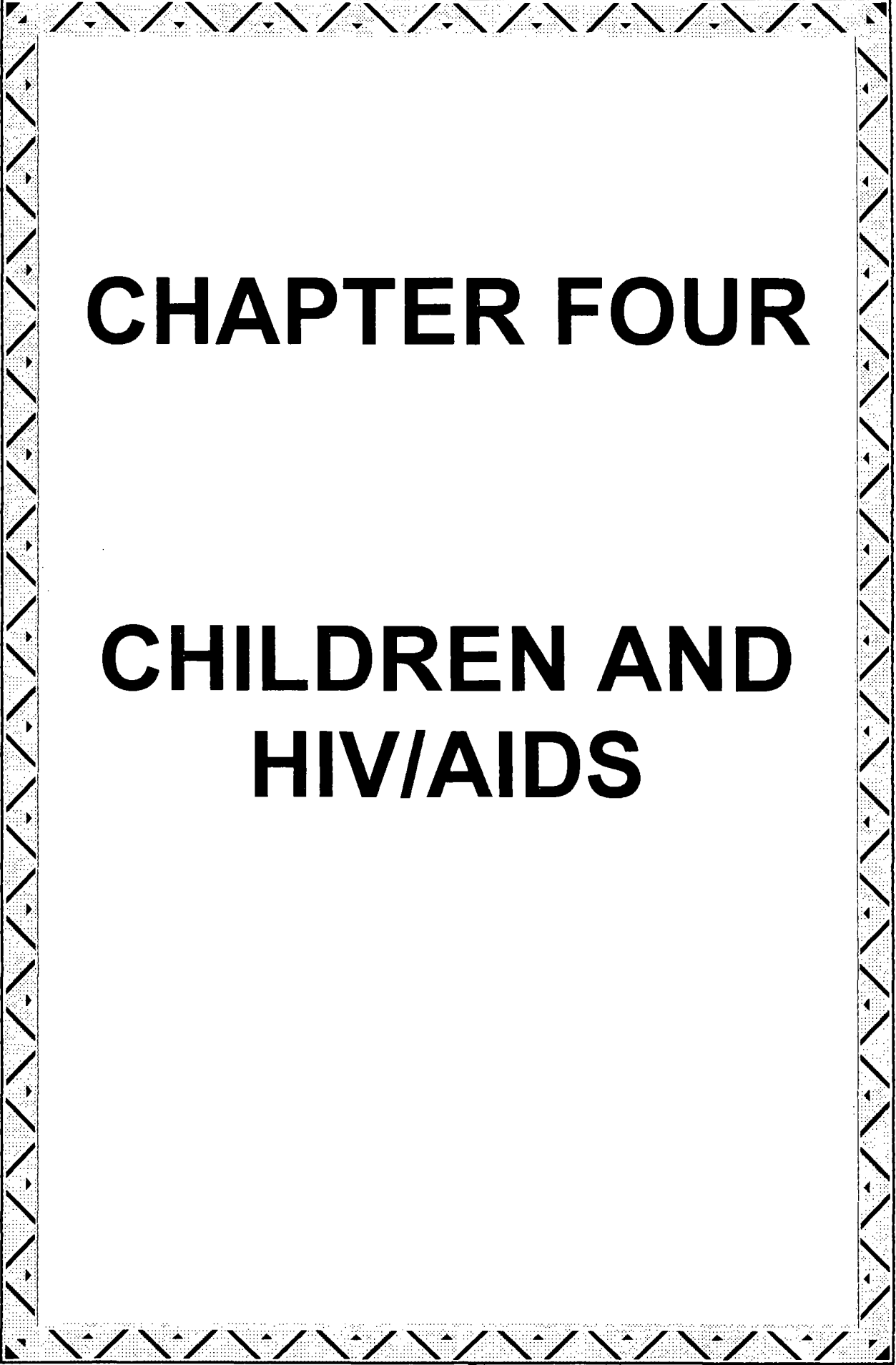
- The disruption of family and communal life, resulting from apartheid and the migrant labour system
- A good transport infrastructure and high mobility (which allows for the spread of HIV into new communities)
- High levels of poverty and income inequality
- Very high levels of other STDs
- The low status of women in society and in relationships
- Social norms which accept or encourage high numbers of sexual partners
- Resistance to the use of condoms

SUMMARY OF KEY POINTS

- ✂ Globally in 1999, 510 000 children under the age of 15 died of AIDS and an estimated 570 000 were newly infected with HIV.
- ✂ AIDS is eroding infant and child survival gains particularly in Africa, where infection levels are highest, access to care is lowest and the social and economic safety nets that might help families cope are badly frayed.
- ✂ Women, particularly young women, children and the elderly are the most vulnerable to the impact of the epidemic.
- ✂ The effects of the epidemic will be felt from the micro to the macro levels.
- ✂ South Africa has the fastest growing epidemic in the world. Between 1994 and 1997 there was a 400% increase in the number of children orphaned by HIV/AIDS. By 2010, orphans will comprise 9 – 12% of the total population (3.6 – 4.8 million children).
- ✂ Traditional models of surrogate care are overwhelmed, communities cannot absorb children without support and the stigma associated with HIV/AIDS remains prevalent.

¹⁹ McKerrow, NH; and Verbeek, AE; *Models of care for children in distress* (1995)

²⁰ Department of Health; *HIV/AIDS in South Africa: the impacts and the priorities* (1998)



CHAPTER FOUR

CHILDREN AND HIV/AIDS

CHAPTER FOUR: CHILDREN AND HIV/AIDS

Chapter Four describes the basic facts about children infected with or affected by HIV/AIDS.

In the context of HIV/AIDS, children fall into two main groups:

- Infected children (who may have been infected vertically, sexually or from unsafe health practices)
- Affected children (who may be abandoned or orphaned as a result of HIV/AIDS, may be from an HIV infected family, may be vulnerable to becoming HIV infected or may be from an uninfected family in an affected community)

INFECTED CHILDREN

Vertical or mother to child transmission (MTCT)

In South Africa almost all HIV infections in children below the age of 13 are the result of transmission from an infected mother to her child, during pregnancy, at birth or from breastfeeding. Approximately 1 in 3 babies born to infected mothers will themselves be infected (23% prenatal, 65% intrapartum or from early breastfeeding, 12% post-natal).

The risk of transmission is influenced by certain maternal factors such as the severity of maternal disease, low serum vitamin A levels and anaemia, prematurity, breastfeeding and maternal antiretroviral use.

World-wide the additional risk of transmission of HIV from an infected mother to her child via breastfeeding is of the order of 14% (1 in 7) and this effectively doubles the risk of HIV transmission from between 17% - 25% to between 35% - 45%. Current evidence suggests that the risk of transmission through breastfeeding is greatest when the mother becomes infected during the breastfeeding period or has advanced HIV disease.

The risk of acquiring HIV from breastfeeding

4 – 6% in the first 6 months
(0.7 – 1% per month in the first 6 months)

3.2% per year, up to 2 years
0.2% per month at 2 years

On average, 100 mls of colostrum has 24 000 HIV infected cells and 800 mls of mature milk has 24 000 HIV infected cells. The viral load in breastmilk increases in association with mastitis, a condition which occurs in 20 – 33% of breastfeeding women, independent of their HIV status. Within the first two months of breastfeeding, mastitis is associated with a two-fold increase in MTCT.

In a recent study in Durban the rate of transmission at 3 months in infants who were exclusively breastfed was 14.5%, in those who were formula fed, 18.8% and those who had mixed feeding, 24.1%. Clearly further information is needed to establish guidelines for advising infected mothers.

All children born to HIV infected women will test positive for HIV antibodies, from birth until at least 15 months. In many children, this HIV positivity may merely indicate that the mother is HIV positive. In those children who are truly positive, proof of infection may require further testing for direct evidence of the virus, or the persistence of antibodies beyond 15 months, or rapid progression to clinical AIDS.

The majority of infected children will show signs of HIV disease or AIDS in the first year of life and most will die before their third birthdays. However, 25% of infected children will survive to 5 years and, with good care, this figure can increase to 45%. Of those children who only progress to AIDS after infancy, 30 – 40% will remain healthy into their late childhood or early teens.

Summary of facts about children infected with HIV

Most infants infected with HIV show no symptoms at birth.

In developing countries, children with HIV often have the same illnesses as children without HIV, such as measles, diarrhoea and respiratory infections. However, children with HIV may:

- Have common illnesses that are more severe, more frequent and more persistent
- Present with recurrent serious systemic bacterial infections and opportunistic infections
- Show signs of failure to thrive.

Children infected sexually²¹

The highest rates of HIV infection are found amongst young people (between the ages of 15 and 29). Girls and young women may be particularly susceptible to HIV infection not only because they are less able to control the situations in which they have intercourse but also because their reproductive tract provides less of a barrier to the virus and is easily damaged.

Children infected from unsafe health practices

These practices include:

- traditional health practices (such as scarification)
- cultural practices such as circumcision
- unscreened blood products
- the use of contaminated medical instruments (such as used needles)

The number of children infected in the above ways is not likely to be great, but no data are available to establish the extent of these forms of transmission.

²¹ See also: *Children who are vulnerable to HIV infection - sexually exploited children*

AFFECTED CHILDREN

For generations, the extended family system has met most of the basic needs of children and provided a protective social environment in which they could grow and develop. Kinship systems have dictated various social, economic and religious obligations towards the family lineage as well as the social and material rights of the individual within the lineage. Social upheaval, rapid urbanisation, war, drought, famine and acute political and economic stress have threatened the integrity of the extended family and have undermined its efficacy as a social support network.²² And now, at a time when the family is most needed as a support system for children in distress, the stigma associated with HIV/AIDS is affecting the willingness of families to take in orphaned children. This is resulting in increased child mobility and the exploitation and neglect of children.

Children from households with infected family members

The reality of AIDS in the family is that children are caring for the sick and assuming adult responsibilities before they are ready to do so. Children are leaving school earlier, they marry earlier, enter the labour force earlier and are they are frequently sexually exploited.²³

'The parentification process' which refers to creating a parent out of a child, to care for a parent or siblings, is associated with social isolation. Younger children not only assume responsibility for more complex household chores but are also deprived of the nurturing previously received from their now ill parents. Uninfected children born to infected mothers have a 2.4 – 3.6 times increased mortality rate than children born to uninfected mothers.

During a review of the COPE²⁴ (Community-based Options for Protection and Empowerment) Programme in Malawi in 1996 an assessment was done of the levels of economic stress related to different household characteristics.

Household Characteristics	Economic Stress
Two parents, one of whom is periodically ill	moderate/high
Household headed by single surviving parent	moderate/high
Single head of household who is periodically ill	severe
Two-parent household caring for children whose parents have died	moderate
Household headed by a grandparent	high
Adolescent-headed household	high

Unless suitable arrangements are made for children before their parents' deaths, the trauma, guilt and grief so common amongst these children is compounded by uncertainty regarding their future.

²² McKerrow, NH; and Verbeek, AE; *Models of care for children in distress* (1995)

²³ Parry, S; *Farm Orphans: Who is coping?* FOST (1998)

²⁴ Donahue, J & Williamson, J; *Developing interventions to benefit children and families affected by HIV/AIDS: A review of the COPE Program in Malawi* (1996)

Abandoned children

A spokesperson for the Department of Welfare estimated that between 3 000 and 4 000 babies and children were abandoned during 1997. The recorded number more than doubled between 1997 and 1998, with the highest number coming from KwaZulu-Natal. Approximately the same number of boys and girls were abandoned, with peaks noted between 2 and 6 months, followed by children a year old, then babies between birth and 1 month and finally there is another peak between 6 and 10 years.²⁵

With the information which is available, it is not possible to link these trends to HIV/AIDS.

Children orphaned as a result of HIV/AIDS

Many of the most striking images of the HIV epidemic are of families, but of unfamiliar families: a grandparent surrounded by grandchildren, adolescent-headed families, often siblings and cousins bonded together, dying adults tended by their children and communities as families²⁶

Neither words nor statistics can adequately capture the human tragedy of children grieving for dying or dead parents, stigmatised by society through association with HIV/AIDS, plunged into economic crisis and insecurity by their parents' death and struggling without services or support systems in impoverished communities.²⁷

Orphans are sometimes described as maternal, paternal or double orphans. Such a classification is less helpful than one which describes degrees of vulnerability. But, regardless of how an orphan is described, the needs of these children start with the knowledge that someone in their family is infected and continue until their social and sexual maturity.

In most parts of the industrialised world usually no more than 1% of the child population is orphaned. Before the onset of AIDS, societies in the developing world absorbed orphans into extended families and communities at a rate just over 2% of the child population (between 2 and 5% in South Africa) and traditionally orphanhood was not perceived to be a problem. Today, because of AIDS, 11% of children in Uganda are orphans, 9% in Zambia, 7% in Zimbabwe and 6% in Malawi.²⁸

AIDS produces younger orphans and these younger children are especially at risk.

- They tend to be nutritionally deprived (at a time when they have higher nutritional needs).
- In many communities, children whose parents have died of AIDS are at greater risk of dying of preventable diseases, because their illnesses tend to be attributed to AIDS and thus go untreated.

²⁵ Personal communication: Linda Lindeque and the SA National Council for Child Welfare

²⁶ Reid, E; *Children in families affected by the HIV epidemic: a strategic approach*, UNDP (undated)

²⁷ UNICEF; *Children orphaned by AIDS; Front-line responses from eastern and southern Africa* (1999)

²⁸ *The Progress of Nations Report* (1999)

- Orphans are also less likely than other children to be immunised and to have their health care needs adequately met

For the extended family, additional children increase financial hardships and pressures on relationships, weakening the capacity of the family to cope. The overriding constraint to the care of additional children therefore is the capacity of the extended family to cope.²⁹

And how communities themselves deal with death and dying has grave implications for children, as illustrated in a recent study done by the University of Natal in the KwaZulu-Natal Midlands. Key observations included:³⁰

- The social and economic consequences of a death in the family are profound and essentially negative
- The social and economic consequences of an adult death for the children they leave behind compound the severity of the personal loss and the psychological pain which they experience
- The low levels or absence of social preparation for death leaves many survivors in dire straits
- In many instances children are not 'told' – it is assumed that they will 'see' for themselves
- There is displacement of children – they find themselves out of family and/or out of community
- Historical community practices are altered and undermined by the impact of terminal illness and death of many young adults

When the extended family either does not exist or simply cannot cope, the only alternative is often for siblings to live together, frequently with no adult supervision. This brings its own unique problems.

Problems in child-headed households

Poverty
Lack of supervision and care
Stunting and hunger
Educational failure
Lack of adequate medical care
Psychological problems
Disruption of normal childhood and adolescence
Exploitation
Early marriage
Discrimination
Poor housing
Child labour

²⁹ Parry, S; *Farm Orphans: Who is coping?* FOST (1998)

³⁰ Marcus, T; *Wo! Zaphela izingane – it is destroying the children – living and dying with AIDS* (1999)

What are the needs of orphans?^{31 32}

Physical and material needs

Food and food security

These children are vulnerable to both malnutrition and under-nutrition, due both to the scarcity of food and to the weak position they occupy within guardians' homes in the household resource distribution process.

Housing, clothing and bedding

Elderly grandparents and children often cannot maintain their homes in good repair. Poverty within the extended family frequently results in repairs being neglected. Often the family's supply of bedding is reduced because the deceased parent was bedridden and incontinent before death and it is common for children to sleep on sacks on the floor. Many children have no footwear at all and own only one set of clothes.

Health care

Immunisation and simple medical care may not be reaching these children, and children under the age of five are particularly vulnerable.

Intellectual needs

Educational needs

These include books, school fees, uniforms, shoes and school trip funds. For the younger children there is also the need for after-care facilities.

Income generating skills

There is a need to provide older children with simple, marketable skills.

Psychosocial needs

Parenting

Most children have not come to terms with the reality of being orphaned and feel the loss of parental attention and of physical and social security. With the death of their parents, the normal grief process is aggravated by guilt that they were unable to save their parents, often resulting in behavioural problems. Because the independence of the nuclear family has been compromised, they are unable to participate effectively in the kinship network where they are perceived as a liability and many, as a result, show socialisation problems.

Child heads of households confess to being ill-equipped to provide proper parental guidance and discipline to their siblings, let alone the love and care which they themselves need. There is also no moral and ethical guidance for these children, where the only adult attention may be in the form of irregular and inadequate supervision.

Friends and recreation

Most children report having lost their social friends due to their rigid time budgeting which does not allow them time for play.

Non-discrimination and legal protection

Freedom from discrimination within school, foster families, orphanages etc is another need. Where an infected parent may have been ostracised or rejected, after death the stigma may continue to cling to the orphaned children.

These children require legal protection, with respect to inheriting land and other material goods as well as protection from unscrupulous guardians, relatives and others who may abuse their rights in any number of ways. They also require a peaceful, violence and crime-free environment.

³¹ McKerrow, NH; and Verbeek, AE; *Models of care for children in distress* (1995)

³² UNICEF (Kenya); *Needs assessment of children orphaned by AIDS* (1994)

What are the needs of guardians?

Not only may the guardians need assistance with heavy agricultural work, roof repairs etc. but also with a wide range of material needs. In addition, these guardians will need counselling, education and social support. The existence of child care facilities and crèches would ease their burden of responsibility.

What are the community's needs?

The community itself needs help in coping. Help to establish systems to identify and monitor children-in-need and needy families and to supervise the care of children in foster homes or institutions. Supporting organisations such as church or women's organisations may need administrative and technical assistance and training, or help in co-ordinating NGOs involved in programmes caring for these children.

The Botswana orphan study

The Botswana Ministry of Health³³ commissioned a rapid assessment of the orphan situation in the country in 1998. A total of 4 496 orphans were registered in 10 villages and towns. The majority were between 11 and 15 years old and AIDS was the major cause of the death of parents (51%) followed by TB (13%). 30% of the orphans had dropped out of school (more girls than boys) and three out of ten could be considered homeless. Twenty-three homes were headed by orphans, many having lost not only their parents, but second and third generation caregivers as well.

The priority needs of the orphans were food and clothing. Their rights were abused in many ways, including denying them opportunities to attend school, being used as cheap labour by some caregivers, and losing their property. Orphans dropped out of school particularly where caregivers could not afford to provide uniforms, school shoes, school feeding money or money for building funds. 'AIDS orphans' also dropped out of school as a result of stigmatisation, rejection and isolation by other students and occasionally by teachers.

In most cases their access to basic needs i.e. food, clothing and decent shelter was considered a privilege but not a right.

Actual examples quoted in the study depict the reality.

In three cases, the team found siblings who were waiting for their dead mother to come back. They had apparently been told that their mother had gone on a trip and would return.

During the assessment the team was told of four HIV positive orphans who had committed suicide as they could not face the future alone.

A few cases of murder originated from family conflicts based on disagreements on taking in orphaned children from relatives or previous marriages.

³³ Muchiru, SM; *The rapid assessment on the situation of orphans in Botswana* (1998)

A man was reported to have driven his sister's orphaned children more than 100 kilometers and abandoned them by the roadside. He feared that the children could be infected.

In six homes there were between 13 and 21 children living in one hut not more than 5 meters in diameter.

The team identified 21 girls between 15 and 18 who had been sexually abused. Eleven of them had fallen pregnant and dropped out of school. An uncle was reported to have raped his niece the night her mother was buried.

Two orphans were arrested transporting drugs unknowingly on the instructions of their caregivers. Girls assist their caregivers in generating income from trades such as brewing and selling local beer or are encouraged to get involved in commercial sex.

Orphans who are infected with HIV are more disadvantaged than other children. One orphan had been wearing the same clothing for over 4 months since she fell ill and became bedridden.

Many critical needs were identified in the Botswana rapid appraisal. Amongst those was the need for counselling to enable the orphans to cope with the emotional stress of losing their parents, to deal with their fears of infection and to make informed decisions. A further need was to equip children who are providing care with basic home care skills. There were 37 cases of HIV infected orphans who claimed that they were infected as a result of providing care.

The report made a number of recommendations including:

- The urgent need for food and clothing
- Streamlining the referral system between schools, Family Welfare educators and the Department of Social Welfare
- The development of a national policy on orphans
- Immediate nationwide identification and registration and co-ordination, monitoring and management of the data
- A review of existing laws to ensure that they are consistent with the needs of orphans in the broader context of a continuum of care
- Protection of basic rights including those related to property inheritance, social security and identity

If up to one third of the next generation begin their adult lives scarred by the experience of orphanhood, this will have long-term negative effects whose impact on their nation's future can only be pondered with misgiving.

UNICEF

Children who are vulnerable to HIV infection - adolescents at risk³⁴

Adults to trust and talk to - A nation-wide study on adolescents in the US found that the single most important factor in healthy development is a caring adult to whom the young person feels connected – loved by, listened to, cared about. This finding was independent of race, ethnic group and socio-economic status.

³⁴ Attawell, K; *HIV/AIDS Knowledge, Attitudes, Beliefs and Behaviours in South Africa* (1998)

A review of KABP (knowledge, attitudes, behaviour and practices) research in South Africa showed that, while knowledge of HIV/AIDS among adolescents is generally good, many engage in 'high risk' sexual behaviour. This was confirmed by a literature review conducted by CASE in preparing for the *Youth speak out for a healthy future* survey. An extensive survey and follow-up among young urban black youth aged 16-20 years in Soweto, Khayelitsha and Umlazi³⁵ found that 40% of young women and 60% of young men had had more than one sexual partner in the previous six months and that condom use was relatively low.

Key finding

Levels of knowledge of HIV/AIDS are high, but few young people perceive themselves to be at risk.

Failure to practice safe sex is related to pressure to engage in early and unprotected intercourse, coercion, pressure to have a child, lack of access to user-friendly reproductive health services, negative perceptions about condoms, and low perceptions about personal risk, in addition to lack of privacy and time.^{36 37 38}

Various studies show that adolescents commence sexual activity at a young age. The Buga study, in a rural area of the ex-Transkei, where the mean ages of the girls and boys were 15 and 16 years, found that 76% of the girls and 90.1% of the boys were already sexually experienced. Boys started sexual intercourse earlier than girls (13.43 years versus 14.86 years), had more partners and nearly twice as many had a history of STDs. A study of school-going adolescents in Free State,³⁹ revealed that a high proportion of teenagers reported becoming sexually active at around the age of 12 years, due to experimentation or peer pressure and relatively few practised safe sex. A KABP survey among youth in six villages in the Xhalinga District found that about 50% approved of sex before marriage and believed that sexual involvement should start between 10 and 17 years of age; 67% had already had sexual experience. Those with positive attitudes towards contraceptive and condom use were unable to put these into practice due to lack of access to services.

Key finding

Adolescents commence sexual activity at a young age, due to experimentation or peer pressure.

The NPPHCN study, *Youth speak out for a healthy future*,⁴⁰ examined young people's knowledge and experience of sexuality through focus groups in a range of settings in five provinces, with adolescents aged 10-20 years. It found that young people receive conflicting messages about sex and sexuality, that non-penetrative sex is not considered to be proper

Key finding

Young people receive conflicting messages about sex and sexuality. They make decisions about sex in the absence of accurate information and access to support and services

³⁵ Richter, L; *A survey of reproductive health issues among urban black youth in South Africa*, Society for Family Health (1996)

³⁶ Craig, A; and Richter-Strydom, L; *Unplanned pregnancies among Zulu schoolgirls*, SA Med J (1983)

³⁷ Flisher, A; et al; *Risk taking behaviour of Cape Peninsular high school students*, SA Med J (1993)

³⁸ Buga, G; et al; *Sexual behaviour, contraceptive practice and reproductive health among school adolescents in rural Transkei*, SA Med J (1996)

³⁹ Furter, A; et al; *Sexually transmitted infections and HIV/AIDS: a KAPB study among school-going teenagers in Thaba Nchu*, 4th Reproductive Health Priorities Conference (1998)

⁴⁰ NPPHCN/UNICEF, *Youth speak out for a healthy future* (1995)

sex, that widely believed myths reinforce negative attitudes about safer sex and contraceptive use, and that most adolescents make decisions about sex in the absence of accurate information and access to support and services.

The study concluded that these young people lack the confidence and skills to discuss sexual issues, contraception and prevention of infection.

Other studies also indicate that adolescents have inadequate knowledge about reproductive health, relying on friends, siblings, magazines or the television for information. When adolescents participating in the *Youth speak out* survey were asked about what they would like more information, STDs/AIDS was identified by 13.2% and sexual issues in general by 32%. Adolescents rarely communicate with their parents or other adults about sexual and reproductive health issues. Lack of parental guidance needs to be viewed in the context of households where absence due to labour migration, violence, poverty, alcohol abuse and child sexual abuse are common.

Key finding

Adolescents rely on friends, siblings, magazines or the television for information about reproductive health.

Violence is common and even considered the norm in sexual relationships. A qualitative study among Xhosa-speaking pregnant adolescent women⁴¹ revealed that violent and coercive male behaviour, combined with young women's limited understanding of their bodies and of the mechanics of sexual intercourse, directly affects their capacity to protect themselves against STDs, pregnancy and unwanted sexual intercourse. Communication between partners on sexual issues was non-existent and conditions and timing of sex were defined by male partners, giving young women little or no opportunity to discuss or practice safer sex.

A study in KwaZulu-Natal⁴² suggests that, for Zulu township youth living in settings characterised by political violence and high crime levels, HIV has come to be accepted as a new and inevitable part of growing up. A youth culture is described where young people who suspect they may be infected with HIV will avoid a definite diagnosis but at the same time seek to spread the infection as widely as possible.

The *Youth speak out* survey also found that it is boys who determine when and how sex occurs, and that girls commonly experience rape, violence and assault, including within relationships. The Richter survey of urban youth found that 28% of the women (aged 16-20 years) in the sample had been forced to have sex against their will. Another study⁴³ revealed that adolescent women feel unable to refuse sex

Key finding

Boys determine when and how sex occurs. Girls commonly experience rape, violence and assault, including within relationships.

⁴¹ Wood, K; and Jewkes, R; "Love is a dangerous thing"; *microdynamics of violence in sexual relationships of young people in Umtata*, CERSA-Women's Health (1988)

⁴² Leclerc-Madlala, S; *Infect one, infect all: Zulu youth response to the AIDS epidemic in South Africa*, Med Anthropol (1997)

⁴³ Varga, C; and Makubalo, E; *Sexual (non-)negotiation among black African teenagers in Durban, South Africa*, Agenda (1996)

or to discuss safe sex, including contraception or condom use, for fear of violence. Some young men in the *Youth speak out* survey justified rape because of the perception that young girls have sex with older men for material gain. Research with pregnant and non-pregnant teenagers in Khayelitsha to assess risk factors for teenage pregnancy, found that all the girls (mean age 16.4 years) had had sexual intercourse and at least one boyfriend. A third described their first sexual experience as rape or forced sex, and two thirds of both pregnant and non-pregnant teenagers had experienced sex against their wishes. Reasons given for not refusing sex included fear of abandonment or violence.

A report of 30 in-depth semi-structured interviews with youth, mothers and policemen in Umtata found that gaining and keeping boyfriends and girlfriends are critical to status and position within peer groups. Even when aware of it, mothers do not interfere with violence committed within relationships by their sons; the police are reluctant to press charges in cases of gender violence; and authority figures such as teachers are often responsible for sexual exploitation of teenage girls.

Young people in South Africa face increasingly complex issues. They will live most of their lives in a free and democratic society yet, to some extent, the achievement of their aspirations will be guided by the dictates of globalisation. The education and skills requirements expected of them are rapidly changing, and their successes will be largely dependent on their ability to navigate in an increasingly competitive labour market. Given these realities, it is important to look at some of the overarching challenges facing young people. This will provide the context within which it is possible to assess why it is that young women and men are particularly vulnerable to HIV infection.

UNDP Human Development Report

Children who are vulnerable to HIV infection - sexually exploited children

Sexual exploitation of children takes two main forms – commercial sexual exploitation and sexual abuse in the home or community.

Child prostitutes

No one knows how many child sex workers there are in the world and there is a lack of research in this area. Figures reported to the First World Congress Against Commercial Sexual Exploitation of Children (1996) suggested that worldwide, more than a million children enter the sex trade every year. What research has been done indicates that exploitation is growing and the age of the children involved is falling. Most girls in the industry are aged between 13 and 18. Many of them live on the streets, others live in brothels. Those in prostitution are often stigmatised and marginalised, which further undermines their status and reduces their opportunities for accessing education, formal employment and, in many societies, marriage.

Studies indicate that HIV infection among child sex workers is often very high. STD rates are also high and compounded by the lack of health care services which meet the sexual and reproductive needs of children.

Recently, new extraterritorial laws in some countries permit the prosecution of nationals guilty of sex offences against children overseas.

Child abuse in the home or community

A study at the child abuse and neglect clinic of the Transvaal Memorial Institute conducted in 1996 provided a profile of sexually abused children. 80% are girls of whom 7% were under 3 and 55% under 10. 38% of the perpetrators were biological family members, 66% were family members and only 7% were strangers. Behaviour problems were noted in 73% of cases including school problems, unnatural masturbation, 'clingy' behaviour, withdrawal or depression.⁴⁴

Sexual abuse of children has only relatively recently been identified as a significant problem, but figures are rising alarmingly. At Edendale Hospital (KwaZulu-Natal), 2 sexually abused children were seen in the Paediatric Department in 1989, by 1996 this had increased to 306 cases.

There are three possible reasons for the increase.⁴⁵ The first is an increased awareness of sexual abuse of children amongst the general public with a concomitant increase in the number of children presenting for help. The second is the improved services available, resulting in numbers of previously undiagnosed cases now being accurately assessed at health facilities. The last reason is the possible relationship between childhood sexual abuse and the HIV/AIDS epidemic.

Three theories have been proposed to explain this last reason. The first, sometimes known as the prevention theory, is based on the assumption that all sexually active people are likely to be HIV infected and, in order to be 'safe' one must choose a partner who is not yet sexually active. The second, or cleansing theory, suggests that having sex with a child will cleanse the infected individual of the virus. The final theory is linked to retribution, the deliberate spreading of infection to all sectors of society.⁴⁶

With respect to the risk of HIV infection following childhood sexual abuse, there are two considerations, the risk from the actual abuse and high risk adult behaviour linked to childhood abuse. The incidence of HIV infection following childhood sexual abuse has been poorly studied and no useful data are available. Relating to adult high risk practices following childhood sexual abuse, studies have shown for example a four-fold increase in commercial sex work in adults who were sexually abused as children compared to those who were not abused.

Girls employed as domestic workers are vulnerable to another type of sexual abuse – by the male head of the household or his sons. They run a particularly great risk if they live-in and are accessible around the clock.

⁴⁴ de Villiers, FPR & Prentice, MA; *Accumulating experience in a child abuse clinic*, SAMJ (1996)

⁴⁵ McKerrow, NH; *Childhood sexual abuse and HIV/AIDS*, SASPCAN National Conference (1997)

⁴⁶ McKerrow, N; *Childhood sexual abuse and HIV/AIDS* (1997)

Children who are vulnerable to HIV infection - Street children

Worldwide, UNICEF estimates that 30 million children spend most of their time on the streets. Of these, around 10 million are to all intents "abandoned", having lost or severed links with their parental homes. These children are prime targets for HIV infection. Their life style often places them on the wrong side of the law. Emotionally vulnerable and economically hard-up, such children are easily drawn into selling sexual favours.⁴⁷

Focus groups with 141 street children⁴⁸ aged 11-17 years in seven cities, to elicit information about knowledge, attitudes, beliefs and practices related to HIV infection, indicated that these young people were not less informed than other comparable groups of 'hard to reach' youth in developing and developed countries. Their HIV/AIDS risk behaviour was related rather to their low status, powerlessness and social conditions than to lack of knowledge and awareness. More than half of the street boys had engaged in sex for money, goods or protection, several had been raped. Street girls frequently engaged in transactional sex.

In an attempt to differentiate the kinds of street children in South Africa, Richter described "children of the streets" and "children on the streets".

The American National Network Report (1985) defines five kinds of children living on the streets

- *runaways*: children who run away from home for at least one night without parental permission
- *homeless children*: children who are forced out of home and have no parental, substitute, foster or institutional home
- *system kids*: children who are under the supervision of the State because of abuse, parental neglect and other serious family problems
- *street kids*: children who are long-term runaways or homeless children who are able to fend for themselves on the streets
- *missing children*: children whose whereabouts are unknown; usually they have been abducted or are victims of foul play

- Children **of** the streets are those children who have decided to make the streets their living place
- Children **on** the streets are those children who are working to assist their families financially and who retain contact with their families⁴⁹

⁴⁷ UNICEF; *Children & AIDS: an impending tragedy*

⁴⁸ Richter, L; and Swart-Kruger, J; *AIDS-related knowledge, attitudes and behaviour among South African street youth*, Vancouver AIDS Conference (1996)

⁴⁹ Kuse T; *The phenomenon of street children in the former Transkei: towards a new preventative approach*, Social Work Practice (1997)

The major causes of street children	The problems and needs of street children
• war and civil violence • deterioration of family life and disintegration of the family unit • alcohol • child abuse • poverty & unemployment • prostitution • orphanhood • psychological instability • urbanisation • delinquency • peer pressure • lack of recreational facilities • lack of parental control, discipline & moral values	• discrimination • lack of housing and access to health care • unemployment • lack of security • lack of parental involvement to provide guidance • HIV infection and other STDs • teenage pregnancy and lack of family planning • exploitation for labour and sex • alcohol and drug use • harassment by the police and other authorities

Children who are vulnerable to HIV infection - children in detention

Children who are in detention are often exposed to violence, abuse and unwanted sex. Sexual victimisation is common, associated with their first night in police cells, awaiting trial children and sentenced children. Drug use is also a compounding factor, so are body piercing and unsanitary tattooing. In South Africa, injecting drug use is uncommon in prison, but use of other drugs such as dagga is very prevalent. Girls in custody frequently cut themselves in rituals, introducing a risk of transmission and infection.⁵⁰

Children who are vulnerable to HIV infection – children using drugs

Drugs do not have to be injected to carry an HIV risk. Alcohol, smoking drugs or glue-sniffing may lead to risk taking behaviour. The association between drug use and HIV infection appears to be particularly dangerous for young people of low socio-economic status, including girls involved in commercial sex and boys living on the street.

Children from uninfected households living in affected communities

All children, not only those in direct contact with an HIV infected family member, will be affected by the epidemic. They may be affected directly though day-to-day contact with peers who have been personally affected, by sharing their homes with orphaned children, or by participating in community programmes to address the needs of infected and affected community members.

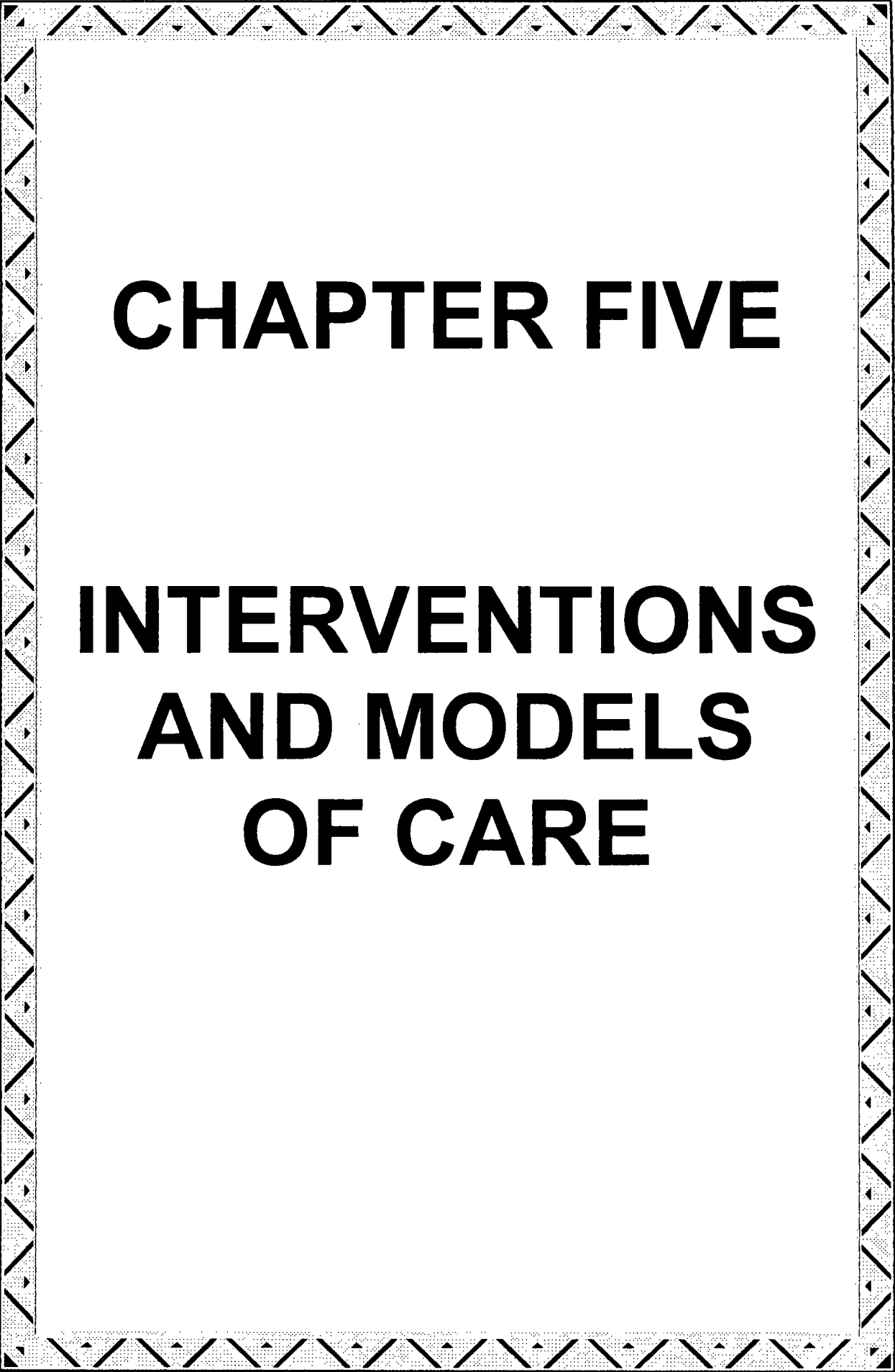
Indirectly they will be affected by the socio-economic sequelae of the epidemic such as deteriorating levels of education, health care and social services.⁵¹

⁵⁰ Personal communication; Ann Skelton, Department of Justice

⁵¹ Barrett, K, McKerrow, N, Strode, A; *Consultative Paper on children infected and affected by HIV/AIDS* (1999)

SUMMARY OF KEY POINTS

- ⌘ In the context of HIV/AIDS, children may be classified as infected or affected.
- ⌘ Almost all HIV infections in children under 13 are the result of transmission from mother to child; during pregnancy, birth or from breastfeeding. Other modes of transmission are sexual transmission and transmission from unsafe health practices.
- ⌘ The AIDS epidemic is producing large numbers of affected children and orphans and resulting in increased hardship, particularly for impoverished families.
- ⌘ Orphans have multiple needs – physical and material, intellectual, psychosocial and (discrimination and legal) protection needs.
- ⌘ Children from households with infected family members are frequently forced to assume care and other adult responsibilities.
- ⌘ Adolescents at risk of HIV infection, have high levels of knowledge about HIV/AIDS, but do not perceive themselves to be at risk and do not take the need for safer sex seriously.
- ⌘ Children who are sexually exploited (either commercially or at home) are particularly vulnerable to HIV infection.
- ⌘ Street children are also prime targets for HIV infection, not because of a lack of knowledge and awareness, but rather because of their low status, powerlessness and social conditions.
- ⌘ Children in detention are often exposed to violence, abuse and unwanted sex.
- ⌘ Children from uninfected households living in affected communities are also affected, either directly, for example through day-to-day contact with their peers who have been personally affected, or indirectly by the sequelae of the epidemic such as deteriorating levels of education and health care.



CHAPTER FIVE

INTERVENTIONS AND MODELS OF CARE

CHAPTER FIVE: INTERVENTIONS AND MODELS OF CARE

Chapter Five explores interventions and models of care for children infected with or affected by HIV/AIDS.

PREVENTING MOTHER TO CHILD TRANSMISSION OF HIV

A 'vaccination' with a 50% success rate⁵²

ACTG 076, a study conducted in 1994, indicated that a long and costly drug regimen, combined with avoidance of breastfeeding, could drastically cut mother to child HIV transmission. In industrialised countries this regimen (which costs \$800 per woman for the drug alone) is used extensively and has resulted in significant declines in perinatal HIV infection. For many reasons, including limited resources and inadequate health facilities, implementation of this regimen was not possible in developing countries, meaning that a regimen proven effective for perinatal HIV prevention was essentially out of reach in situations where over 90% of HIV infections occur. The ACTG 076 findings prompted a focused effort to develop regimens more suited logistically and financially to the developing world, where breastfeeding is common and the overall risk of maternal HIV transmission to infants is around 35%.

Short courses⁵³

On 2 March 1998, the first results of these studies were announced. In a non-breastfeeding population of HIV infected women in Thailand, short-course AZT (started orally at 36 weeks gestation and continued throughout pregnancy and labour) resulted in a 51% reduction in perinatal transmission. All the women were provided with infant formula and counselled not to breastfeed, which is consistent with the Thai national guidelines for HIV infected women.

Essential pre-requisites for the implementation of a short course antiretroviral intervention

- access to pre- and post-natal care
- access to voluntary counselling and testing (VCT)
- access to reliable and affordable laboratory facilities
- access to available and affordable antiretrovirals
- access to safe alternatives to breastfeeding
- access to sustained social support

Main factors affecting affordability

- the cost of drugs
- the cost of HIV testing (including counselling)
- the cost of milk substitutes

In South Africa, the PETRA study used a combination of two antiretroviral drugs (AZT and 3TC) from 36 weeks, during labour and for one week post natally. This reduced the chances of the infant becoming infected by 37%. Since these results have been announced, developing countries across the globe have been considering how such a shortened regime could be implemented.

⁵² UNAIDS; *Questions and Answers; Mother-to-child transmission of HIV* (1999)

⁵³ UNAIDS; *Meeting statement on MTCT* (March 1998)

Nevirapine – new hope

In July 1999 the results of a study using a short-course regimen of nevirapine resulted in a 47% reduction in mother-to-infant HIV transmission compared with a short course of AZT. This is more affordable and practical than any other examined to date. A single oral dose of nevirapine (NVP) is given to an HIV infected woman in labour and another to her baby within three days of birth. If implemented widely in developing countries, this intervention potentially could prevent some 300,000 to 400,000 newborns per year from beginning life infected with HIV. It is 200 times cheaper than the long-course AZT used in the United States, and almost 70 times cheaper than a short course of AZT.

The diagnosis dilemma

Early diagnosis is essential to prepare the mother either to cope with a serious disease in her newborn or to reassure her that her baby is not infected. The presence of passively acquired maternal HIV antibodies that persist in an infant's circulation until 15 months renders the standard ELISA test unreliable for early diagnosis of HIV infection in an infant. Tests such as p24 antigen or PCR can detect viral activity within 6 weeks. These tests are available in hospitals but not in clinics in South Africa.⁵⁴

What else is being researched? (to reduce MTCT)

- chlorhexidine-based vaginal disinfection before delivery (associated with a reduction in transmission where membranes are ruptured for more than 4 hours)
- elective Caesarean section (a metanalysis showed a 57% reduction in transmission)
- vitamin A supplementation (supplements reduced the incidence of pre-term delivery, but not of MTCT)

The breastfeeding debate

Are we to accept that our children's survival should be compromised by the risk of infant AIDS in the cruellest sense through the promotion of unlimited, unmodified and unchallenged breastfeeding policies?

Dr T. Stamps, Zimbabwe

There are areas of potential conflict between the recognised risk of transmission of HIV from infected mother to child via breastfeeding and the importance of breastfeeding for child survival and health. This represents a challenge to policy makers who will need to resolve these apparently opposing viewpoints in a manner that is appropriate for the South African context. UNICEF has provided a clear statement on the issue which can serve as a useful starting point.

Reasoned advocacy for breastfeeding includes consideration of alternative feeding options in those situations when they may increase rather than diminish a child's chances of survival.⁵⁵

⁵⁴ Moodley, D; *An overview of HIV transmission from mother to child* (1998)

⁵⁵ UNICEF statement regarding HIV and breastfeeding for WHA (1997)

Guiding principles on MTCT

All women, irrespective of their HIV status, have the right to determine the course of their reproductive life and health. This is entrenched in the Bill of Rights which states that everyone has the right to life, and everyone has the right to have access to health care services, including reproductive health care.

In developing policies and programmes, the overarching goal must be to reduce women's vulnerability to HIV infection and to prevent new HIV infections.

In infected women the aim should be to reduce foetal exposure by reducing maternal viral load and intrapartum exposure.

It is universally acknowledged that breastfeeding not only saves lives, but generally improves the quality of life of babies and mothers. However, where the risks of HIV transmission through breastfeeding are greater than the protective effects of breastmilk, alternative safe feeding opportunities should be considered.

Individual choice must be encouraged by the provision of adequate information regarding responsible breastfeeding in conjunction with support for women to put into practice their decisions about infant feeding.

Policy considerations

Interventions to reduce transmission of HIV from mother to child during pregnancy, labour and delivery that are simple, affordable, effective and appropriate for developing countries should be instituted. These include:

- Access to barrier methods and the promotion of their use particularly during pregnancy and lactation;
- Adequate, timely treatment of sexually transmitted diseases; and
- Access to voluntary, confidential HIV testing which is accompanied by counselling on reproductive health and alternative feeding options.

Where artificial feeding is the preferred option, the following requirements should be met to minimise the risks of artificial feeding:⁵⁶

- Clean, readily available water
- Appropriate household sanitation
- Utensils: bottles, teats etc
- Facilities to wash and clean utensils, including adequate fuel for sterilisation
- Family resources to purchase infant formula
- Education and support of mothers
- Education and support of other carers
- Education of health care workers

Any institution or organisation which provides an infant with a breastfeeding substitute for home use should ensure that the supply is continued as long as the infant needs it. The International Code for Marketing of Breastfeeding Substitutes allows for the use of artificial feeding for **medical** indications. A woman's HIV positive status could be viewed as a medical indication for artificial feeding.

⁵⁶ Statement on HIV transmission and breastfeeding, workshop on breastfeeding choices for the HIV seropositive mother, Durban (1996)

CHILDREN INFECTED WITH HIV⁵⁷

Children with HIV are not sick all the time and they should lead as normal a life as possible.

Caring for children with HIV infection can be a difficult and challenging task. Whilst the interventions may not be significantly different for children who are not HIV infected, the stigma attached to HIV infection cannot be ignored. Care needs to be provided in the context of a confidential, non-discriminative and supportive environment.⁵⁸

Policy considerations

HIV infected children should have:

- Good nutrition (including nutritional supplementation where necessary)
- Good hygiene, clean water and sanitation and protection from toxins
- A balance between exercise and rest
- Psycho-social support for the child and parent or care giver
- Comfort when in pain and distress
- Care and follow-up (growth and development monitoring)
- Early treatment of common childhood infections, including regular treatment for parasitic infections
- Prophylaxis for candida infections toxoplasmosis, recurrent bacterial infections and PCP
- Treatment of common opportunistic infections
- Drugs (such as antibiotics and antifungals)
- Complete immunisation coverage

Children infected sexually

There have been no studies done on the possible benefits of post-exposure prophylaxis (with antiretroviral drugs) for children who have been sexually abused.

Guiding principles for infected children

Infected children have the right to the benefit of family life. In the absence of family care infected children have the right to alternative care.

Infected children have the same rights to health care as uninfected children.

Disclosure of a child's HIV status must be in the child's best interests.

⁵⁷ National guidelines are available from the DOH on the treatment and care of HIV infected children

⁵⁸ Fransman, D; and Hussey, G; Promoting the rights of the child affected/infected with HIV, MCH News (1999)

AFFECTED CHILDREN

Young people participating – a force for change

There is a call for young people to work in partnership with adults who encourage their participation and are receptive to their ideas. This means listening to young people, understanding how they think and act, offering assistance and support without dictating the outcome and engaging them as active participants in activities and decision-making.

In Lusaka, Zambia, involving young people as peer counsellors had the effect of (a) increasing attendance at the clinic because the services were more suited to the needs of young people and (b) creating strong links between the adults and the young people in the community.

At the 1995 ICASA Conference in Kampala, Uganda, young Africans from 11 countries, ranging in age from 14 to 24, issued a declaration of their needs and priorities.

- **Youth participation:** involve us in programme planning, implementation and evaluation and policy development in community decision-making processes
- **Youth-friendly services:** support the provision of services, including centres where we can access information, support and referral
- **Parental involvement:** strengthen the capacity of parents and other significant persons in our lives to better communicate with us and provide guidance and support to us, our brothers and sisters
- **Education about HIV/AIDS and sexuality:** promote skills-based education on physical development, reproductive health and sexuality for youth both in and out of school
- **Protection of girls and young women:** prevent the sexual abuse and exploitation of girls in vulnerable situations; emphasise the sensitisation of boys, young men and older men
- **Partnership with people with HIV and AIDS:** build networks between young people with HIV/AIDS and other youth to promote prevention of HIV/AIDS, protection of human rights and acceptance of people with HIV/AIDS in society
- **Young people's commitments:** commit ourselves to responsible decision-making about our own sexual behaviour and positively influence our peers

Protecting young people from HIV infection⁵⁹

At the end of the day the frequently asked question that must be answered is:
Does sexual health education lead to earlier or increased sexual activity?

A major literature review, carried out in 68 countries by the UNAIDS Secretariat, confirmed that it does not. Instead, such education encourages young people to postpone their sexual initiation and lowers their risk of unwanted pregnancy, sexually transmitted disease and HIV infection.⁶⁰

The UNAIDS review found that effective programmes share certain features:

- They have as specific aims both delayed first intercourse and protected intercourse
- They encourage the learning of life skills
- They discuss clearly the results of unprotected sex and ways to avoid it
- They help young people 'personalise' the risk through role-playing
- They reinforce group values against unsafe behaviour, both at school and in the community

Programmes should:

- ✓ be aimed at life, not death
- ✓ minimise fear
- ✓ eliminate discrimination
- ✓ emphasise the positive aspects of sex
- ✓ provide frank information
- ✓ utilise humour
- ✓ incorporate AIDS information into sex and health education programmes
- ✓ take place both in schools and in recreation areas
- ✓ familiarise pupils with condoms
- ✓ make condoms readily available
- ✓ promote safe sex
- ✓ include teachers
- ✓ utilise the creativity of pupils
- ✓ take into account the specific needs of each group

From NEPI

A note of caution - The evaluation of one school AIDS programme showed that programmes can increase knowledge about HIV transmission and prevention and improve acceptance of people with AIDS. However, even after the programme, relatively few students believed that AIDS could affect them, and although some said they would use condoms in future, attitudes towards condoms remained largely negative.

Youth to youth – peer education at work

It is useful to divide peer approaches into three types:

- Peer communication which involves briefing people to provide information, often to large groups on a once-only basis
- Peer education which involves training people to carry out informal or organised educational activities with individuals or small groups over a period of time
- Peer counselling which involves training people to carry out one-to-one counselling including support and help with problem solving.⁶¹

⁵⁹ Attawell, K; *HIV/AIDS Knowledge, Attitudes, Beliefs and Behaviours in South Africa* (1998)

⁶⁰ The UNAIDS Report (1999)

⁶¹ AIDS action; Issue 25 (1994)

Guiding principles for youth programmes

(drawn from the experience of peer education programmes in Benin, Botswana, Ghana, Jamaica, Kenya and Zambia)

- ✓ Understanding young people's specific problems, attitudes and needs for information and skills, and finding out what they know and feel about themselves and their lives
- ✓ Responding to young people's priorities such as advice about training or jobs
- ✓ Making sure that peer educators are involved in defining their roles and responsibilities
- ✓ Stressing development of skills, as well as attitudes and knowledge, in training and educational activities, and increasing access to and use of condoms
- ✓ Ensuring that peer educators know where to refer their peers for condoms and appropriate counselling, STD treatment and family planning services
- ✓ Understanding that peer educators may be active for only a limited time, although with good support, increased responsibility and varied activities, they may continue for a few years
- ✓ Combining peer education with other approaches that reinforce HIV/STD prevention messages and reach more young people, such as radio, posters and community sports and social events
- ✓ Gaining the support of parents, health workers and community leaders, especially for involving young women and providing condoms

Policy considerations

All adolescents need:⁶²

- Factual information on the prevention of HIV infection
- Access to school and community-based physical and mental health services
- Counselling concerning adolescent development, sexuality, identity formation, peer pressure and death and dying
- Skills in communication, assertiveness, decision-making and problem-solving
- Peer acceptance of a range of healthy sexual attitudes and behaviours, which can be fostered and encouraged by school staff
- Help in recognising personal vulnerability to HIV infection
- A supportive environment in which to express fears and anxiety about HIV infection.

Important life skills in the HIV/AIDS era

- ✓ How to make sound decisions about relationships and sexual intercourse, and stand up for those decisions
- ✓ How to deal with pressures for unwanted sex or drugs
- ✓ How to recognise a situation that might turn risky or violent
- ✓ When ready for sexual relationships, how to negotiate protected sex or other forms of safer sex
- ✓ How to show compassion and solidarity towards people with HIV/AIDS
- ✓ How to care for people with AIDS in the family and the community

⁶² NEPI; *National Education Policy Initiative*

Guiding principles on HIV/AIDS in schools(from the SA Law Commission's *Consultative Paper on children infected and affected by HIV/AIDS*)

- Learners with HIV/AIDS should not be unfairly discriminated against; any special measures to be taken in respect of a learner with HIV/AIDS should be fair and justifiable in the light of medical facts, school conditions and the best interests of the learner or those of other learners.
- No learner should be denied admission to or attendance at school on the basis of his or her HIV status.
- Testing of learners for HIV for admission to or attendance at school is prohibited.
- The needs of learners with HIV should be accommodated within the school environment, as far as is reasonably practicable.
- A learner's HIV status is confidential and may not be disclosed without his or her consent, or the consent of his or her parent or guardian. No learner, or his or her parent or guardian is compelled to disclose his or her status to the school authorities.
- All schools should implement universal precautions to eliminate the risk of transmission of blood-borne pathogens, including HIV, in the school environment.
- While the risk of HIV in contact play and sport is insignificant, all schools should take measures to eliminate this risk. This includes the use of universal precautions, and prohibiting any learner from participating in any contact sport with an open wound, sore, break in the skin or open skin lesion.
- A continuing HIV/AIDS education programme should be implemented at all schools for all learners, educators and other staff. This includes, inter alia, cultivating an enabling environment and a culture of non-discrimination towards persons with HIV, and encouraging learners to use health care, counselling and support services offered by community service organisations and other disciplines.

Programmes for street children

The objectives of street children programmes⁶³ are generally to:

- Reform, rehabilitate or resettle the children
- Provide basic needs
- Feed, care and educate them
- Integrate them into society as well adjusted members
- Provide counselling services which respond to the needs of the children
- Provide them with survival skills
- Advocate for them

Policy considerations

Interventions for street children should include:⁶⁴

- Primary prevention programmes which aim at involving communities and at-risk families to prevent children from turning to the streets
- Secondary prevention programmes which aim at developing pro-active intervention strategies within communities to prevent children on the streets who maintain contact with their families from making the street their permanent home.

⁶³ Report from SANASO workshop on children affected by HIV/AIDS (1994)

⁶⁴ Kuse T; *The phenomenon of street children in the former Transkei: towards a new preventative approach*, Social Work Practice (1997)

Programmes for street children elsewhere in Africa provide guidance for South Africa.⁶⁵

Kenya

Perhaps the best-known programme in Africa is the long-established Undungu Society in Nairobi. The Society has developed a number of projects including Street Girls, Rescue Centres, the Parking Boys Programme, employment creation, small enterprise development, pursuit of affordable shelter, community nutrition and health. The focus is on improving the quality of life of those who are less fortunate while protecting the rights of the children.

One major lesson we have learned from our experience in working with street children is that the process of rehabilitating these children requires a long-term commitment, combining compassion with realism. In our experience at Undungu, education for life is the cornerstone of sustainable rehabilitation.

Father Arnold Grol

Zimbabwe

Some of the lessons learned by service providers in Zimbabwe are that:

- The most visible street children are not necessarily those in greatest need of material and social support
- Any programme assisting children should not end in the street but in the community from where the children come
- The capacity of children to determine their own destinies and to evaluate their own experiences has been underrated, undervalued and undermined

Uganda

At FOCA (Friends of Children), training is taken seriously and a wide range of courses is offered, including skills such as carpentry, tailoring, blacksmithing, radio repairs, bicycle assembly and repairs, charcoal stove making, welding fabrication and aluminium work. There is HIV/AIDS education including a 5-day crash course. There is also a Voice of the Street drama group which publicises the plight of street children.

Ghana

CAS (Catholic Action for Street Children) in Accra runs a refuge for street girls who are pregnant. They receive medical care and advice about how to care for themselves and their babies. At the biggest market CAS has built three crèches where babies and young children are cared for while their mothers are working. Future goals are to offer street-corner literacy, street-corner health posts and street-corner crèches for street babies.

We need desperately to ensure that our children receive the opportunity to acquire basic literacy skills. The challenge, too, is to publishers to come up with innovative material to enable our social and street workers to start street literacy groups.

Father Patrick Shanahan

⁶⁵ Cockburn, A; *Let's learn from our neighbours*, Children First, Vol. 3, No. 25 (1999)

AIDS orphans

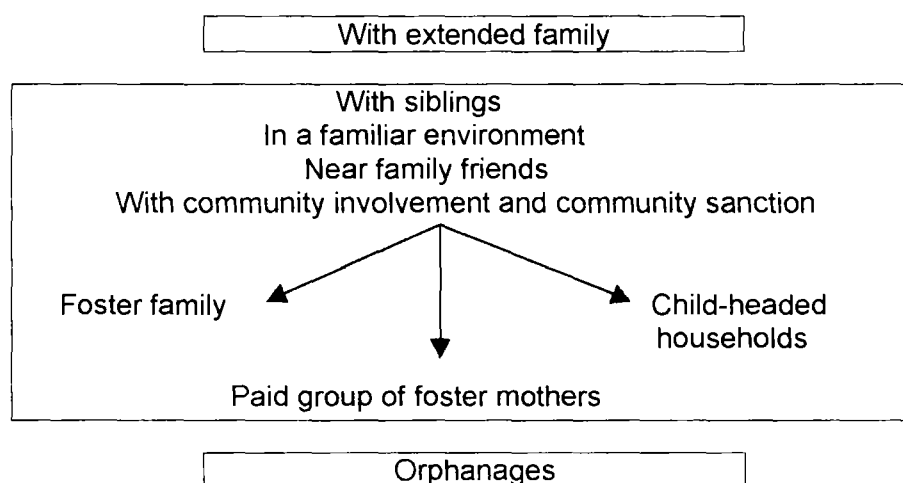
There is no doubt that in both human development and financial terms, the cost of care now will be less than the price society will ultimately pay for the neglect of children left to a life on the streets, in the bush or in overcrowded institutions.

FOST Report (1998)

Models of care for orphans may be classified in the following terms:⁶⁶

- Independent living by orphans
- Independent living with external supervision and support
- Foster care including traditional family care, cluster care of multiple children, collective care of individuals or multiple children
- Adoption
- Institutional care including places of safety, shelters, short-term infant homes and traditional children's homes
- State or NGO sponsored community-based support structures including feeding posts and day care facilities

The FOST (Farm Orphans Support Trust)⁶⁷ model describes alternative models of care for orphaned children as follows:



In the FOST study of responses to orphanhood and foster care, there was much greater acceptability of the concept of foster care and a strong sense that the community *should* respond if support (practical and financial) were made available. It is important to recognise that material needs play a significant role in kinship solidarity.

There is general consensus that interventions to assist orphans should be based in and owned by the affected communities themselves. Members of the community are in the best position to know which households are most severely affected and what sort of help is appropriate. They know who is dying, who has died, who has been taken in by relatives, who is living alone and who has enough to eat.

⁶⁶ SALC, Project Committee on the Review of the Child Care Act; *Consultative Paper on Children infected and affected by HIV/AIDS* (1999)

⁶⁷ Parry, S; *Farm Orphans: Who is coping?* FOST (1998)

Volunteers from within the community are more likely to visit households regularly and the help they offer is more likely to be practical and supportive. The role of outside organisations is to assist communities by capacity building.⁶⁸ In Malawi, Village Orphan Committees are tasked with identifying and registering orphans within their area.

Policy considerations

Due to the unprecedented numbers of children who will be in need of care and protection as a result of HIV/AIDS, it is important that simple effective community-based mechanisms are developed to identify children in need. The challenge is how to provide care that maintains the child within a family and within his culture and community of origin. It is necessary to:

Support parents with:

- ✓ practical, emotional and material support
- ✓ day care and relief care for children
- ✓ health care
- ✓ education and stimulation
- ✓ making a will to protect children
- ✓ selecting a guardian

Support child-headed households by:

- ✓ providing practical, nutritional, health, financial and/or material assistance
- ✓ providing developmental, emotional, spiritual and social support
- ✓ ensuring that educational, training and recreational needs are met
- ✓ facilitating guardianship arrangements

Support the extended family with:

- ✓ training, support and supervision (if necessary)
- ✓ assistance in obtaining resources
- ✓ assistance with income generation (if necessary)
- ✓ facilitating guardianship arrangements

Promote informal foster care for children without families by:

- ✓ mobilising foster carers in communities
- ✓ obtaining community agreement for volunteers to foster children
- ✓ training, support and supervision for caregivers
- ✓ helping to obtain the necessary resources
- ✓ facilitating guardianship arrangements

Strategies for community-based orphan care programmes

Raising awareness about the problem

Documenting the extent of the problem

- (i) assessing the needs
- (ii) keeping a register of orphans
- (iii) finding out what communities can do themselves
- (iv) checking on progress

Mobilising the community for action

- (i) developing partnerships with outside organisations
- (ii) networking
- (iii) mobilising volunteers from the affected community

Making ends meet

- (i) saving labour
- (ii) directly increasing household income
- (iii) relieving the burden (cash grants, food aid, school fees, agricultural inputs, blankets and other essential items)
- (iv) indirect measures (such as protecting the property and inheritance rights of women and children)

Helping to educate and train children

Improving legal systems to help children

- (i) protecting children from exploitation
- (ii) making it easier to get help

⁶⁸ UNICEF & Child Protection Society, Zimbabwe; *How can we help? Approaches to community-based care* (1999)

Orphan programmes in Africa

Many positive women and men deal with the possibility of death by concentrating on practical plans like creating *memory books or boxes* for their children. These can contain photographs with descriptions of who is in the picture, poems and stories, trinkets or baby toys, and a family tree which records information about relatives and ancestors. When children are involved in helping their parents collect the 'memories' it is an easy step to go on to talk about loss and changes ahead.⁶⁹

Zimbabwe

Three phases constitute Zimbabwe's community-based orphan care projects.

Phase One: Assessing the situation

Data are collected to determine not only the number of AIDS orphans and other children in need of special protection, but also who is caring for these children and how are they living.

Phase Two: Increasing awareness of problems affecting AIDS orphans and children in need of special protection

The data and information from Phase One are used to raise awareness and encourage communities to discuss the problems and share their experiences in order to develop possible solutions.

Phase Three: Strengthening communities

Projects and activities are implemented which aim to improve the capacity of caregivers to provide for the children in their care.

Salvation Army, Masiye training camps, Zimbabwe

The programme offers 3 types of camps for orphans

1. Life skills and coping capacity camps with the aim of rebuilding their confidence and helping them to overcome the loss of their parents
2. Teenage parenting courses to equip orphans looking after their siblings with positive parenting skills, knowledge of children's rights, hygiene, nutrition and first aid
3. Vocational training programmes in arts, crafts and hospitality and catering management

Malawi

Community-based care of orphans in Gandali, Malawi

The village had 44 orphans living with relatives in 12 families. Problems faced included the lack of food, clothes, bedding, washing and bathing soap and school writing materials.

A village orphan care committee was elected. Communal maize gardening was proposed as a solution to provide extra food. Skills training was provided for older orphans to enable them to contribute to the family income – tinsmith training for the boys and sewing for the girls.

⁶⁹ Healthlink; AIDS action (1999)

Malawi's national orphan care guidelines describe the commitment to care.

- The first line of approach must be community-based programmes. Formal foster care will be expanded as the second preferred form of care. Institutional care should be the last resort, though temporary care may be necessary for children awaiting placement.
- Hospitals should record next of kin so that relatives can be traced if children are abandoned. The registration of births and deaths should be improved, to assist in the monitoring of orphans.
- The Government will protect the property rights of children and these rights will be widely publicised.
- Self-help groups should be developed to help affected families. NGOs are encouraged to set up programmes of community-based care.
- The needs of all orphans should be considered on an equal basis, regardless of the cause of death of the parent or parents. The lead body will be the Ministry of Gender, Youth and Community Service.

*Tanzania*⁷⁰

In the Kagera and Dar-es-Salaam regions, direct aid to the needy in the form of food, child care and counselling is provided to families with orphans by the Social Welfare Office. Recipients of aid are identified by local community structures, usually the village leaders.

There are 252 feeding posts providing a daily meal to children aged 0-6 years. Costs of staff and the centres are borne by the local communities themselves, whilst start-up funding, staff training and transport costs are borne by donors.

Day care centres are supervised by the Department of Social Welfare and run by formally trained and paid staff who work half a day. They provide a meal, education, developmental activities and play for children aged 2 – 6 years. This relieves parents and older siblings of their care and enables them to engage in economic activities or to attend school.

At WAMATA centres, full-time staff are responsible for counselling and home-based care services as well as for the recruitment, training and support of volunteer counsellors. The primary emphasis is to enable families to support their orphaned members. This is achieved by (i) identifying and registering all orphans; (ii) providing social support in the form of food, clothes, bedding, school fees and uniforms; and (iii) establishing a revolving fund to act as seed funding so that families can start income generating activities to supplement the household income.

34 orphanages run by NGOs and subsidised by the State provide temporary homes for children aged 0 – 3 years, whereafter they are returned to their extended families, fostered, adopted or transferred to the single State orphanage which caters for older children.

⁷⁰ McKerrow, N; *Implementation strategies for the development of models of care for orphaned children* (1996)

Swaziland⁷¹

An extensive study into the education system has made a number of recommendations related to orphans:

- That a needs assessment of orphans and caregivers be conducted, carefully defining what an orphan is in the Swaziland context, and identifying orphans in need
- That exemptions be offered to homesteads/institutions with orphans to enable children to attend school; waiving school uniform requirements when affordability is a problem; expanding school-based feeding programmes for school-children; and introducing flexible schooling hours, where possible, to keep children in school who might otherwise have to drop out due to labour requirements elsewhere
- Increasing day-care facilities, particularly at the schools, to allow children who would otherwise have to take care of their younger siblings to attend classes
- The creation of an educational insurance scheme permitting parents to invest in policies catering for their children's school fees in the event of their death
- The use of national funds as an investment in the education of children.

Kenya

Kariobangi Community and Home-Based Care Programme: Kenya

The Kariobangi Community and Home-Based Care Programme in a large slum area in Nairobi, Kenya, provides a useful example of a programme which attempts to address the needs of children. Kariobangi has a population of over 100 000. 60% of the homes are headed by women and most earn a living by scavenging on the city dump, alcohol brewing and survival prostitution. Persons who become ill are identified to the voluntary community health workers (CHW) all of whom have been trained (weekly classes for 5-6 months).

Clients are nursed at home until they die. Their children are invited to join the *Children's Programme* which teaches them how to care for their sick parents, how to raise their younger brothers and sisters and prepares them for life without parents. They are provided with basic materials for care (old sheets and polythene bags) and where necessary food, either as a cooked meal once a day or dry food which can be prepared at home.

There is a *Child Crisis Centre* where children can stay temporarily if a mother is too sick to cope or dies suddenly. It also serves as a haven where children can come for advice or moral support. Children with HIV receive medical care as part of the programme.

The costs of the programme are:

Medicines per patient per year	\$2.2
Cost of food per patient & family per day	\$0.5
Cost of training per CHW	\$7
Transport to hospital, clinic per patient	\$1
Cost of X-rays, lab tests etc per patient	\$0.7
Total programme costs per patient per year (meds, salaries, transport, admin)	\$13.4

Issues relating to children which the project has identified as problematic include:

- That parents are not willing to disclose their status to their children
- That planning for the future security of the children does not take place

⁷¹ King, JR; *Report to the Ministry of Education* (1999)

Zambia⁷²

In 1996, community workshops were held as part of a UNICEF-funded process to identify innovative or indigenous models of care for orphaned children. A four-tier response was identified:

- The family must identify vulnerable children and orphans and provide the basic day-to-day needs of the children as well as emotional support
- The community must support both the children and their caretakers as well as act as a forum for lobbying authorities to assist in providing an effective response
- Churches, NGOs and CBOs must co-ordinate all responses whilst also providing material support and support services
- The State must develop local infrastructure, empower state personnel, create an enabling environment at all levels, modify state services and facilitate funding for grass-roots services

Zambian principles

- Orphans must not be targeted in isolation from other vulnerable children
- Siblings should remain together
- Children should, as far as possible, remain in their homes or communities of origin
- Caretakers must be supported through skills training in income generating activities and child care skills
- Development of communities is invariably a greater priority for communities, and programmes focusing on vulnerable children must ideally be linked to development programmes
- Communities must provide support systems for both children and their caretakers
- Criteria must be developed at community level for identifying the recipients of aid
- NGOs should work through local CBOs
- In the delivery of child-centred programmes, links to other service or care programmes catering for the sick, the elderly, the handicapped etc are invaluable
- Use must be made of locally recruited co-ordinators and volunteers who must receive appropriate training and supervision
- Responses must facilitate the provision of both direct and indirect aid packages
- Support which benefits the entire community is preferable
- State resources must be made user-friendly

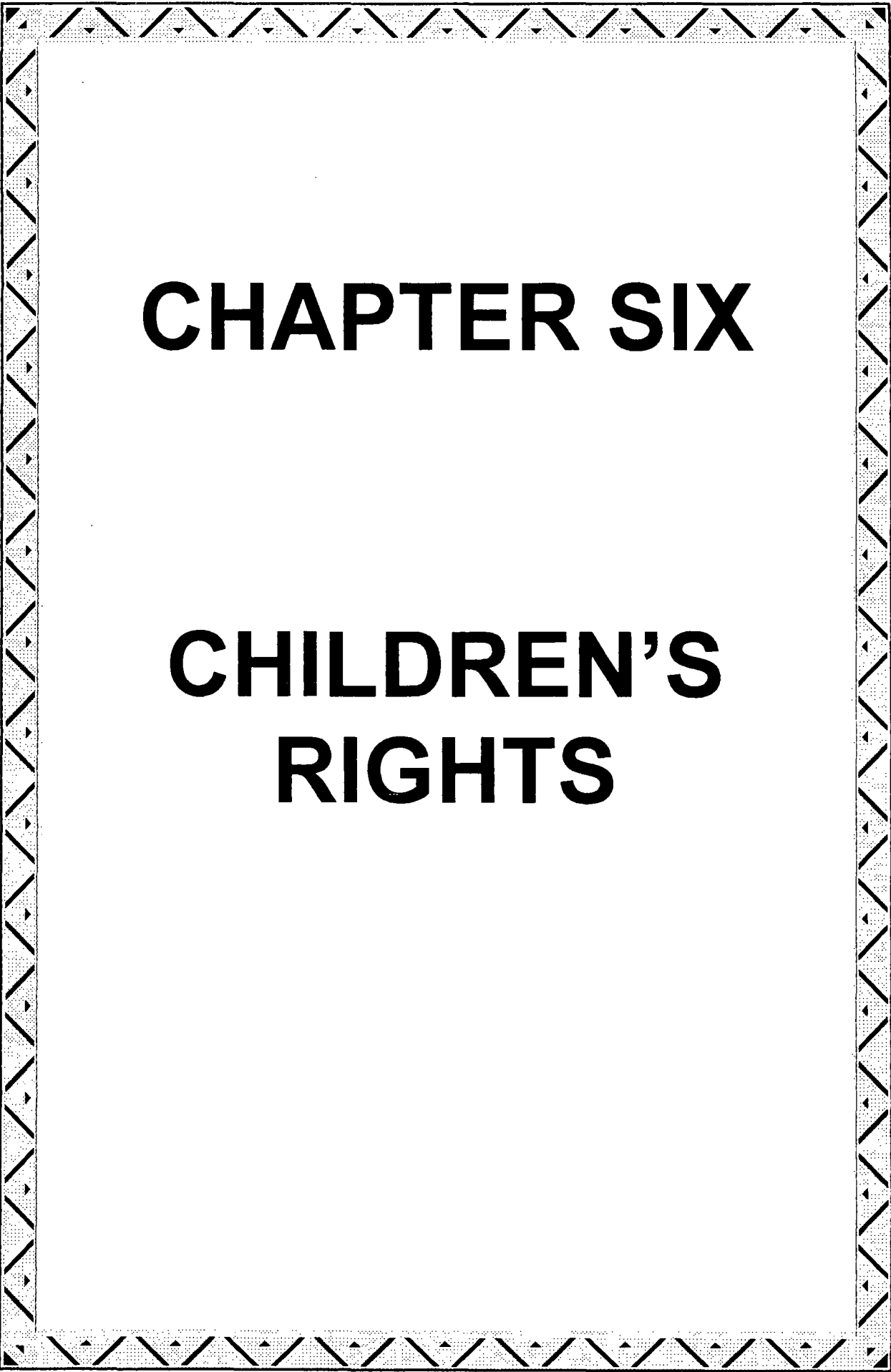
SUMMARY OF KEY POINTS

- ⌘ Limiting mother to child transmission of HIV is possible where access to pre- and post-natal care and to voluntary counselling and testing exists, where laboratory facilities and antiretroviral drugs are available and where safe alternatives to breastfeeding and social support for infected mothers are accessible and acceptable.
- ⌘ Treating HIV infected children requires a holistic approach which includes attention to nutrition, hygiene, exercise, growth and development monitoring, immunisation coverage, early treatment of childhood infections, prophylaxis

⁷² McKerrow, N; *Implementation strategies for the development of models of care for orphaned children* (1996)

for and treatment of common opportunistic infections and psychosocial support.

- ✘ Effective programmes for the youth aim to delay first intercourse and promote protected intercourse within the context of learning life skills and group values.
- ✘ Interventions for street children should include primary prevention to prevent children from turning to the streets as well as secondary prevention, to reform, rehabilitate or resettle the children.
- ✘ Different models of care for orphans have been identified, from independent living by orphans to institutional care. Whatever the model, it should ideally be based in and owned by the affected community. Community responses are strengthened if support (practical and financial) is available.
- ✘ Models and studies from neighbouring countries provide valuable lessons for South Africa, for example:
 - Memory books or boxes create an opportunity to open the discussion with children about loss and future changes
 - Training for orphans could include life skills and coping capacity (to rebuild their confidence and help them to overcome the loss of their parents); teenage parenting (to equip orphans looking after their siblings); and vocational training programmes
- ✘ Key principles which should guide interventions and programmes for children are that:
 - Orphans must not be targeted in isolation from other vulnerable children
 - Siblings should remain together
 - Children should, as far as possible, remain in their homes or communities of origin
 - Caregivers must be supported through skills training in income generating activities and child care skills
 - Programmes focusing on vulnerable children must ideally be linked to development programmes
 - Communities must provide support systems for both children and their caregivers
 - Criteria must be developed at community level for identifying the recipients of aid
 - Use must be made of locally recruited co-ordinators and volunteers who must receive appropriate training and supervision



CHAPTER SIX

CHILDREN'S RIGHTS

CHAPTER SIX: CHILDREN'S RIGHTS

Chapter Six develops the concept of a children's rights framework and proposes a rights approach to services and interventions for children infected with or affected by HIV/AIDS.

INTRODUCTION

Until fairly recently, it was common practice to describe children in terms of the group to which they supposedly belonged (street children, children in detention etc) and then to identify the needs which were common to many of the children in that group. These needs served as a focus for interventions which primarily aimed to address the needs. Much of the literature appears in this form and this is the form that was used in presenting the findings of the desk review (Chapters Two to Five).

However, it is timely to adopt a new framework: one which is based on the rights of children rather than simply on their needs. Whilst this change may not yet be universally accepted, international NGOs and key national Departments in South Africa are seeking ways to move towards it.

This chapter attempts to generate an awareness not only of children's rights, but also to create a philosophical mindset which will serve as a bridge from a needs-based approach to a rights-based approach to children and HIV/AIDS.

THE CONTEXT FOR A CHILDREN'S RIGHTS FRAMEWORK

There is now global consensus that children's rights need special protection. In 1989, a decade after the International Year of the Child, the UN General Assembly adopted the Convention on the Rights of the Child (CRC), which sets out the political, civil, cultural, economic and social rights of children. Less than a decade later all the countries of the world except two (USA and Somalia) have ratified it.

South Africa's commitment to children's rights

South Africa ratified the CRC in June 1995. Children's rights in the CRC are, in turn, reflected in the Bill of Rights of the Constitution (1996). The National Programme of Action (NPA) is the instrument by which the commitments to children are carried out, overseen by an Inter-Ministerial Core Group appointed by Cabinet and a National Steering Committee comprising the Directors-General of seven Ministries, the NCRC and UNICEF. In addition, several of the Presidential Lead Programmes of the RDP focus on the promotion of the health, education, welfare and protection of children.

The CRC guarantees the rights of children to:

- **protection** (from maltreatment, neglect and all forms of exploitation);
- **provision** (of food, health care, education, social security); and
- **participation** (in all matters concerning them)⁷³.

⁷³ Reynolds, L; The Rights of the Child: a Challenge for Health Professionals, MCH News (1999)

These in turn have been defined as the four principles of the CRC:

- ***Non-discrimination***
- ***Best interests of the child***
- ***The right to life, survival and development***
- ***Respect for the views of the child***⁷⁴

The Commonwealth Youth Forum held in Edinburgh in October 1997 put forward a statement of sexual and reproductive rights and urged Commonwealth Governments to protect those rights.

All young people of the world regardless of sex, religion, colour, sexual orientation, or mental or physical ability have the following rights as sexual beings:

1. The right to be yourself – free to make your decisions, to express yourself, to enjoy sex, to be safe, to choose to marry (or not to marry) and plan a family
2. The right to know – about sex, contraceptives, STDs/HIV and about your rights
3. The right to protect yourself and be protected – from unplanned pregnancies, STDs/HIV and sexual abuse
4. The right to have health care – care that is confidential, affordable, of good quality, accessible to all, and given with due respect
5. The right to be responsible – for one's own action and those that affect others
6. The right to be involved – in planning programmes with and for youth, attending meetings/seminars etc at all levels, and trying to influence Governments through appropriate means

Children's rights and HIV/AIDS

Amongst the rights defined in the CRC are many which have particular relevance in the context of HIV/AIDS.

⁷⁴ *Convention on the Rights of the Child, Initial Country Report (South Africa) (1997)*

Children's rights with HIV/AIDS implications

Survival and development

An inherent right to life and efforts to ensure a child's survival and development.

Separation from parents

The right to live with their parents, unless this is incompatible with their best interests.

The child's opinion and freedom of expression

A child has a right to express an opinion, and to have that opinion considered, in any matter or procedure affecting the child.

A child has a right to obtain and make known information, and to express his or her views, unless this would violate the rights of others.

Protection of privacy

Children should be protected from interference with their privacy regarding their families, homes and correspondence.

Access to appropriate information

The media has a responsibility to disseminate information to children that is consistent with their moral well-being, that fosters knowledge and understanding between people, and that respects children's cultural backgrounds.

Protection from abuse and neglect

Protect children from all forms of maltreatment perpetuated by parents and others responsible for their care.

Protection of children without families and adoption

Provide special protection for children deprived of their family environment and ensure that appropriate, alternative family care or institutional placement is made available to them, taking into account the child's cultural background.

Adoption shall only be carried out in the best interests of the child.

Children with disabilities

Children with disabilities have a right to special care, education and training designed to help them achieve the greatest possible self-reliance and lead full active lives in society.

Health and health services

Children have a right to the highest level of health possible which includes the right to health and medical services, with special emphasis on primary and preventive health care, public health education and the diminution of infant mortality.

Social security and standard of living

Children have a right to benefit from social security.

Children have a right to benefit from an adequate standard of living.

Education, leisure, recreation and cultural activities

A child has a right to education – ensure that at least primary education is free and compulsory.

Children have a right to leisure and play and to participate in cultural and artistic activities.

Child labour

Protect children from engaging in work that constitutes a threat to their health, education or development.

Sexual exploitation and drug abuse

Children have a right to protection from sexual exploitation and abuse, including prostitution and involvement in pornography.

Children have a right to protection from narcotic and psychotropic drugs and from being involved in their production or distribution.

Torture and deprivation of liberty, and armed conflict

Children should be treated appropriately, separated from detained adults, allowed contact with family, and given access to legal and other assistance.

No child under 15 should take a direct part in hostilities or be recruited into the armed forces.

The resource manual *HIV/AIDS and the Law*⁷⁵ identifies the rights which are directly in jeopardy because of HIV/AIDS.

- Access to education – the Bill of Rights specifies the right to a basic education. A child cannot be excluded from a private or government school because of his/her HIV status.
- Right to sexuality education – the CRC states that a child should have access to information that will help the child to develop his/her physical and emotional well-being. The Children's Charter of South Africa explicitly states that children have a right to be educated on issues like sexuality and AIDS. All children therefore have a right to sexuality education.
- Testing of children and confidentiality of results – the Child Care Act protects the rights of children, including their medical treatment. At the age of 14, a child can legally consent to an HIV test and he/she has the right to keep the results private.
- Adoption – It is a requirement of Child Welfare that possible future parents are told if a child has HIV.
- Right to contraception and reproductive health – the Constitution provides that all children have the right to health. Children thus have the right to protect and control their reproductive health.

South African laws affecting children

There is no single piece of legislation that embodies all the laws which affect children and which sets out their rights and responsibilities, and many of the laws which do affect children are presently under review. It is also widely felt that current processes, for example the placement of children in alternative care (adoption, fostering or placement in an institution), are deficient for the realities of a well-established epidemic.

The situation in respect of welfare grants illustrates this problem further.

- Child and family grants account for 12% of social security expenditure⁷⁶
- The Child Support Grant (CSG), implemented in April 1998 is to be phased in over a five-year period, aiming to reach the 3 million poorest children.

The laws affecting children are the:

Age of Majority Act No.57 of 1972
 Basic Conditions of Employment Act No.75 of 1997
 Births and Deaths Registration Act No.51 of 1992
 Child Care Act No.74 of 1983
 Child Care Amendment Act No.96 of 1996
 Children's Status Act No.82 of 1987
 Choice of Termination of Pregnancy Act No.92 of 1996
 Correctional Services Act No.8 of 1959
 Guardianship Act No.192 of 1993
 Health Act No.63 of 1977
 Intestate Succession Act No.81 of 1997
 Maintenance Act No.99 of 1998
 Mental Health Act No.18 of 1973
 Natural Fathers of Children born out of Wedlock Act No.86 of 1997
 Domestic Violence Act No.116 of 1998
 SA Schools Act No.84 of 1996
 Sexual Offences Act No.23 of 1957
 Social Assistance Act No.59 of 1992
 Welfare Laws Amendment Act No.106 of 1997

⁷⁵ AIDS Law Project and Lawyers for Human Rights; *HIV/AIDS and the Law* (1997)

⁷⁶ Robinson, S and Sadan, M; *Where poverty hits hardest: Children and the budget* (1999)

- The CSG is available to the primary care giver of a child under 7 years
- The grant is R100 per month per child
- As at November 1999 there were only 132 426 beneficiaries of the CSG, caring for 170 343 children
- The criteria for accessing a CSG present a major barrier
- The Foster Care Grant is available to foster parents of children under 18 (R380 per month)
- The number of foster care families is 51 583, the number of foster children (as at Dec. 1999) is 73 000⁷⁷
- The Care Dependency Grant is available to the parent or foster parent of a child aged 1 – 18 with profound intellectual and physical impairment (R490 per month)

The criteria for accessing a CSG are:

- The parents must be SA citizens and have ID documents
- The child must have a birth certificate
- A copy of a payslip if employed or a sworn statement/affidavit if unemployed
- Income may not exceed R800 for urban residents and R1 100 in rural areas and informal settlements
- If the applicant is married, proof of spouse's income must be produced

Where are children's rights compromised?

The first supplementary report on the UN Convention on the Rights of the Child identifies areas where children's rights are not being met. Many of these are also reflected in the South African initial country report (1997). Those which have HIV/AIDS implications are that:

- Many parents and guardians, especially in rural areas, do not register the births of their children with implications for the child's subsequent access to the education system, grants etc
- Many children over 12 years of age have no access to sex education and sexuality information
- Rape, sexual abuse and neglect is on the increase
- Commercial sexual exploitation of children is on the increase, particularly in areas of severe poverty
- Homeless children remain vulnerable to abuse by law enforcement officials and South African society is hostile to children who live on the streets
- A number of children in all categories of residential facilities claim to be victims of emotional, physical or sexual abuse by members of staff and other young people
- Certain traditional practices (child brides with a bride price affecting girls and traditional circumcision affecting boys) are associated with HIV transmission risk
- Many children are forced to assume parenting roles

⁷⁷ President's report on the State of the Nation's Children (1999)

What progress has been made?

Important achievements that have had positive benefits in relation to HIV/AIDS are that:

- Children under the age of 6 have access to free health care
- The Department of Education has included life skills education in the formal school curriculum
- The Department of Welfare has developed proposals to encourage foster care and adoption of HIV/AIDS orphans
- The Department of Welfare has established a programme for unemployed women with children under 5 (primarily in rural areas)
- Poverty alleviation programmes promote universal household food security
- There is an Inter-Ministerial Committee on Youth at Risk
- Foster care entitles the child to free schooling

Moving from a needs approach to a rights approach

There is a global move to change from a needs approach to a rights approach. The differences between the two approaches becomes clear in the following examples:

NEEDS APPROACH	RIGHTS APPROACH
Needs are met or satisfied Needs do not imply duties or obligations Needs are not necessarily universal Basic needs can be met by goal or outcome orientated strategies Needs can be ranked in a hierarchy of priorities 80% of all children have been vaccinated	Rights are realised Rights always imply duties or obligations Rights are universal Rights can only be realised by attention to both outcome and process All rights are equally important 20% of children have their right to vaccination violated

The starting point for a rights approach is to identify the unmet basic needs of children and the causes of the problems. This is followed by identifying duty-bearers who have duties to respect, protect, facilitate or fulfil. This analysis then provides a framework for intervention. The resulting strategies should:

- Empower parents and guardians or caregivers to meet their obligations
- Empower children to claim their rights
- Influence Governments to avoid actions that violate rights and avoid omissions that may result in violating rights
- Support other actions to respect, protect, facilitate or fulfil the rights of children⁷⁸

The aim is to focus on the whole child and promote the effective realisation of all his or her rights. It is essential therefore to foster an increasing synergy amongst the various sectors which are relevant to the child's life. This spans the relationships between child and family, child and State, child and child and inter-State obligations towards children.

⁷⁸ Jonsson, U; *Realisation of Children's Rights: Charity or Solidarity* (1997)

During the Nineteenth Session of the Committee on the Rights of the Child, held in October 1998, a number of recommendations were defined.

(a) States, programmes and agencies of the United Nations system, and NGOs should be encouraged to adopt a children's rights-centred approach to HIV/AIDS. States should incorporate the rights of the child in their national HIV/AIDS policies and programmes, and include national HIV/AIDS programme structures into the national monitoring and co-ordinating mechanisms for children's rights.

(b) States should adopt and disseminate the International Guidelines on HIV/AIDS and Human Rights and ensure their implementation at the national level. Programmes and agencies of the United Nations system as well as NGOs should contribute to the dissemination and implementation of the Guidelines.

(c) The right of children to participate fully and actively in the formulation and implementation of HIV/AIDS strategies, programmes and policies should be fully recognised. A supportive and enabling environment should be provided, in which children are allowed to participate and receive support for their own initiatives. The proven effectiveness of peer education strategies, in particular, should be recognised and taken into account for its potential contribution to the mitigation of the impact of the HIV/AIDS epidemic. The key objective of HIV/AIDS policies should be to empower children to protect themselves.

(d) Access to information as a fundamental right of the child should become the key element in HIV/AIDS prevention strategies. States should review existing laws or enact new legislation to guarantee the right of children to have access to HIV/AIDS related information, including access to voluntary testing.

(e) Information campaigns targeting children should take into account the diversity of audience groups and be structured accordingly. Information on HIV/AIDS should be adapted to the social, cultural and economic context, and it should be made available through age-appropriate media and channels of dissemination. In the selection of target groups, attention should be given to the special needs of children who experience discrimination or who are in need of special protection. Information strategies should be evaluated for their effectiveness in leading to a change of attitudes. Information on the Convention of the Rights of the Child and on HIV/AIDS issues, including the teaching of life skills, should be incorporated into school curricula, while different strategies should be designed to distribute such information to children who cannot be reached through the school system.

(f) HIV/AIDS data collected by States, and by programmes and agencies of the United Nations system, should reflect the Convention's definition of a child (human beings under eighteen years of age). Data on HIV/AIDS should be disaggregated by age and gender and reflect the situation of children living in different circumstances and of children in need of special protection. Such data should inform the design of programmes and policies targeted to address the needs of different groups of children.

(g) More information should be collected and disseminated on best practices, in particular on community-based approaches to HIV/AIDS which have positive outcomes.

(h) More research should be carried out on mother to child transmission, and in particular on the risk and alternatives to breastfeeding.

(i) Information designed to raise awareness about the epidemic should avoid dramatising HIV/AIDS in ways that can lead to further stigmatisation for those affected by the epidemic.

(j) States should review existing laws or enact new legislation to fully implement article 2 of the Convention on the Rights of the Child, in particular to prohibit expressly discrimination based on real or perceived HIV status and to prohibit mandatory testing.

(k) Urgent attention should be given to the ways in which gender-based discrimination places girls at higher risk in relation to HIV/AIDS. Girls should be specifically targeted for access to services, information, and participation in HIV/AIDS related programmes, while the gender-based roles predominant in each situation should be carefully considered when planning strategies for specific communities. States should also review existing laws or enact new legislation to guarantee inheritance rights and security of tenure for children irrespective of their gender.

(l) Prevention and care strategies designed to deal with the epidemic should focus on children in need of special protection, including those living in institutions (whether social welfare ones or detention centres), those living or working in the streets, those suffering from sexual or other types of exploitation, those suffering from sexual or other forms of abuse and neglect, those involved in armed conflict, etc. States should, in particular, review existing laws or enact new legislation to protect children against sexual exploitation and abuse and to ensure rehabilitation of victims and the prosecution of perpetrators. Particular attention should also be given to discrimination based on sexual orientation, as homosexual boys and girls often face acute discrimination while being a particularly vulnerable group in the context of HIV/AIDS.

(m) HIV/AIDS care should be defined broadly and inclusively to cover not only the provision of medical treatment, but also of psychological attention and social reintegration as well as protection and support, including of a legal nature.

(n) Barriers to the provision of youth friendly health services should be identified and removed. States should review existing laws or enact new legislation to regulate the minimum age for access to health counselling, care and welfare benefits. The formulation of comprehensive adolescent reproductive health policies should be based on the right of children to have access to information and services, including those designed to prevent sexually transmitted diseases or teen-age pregnancy.

(o) States should review existing laws or enact new legislation to recognise the specific rights of the child to privacy and confidentiality with respect to HIV/AIDS, including the need for the media to respect these rights while contributing to the dissemination of information on HIV/AIDS.

(p) States, programmes and agencies of the United Nations system, and NGOs should explore the possibilities for new partnerships which could bring together organisations that deal with human rights, children-centred ones and AIDS-focused ones to look together for ways to respond to the epidemic, and to work together in reporting to the Committee on the Rights of the Child.

Focusing attention on children and HIV/AIDS

The UNAIDS World AIDS Campaigns over the past few years are good examples of presenting objectives and ideas for action within a rights framework. In 1997, the international spotlight was on children who are infected, at risk of infection, or living in families affected by AIDS, promoting the objectives of:

- Increasing public understanding of the impact of the epidemic on children
- Involving children and young people in the development of policies affecting them
- Improving services and the access of children to prevention and care
- Increasing children's access to quality education and information
- Increasing understanding of the interaction between the epidemic of HIV/AIDS and efforts to protect children's rights

The 1999 World AIDS Campaign, **Listen, Learn, Live!** continued to focus on people under 25.⁷⁹ **Listen** to children and young people, hear their views and concerns and understand what is important in their lives. **Learn** from one another about respect, participation, support and ways to prevent HIV infection. **Live** in a world where the rights of children and young people are protected and where those living with HIV/AIDS are cared for and do not suffer from discrimination.

Ten action areas to strengthen AIDS programmes with children and young people

1. National policies that protect children's and young people's rights and reduce their vulnerability to HIV/AIDS
2. Participation of children and young people in making decisions and supporting and educating their peers
3. Communication to challenge the social norms that increase children's and young people's risk for HIV infection
4. Quality dialogue between adults, young people and children
5. Economic opportunities and vocational training to reduce children's and young people's vulnerability to HIV infection
6. Quality life skills, sexual health and HIV/AIDS education in and out of schools
7. Child-friendly and youth-friendly health services
8. Support and care for children and young people living with, affected or orphaned by HIV/AIDS
9. Reduction of stigma and discrimination surrounding HIV/AIDS
10. Prevention of mother to child transmission of HIV

A practical tool to move towards a children's rights position

Key to this is the belief that young people are active participants in their development, and should be provided an opportunity to express their ideas, be informed and participate in decisions regarding their lives. This definition does not exclude parents' roles as protectors and guardians, but rather extends traditional support to families to include specific actions with children and youth. Children are not seen in isolation, but rather as one actor in a system of many players.

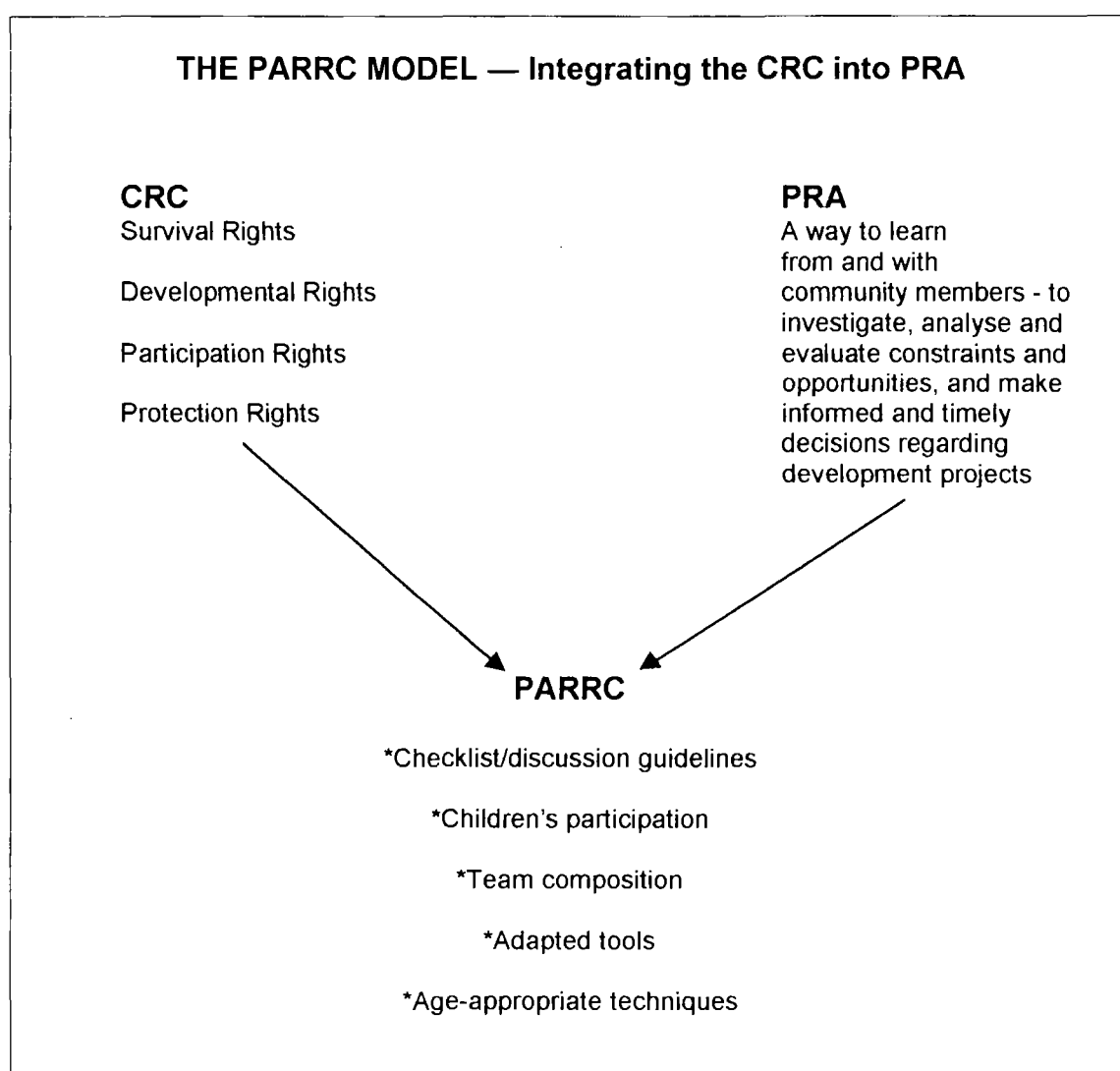
Traditionally, NGO personnel worked primarily with adults to study children's problems and identify solutions. Participatory Action Research for the Rights of the Child (PARRC) recognises children and youth as full and capable participants in the development process and uses tried and tested PRA techniques to identify issues and develop interventions for children within a rights framework.⁸⁰

⁷⁹ The UNAIDS Report (1999)

⁸⁰ De Lay, BA; *Participatory action research for the rights of the child - an IRC training manual for developing and designing participatory, rights-based children's programs* (1998)

Using age-appropriate techniques, either by adapting tools to be more like games, or by organising games so they are more like tools and using the CRC as the discussion framework, community members (children/youth and adults) are provided with an opportunity directly and immediately to assess children's situations, identify solutions and build action plans which respond to the major gaps.

Teams can include a health profession (survival rights), and education specialist (development rights), and legal person (protection rights), a youth worker (development, participation rights), a social scientist (psychology, social worker, sociologist for development rights) and an economist (survival, development). Gender and generation balance are also important.

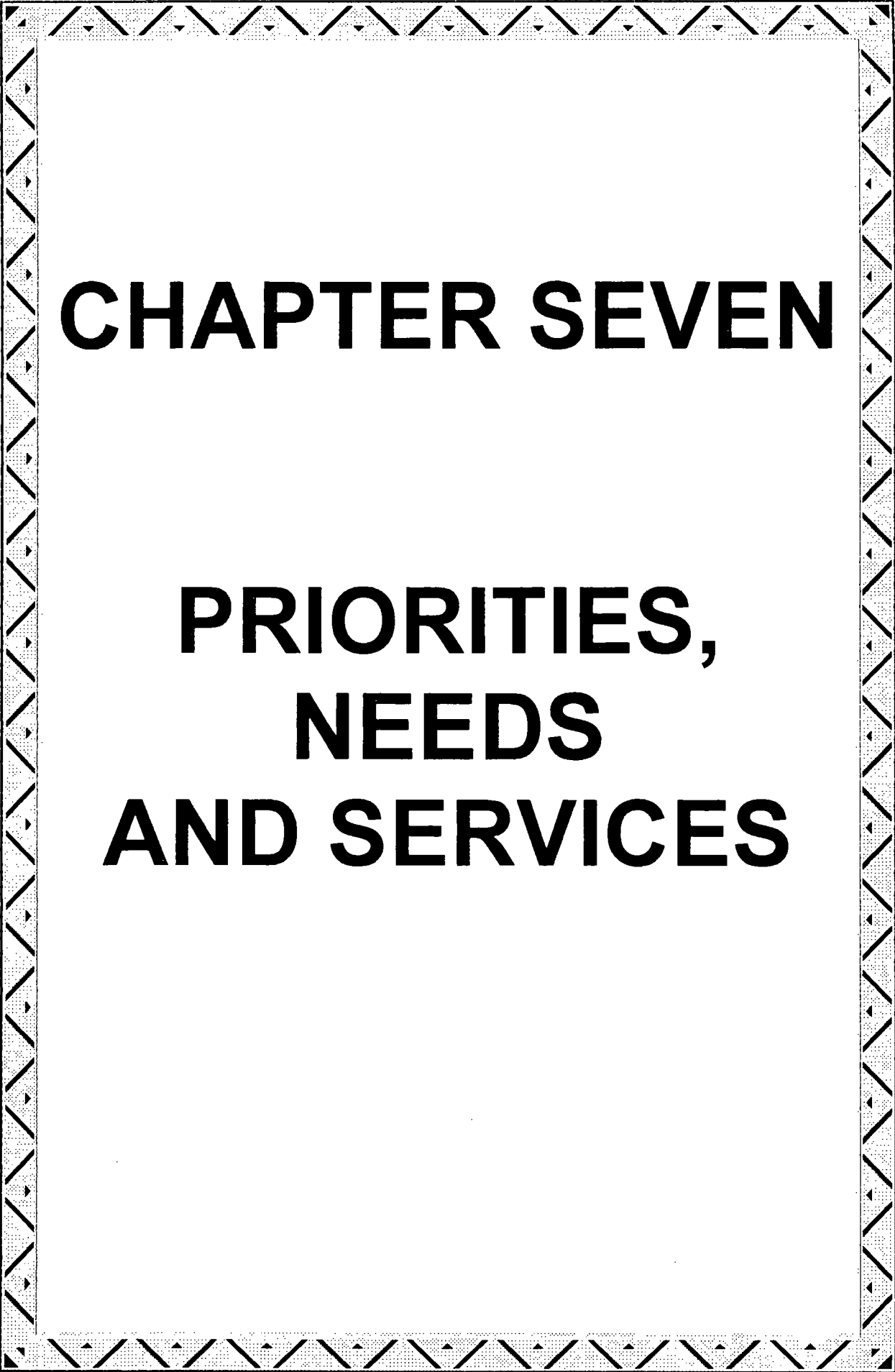


Proposed charter of children's health rights - rights related to HIV/AIDS

Non-discrimination on the basis of HIV status
 Equal access to health care services
 Access to termination of pregnancy
 Provision of HIV/AIDS prevention and health promotion information
 Confidential access to contraceptives (regardless of age)
 HIV testing only when it is in the child's best interests (and with informed consent)
 Confidentiality regarding HIV status
 The right to be treated with dignity, regardless of health status
 Access to treatment of an acceptable standard
 Protection against female circumcision and other harmful traditional practices
 An accessible complaints procedure
 The right to use alternative health care

SUMMARY OF KEY POINTS

- ⌘ There is now global consensus that children's rights need special protection and there is increasingly a move to describe children's issues and define responses in terms of rights as opposed to needs.
- ⌘ The Convention on the Rights of the Child (CRC) sets out the political, civil, cultural, economic and social rights of children – many of these have special relevance in the context of HIV/AIDS.
- ⌘ Focusing on the rights which have HIV/AIDS implications, in South Africa there are both achievements as well as areas where children's rights are still not being realised.
- ⌘ In moving from a needs-based framework to a rights-based one it is important to understand that:
 - Rights are realised
 - Rights always imply duties or obligations
 - Rights are universal and
 - All rights are equally important.
- ⌘ A practical tool, known as Participatory Action Research for the Rights of the Child or PARRC can be used to develop programmes for children which arise from and are implemented from within a rights framework.



CHAPTER SEVEN

PRIORITIES, NEEDS AND SERVICES

CHAPTER SEVEN: PRIORITIES, NEEDS AND SERVICES

Chapter Seven summarises the Rapid Appraisal of perceived priorities, the needs of children, the services available and the gaps.

Childhood is a period when minds and bodies values and personalities are being formed and during which even temporary deprivation is capable of inflicting life-long damage and distortion on human development.

James Grant, UNICEF

Methodologies

The Rapid Appraisal took three forms:

- A questionnaire to assess perceptions regarding the needs of children and the available services, linked to the development of the national strategy
- Interviews with key stakeholders in Government and NGOs to validate the information from the questionnaires
- In-depth analysis of selected projects in four provinces to identify criteria and lessons which in turn can be used in selecting models which are appropriate for South Africa

The first two are summarised in Chapter Seven, the in-depth descriptions of the projects is in Chapter Eight.

As mentioned in Chapter One, a limitation of the Rapid Appraisal is that it did not include focus groups with service providers and users, nor was there an opportunity to interview community leaders.

Questionnaires

The analysis of the questionnaires is included in Appendix One. The suggestions of how South Africa should be preparing for the increasing numbers of children infected and affected covered a broad range of issues all of which are reflected in the National Strategy Framework.

They included:

- Policy development – national and local policy and planning leading to the assumption of responsibilities by all sectors and partnerships
- Advocacy with an emphasis on family and community awareness, mobilisation, empowerment, involvement
- Capacity building and training at all levels
- Mainstreaming children's issues into other programmes such as into strategies to eliminate poverty
- Accessing resources - financial and material
- Co-ordination of services and the need for a database of children in need
- Legal reform - linked to the Child Care Act
- Research to provide relevant data
- The development of new models

The results from the questionnaires are generally consistent with the recommendations from the SA National Council for Child Welfare's document *HIV/AIDS and the Care of Children*. Those related to abandoned and orphaned children are:

Abandoned babies

- Information for prospective mothers on alternatives to abandonment
- Community support for 'new mums'
- Reduce delays in placing abandoned babies

Orphans

- Support and enhance existing coping mechanisms
- Promote traditional models
- Assist communities to overcome poverty
- Improve ways of registering orphans
- Simplify adoption procedures
- Find ways to support women who care for children
- Explore incentives for carers
- Provide nutrition programmes for over-sevens
- Promote planning for children's futures
- Develop strategies to keep siblings together
- Increase the pool of adoptive parents
- Develop monitoring mechanisms for the protection of orphans

Process issues which were identified included the importance of focusing interventions on the areas most affected by the epidemic and the need for good management strategies including the establishment of community monitoring groups.

Specific *prevention issues* mentioned included the provision of anti-HIV drugs to infected pregnant women and interventions in schools, starting in junior schools.

Care and support recommendations highlighted the need to improve social services for orphans, physical, economic and emotional support for the grieving process, home/community-based care and support to extended families and communities.

In response to the question of what challenges would face organisations caring for children the responses identified:

- The scope of the problem, the need to reach as many children as possible, the scarcity of resources and the limited ability of poor communities to cope
- Societal mobilisation and community participation
- The need for long-term holistic care to enable children to take their place in society and ensure that infected and affected children are not marginalised
- The lack of indigenous alternative models of foster and adoptive care and lack of a continuum of care
- The need for appropriate services for adolescents
- The prevention of MTCT and the provision of support to infected mothers

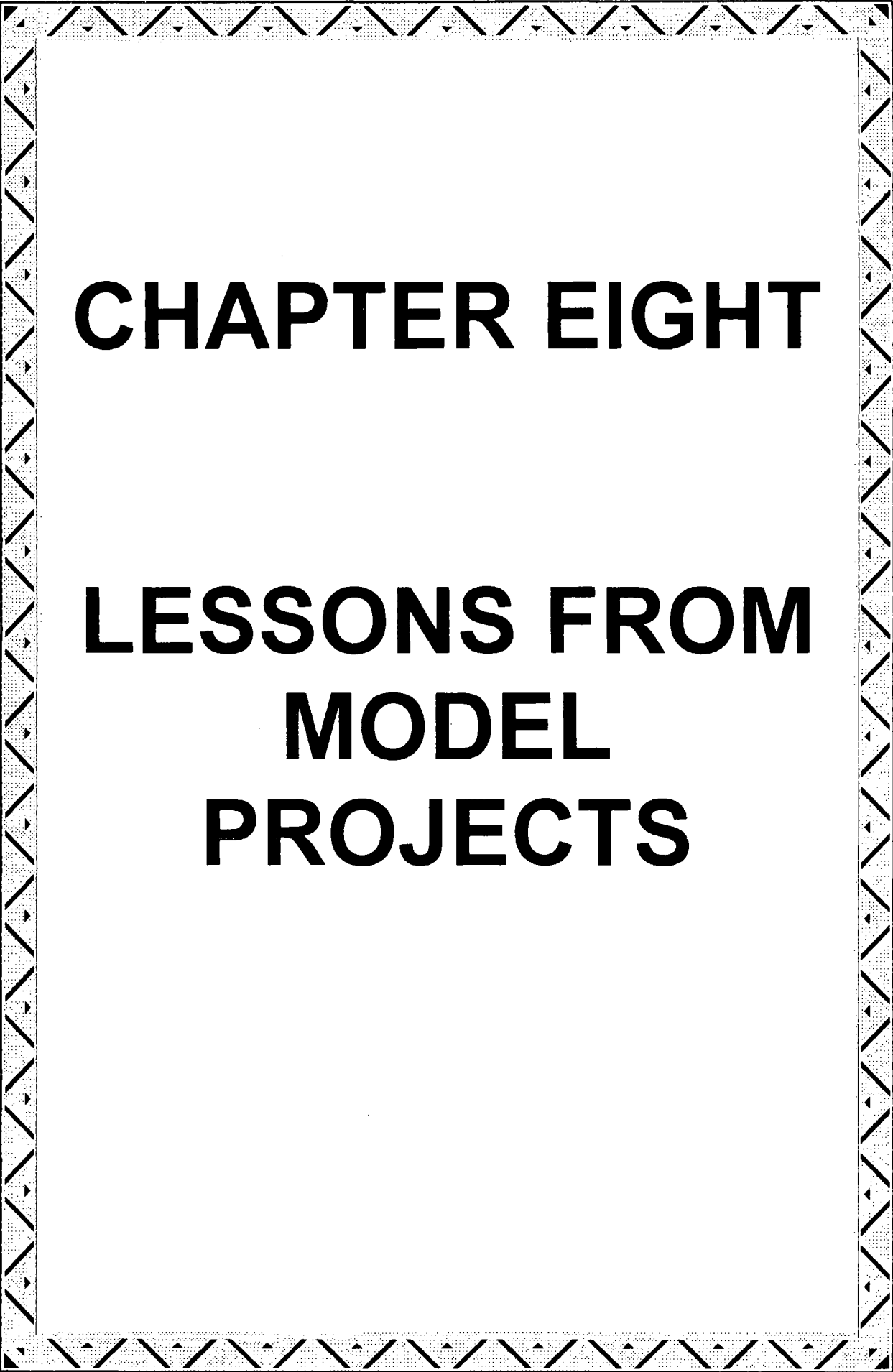
Services for children

There is no database of organisations working with and for children. The following observations are therefore the result of an analysis of the information provided by the respondents who completed the questionnaires.

- It is starkly apparent that there are very few organisations providing services for affected children as their primary function.
- Of the organisations identified as providing services for infected and affected children, their primary functions were (ranging from the greatest number to the smallest):
 - Institutional/residential care for infected children
 - Welfare organisations
 - NGOs with a youth prevention focus
 - Municipal clinics
 - NGOs with a development/IGA focus
 - NGOs focusing on affected children
 - A children's rights organisation
 - A research project
- NGOs working with and for children are mainly clustered in certain Provinces (Gauteng, KwaZulu-Natal and Western Cape)
- Apart from a few well-known programmes, there is generally poor knowledge of what organisations do exist and the scope of their functions

SUMMARY OF KEY POINTS

- ⌘ The Rapid Appraisal sought to describe common perceptions amongst stakeholders of the priority needs (linked to the development of a national strategy on children and HIV/AIDS)
- ⌘ The priority needs identified include:
 - a policy framework within which to plan and work
 - advocacy, particularly at a community and family level
 - capacity building and support in the form of financial and material resources
 - co-ordination of services and the need to register and maintain a database of children in need
 - the development of new models of care and to mainstream children's issues into development programmes
 - legal reform that is more responsive to the demands of the epidemic
 - research
- ⌘ There are very few organisations whose focus is primarily on affected children. However, the real situation is not clear in the absence of a database of organisations working with and for children.



CHAPTER EIGHT

LESSONS FROM MODEL PROJECTS

CHAPTER EIGHT: LESSONS FROM MODEL PROJECTS

Chapter Eight describes selected model projects and identifies lessons for implementation.

INTRODUCTION

There are a number of excellent projects for children in South Africa: however, very few of these have been well documented and it is thus difficult to extract useful lessons from them either for other projects or as guidelines for the national strategy. The Rapid Appraisal sought to describe selected projects in certain provinces, and to identify issues common to a number of projects and the elements which set them apart and contribute to their success. A similar format was used in describing each project to facilitate the identification of these elements.

The selection of projects was influenced by a number of factors, namely:

- Their location - Gauteng, Eastern Cape, Free State and Mpumalanga were identified as the focus Provinces by the NACTT
- The projects identified by the Department of Welfare for replication and expansion as part of implementation of the national strategy
- The main focus of the project – in order to cover both infected and affected children and to get a spread of projects from institutional care to home-based care projects

The following projects were selected:

PROJECT NAME	PROVINCE	MAIN FOCUS
The House of Resurrection Haven	Eastern Cape	Residential care for infected adults and children
Diana, Princess of Wales Mohau Children's Centre	Gauteng	Institutional care for infected and affected children
CINDI	KwaZulu-Natal	Network for community mobilisation and partnerships
Bastion Street Child Project	Free State	Prevention, care and rehabilitation for vulnerable children living on the streets
Masoyi Home-Based Care Project	Mpumalanga	Community home-based care and support for orphans
St Nicholas Children's Hospice	Free State	Hospice and community care for infected children and support for affected children and their caregivers
Tateni Home Care Services	Gauteng	Community/home-based care

The House of Resurrection Haven

Origin and location

Established in 1994 as an ecumenical non-profit organisation, the Haven is situated in the peri-urban suburb of Salsoneville outside Port Elizabeth. The Haven does not have a defined catchment area – patients are referred from all over the Eastern Cape and parts of the Western Cape.



Description/Model

The Haven provides residential care for symptomatic HIV infected adults and children. The project also provides training for individuals and organisations (from hospices to business).

Programme for children

Because of the close links between the different programmes at the Haven, it is necessary briefly to describe those which do not specifically focus on children.

The Haven offers residential care to people with symptomatic AIDS, including training them to medicate themselves and plan healthy diet, exercise and personal hygiene regimens. The care programme is known as *wellness management* - a holistic approach aimed at extending wellness and limiting the impact of HIV disease.

The unique components of the programme are the focus on hygiene and nutrition. Most of the clients/patients arrive at the Haven critically ill and suffering from micronutrient deficiencies at the very least, but often from malnutrition and even starvation. The improvement in patients once on the Haven diet is little short of miraculous.

Adults receive intensive one-on-one counselling on diet over a number of days and, once adult patients are well, they help prepare meals which gives them practical experience for when they return home.

The 10 children who live at the Haven are either abandoned or orphaned. They currently range in age from 11 months to 7 years. Children and adults are not separated and the Haven has a wonderful family atmosphere.

Fungal infections and severe itching are common and are treated with medications, diet and meticulous personal hygiene. The children are bathed twice a day. Linen and clothing is washed regularly, bleached and hung in the sun.

The Haven diet

No: red meat, alcohol, oil

Restricted: animal fat, dairy products, caffeine, sugar, yeast, fruit, eggs

Allowed: chicken, fish, liver, lean pork

Encouraged: cooked vegetables, all beans, soya products, maize, rice, pasta, sorghum, natural low fat yoghurt, soured milk, rooibos tea, herbal and energy drinks

Supplements:
micronutrients in fortified soya
1 tsp of cod liver oil daily

No bottles or dummies are permitted. All the staff, patients, children and the resident dog are dewormed every six months.

All children attend play school daily. If they are sick (but not infectious) they may still attend play school. All the children have 'godparents', local people who maintain an interest in the child, hold birthday parties for them etc.

Referrals: Children are primarily referred from the local hospital and clinics. Many arrive with evidence of psychological damage or physical abuse.

Staffing: Volunteers from overseas assist with a range of functions. The permanent staff comprises 20 staff including 4 professional nurses and a pre-school teacher. In-service training for the staff aims to equip them with skills to counsel patients.

Governance

The Haven is managed by an Executive Committee of 17 people including staff who work at the Haven, local community members, people living with HIV/AIDS, and medical and community health specialists. The Matron reports to the Executive Committee.

The Haven is registered as a Place of Safety. Food for the children is subsidised through the Children's Feeding Trust. Place of Safety fees for some of the children are received every 6 months.

Limitations/needs and key observations from staff

- There is general poverty in the community, exacerbated by limited access to social grants. There is a lack of knowledge of healthy living in the community from which the Haven patients originate and a lack of support structures to deal with emotional stress.
- Because the Haven can only take a limited number of children, many children are dying unnecessarily in the community.
- Many teenagers are caregivers in the community. There needs to be education and training for these children.

Lessons learned

- The aim is to keep the mothers and their babies together – this results in less abandonment.
- Simple interventions, such as good hygiene and nutrition, have been proven to be extremely beneficial as part of a holistic care package for both adults and children.
- Training community members in the Haven model of care has resulted in many successful initiatives by trainees.

Diana, Princess of Wales Mohau Children's Care Centre

Origin and location

Started in October 1994, the KERUX-Mohau-Kalafong project draws clients from an area estimated at 90 000 square kilometers in Gauteng, North West Province and Mpumalanga, and a population of 12 million (of which an estimated 3 million are living with HIV).

Description/Model

The project offers a range of care interventions, training and educational programmes for adults infected with or affected by HIV/AIDS and a haven for children infected with or affected by HIV/AIDS. KERUX focuses on adults whilst the Mohau Centre is for children.

The aim of the Mohau Centre is to provide a secure, homely, loving, caring and stimulating haven for children abandoned or orphaned by AIDS, until such time as they can be reinstated back into the community and take their rightful place in society.

Programme for children

The facilities for children include:

- A 30 bed hospice for children with life-threatening or life limiting conditions. There is a commitment that no child will have a pauper's funeral.
- A 35 bed home for orphans and abandoned children. Full and part-time fostering or adoption is encouraged to expose the children to normal life. All the children are fostered to some degree, for example over weekends. This is facilitated by the Foster Group in conjunction with the hospital social workers.
- A Child Life Development Centre. This has been established in response to finding that most of the children referred to the Mohau Centre are developmentally retarded both mentally and physically in comparison to their peers. Infected mothers also have access to this Centre.

The children's programme needs to be understood within the broader KERUX programme for adults which comprises poverty alleviation programmes, job creation and training, counselling and legal services and training. This constitutes the KERUX/Mohau holistic care cycle, which aims to address physical, emotional, spiritual, socio-economic and information needs. The material resources available to clients include high-protein food parcels and fresh vegetables, which are distributed on clinic days, clothing, and transport and social funds to cover fares to and from the hospital and for hospital registration.

Apart from the hospital-based services, there is also a community programme. In Atteridgeville, 50 community members have been trained in holistic home care and are caring for sick persons in their homes.

Staffing: Multi-disciplinary teams comprising professional and volunteer caregivers (doctors, nurses, para-medical specialists such as dieticians, physiotherapists, occupational therapists, social workers, speech therapists and child caregivers) provide holistic care for the children. The volunteers are often professionals in their own right.

"Huggers" are the TLC gang and serve in a voluntary capacity: they are international volunteers who spend from a few weeks to a year at Mohau and fulfil functions according to their areas of expertise. The FRIENDS OF MOHAU promote and provide for the Centre.

All staff undergo an initial screening and compulsory training - basic HIV/AIDS education, basic general counselling, introduction to grief and bereavement counselling, and child stimulation care and guidance training. In-service training takes place regularly and staff attend conferences.

Case load: In October 1994, the programme started with 34 HIV positive children. By April 1999 there were 2 500 children in the programme (current, not cumulative), plus 7 500 infected adults and an estimated 10 000 - 12 000 family members. The average age of the children ranges from 18 months to 2 years.

Referrals occur primarily from the hospital and clinics.

Cost per child: The all-inclusive cost (medical and nursing care and general living expenses) per child living at the Centre is R3 800 per month.

Governance

The Motivation Educational Trust is the overarching governing structure to which the Project Director reports. A Steering Committee of KERUX, hospital and university representatives plus the 3 Project Managers (KERUX, Mohau and the Community-related Programmes) provides an oversight, technical assistance and monitoring function. Under each Project Manager in turn is an Executive Committee to assist the Project Manager with day-to-day matters. People living with HIV/AIDS are represented on all committees.

Mohau is registered as a children's home and, as such qualifies for R800 per child per month. Many problems have however been experienced in accessing the grants.

Limitations/needs and key observations from staff

- Community located accommodation for abandoned or orphaned children and rejected infected mothers and children is an urgent need. The aim would be to keep these mothers and children in their communities by supporting extended families and child-headed households. Support for existing family structures is thus an urgent need.
- A common occurrence is the abandonment of children of infected mothers – the majority of the children in the home fall into this category.
- Children who are caregivers are not prepared in any meaningful way for the death of their parents. This would be done best by the home-based care teams working in the community.

External constraints

The magnitude of the epidemic and the resultant problems is the main issue – there are too many patients and too many affected family members.

Lessons learned

- Integrating prevention and care, both formally and informally - having economic security is an important requirement for effective prevention.
- Training - all professional and volunteer staff are required to attend basic AIDS education and orientation courses.
- The holistic model of care with all the elements available at a single point is attractive to clients.

CINDI (Children in Distress Network)⁸¹Origin and location

Established in mid 1996, the CINDI Network operates in 9 communities in and around the Provincial capital of Pietermaritzburg-Msunduzi which has a population of 600 000.

Description/Model

CINDI is a network of about 40 concerned organisations which:

- seek effectively to respond to the growing numbers of children affected by HIV/AIDS
- look to each other for support
- unite for action

Programme for children

CINDI's vision is to be a multi-sectoral well-resourced network of civil society and Government agencies, capable of implementing diverse, effective, sustainable care and preventative programmes for children affected or orphaned by HIV/AIDS. Its mission is to foster among partners a spirit of Ubuntu, the principal of caring for each other's well-being with an attitude of mutual support. CINDI has aligned its work, and that of its partners, with the new paradigms of child and youth care. These are founded on the principle of acting in the best interest of a child in every matter concerning him or her.

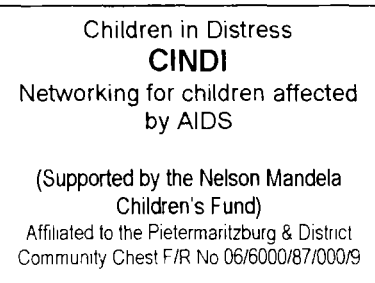
As a collection of independent initiatives, the CINDI partners retain individual character, flexibility and the ability to respond to individual children. Each partner organisation is however strengthened and guided by their link to the network. The partners collaborate in various ways to provide material resources, information, or to intervene on behalf of children in distress.

Examples of the partner organisations are:

The Thandanani Association which runs a ground-breaking AIDS orphans community programme to establish Community Child Care Committees and to build the capacity of caregivers to raise the generation of AIDS orphans. In addition, Thandanani runs the Abandoned Children's Hospital Project to care for and advocate for the placement of children abandoned in public hospitals.

Khayaletu, a project of Youth For Christ, runs the Rapid Intervention Programme. It identifies homeless children and returns them to their communities or to alternative child care through street work, a drop-in-centre, a children's home and community and home education and support of children who return to their families. Khayaletu also advocates on behalf of homeless children.

The Pietermaritzburg Child and Family Welfare Society (PCW) identifies, recruits and trains cluster foster care "parents" and places children with special needs, particularly those thought to be HIV positive, with these parents. It also runs a short-term Place of Safety, to care for children from



⁸¹ Simon-Meyer J; *Children in distress – a best practice response to children affected by the HIV/AIDS epidemic* (1998)

one day to three months who are awaiting hosting, fostering or adoption. PCW also runs an innovative adoption unit that has been able to place HIV positive children in caring homes.

Kenosis is a new, small farm-based project comprising two housing units for orphans and an early childhood development centre within a village community of farm labourers. The aim is to develop a farming community-based model of care.

Project Gateway facilitates economic empowerment of child caregivers through projects which foster skills appropriate to the needs of caregivers and the socio-economic environment likely to characterise poorer communities during the next decade. Job skills training is run in tandem with business skills and entrepreneurial training to promote self-employment.

God's Golden Acre is an umbrella body controlling three centres in rural and peri-urban areas which provide appropriate, stable, nurturing homes for 123 abandoned or orphaned children. The centres are Khayalile, which offers cluster foster care to children who are too ill, disabled or traumatised to be placed in extended families; Fundisanani, a home-schooling bridging programme to educate children who have had to fend for themselves; and Gcinopho, which supports children in extended families.

Pietermaritzburg Children's Home (PCH) provides residential care to 125 children placed in long-term care by legal procedure. PCH also works with the Child Protection Unit to offer short-term emergency care for children awaiting appropriate placement, and an innovative training programme for child care workers.

The Msunduzi Hospice Association provides home care and nursing for the terminally ill, primarily adults. Hospice also aims to provide bereavement counselling, capacity building for caregivers and life skills programmes for the youth.

Apart from the networking activities of CINDI, a number of collaborative initiatives have been developed in response to specific needs which have arisen from time to time. The collaborative projects are:

- *The Child Intervention Panel (CHIP)* – a monitoring and advocacy group which intervenes on behalf of children not receiving due care from social workers or any care setting in which they have been placed. CHIP works to secure administrative justice for children caught up in bureaucracy or those whose well-being is compromised by poor service delivery. CHIP comprises 9 elected panellists who hold weekly teleconferences, keep meticulous records and have access to pro deo legal counsel.
- *The Thapelo Project* – which aims to provide non-script, palliative care medicines for children with limited life spans who are being cared for by members of the CINDI Network.
- *The CINDI Research and Reference Group* – which commissions research to inform the work of all partners, the first being the ground-breaking research 'Wo! Zaphela Izingane: Living with AIDS – Preparing for Death'.

- *The Home-Based Care Consortium* - which is attempting to streamline the plethora of home-based care initiatives in the area and is also piloting a tutor training curriculum in Zulu which is sensitive to culture and literacy levels.
- *The Materials Resource Bank* – which is run by the Pietermaritzburg Mental Health Society and is an initiative to address the desperate and growing needs for food and clothing.
- *The Children's Participatory Project* – which has enabled 72 children to participate in workshops as part of the consultations for the South African Law Commission's review of the Child Care Act.
- *The Home/Child Care Training Project* – which runs a training project for unemployed, out-of-school caregivers in home/child care practice. This is a combined project of two local organisations, the Pietermaritzburg Children's Home, and concerned health workers of the South African Health Care Organisation (SAHECO).

The CINDI compendium focuses on specific issues. These are:

- *Prevention* - aiming to build the capacity of families and communities to take care of their own vulnerable children or AIDS orphans.
- *Early Intervention* - aiming to intervene rapidly with children who are vulnerable and divert them towards community rather than residential care.
- *Children-in-Care* - aiming to ensure that children in care get optimum, all round interventions.

Governance

Membership is voluntary and informal and there is no hierarchy: organisations have equal status, regardless of their size. A chairperson is elected at the AGM - CINDI's current chairperson is the Director of the Pietermaritzburg and District Community Chest, the organisation which runs the CINDI finances. A part-time paid co-ordinator facilitates the administration and activities of the network. A nominated mentor group guides the CINDI co-ordinator and the chairperson on an ad hoc basis, and is available at short notice if urgent decisions need to be made.

Limitations/needs and key observations from staff

Funding for the individual organisations is often in jeopardy. In addition, the organisations are constrained as to the numbers of children that they can reach.

External constraints

- Alleviating poverty will be a major challenge, particularly as the needs become greater.
- Political will is not always evident.
- It is difficult operating without a policy framework, particularly in relation to education.

Lessons learned

- Networking helps drive collaborative initiatives around advocacy, material aid, statistical information and child care training. This, in turn, assists the partners in delivering services.

- Once a problem is identified, the network coalesces and finds ways to address it and then a lead partner organisation takes over and CINDI steps back (having served as the catalyst).
- Innovative ways of identifying CINDI have been developed eg linked to the street children project and the HBC project.
- Strategies to stretch capacity include the placement of children in cluster foster care and small units on farms.
- Communities are assisted to take responsibility through initiatives such as the Community Child Care Committees (CCCC) which identify and report cases of starving, abused, abandoned or exploited children, identify existing resources for care and potential surrogate parents and families, and help caregivers find additional support through schools, clinics, material aid and grants. They further assist communities in setting up communal gardens and sewing groups, distribute material aid for children in distress, and arrange the waiving of school fees for those who cannot afford them.
- Innovative strategies to protect children such as the Child Intervention Panel (CHIP), which champions a child's best interests when he or she is not receiving due care. CHIP is able collectively to pressurise individual agencies/institutions or social workers, streamlining procedures used to process a child through various institutions or agencies and hold individual service providers responsible for unnecessary delays.
- Innovative means to support the family have been identified, for example by developing income-generating skills which assist in staving off destitution. This is also of help in rescuing mothers who have been ejected from their homes because of the stigma of being HIV positive.

Below is an example of the advocacy role which CINDI plays on behalf of its partner organisations. In this instance CINDI has joined with the Children's Rights Centre to issue a press release.

JOINT PRESS RELEASE	
AIDS is a disaster for our children – where is the plan? Break the Silence – HEAR what Children need NOW CINDI (Children in Distress Network) and the Children's Rights Centre together represent networks of over 70 organisations involved in the children's sector. We jointly believe that governments at national, provincial and local levels need to do far more to meet the growing needs of children in the light of the devastating impact that HIV/AIDS is having on their lives, whether they themselves are infected or affected. <i>WE CHALLENGE GOVERNMENT TO CONSULT WITH SERVICE PROVIDERS IN THE NGO SECTOR TO DRAW UP AND IMPLEMENT STRATEGIES TO ENSURE THE SURVIVAL, DEVELOPMENT, PARTICIPATION AND PROTECTION OF CHILDREN</i>	
Specifically: ☐ We support the Treatment Action Campaign's call for Antiretroviral Treatment for HIV Positive pregnant women, and for palliative treatment for HIV positive caregivers (mothers and their surrogates) in order to lengthen the lives of parents/ mothers, and thereby to increase the age at which children become orphaned and thereby increasing the quality of their parenting ☐ We support the Black Sash's campaign to have Child Support Grants extend beyond the age of seven, and to have the amounts increased, including a cost of living adjustment ☐ We support the Minister of Welfare Dr Z. Skweyiya's ten point plan to alleviate poverty and call on Parliament to budget accordingly	

- We support the Minister of Education, Prof K Asmal's call for schools to be community centres, and urge him to address the total needs of children in this effort, including meeting their nutritional, health and housing needs.
- Further
- We call on the government to put into place effective Inter-Ministerial mechanisms to plan, implement and ensure that children's needs, in particular those of orphans, are met in a co-ordinated fashion in responding to this disaster.
- We call on the Minister of Education, Prof Kader Asmal, to develop and implement strategies to ensure that **orphan children access their right to education**, and to put into place mechanisms for co-ordinating this at provincial level.
- We call on the Minister of Health, Dr Tshabalala-Msimang, to put into place strategies and programmes to address the urgent need for sufficient numbers of **trained adult home-based carers** throughout the country to relieve the burden of care from the shoulders of children.
- We call on the Minister of Health, Dr Tshabalala-Msimang, to ensure **adequate palliative medication is available for dying children**.
- We call on local governments practically to address the changing needs of children and to develop **Child-friendly cities and communities** in their built environments (housing, water, etc). **We particularly call on the Durban Unicity to implement Child-friendly policies and programmes for our HIV Positive World as host city to the AIDS 2000 Conference.**
- We call on local governments to support adult home-based carers, and alleviate the burden on children of this inappropriate task.
- We call on the Minister of Welfare, Dr Skweyiya, to lower the pension age and to reflect the changing demographics, and provide support to the elderly who are caring for child orphans.
- We appeal to the Minister of Home Affairs, Dr Buthelezi, to work closely with Welfare to streamline ID and grant applications. We call on the Government to use mobile offices to facilitate this.
- We call on the Government to be transparent and inclusive in who represents children in the NGO sector on the National AIDS Council. We wish to know who, if anyone, acts in this capacity. And if so by what process was this person selected?
- CINDI and CRC are concerned that men need to mobilise together with women and care for the children of this country. And we call on men to be responsible role models.

Bastion Street Child Project

Origin and location

The project is situated in the inner city of Bloemfontein, a city of approximately 350 000 people. There are about 20-30 'real' street children in the inner city.

Description/Model

Prevention, care and rehabilitation project for vulnerable children.

Programme for children

The children are on the streets primarily because of problems between them and their parents. Typically the child's biological parents may have separated and a new partner does not care for the child. Children in such situations either walk away from their homes or are chased away.

The programme is described in 3 phases:

- Meeting the children and building up a relationship on the streets
- Informal referral to the shelter/drop-in centre
- Helping the children to be positive about their education

The majority of children are between 10 and 16 and most are boys. A few of them are double orphans, having lost both parents, about 4 more have lost their mothers.

Services:

There is informal schooling offered at the shelter. Where possible the children are sent back to school; presently, in 2000, 15 children are in school. These children stay in an informal children's home (an old prison) with houseparents. The houseparents receive informal training in how to care for the children, including life skills, value education and the rights of children. This then forms the basis upon which they, in turn, raise the children. Where the children previously responded to the abuse of their rights by leaving home and coming onto the streets, there is evidence that raising them to understand their rights results in them developing other means of dealing with abuses of their rights.

All the children are given talks on various life skills topics, including AIDS from time to time.

The programme tries to make contact with the parents of the children. The success rate in rehabilitating the children back into their families is not good, but where this does happen the families are supported by means of regular visits and food. In addition, the programme creates employment opportunities for parents, such as vegetable growing and other small business opportunities.

Case load: There are 25 children in the programme.

Referrals: Children are received either through self-referrals, through street work (75%) or via the Community Police Forum.

Staffing: There are 2 houseparents and 1 housekeeper at the home. The 4 Drop-in Centre staff work either part-time or full-time. A social worker employed by KMD (Church Social Work Services) works part-time in the project. Approximately 12 volunteers assist with tasks such as maintenance, providing food and fund-raising.

Partners: The Dutch Reformed and Presbyterian Churches (10 congregations) assist with food and funds and another church provides access to a soccer field. The Volksblad newspaper provides funding from their Christmas Fund and the Development Trust supports the project financially.

The programme makes no attempt to identify children who may be HIV infected, nor is there any real evidence of an association between the reasons why the children are on the street and HIV.

Governance

The project operates under the auspices of the KMD. A Management Committee of community representatives with an Executive Chairperson meets quarterly. On a weekly basis the Chairperson and social worker meet with the staff and discuss each child.

The programme is registered with the Department of Welfare and receives a subsidy as a Shelter.

Limitations/needs and key observations from staff

- Dagga-smoking and glue-sniffing are prevalent – hard drug and alcohol use do not appear to be a problem.
- In the past there were one or two convictions for commercial sex, but recently that does not appear to be a problem: however sex between the older and younger children definitely does occur.
- The availability of personnel is a constraint, and the project would benefit from having a full-time social worker.
- Getting families to the point where they are prepared to take children back remains a problem.
- The focus is of necessity on the physical needs of the children – not sufficient attention is given to matters like counselling.

External constraints

There are a number of 'pulling factors' which result in children coming onto the streets.

Lessons learned

- Putting children back into their homes without effecting change in the home environment is destined to fail. Parents need parenting skills and jobs.
- Glue-sniffing was greatly reduced following an approach to the businesses supplying glue - prevention is assisted when working with partners.
- A very informal but firm approach to the children is needed – boundaries must be set as this gives them security. If the children break the rules they are disciplined.
- It is important to have access to professional expertise (such as a social worker), particularly to facilitate access to grants and to deal with statutory issues. A full-time professional would be needed if there were 40 children as this, in turn, would mean working with about 100 people (the families of the children).

Masoyi Home-Based Care ProjectOrigin and location

The project is situated in the Masoyi area with a catchment of 150 000 people. It was founded by the African School of Missions, in conjunction with community members.

*To care for
people with AIDS
means to care for
orphans*

Description/Model

Community project caring for the chronic and terminally ill people in their homes and for orphaned children. 75% of patients receiving care have HIV.

Programme for children

Local volunteers are trained and supported by a project nurse, occupational therapist, physiotherapist, doctor and the project co-ordinator. They are divided into teams working in different zones, according to where they live. Each team works closely with the clinic in their zone. Clinics serve as meeting places and for referrals.

Training for the volunteers consists of an initial week, followed by 4 months in the field with an experienced volunteer, after which they graduate. In-service training takes place at monthly get-togethers. The initial training covers the concepts of community work, basic nursing, counselling and ethics.

During 1999, the volunteers reported finding more and more orphans, and, as a result, the orphan project was launched. There are currently 300 orphans receiving food (every 2 weeks), school fees, clothes and medical care. The food parcel consists of mealie meal, beans, salt and sugar. School fees are between R40 and R100 per annum.

There is a principle of *no school, no food*, so all the orphans are in school. The volunteers attend school meetings as 'parents' of the orphans, to look after their interests.

The orphans remain in their homes and where possible a single 'grandmother', who is usually but may not always be a biological grandmother, is identified and trained to become a caregiver. The training is informal and consists of basic first aid, nutrition and information on the resources which she can access. She receives on-going support from the volunteers.

The project volunteers identified patients requiring care through a door-to-door survey. This also allowed for the identification of orphans and potential orphans. On an on-going basis, orphans come into the programme at the rate of 50 per month from the HBC programme, the clinic and the community. Once identified, the Orphan Co-ordinator does an assessment of the children's situation – their health risks, social problems and family history. A form per child is completed monthly by the school, clinic and a volunteer.

There are attempts to place children who have finished school in employment. Once a year the children come together for a Christmas party.

In September each year seeds are distributed and the project monitors the recipients to check if they have been planted.

Staffing: There are 5 teams, each with 8 volunteers, with 1 new team being established every 6 months. A team leader is identified from each team. The volunteers receive R200 per month. They are supposed to work no more than 16 hours per week, but most work full-time.

An Orphan Co-ordinator has been appointed. She earns R400 per month.

Costing: It costs an average of R12 per visit, calculated simply as the number of recorded visits divided into the amount of funding available to the project. The R12 includes the home care services, staff, medicines, school fees, transport etc.

It is estimated that each team saves the Provincial Department of Health R450 000 per annum.

Governance

Management of the project began fairly informally. A monthly meeting takes place with the Project Co-ordinator, the Government/DOH representative and the Team Leaders.

Recently the project was registered as a Section 21 Company as *The AIDS Care, Training and Support Initiative*, with a Management Board. Funds are channelled through the African School of Missions. The intention is progressively to train each zone to become autonomous.

Limitations/needs and key observations from staff

- It takes 2 to 3 months to get a Child Support Grant.
- There are problems with finding and obtaining death certificates for parents, birth certificates for children and clinic cards.
- Orphaned children are subject to sexual abuse by neighbours.
- There is a need for counselling for children.
- Although attempts are made to place orphaned children who have finished school in employment, this area needs to be strengthened.
- There are no real opportunities for orphaned children to meet in peer groups, though the benefits of this support are obvious.
- Openness about HIV status remains a problem which has limited opportunities to establish support groups for people living with HIV/AIDS.
- It would be beneficial to have a specialised clinic and a training centre.

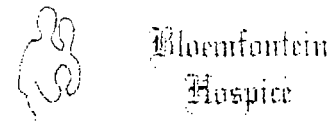
External constraints

- Constitutionally children are entitled to free education. Whilst the project is currently paying for schooling, it is hoped that negotiations with the Department of Education for free education will be successful.
- There are often no drugs in the clinics.

Lessons learned

- Home-based care programmes must address the problem of orphans.
- Orphans should remain in their communities with support (including material support).
- 'Grandmothers' caring for orphaned children require training which includes how to access resources. Projects can act for such families, for example in dealing with school problems.

St Nicholas Children's Hospice



Origin and location

Started in 1998 as a branch of the Hospice, and situated in Bloemfontein, the St Nicholas Children's Hospice serves the Southern Free State which has a population of about 1 million.

Description/Model

Its key functions are to care for children with terminal illnesses and to support AIDS orphans and their caregivers in the community. The children's project has strong links with the HBC programme which consists of the Home Care Teams (2) and the Mobile Care Team (1), in effect constituting a continuum of care.

Programme for children

The St Nicholas Children's Hospice programme was developed to:

- Meet the needs of the increasing number of children being referred for hospice care
- Assist in the care, support and placement of AIDS orphans
- Equip family and community members to care for these children

Services include:

- (i) Day care, twice weekly at Sunflower House (sometimes called the Halfway House), for infected children who are well enough to attend. Activities such as pre-primary school activities are arranged, and occupational therapy students assist with these. Informal support groups for older children and individual therapy and counselling take place as required. Physical assessments are done and treatment or admission provided if required.
- (ii) In-patient care for children requiring pain and symptom management, as well as terminal care and respite care. Care training of family members also takes place.
- (iii) Mobile outreach, utilising a vehicle outfitted as a clinic, to reach children in more remote areas. Care and support includes medical care, counselling and assistance to access grants and to liaise with the public health and welfare sectors. Community members are identified, or volunteer and are trained in care.

AIDS awareness to communities and families takes place in conjunction with the care. Orphans and potential orphans are identified and the project assists with their placement or referral. Bereavement support for children is on-going for as long as is required, based on assessments by the volunteers.

- (iv) Training courses - Care of the Child with AIDS and Home Care of People with AIDS. Both are week-long courses, conducted bi-monthly. With the increasing demands for training, mobile outreach training has been started in affected communities.
- (v) Research – one project studying the effectiveness of Vitamin A in preventing MTCT and another testing guidelines for the care of children with AIDS are currently underway.

Staffing consists of professional nurses and community care workers who are trained over a period of 3 months to provide holistic care to the children and support to the families. Each Outreach Team consists of 6 community care workers under the supervision of a professional nurse.

Volunteer caregivers undergo a 24-hour training focusing on bereavement and emotional and social support. An interdisciplinary team of voluntary professionals (doctor, social worker, psychologist, occupational therapist, chaplain and pre-primary school teacher) provide services according to their areas of expertise.

An Orphan Co-ordinator was appointed in 2000.

Case load: 1 400 infected babies and children in 1999 with the potential to reach 1 000 children per month.

There are 2 to 3 affected children per infected mother – these children presently represent 20% of the children's programme.

Referrals: Infected children come from 6 PHC clinics and from the Phelenomi Hospital. Affected children are identified through the adults' and children's programmes as well as being referred from the clinics and hospitals.

Project partners include the public health and welfare services. The health sector assists with medications, referrals from and to clinics and hospitals, and with compiling statistics. The welfare sector assists with social needs, primarily by facilitating the process of accessing grants. 70% of the infected mothers receive disability grants. The private sector assists with financial and other resources as part of their social responsibility programmes. NGOs assist in line with their functions.

Limitations/needs and key observations from staff

- Counselling for children is a growing need, however many of the children are very young.
- There is a need to bring affected children into day care, but this will require that child care workers and pre-primary teachers are employed.
- Children as caregivers constitute 15% of primary caregivers. There are plans to establish a respite system where the infected family member can be brought into the Hospice to allow the child to go to school.
- Older infected children who are at school are frequently off sick, which they find very distressing. The project plans to retain a teacher to conduct lessons and school activities at Sunflower House for those children well enough to attend but not well enough to attend regular school.
- People in communities are unaware of the grants for which they qualify, such as Child Support Grants.
- There is a need for a centre, linked to the outreach work, to which children can come for a wide range of support needs.

External constraints

- The levels of poverty in the community are severe. Children are often admitted with malnutrition rather than with conditions related to their HIV status.
- The time it takes to access birth certificates and grants is problematic.

Lessons learned

- The continuum of care is all-important. Many projects are conceptualised around a 'home for infected children' – this does not take account of the broader context of HIV/AIDS in communities.
- Hospice cares for all people with incurable conditions, not only AIDS. This reduces the fear of identification and stigmatisation.
- Families and community members are supported by the project to provide care and to access health and social services.

- Awareness is facilitated when services are provided.
- In order to prepare for eventualities after a mother's death, families are encouraged to hold a family conference to identify who will look after the children and what their requirements are (support grants, food, schooling etc). The conference involves the family as a whole and the process recognises that caregivers such as Grannies require training.
- The project has embarked on the Memory Book idea, which enables dying parents to collect mementoes for their children and to use the joint creation of a Memory Book to enable them to discuss with their children their imminent death and the plans which have been made for the future of their children.
- Social workers are a necessary part of a project team, particularly to facilitate accessing grants.
- Projects are being drawn into undertaking more and more training (on nutrition, symptom identification, immunisation etc), for example for community workers and potential foster parents.

Tatani Home Care Services - Mamelodi

Origin/location

The Tatani programme started in 1995 when there were still only a few HIV positive clients, yet the trend of turning them away from hospital had already started. The programme serves the Mamelodi district (1,2 million people).

The volunteers found a young boy locked into a hut whilst his family were at work. He begged for water, but they couldn't get it to him because the door was locked.

Description/Model

Integrated home care services for people with chronic and life limiting conditions.

Programme for children

Since the beginning, the focus has been broader than HIV/AIDS. Initial research in 1995 showed that there were 427 people confined to bed in West Mamelodi. Attention to affected children has only fairly recently become part of the programme and needs to be understood within the broader context of the services provided.

Services:

- (i) Home care for people with chronic and life limiting conditions. Volunteers caregivers provide the care. There is a district sister who can be contacted to give antibiotics - but this is often difficult. Food supplements (such as Uphuza Amandla) are distributed when required. Less than 10% of clients pay for the service. Although the programme is registered with RAMS, few clients have any medical aid benefits remaining when they are referred into the programme.
- (ii) Training of volunteers to care for and cope with ill persons in the community. Training takes place over 6 months and is supported by weekly meetings during which the volunteers write reports and discuss their work.

- (iii) Counselling and support services for infected and affected persons.
- (iv) Support for orphans. The volunteers try to find an adult to supervise the children. Orphans do seem to go to school, though it is not clear where money comes from for fees – even rent is often a problem.

Staffing: The initial group of volunteer trainees was primarily of women at high risk (many of whom were involved in sex work). There are currently 25 volunteers, working in pairs, who see 5 clients per day (so they are working almost full-time). They receive shoes and very small cash incentives.

The staff consists of 3 registered nurses and a social worker.

Case load: In 1995 there were 90 clients and 339 in 1996. In 1997 there were 301 - the programme was restricted due to funding constraints. In 1998 there were 1085 and in 1999, 1495 clients. The numbers of orphans has been recorded since 1997 – the total since then is 120.

Referrals of clients for home care come from multiple sources such as the community, friends and the Pretoria Academic Hospital. Referrals of infected children are primarily *from* the programme to the Mohau Centre or Cotlands.

Referrals of affected children come to the project from community members who perceive the project as a welfare project. These cases are, in turn, referred to the Local Authority social workers.

Partners include a religious organisation that delivers bread to 19 houses daily, community services such as the German Old Age Home and the Mamelodi Association for the Care of the Aged. The ATICC branch in Mamelodi is a long-term partner, as is the Welfare section of the Local Authority. A relationship with the Department of Education is gradually emerging.

Governance

A Board of Directors meets a few times a year. A Management Committee meets monthly and presently attempts are underway to strengthen the Management Committee by including community members with specific talents such as legal expertise. Staff meetings are held monthly.

Limitations/needs and key observations from staff

- Caregivers have observed that secrecy about one's HIV status results in a rapid deterioration in health (probably related to stress and the inability to seek support).
- A day-care centre where clients can come to get out of their homes and for exercise and income-generating activities is needed. Blindness is a real problem in HIV infected clients and so is loneliness. The day-care centre could also cater for orphaned children. It could serve as a soup kitchen where they could get a meal after school and interact with adults who could also supervise their homework. Orphaned children who have left school could join in the income-generating activities.

External constraints

The programme receives no assistance from the local hospitals and clinics, not even TTOs (medicines and supplies). The ambulance services do not take 'cold cases' to hospital.

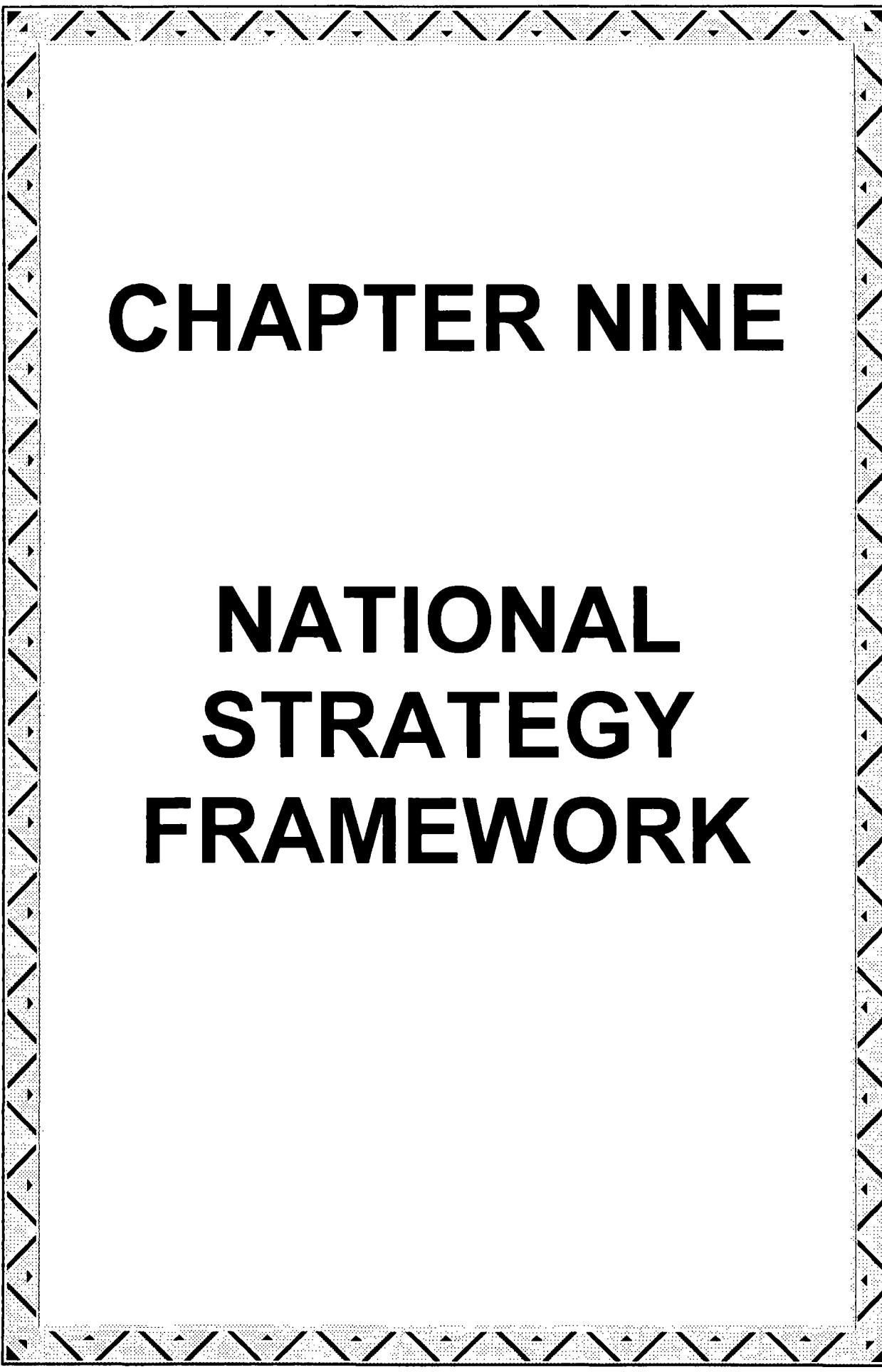
Lessons learned

- The programme keeps comprehensive records of numbers of clients, numbers referred (eg to hospital) and the number of deaths.
- The project arose as an emotional response to a community need. In many ways this was problematic, as no effective planning took place and the necessary expertise, particularly for project management, was not in place (nurses are not accountants).
- Community ownership is important – Tateni is highly regarded in the community and this has contributed to its success.

SUMMARY OF KEY POINTS

- ⌘ Selected projects from 5 Provinces are described to identify common issues and key elements which contribute to their success and effectiveness.
- ⌘ The House of Resurrection Haven provides residential care for infected adults and children. At the Haven simple interventions, such as good hygiene and nutrition have been proven to be extremely beneficial as part of a holistic care package for both adults and children.
- ⌘ The Diana, Princess of Wales Mohau Children's Centre provides institutional care for infected and affected children. The holistic care cycle which is the KERUX-Mohau model allows clients to access a range of services at a single point. There is an explicit recognition of the importance of economic security as a necessary component of holistic care.
- ⌘ The CINDI network represents a number of organisations working for and with children. The partners collaborate in various ways to provide material resources, information, or to intervene on behalf of children in distress, in the process strengthening the partner organisations. The best interests of the child guide all the CINDI functions and initiatives.
- ⌘ The Bastion Street Child Project provides vulnerable children living on the streets with prevention, care and rehabilitation services. Even in a context where the most basic needs are the priority, educating caregivers and children about their rights has had very positive consequences. However rehabilitation of children back into their families only succeeds when changes to the environment which resulted in them being on the streets takes place.
- ⌘ The Masoyi Home-Based Care Project provides home-based care for people with life limiting conditions and support for orphans. Home-based care programmes are the optimum vehicle for identifying orphans and establishing programmes for them. The project aims at all times to keep the orphans in their community, ideally supported by an adult such as a grandmother. These caregivers however require training and support.

- ⌘ The St Nicholas Children's Hospice provides hospice and community care for infected children and support for affected children and their caregivers. Because of the project's close relationship with the Department of Welfare 70% of the infected women in the project are receiving disability grants. Stigma and discrimination associated with HIV/AIDS are lessened when a project is not AIDS-specific. Talking to children and preparing for death is facilitated by holding family conferences and creating Memory Books.
- ⌘ Tateni Home Care Services provides community/home-based care services to people with chronic and terminal conditions. Whilst an emotional response to an observed need often results in the birth of a project, careful planning in developing a project will ensure that it is appropriate and sustainable. Access to relevant expertise, to strengthen the management of a project, must be sought.
- ⌘ Common observations from all the projects include the following:
- Extensive poverty forms the backdrop of all the projects.
 - Many children do not have birth certificates, which is a barrier to accessing grants. This is only one of the problems related to grants – many people do not know that they qualify to apply for a grant eg for a Child Support Grant.
 - The extent of capacity building needs has resulted in projects across the board taking on training functions.
 - Children are frequently the caregivers of their dying parents and there is minimal or no support for them.
 - Counselling for children is recognised as an important intervention, yet it is poorly developed in all projects.
 - There is a need for centres of support for affected children where they could access a meal, have counselling, do homework, and participate in peer group activities and/or income-generating activities.



CHAPTER NINE

NATIONAL STRATEGY FRAMEWORK

CHAPTER NINE: NATIONAL STRATEGY FRAMEWORK

Chapter Nine proposes a framework for a national strategy on children and HIV/AIDS based on common themes which emerged from the Rapid Appraisal.

INTRODUCTION

In January 2000, a *Draft National Strategic Framework for Children infected and affected by HIV/AIDS* (NSF) was submitted to the Inter-Ministerial Committee on HIV/AIDS. Its 8 objectives are:

- A rapid appraisal of services for children infected and affected
- The establishment of community-based programmes
- Implementation of effective, affordable models
- Review of child care legislation related to orphans
- Strengthening poverty alleviation programmes
- Training programmes
- Collaboration to establish integrated institutional arrangements
- Determination of the financial implications of the NSF

The IMC resolved that the NSF should reside within the Five-year National AIDS Plan which has 5 themes, one of which is *children*.

ELEMENTS OF A NATIONAL STRATEGY

Taking cognisance of the events which have taken place recently, the following ten elements are proposed as a framework for a national strategy on children and HIV/AIDS. The sub-elements under each of the ten main elements may constitute the *objectives* of the national strategy and may serve as a basis for the development of a detailed operational plan.

The national strategy must be situated within the country's context. An introduction is proposed which consists of a description of:

- The current and future scenarios
- The aims, the parameters and the beneficiaries of the national strategy
- The guiding principles which underpin the national strategy
- International and national agreements which apply (such as the CRC)
- Any global best practices relating to prevention, care and support which can inform the national strategy

Element One: **Multisectoral policy development**

- Develop a national policy framework (social, ethical, legal and rights) to define a common vision and guide and support appropriate responses
- Facilitate the effective participation of children at all levels and at all stages
- Review existing policies and legislation (for their direct or indirect impact on children)
- Enact legislation which enables progress and facilitates the implementation of appropriate responses
- Determine the direct and indirect financial implications of the national strategy

Element Two: Advocacy

- Secure commitment to the issues of children and HIV/AIDS from political and public leadership
- Create national awareness and engagement
- Generate consensus on the most effective and sustainable responses
- Create an environment which minimises stigma, challenges social norms that increase children's and young people's vulnerability, improves dialogue between adults and children and is supportive of interventions which secure the rights of children
- Build consensus on children's rights which relate to HIV/AIDS
- Establish and support partnerships for effective action (with public, private, NGO, civil society and donor partners)
- Conduct campaigns aimed at mobilising communities to respond
- Identify and mobilise resources

Element Three: Mainstream HIV/AIDS and children's issues into key programme and development areas

- Integrate children's issues into public, private, and NGO sector policies and programmes at national, provincial and local level
- Facilitate and support the inclusion of activities related to children and HIV/AIDS in development programmes (poverty alleviation, income generation etc)
- Identify mechanisms to ensure that children's (and gender) issues remain mainstreamed and integrated in related programmes

Element Four: National and provincial capacity building

- Identify strengths and weaknesses and capacity needs
- Improve technical, programming, co-ordination and management capacity of national and provincial personnel and organisations
- Minimise constraints to action

Element Five: Local and community capacity building

- Ensure effective participation at local and community level
- Identify strengths and weaknesses and capacity needs
- Strengthen existing capabilities by building support networks, accessing external support etc
- Improve technical, programming, co-ordination and management capacity of local and community-based initiatives
- Provide appropriate training for community leaders, community workers, child and youth workers, NGOs and CBOs
- Support families affected by HIV/AIDS to cope
- Support older people to cope as guardians of affected children

Element Six: Build capacity in children

- Identify strengths and weaknesses and capacity needs
- Prepare affected children for life without parents
- Improve access to services
- Ensure that services are 'child-friendly' and 'youth-friendly'
- Establish networks where children can support one another

Element Seven: Establish priority needs across the continuum from prevention to care and support

- Identify the most vulnerable children and the situations of risk
- Conduct a needs assessment
- Identify short- medium- and long-term priorities – in the areas of prevention, early intervention, care and support
- Define a continuum with effective referrals and links

Element Eight: Research

- Identify operational research priorities
- Commission research
- Establish mechanisms to integrate results into activities

Element Nine: Project and programme development

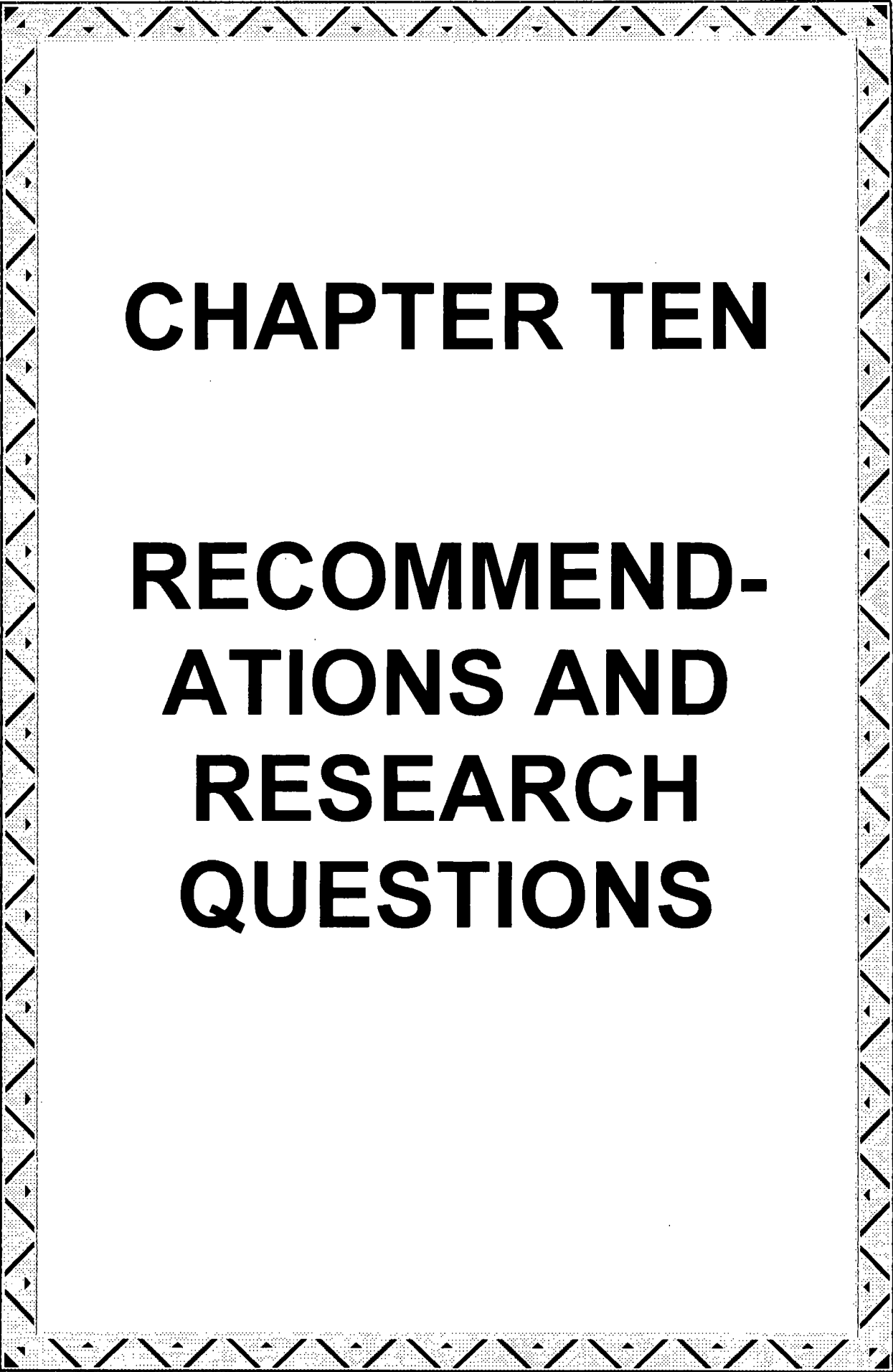
- Fund the development of community-based models which address the identified priorities
- Develop mechanisms to ensure resources are used effectively and equitably
- Identify processes to share lessons learned and to scale up models

Element Ten: Mobilise and co-ordinate the response

- Establish a system to monitor the situation and measure the impact of interventions
- Identify indicators for each element of the national strategy and the process by which they will be measured
- Identify persons with responsibility for all elements of the national strategy and the roles and responsibilities from the “lead” Department/s to those with responsibilities at the local/community level
- Establish multisectoral committees at national, provincial and local level to co-ordinate the responses
- Co-operate with neighbouring countries to ensure an effective regional response

SUMMARY OF KEY POINTS

- 8 A framework for a national strategy is proposed consisting of 10 elements:
- Multisectoral policy development
 - Advocacy
 - Mainstreaming HIV/AIDS and children’s issues into key programme and development areas
 - National and provincial capacity building
 - Local and community capacity building
 - Building capacity in children
 - Establishing priority needs across the continuum from prevention to care and support
 - Research
 - Project and programme development
 - Mobilising and co-ordinating the response



CHAPTER TEN

RECOMMEND- ATIONS AND RESEARCH QUESTIONS

CHAPTER TEN: RECOMMENDATIONS AND RESEARCH QUESTIONS

Chapter Ten makes recommendations, for the national strategy and for projects, based on the findings of the Rapid Appraisal, and poses key research questions.

Common issues emerged from the desk review, the stakeholder questionnaires and interviews and the description of selected models. These constitute the recommendations to guide both the national strategy and projects working with and for children. The 16 recommendations, focusing primarily on *affected children*, are presented by firstly summarising the issue and then presenting the possible actions to address the issue.

A policy framework

The lack of a policy framework within which to understand the whole subject of children and HIV/AIDS in South Africa was identified as a barrier to effective, co-ordinated action. This is supported by the emphasis which has been placed on the development of such national strategies in other Southern Africa countries.

The NSF should be finalised as a matter of urgency, incorporating the findings from the Rapid Appraisal. It should then be disseminated and actively promoted as the framework within which all sectors of society should develop their initiatives.

Database of organisations working with and for children

Many people interviewed identified isolation from and a lack of knowledge of what was happening outside their immediate area as a real constraint.

The compilation of a comprehensive database of organisations working with and for children in South Africa - who is doing what and where - would greatly facilitate communication and co-operation. It will be necessary to distribute the database widely and to ensure that it is regularly updated.

Networks and co-ordination mechanisms

The advantages of a network of organisations working together for the benefit of children in distress are obvious from the CINDI example. Not only are there advantages for the individual organisations from working closely with each other, but their collective strength enhances the overall ability to cope with the magnitude of the problem.

Networks do not spring up without conscious actions being taken. A generic model of how a network can operate should be developed and training conducted with potential partners in all parts of the country on how to initiate, construct, manage and sustain a network. Where necessary, resources should be found to support the resultant networks.

Poverty

The fact that HIV infected children are often in Hospices with malnutrition and starvation, rather than as a result of HIV-related conditions is just one

example of the extent of poverty. HIV/AIDS precipitates families into poverty and even into destitution. An appreciation of this is fundamental to developing appropriate responses.

Wherever possible poverty alleviation programmes should work hand-in-hand with projects for children, and all projects should aim to have the means to provide basic necessities such as food and clothing.

Identifying children in distress

The identification of children in distress is frequently ad hoc. In most instances there is no information about the whereabouts or condition of the children 6 months after a mother's death. Only one project has set out *actively* to identify children in distress, not only once they had been orphaned, but even before the death of their mothers. This project maintains a register and formally reports on each child, using a form which is completed every month by the community care volunteer, the school and the clinic.

A standardised form for registering children in distress should be developed. The opportunities for identifying these children differ in different parts of the country, but schools, clinics, churches and home-based care projects are generally such opportunities. Registration of children in distress could feed into the process of allocating grants and would provide invaluable data with which to plan for the emerging impact of increasing numbers of AIDS orphans.

Using home-based care as the access point

The issue of children affected or orphaned by AIDS is a natural extension of any home-based care programme caring for people with HIV/AIDS.

Every home-based care programme, at whatever stage of its existence, should also cater for affected and orphaned children, not as an after-thought but as an integral part of the programme.

Holistic care and support within a comprehensive continuum

Care and support are the two terms most frequently used when considering children affected by HIV/AIDS. Traditionally, holistic care has looked at the individual as a complete person with physical, emotional, spiritual and social needs. This concept needs to be extended into the understanding of support as well, for children, extended families and communities. This can then define the parameters of each element of a continuum of care and support which includes prevention and does not end with home-based care for the infected person but extends far beyond.

To translate this concept from the theoretical into the practical requires that health-focused initiatives consider a new expanded model and welfare-focused initiatives do likewise. Research into specific aspects may be beneficial.

Planning for the future of children who will be orphaned

The stigma associated with disclosing an HIV diagnosis remains prevalent and results in many ill and dying parents choosing not to disclose to their caregivers, families or children. This often results in a 'silence' about their impending death which becomes a barrier to making plans for their children's future. In stark contrast, parents and mothers in particular who are confronting their imminent death, universally express concern about who will care for their children.

Whether through the means of a Memory Book, as has been used in East Africa, or in a family conference which has been found to be effective in Bloemfontein, the benefits for both the parents and their children of creating a safe environment to talk about the future are obvious. The parents will be relieved of worries about the children's future, and the children will be spared some of the devastation which accompanies a parent's death. On a very practical level, documents such as birth certificates can be located or affidavits applied for, which will improve the chances of accessing grants.

Supporting children as caregivers

All projects report that children are caring for dying parents, yet, perhaps because it is so unacceptable a concept, little has been done to prepare them for this role or to support them in carrying it out.

Where there is no viable alternative, children must be prepared to care for their infected parents. They must be trained and resourced to do so and provided with information on where to go for help. The development of appropriate training materials will greatly facilitate this.

Promoting a rights based approach

Training caregivers and children in understanding children's rights equips children with alternatives based on these rights. The best interests of the child should be a guiding principle in all projects and modules on children's rights should be included in all training programmes.

The principle of the participation of children and the youth in all programmes remains illusive – none of the projects had strategies to ensure that this happens. Such strategies should become an integral part of all programmes.

Support for affected children

Affected children are generally neglected and services and resources for them are negligible. There is however growing consensus that 'drop-in centres' which could cater for support groups, counselling, homework supervision, meals, IGAs etc would fulfil a valuable function.

Community-based projects should undertake a process to identify the specific needs of affected children in their programmes, and then consider the feasibility of establishing centres which would address these needs.

Community mobilisation

The term *community mobilisation* is used as a catch-all phrase which is differently understood by different people. But there is universal agreement that effective responses to HIV/AIDS must be situated in and owned by

communities. Yet the reality is that AIDS is impoverishing communities and unravelling families, the very structures which constitute communities. So how can communities be *mobilised* within the reality of AIDS to lead, develop and sustain programmes for children?

The starting point is to let the community identify its own concerns and what responses are possible with existing internal resources, knowledge, skills and talents. A process is then required to decide on priority needs and, only at this point, should any outside capacity or resources be added that are needed to carry out the chosen activities.

Discrimination and stigma

Stigma and discrimination associated with HIV/AIDS still constitute significant barriers to effective service delivery. Projects have found that not being AIDS specific, for example providing home-based care to anyone with a life limiting disease (not just people with terminal AIDS), or supporting all orphans (not only AIDS orphans), minimises this barrier. This decision also has the long-term potential to normalise AIDS.

It requires a debate and a conscious decision as to the criteria for acceptance and inclusion of clients, and projects would be well advised to ensure that these criteria are set in consultation and preferably at the start of the life of the project.

Capacity building

Critical capacity building needs have been identified at every point during the Rapid Appraisal – from grandmothers who are caregivers of orphans, children who are caregivers of dying parents, and children who are the 'parents' of their younger siblings, to community volunteers who are supporting children in one way or another, and so on and so on. Across the board, projects whose primary aim was initially service delivery are being drawn into providing training, many to the extent that this is changing their focus.

A process is necessary to identify who requires training at national, provincial and local/community level. There should be attempts to share training resources and experiences, so that individual projects are not each independently reinventing the wheel. Finally, the investment in training should be protected and monitored by ensuring that on-going, in-service training takes place and monitoring processes are built into all projects.

Grants

Awareness of the availability of grants is limited, the process of applying for grants is fraught with difficulties, particularly where birth certificates and other identity documents are missing and processing of applications is protracted, with bureaucratic problems often resulting in the necessity to use meagre savings to travel again and again to local welfare offices.

Understanding the processes and supporting families to access grants will greatly alleviate poverty. Where projects have developed a close relationship with local welfare officials this has enhanced their ability to utilise the welfare system. Projects should ensure that training incorporates modules on the relevant welfare legislation and the criteria and processes which apply.

Guidelines for projects

Many projects arise as an emotional response to an observed need and adequate planning is not done in the initial stages. Sufficient thought is not given to issues such as the criteria for acceptance of clients and difficult decisions to exclude certain categories often have to be made later in the life of the project. Those working in the project may be skilled in the health field for example but lack the financial and management skills to run the project efficiently.

Proper planning, which anticipates the demands on the project and locating the necessary expertise, for example by ensuring that people with suitable qualifications are represented on management structures, will assist.

RESEARCH QUESTIONS

No systematic attempt has been made to identify a research agenda from the Rapid Appraisal, indeed the need for a research agenda is a final recommendation of the Rapid Appraisal. What was undertaken was an informal identification of research issues which emerged either from the literature or from discussions with stakeholders. These are listed under the headings of MTCT, infected children, vulnerable children, affected children, models and integration, and impact research questions.

MTCT

- What should we be promoting: exclusive breastfeeding, limiting the duration of breastfeeding, exclusive formula feeding? What are the transmission risks during exclusive breastfeeding versus mixed infant feeding?
- Is pasteurisation of breastmilk a feasible option?
- What breastfeeding advice should be given at different disease stages?
- What are the rights of mothers to treatment?

Vulnerable children

- What is the risk of HIV transmission during childhood sexual abuse?
- What is the contribution of childhood sexual abuse to the overall picture of HIV infection in children?
- Why is continuity so poor after children have been presented to services following sexual abuse?
- What are the barriers to providing post-sexual abuse services for children?
- What are the counselling needs of children and the primary caregivers, following childhood sexual abuse?
- What are the sexual attitudes towards women and children in the light of the HIV epidemic – specifically the motivation of perpetrators?
- What is the extent of public awareness of the relationship between HIV and childhood sexual abuse? What are the responses to this awareness?
- What is the role of post-exposure prophylaxis (PEP) in childhood sexual abuse?
- What is the scope and impact of child prostitution?

- What is the impact of HIV/AIDS education programmes on behaviour change?

Infected children

- Are children abandoned because they are HIV positive?

Affected children

- How can the capacity of children to support themselves be strengthened?

Models and integration

- How can existing models be replicated?
- How can the issues of AIDS orphans and vulnerable children best be integrated into the transformation of the health and welfare services?
- How can families and communities be strengthened to cope with AIDS orphans and vulnerable children?
- What structures exist that can be used and or strengthened in order to provide solutions to the potential orphan crisis?
- What services are needed to alleviate the additional burden that will be placed on communities and caregivers?
- Who decides on who is a community caregiver - against what criteria, who are they accountable to, who monitors their activities and provides them with ongoing support and guidance?
- How sustainable are programmes relying on voluntarism?
- How can poverty alleviation funds and feeding schemes/nutrition programmes be used to complement programmes for affected children?
- How can non-profit organisations work with Government Departments to provide a comprehensive service which provides an effective safety net for children in distress?
- How can take-up of child support grants be improved?

Impact

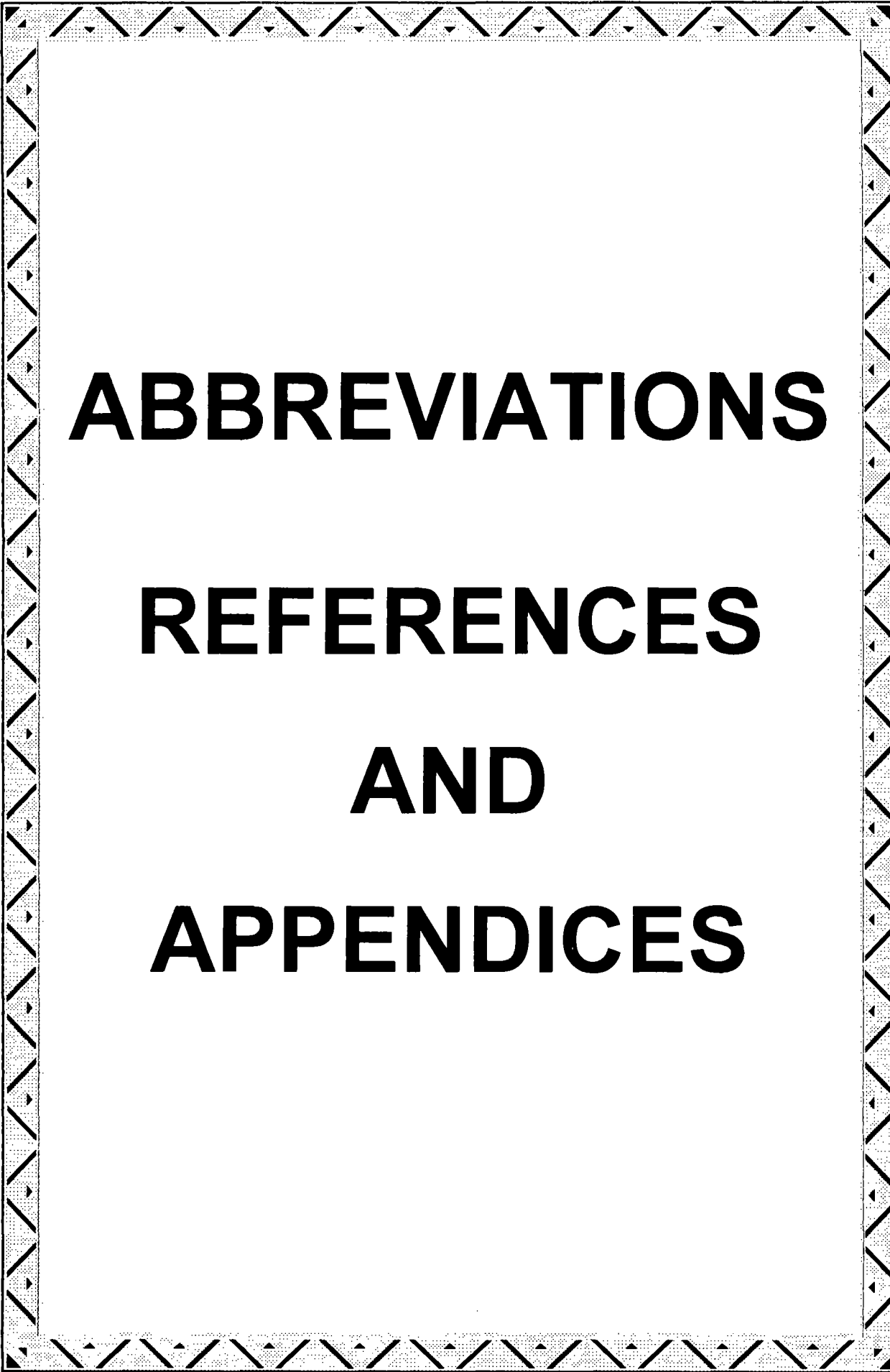
- What is the extent of HIV prevalence in various sub-groups - youth, orphans etc?
- What models are required to extrapolate the existing antenatal survey data to understand the epidemic as it impacts on children?
- What are the implications if Government re-routes subsidies from children's homes to foster care?
- What is the impact of HIV/AIDS on existing social safety nets?
- How can the impact of HIV/AIDS on children and families be monitored?

What purpose can research and data collection serve?⁸²

There can be little debate about the need for research and data collection, however it is useful to identify the benefits. These include:

- For monitoring and evaluation
- To call for and encourage action at different levels
- To strengthen and increase political commitment
- To review and refine current programmes and campaign strategies
- To develop strategies to deal with stigma and victimisation

⁸² UNICEF study tour report (to Rwanda, Uganda and Zambia) (1999)



ABBREVIATIONS REFERENCES AND APPENDICES

ABBREVIATIONS

ATICC	AIDS Training, Information and Counselling Centre
CBO	Community-based organisation
CCCC	Community Child Care Committees
CHIP	Child Intervention Panel
CSG	Child support grant
CRC	Convention on the Rights of the Child
ECD	Early childhood development
IMC	Inter-Ministerial Committee
IMR	Infant mortality rate
KABP	Knowledge, attitudes, behaviour and practices
MTCT	Mother-to-child transmission
NACTT	Interim National HIV/AIDS Care and Support Task Team
NCRC	National Children's Rights Committee
NGO	Non-governmental organisation
NPA	National Programme of Action for Children in South Africa
NPPHCN	National Progressive Primary Health Care Network
NSF	National Strategic Framework
PARRC	Participatory Action Research for the Rights of the Child
PEP	Post-exposure prophylaxis
PRA	Participatory Rural Appraisal
RDP	Reconstruction and Development Programme
SAHECO	South African Health Care Organisation
SCF	Save the Children Fund (UK) South Africa
STDs	Sexually transmitted diseases
TTO	To take out (medicines and supplies)
U5MR	Under 5 mortality rate
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing

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APPENDICES

1. Summary of responses to questionnaire
2. List of stakeholders interviewed
3. Contact details – model projects

Appendix One: Summary of responses to questionnaire

Questionnaires were distributed by post and at the DOW consultative meeting in November 1999

Analysis of responses

No. of responses: 28

National organisations: 4

Provincial: 24

Gauteng - 7

KwaZulu-Natal - 11

W Cape - 3

NP/Mpumalanga - 1

E Cape - 2

Description of respondents' organisations (as described by the respondents):

Private sector:	1
NGO:	13 (1 international NGO)
Network:	1
Church organisation:	2
Local Government:	1
Hospital/PDOH:	5
Welfare/service organisation:	3
Research:	1

Description of services:

General services:

- Private sector - primary care for employees and rural dependants
- NGO - mass media research and development in the fields of health and development; TOT courses, community-based distribution of contraceptives, reproductive health services and counselling; income-generating projects; lobbying and advocacy on HIV/AIDS, policy and programme development and networking; HIV/AIDS care and training; awareness, counselling and support; education campaigns; sex, sexuality and gender awareness; medical care, poverty alleviation, employment for PWAs, legal counselling, community home care
- Network - co-ordination, information sharing, common research, lobbying (related to children and HIV/AIDS)
- Church organisation - AIDS prevention and care, economic justice and empowerment, community policing, survivors' support
- Local Government – PHC services, training, counselling and support groups, palliative care, workplace programmes
- Hospital/PDOH - inpatient, outpatient and tertiary comprehensive medical care
- Welfare/service organisation - training in first aid and home care, first aid duties, ambulance transfers; child and family welfare services
- Research - social science research

Services for children:

- Private sector - health education, immunisation, nutritional support for employees and their children

- NGO - awareness programmes; edutainment, mass media and materials development for children 8 - 12; life skills training; peer education; primary child care support and establishment of child care committees; support for adolescent parents; advocacy and lobbying on children's issues; place of safety, care for symptomatic children with HIV, play school and education of mothers and carers on wellness management and counselling for children; "children at war against AIDS" (linked to ECD); home for abandoned and abused children, foster care and adoption, nursery school and hospice; feeding/clothing schemes; placement in foster care
- Network - co-ordination, information sharing, common research, lobbying (related to children and HIV/AIDS)
- Church organisation - residential care and development
- Local Government – preventive and promotive care
- Hospital/PDOH - inpatient and outpatient comprehensive medical care; family clinic for children with HIV; HBC (planned); social work services;
- Welfare/service organisation - community care (formal and informal, day and residential, street shelter) and community family care pilot project; care for abused, neglected and abandoned children;
- Research - welfare and health research

No services for children: 1

No information provided: 1

How should SA be preparing for the increasing numbers of children who will be infected or affected as a result of HIV/AIDS?

1. General

- National AIDS policy and planning - multisectoral - leading to assumption of responsibilities by all sectors and partnerships
- Involve local Councils in planning strategies and devolve responsibilities to the local level
- Resources - financial (including tax relief and educational grants) and material (medication, food tokens)
- Co-ordination of services
- Database of children in need
- Training (prevention and care)
- Strategies to eliminate poverty (especially in rural areas)
- Family and community awareness, mobilisation, empowerment, involvement
- Legal reform - linked to the Child Care Act
- Research to provide relevant data
- Development of new models
- Focus interventions on areas most affected
- Good management strategies including the establishment of community monitoring groups

2. Prevention

- Provision of anti-HIV drugs to infected pregnant women
- Awareness in schools and education systems
- Information for children on AIDS and sexuality
- AIDS education introduced into junior schools
- Make life skills examinable
- Upscale programmes and include outreach programmes

3. Care and support

- Improve social services for orphans (including foster care and access to grants)
- Physical, economic and emotional support for the grieving process (when parents die)
- Home/community-based care
- Support to extended families and communities

What is the greatest challenge to your organisation as a result of the impact of HIV/AIDS on South Africa's children?

- Growing numbers of children (infected and affected) and limited resources/capacity to cope (including limited and overworked staff) and to support poor communities to cope
- Ability to provide high level, holistic care to the dying and enable the affected to assume their place in society
- Providing services long-term, throughout the life-span of infected and affected children
- Training for caregivers
- Lack of indigenous alternative models of foster and adoptive care and lack of a continuum of care
- To reach as many children as possible and encourage them to support each other
- Appropriate services for adolescents (utilising resources optimally and well co-ordinated)
- Ability to access funding (particularly from Government)
- Lobbying for MTCT interventions and for greater participation by sectors, partners and different levels of Government
- To ensure that infected and affected children are not marginalised
- Preventing MTCT and providing support to infected mothers
- Societal mobilisation and community participation
- Monitor the DOW
- Effective publicity campaigns

Appendix Two: List of stakeholders interviewed

Dr Maria Mabetoa, Director: Social Welfare Services to Women, Department of Welfare
Ms Johanna de Beer, HIV/AIDS Co-ordinator, Department of Welfare
Dr Kelvin Billingham, Provincial Programme Manager HIV/AIDS/STDs, Department of Health, Mpumalanga
Ms Tamera Mathebula, Eastern Cape Provincial Programme Manager, PPASA

Appendix Three: Contact details of model projects

The House of Resurrection Haven
Rev Jean Underwood (041) 481-1515

Diana, Princess of Wales Mohau Children's Care Centre
Father Barry Hughes Gibbs (012) 318-6729

CINDI Network
Ms Yvonne Spain (033) 345-2970

Bastion Street Child Project
Ds Andre Olivier 082 578 0687

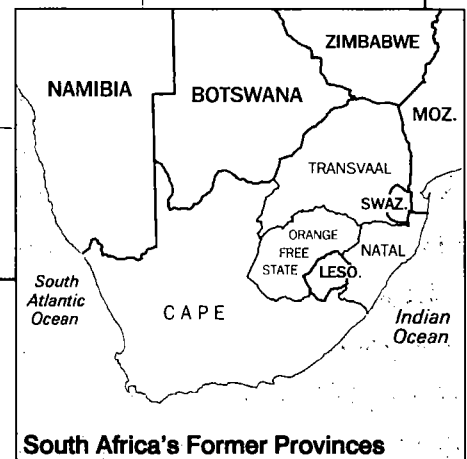
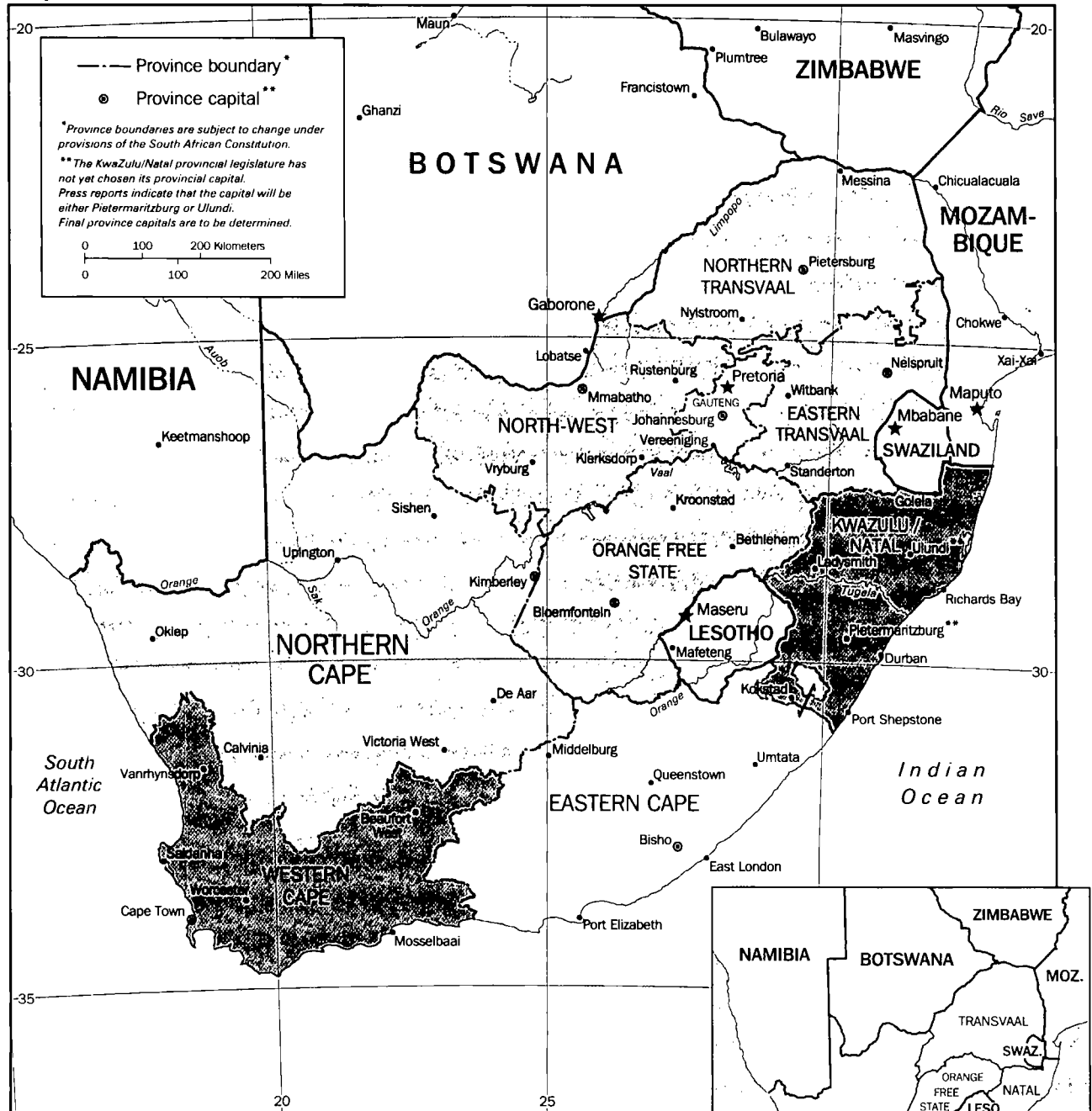
St Nicholas Children's Hospice
Ms Joan Marston (051) 447-7281

Masoyi Home-Based Care Project
Dr Margie Hardman (013) 750-1340

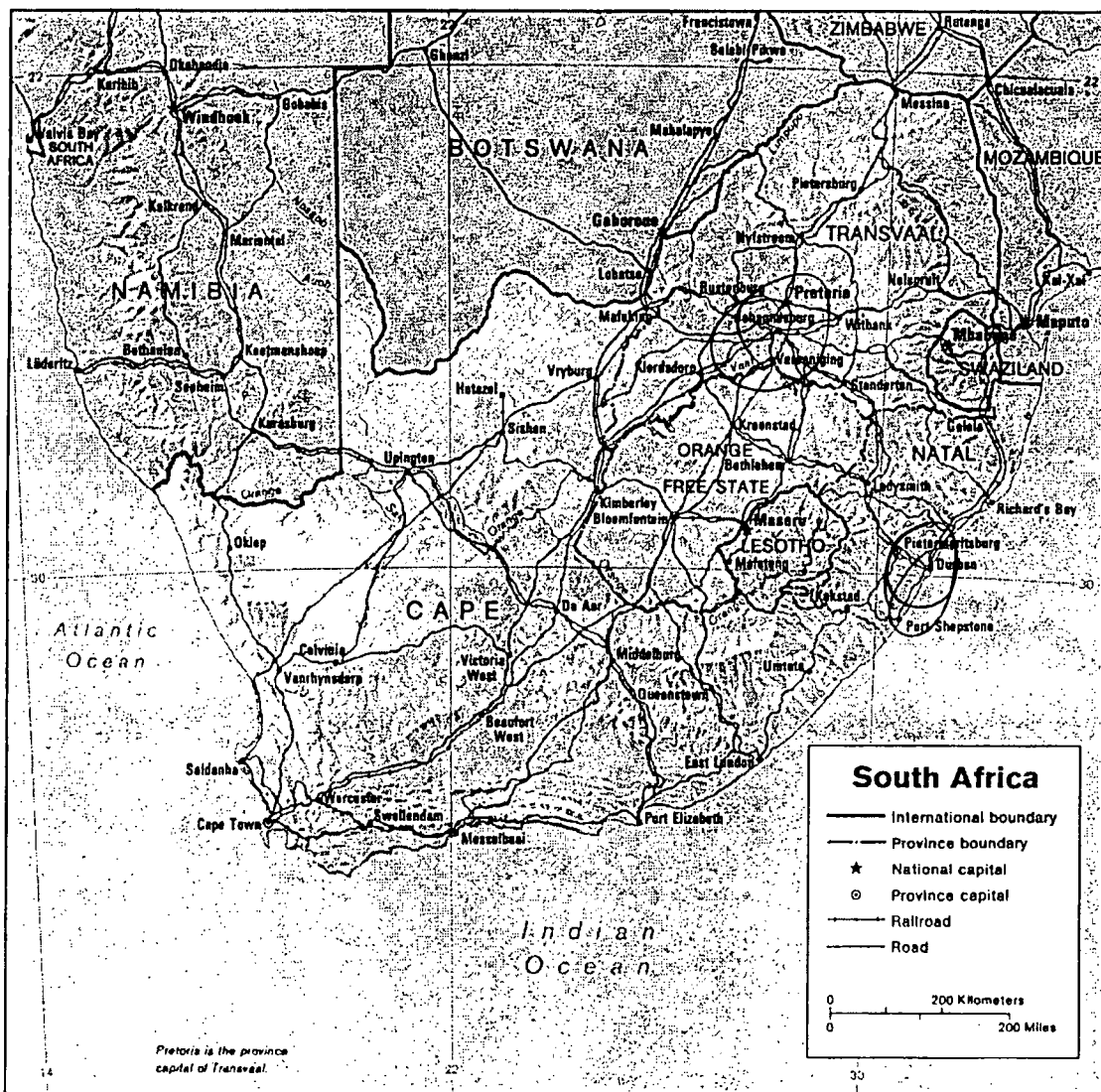
Tateni Home Care Services
Ms Veronica Khoza (012) 805-7638

C-SA

Republic of South Africa



South Africa



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South Africa's Cabinet

Under the interim constitution, the Cabinet consists of a president (elected by the National Assembly), deputy presidents (one for each party with at least 80 seats in the National Assembly), and ministers (allocated proportionally among the parties that hold at least 20 seats in the National Assembly; appointed by the president upon recommendation by the respective parties). Although entitled to a deputy president and minister positions under these rules, the National Party withdrew from the government in June 1996.

Executive

Name	Portfolio	Age	Education/Background	Ethnicity	Comment
Mandela, Nelson (ANC)	President	78	Law	Xhosa	"My intention is to promote national unity and reconciliation." ----Mandela in speech at Potchefstroom University on 20 February 1996.

Maki, Thabo (ANC)	Executive Deputy President	54	Economics	Xhosa	Described in press as Mandela's heir apparent and de facto prime minister
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African National Congress (ANC)

Asmat, Kader	Water Affairs & Forestry	58	Law	Indian	Constitutional lawyer, human rights activist.
Bengu, Sibusiso	Education	62	Political Science	Zulu	Former secretary general of Inkatha Freedom Party.
Erwin, Alec	Trade & Industry	48	Economics	White-Eng. speaker	Former Deputy Finance Minister; former prominent leader in trade union movement.
Fraser Moleketi, Geraldine	Welfare & Population Development	36	*	Colored	Promoted from Deputy Minister position; active in development work during years in exile.
Hanekom, Derek	Agriculture & Land Affairs	43	Agriculture	Afrikaner	Former coordinator of ANC's Department of Land & Regional Affairs.
Jordan, Pallo	Environment Affairs & Tourism	54	History, Sociology	Xhosa	Former head of ANC Information & Publicity Department.
Maduna, Penuell	Mineral & Energy Affairs	43	Law	Zulu	Former Deputy Minister of Home Affairs.
Maharaj, Mac	Transport	61	Business Administration	Indian	Strategist in ANC leadership for many years.
Manuel, Trevor	Finance	40	*	Colored	Former head of ANC's Department of Economic Planning
Shepard Madiadana	Labor				
Modise, Joe	Defense	67	*	Tswana	Former chief of ANC's military wing, Umkhonto we Sizwe (MK)
Moss, Mohammed Vusi	Provincial Affairs & Constitutional Development	39	Physics, Mathematics	Indian	Promoted from Deputy Minister position.
Mimam-Mahanyele, Sankie	Housing	45	Education	Shangaan	Former Deputy Minister of Welfare & Population Development.
Motlamo, Sydney	Safety & Security	37	*	Venda	Founding member of the United Democratic Front--South Africa's largest internal antiapartheid organization in 1980s; former trade union leader
Nkomo, Jay	Posts, Telecommunications, & Broadcasting	41	*	Indian	Former general secretary of COSATU--South Africa's largest trade union federation.
Izoo, Alfred	Foreign Affairs	71	*	Xhosa	Former ANC secretary general.
Omar, Dullah	Justice	62	Law	Indian	Defense lawyer in political and human rights trials during apartheid era.
Radebe, Jeff	Public Works	43	International Law	Zulu	Former ANC Chairman of southern Natal region.
Sigcau, Stella	Public Enterprises	59	Education	Xhosa	Held several posts in government of now-defunct Transkei homeland.
Skweyiya, Zola	Public Service & Administration	53	Law	Xhosa	Former head of ANC's Department of Legal & Constitutional Affairs.
Tshwete, Steve	Sport & Recreation	57	English, History	Xhosa	Former head of ANC sports desk during transition to majority rule.
Zuma, Nkosazana	Health	47	Medicine	Zulu	Former ANC Women's League Chairwoman of southern Transvaal region.

Inkatha Freedom Party (IFP)

Buthelezi, Mangosuthu	Home Affairs	68	Administration, History	Zulu	President of IFP; formerly Chief Minister of now-defunct KwaZulu homeland.
Mishali, Lionel	Arts, Culture, Science & Technology	62	Education, History	Zulu	Former Education Minister of now-defunct KwaZulu homeland.
Mzimela, Sipo	Correctional Services	59	Episcopal priest	Zulu	IFP Deputy National Chairman; former IFP representative in the United States.



Nelson Mandela



Thabo Mbeki

* = No or incomplete post-secondary education

01 November 1996

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DRAFT

September 15, 1999

MEMORANDUM TO THE VICE PRESIDENT

From: Sandra L. Thurman, Director, Office of National AIDS Policy

SUBJECT: Response of the South Africa Government to the AIDS Epidemic

BACKGROUND

South Africa has the fastest growing epidemic in Africa with up to 1600 new infections occurring daily. One out of every 10 new infections worldwide occurs in South Africa – nearly two thirds of whom are under the age of 25. The most recent annual survey demonstrates raging epidemics in the provinces of Kwazulu-Natal, Mpumalanga, Free State, Gauteng and Northwest where 20 to 35% of pregnant women are infected with HIV. HIV prevalence has doubled since the post Apartheid era was ushered in.

The former apartheid government of South Africa had turned a blind eye to the epidemic. Furthermore many of the structures of the old apartheid government continue to fuel the epidemic. The system of migrant labor in particular separates men from their families and creates conditions that support the rapid spread of HIV. In the communities surrounding South Africa's gold mines the HIV prevalence has reached shocking levels. For example, in Carletonville more than 65% of women 20 to 24 years old are infected.

The post apartheid government response to the HIV/AIDS epidemic in South Africa has been silent, slow, mis-directed, and marred by political controversy.

Silent: While focusing on the central transformation issues, the new Mandela government was silent on the epidemic. In fact it wasn't until the most recent World AIDS Day (Dec 1, 1998) that President Nelson Mandela finally made his first public statement (in South Africa) on the epidemic.

Slow: While the Mandela government took official action right away creating a National AIDS Plan, the plan floundered in the new decentralized health care system. The effectiveness of the national Department of Health to impose policy at the Province and District level was severely limited. Furthermore, the monetary and human resources required to make the plan real never materialized.

Mis-directed and controversial actions: The South African Department of Health, under the leadership of Dr. Nkosazana Zuma (now Foreign Minister) devoted millions of dollars to an anti AIDS play (Sarafina II) and the promotion of an ineffective AIDS cure. Her decision *not* to provide AZT to pregnant women and support of the Medicines and Related Substances Act has resulted in controversy that has diverted the government's attention away from the enormous tasks it faces.

New Minister of Health: Under Dr. Manto Tshabalala-Msimang, it is hoped that the silence and indecision will subside. Already President Mbeki has spoken out strongly about the need to act. This is to be commended and encouraged. But the constraints of the last five years still exist. These include the weak management capacity and commitment at the provincial level that led to the failure of previous plans; budget limitations that reduce the government's ability to act; the extreme stigmatization of people with HIV/AIDS which culminated in the stoning death of an AIDS activist last year.

RECOMMENDATION

The Mbeki Administration needs to be pressed to make AIDS a real national priority commensurate with the magnitude of this emergency. They need to understand that a "business as usual" approach threatens the future of South Africa. Strategic plans exist, but it is long past time to move from paper to practice. This will require the full weight of the Mbeki Administration and a firm commitment of the resources, personnel and political will to get the job done. This must also include the launching of an effective multi-sectoral response (education, business, trade, communications, etc.).

Country Brief



Socio-Economic Data

Total population (thousands), 1997	43,336	UNPOP
% of population urbanized, 1996	51	UNPOP
Annual population growth rate, 1980-1995	2.3	UNPOP
Infant mortality rate (per 1,000 live births), 1996	50	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births), 1990	230	WHO/UNICEF
Life expectancy, 1996	65	UNPOP
Adult literacy rate, 1995	M 82, F 82	UNESCO
Per capita GNP (US\$), 1995	3,160	World Bank

Status of the Epidemic

Prevalence – Year	Trend
16.7 – 1998	Rapid growth with all age groups in surveillance sites showing between 15 and 65 percent growth between 1997 and 1998. Highest growth rate was in the under 20 age group.

National Response

National AIDS Programme

- The HIV/AIDS and STD Directorate is located within the Ministry of Health which is the lead ministry in the response to the epidemic;
- An Inter-Ministerial Committee on AIDS was established in 1998 to provide political direction and policy guidance to the national AIDS programme;

National Strategic Planning

- The development of the national strategic plan occurred during the months of July- November 1999;
- The plan, still in draft form, is a five-year plan;
- The priority areas include prevention, human rights, care and support, research monitoring and evaluation, youth and policy implementation.

Political Commitment

- The President launched the Partnership against AIDS in 1998 to broaden and formalise the participation by all sectors in the response to the epidemic;
- The President also launched the South African National AIDS Council on 1 December 1999. It is a multisectoral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan.
- The current Minister of Health initiated the development of the strategic plan;

Country Brief

- It was in response to the statement by the newly elected President calling all South Africans to action in the fight against AIDS. He challenged all sectors of society to be actively involved in the response to HIV/AIDS.

Multisectoral Involvement

- Initial efforts in the South African response to HIV/AIDS were implemented mainly by non-governmental organizations and the Ministry of Health;
- There has been gradual involvement by other government departments and civil society;
- Participants in the recent national strategic planning process included representatives from faith based organisations, people living with HIV/AIDS, non-governmental organizations, human rights organisations, academic institutions, the civil military alliance, the media, organised labour, organised sports, business, insurance companies, women's organisations, youth organisations, international donors, medical and health professionals, medical and health consulting organisations, political parties and other relevant government departments;
- The Response Analysis calls for all provincial authorities to designate co-ordinators responsible for STD/HIV/AIDS at the province and district levels.

UN Theme Group on HIV/AIDS

Chair:

UNICEF Representative

Members:

UNDP, WHO, UNFPA,
UNICEF, UNESCO, World Bank

Participants: ILO, UNHCR, UNIC, IOM and UNAIDS/ICT

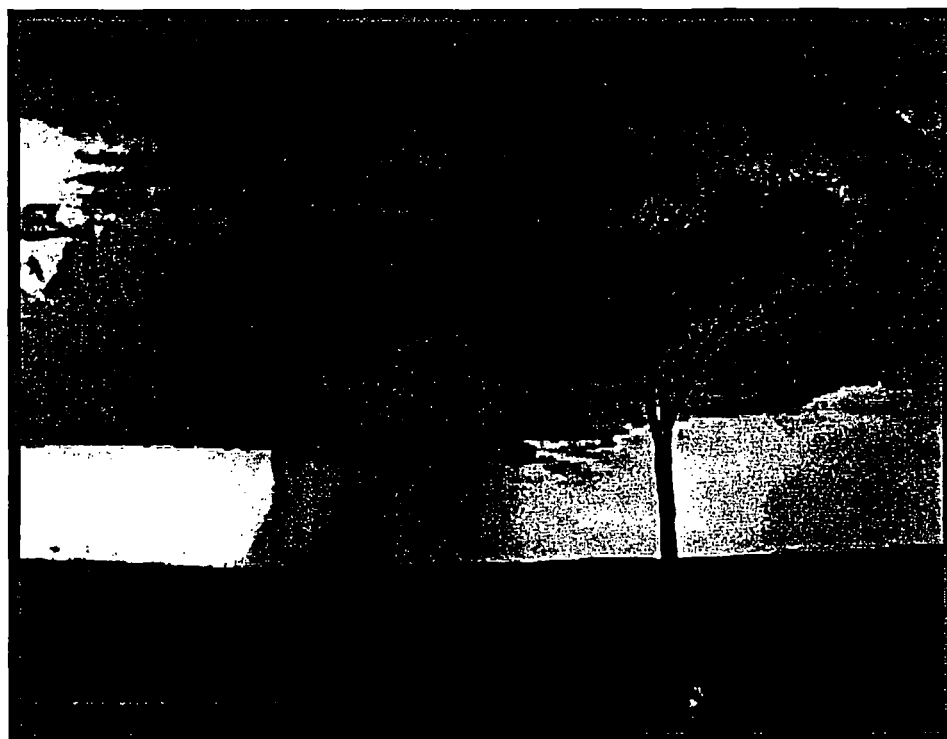
Support from UN System Agencies for HIV/AIDS activities in 1998-1999

<i>Organization</i>	<i>Amount US\$</i>
WHO	80 000
UNDP	200 000
UNFPA	10 000
UNESCO	5 000
UNAIDS	683 450
Total	978 450

Economic Impact of AIDS in South Africa

A dark cloud on the horizon

APRIL 2000



- **South Africa is faced with a worsening AIDS epidemic, which will have a profound impact on the country's economic outlook.** We forecast HIV infection rates to peak at almost 17% by 2006 for the population as a whole. AIDS-related deaths will peak about five years later at 256 AIDS deaths per 100 normal deaths.
- **The economically active population will be worst affected, with infection rates forecast to reach 26%.** The lion's share of the infections and deaths will be borne by the unskilled and semi-skilled part of the workforce, with infection rates likely to top the 30% mark. Nevertheless, the skilled and highly skilled will also be profoundly affected, with infections forecast to reach 23% and 13% respectively. South Africa is already battling with a skills shortage, which will be further exacerbated by the AIDS epidemic, raising remuneration and replacements costs for companies.
- **The epidemic impacts on the economy in various ways.** It leads to a smaller labour force, lower labour productivity, cost pressures for companies, lower labour income, and increased demand for health services from the private and the public sectors.
- **In our non-alarmist scenario, we believe GDP trend growth is forecast to be on average 0.3-0.4 percentage points pa lower than in a no-AIDS baseline.** CPI inflation will pick up due to cost pressures on companies that are passed on. This will exert some upward pressure on interest rates. Capacity utilisation and investment holds up fairly well, as the lower labour supply and productivity encourage a switch towards technology away from labour and narrow the gap between potential and actual output.
- **The costs of the AIDS epidemic are likely to cause a domestic savings squeeze – and this could potentially set off a vicious spiral.** Domestic savings as a percentage of GDP are expected to be on average 2 percentage points lower than in a no-AIDS scenario. In order to support investment demand in the economy, South Africa would need to attract foreign savings to plug the gap. Should foreign inflows not materialise, a savings-investment crunch will ensue, pushing interest rates markedly higher and further slowing GDP growth than is expressed in our AIDS baseline case.
- **The lower growth and higher risk profile for South Africa will not bode well for financial markets and may well deter foreign investors.** We look at relative risk exposure of sectors in terms of two factors – firstly, their reliance on a workforce that has a high infection risk and, secondly, their reliance on skilled workers, the replacement cost of whom is much higher than of the unskilled. Aggregating those two factors, we find that transport & storage and catering & accommodation are the sectors most exposed to the AIDS risk, while machinery, communication and metals fare relatively better. An important finding is, however, that service industries, such as finance and business services (including IT), rank in the middle field, as their reliance on skilled personnel makes them more vulnerable to a rising remuneration bill.

Figure 1

**% POINT DIFFERENCE IN GROWTH RATES BETWEEN THE AIDS
AND NO-AIDS SCENARIOS**

	2001F	2002F	2003F	2004F	2005F	2006-10F	2011-15F
Real GDP	-0.3	-0.2	-0.2	-0.2	-0.3	-0.4	-0.3
Employment*	-1.5	-2.1	-2.8	-3.7	-4.7	-8.3	-14.1
Unemployment	-0.3	-0.3	-0.4	-0.5	-0.6	-0.9	-1.2
Real household disposable income*	-1.3	-1.7	-2.1	-2.4	-2.8	-4.4	-5.8
Real PCE	-0.3	-0.4	-0.3	-0.4	-0.5	-0.8	-0.8
Real govt consumption	0.1	0.1	0.1	0.1	0.1	-0.1	-0.2
Real GDFI	-0.1	0.1	0.2	0.2	0.1	-0.1	0.0
Real inventory investment (Rm difference)	-130	-698	-935	-852	-1,116	-4,014	-4,676
Real exports	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Real imports	0.4	-0.2	0.2	0.0	-0.1	-0.3	-0.5
Current account balance/GDP**	-1.0	-1.2	-1.4	-1.7	-1.7	-2.4	-2.4
Trade weighted nominal exchange rate*	-0.7	-1.3	-1.4	-1.8	-2.1	-3.0	-3.9
Budget deficit/GDP**	-0.3	-0.3	-0.4	-0.5	-0.6	-0.8	-0.9
CPI inflation rate	0.7	0.2	0.4	0.3	0.4	0.4	-0.1
Prime lending rate**	0.0	0.0	0.0	0.1	0.2	0.3	0.6

Difference between YoY growth rate of AIDS and no-AIDS scenarios

** Real % difference between AIDS and no-AIDS scenarios, not YoY growth rate differences*

*** % point difference*

Source: WEFA

INTRODUCTION

The uncertainty over the impact of the AIDS epidemic on the South African economy causes some discomfort with regard to the country's investment risk profile in the future. In order to shed some light on the effects of the AIDS issue, we have attempted to model some of the possible channels through which the epidemic impacts on the economy. We approached the problem in two steps,

Our goal was to model the possible macroeconomic effects of AIDS

- Firstly, we modelled the demographic changes that are likely to occur, using the Actuarial Society's (ASSA) demographic model, and produced infection and mortality profiles by skills levels and for selected sectors. The results were discussed in our first report 'The Demographic Impact of AIDS on the South African Economy', dated 17 December 1999.
- Secondly, we conducted long-term economic forecasts to take into account the AIDS effect. Clearly, the demographic projections, which we updated for this second part of the study, formed the backbone to the analysis. In addition, we formulated assumptions on costs to consumers, companies and government. The results are presented in this report.

As little work had actually been carried out before with regard to econometric modelling of the epidemic, the research took several months. The further we went in our endeavours, the more gaps we discovered in the existing data on the demographic profile of the disease, government policy and estimated expenditure, changing household consumption and expenditure patterns and the costs arising for companies. It is therefore important to emphasise the imperfect nature of the information.

However, our work was greatly helped by informal cooperation with AIDS experts and other modellers. We were able to host a workshop in January that included the World Bank, the Department of Finance and the Bureau for Economic Research (BER) in Stellenbosch to discuss the modelling approach and the validity of the assumptions. A follow-up workshop was held at the BER in early March, which also included, among others, Professor Dorrington, who is responsible for the ASSA demographic model, and Metropolitan Life. We benefited greatly from the discussion and would like to thank all participants for their comments and inputs. Over the coming months, we will probably see different angles to the economic analysis of AIDS explored by other participants, which should add further to the debate on the impact of AIDS.

Most importantly, we would like to thank WEFA for helping us model the long-term demographic trends and the macroeconomic outlook.

RECENT INTERNATIONAL TRENDS

According to the UNAIDS December 1999 figures, some 33.6m people worldwide are currently living with HIV – 32.4m adults and 1.2m children. Some 70% of the global total of HIV infected live in sub-Saharan Africa. Life expectancy at birth in southern Africa, which was 59 years in the early 1990s, is set to drop to just below 45 years between 2005 and 2010.

Figure 2

REGIONAL HIV/AIDS STATISTICS AND FEATURES, DECEMBER 1999

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV in 1999	Adult prevalence rate ¹ (%)	Women as a % of HIV+ adults	Main modes of transmission ² for adults living with HIV/AIDS
Sub-Saharan Africa	Late 1970s-early 1980s	23,300,000	3,800,000	8.00	55	Hetero
North Africa & Middle East	Late 1980s	220,000	19,000	0.13	20	IDU, Hetero
South & South East Asia	Late 1980s	6,000,000	1,300,000	0.69	30	Hetero
East Asia & Pacific	Late 1980s	530,000	120,000	0.07	15	IDU, Hetero, MSM
Latin America	Late 1970s-early 1980s	1,300,000	150,000	0.57	20	MSM, IDU, Hetero
Caribbean	Late 1970s-early 1980s	360,000	57,000	1.96	35	Hetero, MSM
Eastern Europe & Central Asia	Early 1990s	360,000	95,000	0.14	20	IDU, MSM
Western Europe	Late 1970s-early 1980s	520,000	30,000	0.25	20	MSM, IDU
North America	Late 1970s-early 1980s	920,000	44,000	0.56	20	MSM, IDU, Hetero
Australia & New Zealand	Late 1970s-early 1980s	12,000	500	0.10	10	MSM, IDU
Total		33,600,000	5,600,000	1.10	46	

¹ The proportion of adults (15-49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.

² MSM (sexual transmission among men who sleep with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

Source: WHO

Following the publication of our 17 December 1999 report 'The Demographic Impact of AIDS on the South African Economy', the Actuarial Society of South Africa (ASSA) on whose model our forecasts were built, updated some of its assumptions flowing into the model. We have amended our forecasts to reflect these latest revisions.

THE ACTUARIAL SOCIETY OF SOUTH AFRICA (ASSA) NATIONAL AIDS MODEL

The Actuarial Society of South Africa (ASSA 600, Dorrington, 1998) model was developed to forecast the South African population and the impact of AIDS on its various segments. This version of the ASSA model is currently set up to reflect the entire population in South Africa, which is divided into three distinct age groupings: young (0-13 years old), old (60 years and older) and adult. On reaching their 14th birthday, individuals are allocated into the various other risk groups according to the assumed proportions of the population as a whole. It is assumed that none of the perinatal infections will survive to age 14. The adult group is divided into four subgroups, differentiated by their level of exposure to the risk of a heterosexual epidemic.

- PRO – Individuals whose level of sexual activity is such that their HIV prevalence is similar to that of sex workers and their clients
- STD – Individuals whose level of sexual activity is such that their HIV prevalence is similar to that of people being treated for sexually transmitted diseases at STD clinics
- RSK – Individuals with a lower level of sexual activity but who are still at risk from HIV
- NOT – Individuals who are not at risk of HIV infections

A pattern of contact is assumed both within and between risk groups. Instead of modelling the various factors involved during a single sexual encounter, the model uses an average 'force of infection' to determine the spread of HIV. The force of infection is a combination of 'number of sexual partners', 'number of new contacts' and 'ease of infection'. The age and sex of the specific force of infection is then derived by incorporating the relevant sexual activity index for age and sex. Although the sexual activity curve is arbitrarily chosen, it is chosen such that the shape of new HIV infections matches known data.

Figure 3 shows the further assumptions that feed into the model.

Figure 3 ASSA AMENDED ASSUMPTIONS

Risk group	Description of risk group	% population	Relative fertility* (%)	Probability of HIV+ infection per year
PRO	Sex workers and clients	1	40	0.85
STD	Treated for sexually transmitted diseases	20	70	0.47
RSK	Normal HIV risk	40	100	0.09
NOT	No HIV risk	39	117	0.00
General		Value		
Infant AIDS mortality (%)		30		
Median term to death of HIV+ (14+ yrs)		10		
Proportion of perinatal infection (%)		25		
Proportion of infected via breast-feeding (%)		10		
Proportion of male births (%)		51		
Relative male to female infectivity		2:1		
Imported infectivity (male PROs)		300		
Imported infectivity (female PROs)		450		

* To RSK group

Source: Dorrington, ASSA 600, A User's Guide

We start our analysis at the most aggregated level, ie, at the level of the total population, and present our results of a baseline AIDS-inclusive population forecast and a no-AIDS population forecast. The no-AIDS scenario is recreated by adding back to the current (AIDS-inclusive) population forecasts the AIDS deaths while adjusting for their fertility and mortality. The ASSA model is operated from a 1985 base year in 15-year cycles, and it should be noted that in our baseline case, we have not changed any of the ASSA assumptions in the second cycle that runs from 2000 to 2015. We assumed that sexual behaviour such as that implied by Figure 3 does not change and that no medical advances are made during as well as between the cycles.

GENERAL POPULATION FORECASTS

The modelling results are shown in Figure 4. It can be seen that for 2000 the ASSA model suggests that without AIDS the population would be 1.1% higher than under the current AIDS-inclusive scenario. This differential is forecast to rise to 23% by 2015.

Total population will be 23% lower by 2015 than in a no-AIDS case

In the no-AIDS scenario, population growth rates are expected to come down from well over 2% pa to 1.5% by 2015. By contrast, ASSA's recent population projections including AIDS indicate that the growth rate has come down more rapidly since the early 1990s. By 2004, the growth rate is forecast to drop to below 1% and to reach 0% by 2011.

Given the new assumptions on infection rates, propagation, fertility and mortality, HIV+ infection rates are forecast to peak at 16.7% in 2006 and taper off thereafter. The number of AIDS deaths is expected to rise rapidly and should peak with a four to five year lag in 2010 with 1.8 AIDS deaths per 100 people and 256 AIDS deaths per 100 normal deaths. As shown in our previous report, apart from the 0-9 age group, which reflects the high rate of infant deaths associated with mother-to-child transmissions, AIDS deaths are mainly concentrated in the 25-50 age groups. That means that the labour force is disproportionately more affected than the overall population. The repercussions of this for the economy will be discussed later in the report.

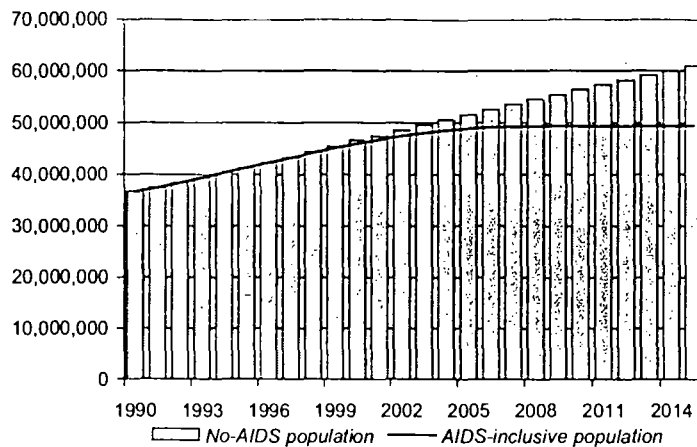
Infection rates are forecast to peak at almost 17%

Figure 4 POPULATION FORECASTS OF NO-AIDS AND THE AIDS-INCLUSIVE SCENARIOS

	AIDS-inclusive scenario	Growth (%)	No-AIDS scenario	Growth (%)	No-AIDS/AIDS (%)	HIV+	AIDS deaths	AIDS deaths per 100 normal deaths
1999	45,100,513		45,414,112		0.7	11.58	0.42	57.6
2000	45,951,123	1.89	46,447,874	2.28	1.1	12.99	0.56	76.7
2001	46,725,267	1.68	47,478,275	2.22	1.6	14.17	0.71	99.2
2002	47,407,203	1.46	48,503,417	2.16	2.3	15.12	0.89	124.6
2003	47,984,178	1.22	49,521,688	2.10	3.2	15.83	1.07	151.7
2004	48,448,709	0.97	50,531,745	2.04	4.3	16.31	1.26	178.7
2005	48,800,591	0.73	51,532,490	1.98	5.6	16.58	1.43	203.5
2006	49,047,777	0.51	52,523,054	1.92	7.1	16.67	1.57	224.3
2007	49,205,482	0.32	53,502,785	1.87	8.7	16.62	1.67	239.9
2008	49,293,678	0.18	54,471,262	1.81	10.5	16.45	1.74	249.9
2009	49,333,750	0.08	55,428,279	1.76	12.4	16.22	1.78	254.8
2010	49,345,370	0.02	56,373,740	1.71	14.2	15.96	1.78	255.5
2011	49,344,408	0.00	57,307,533	1.66	16.1	15.70	1.77	253.4
2012	49,342,079	0.00	58,229,435	1.61	18.0	15.46	1.74	249.3
2013	49,345,084	0.01	59,139,066	1.56	19.8	15.25	1.71	244.4
2014	49,356,321	0.02	60,035,874	1.52	21.6	15.09	1.67	239.2
2015	49,375,762	0.04	60,919,128	1.47	23.4	14.97	1.64	234.2

Source: ASSA

Figure 5

POPULATION FORECASTS FOR AIDS AND
NO-AIDS SCENARIOS

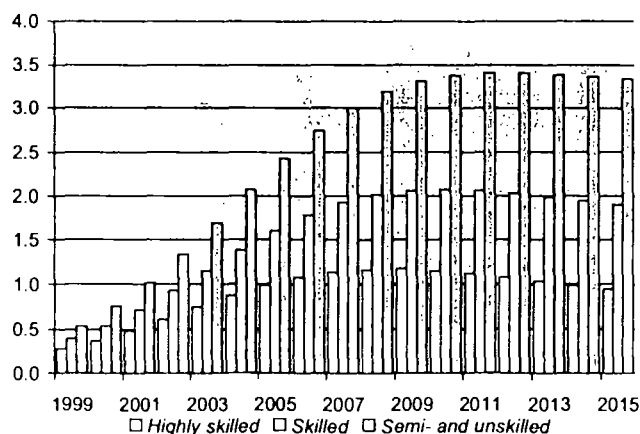
Source: ASSA

EFFECTS ON THE LABOUR FORCE BY SKILLS AND SECTORS

The infection rate among the economically active population peaks at about 25.5% by 2006, well above the 16.7% peak for the total population. As in our last report, we translated the overall infection rate among the economically active into infection rates by skills group. We combined the age, ethnic and gender profiles from the ASSA forecast with provincial information from J Slawski (*AIDS where are we*, 1998 unpublished report for ASSA) and overlaid this information on employment data by skills categories and economic activity from the 1996 population census. When examining the infection rates by skills groups, we find that the HIV+ rate of semi- and unskilled labour is over three times as high as that of the highly skilled. A similar observation can be made with regard to the number of AIDS deaths by skill category. Nevertheless, while the semi and unskilled portion of the labour force is disproportionately affected by the AIDS epidemic, it is important to realise that infection rates among the highly skilled will be substantial as well, exacerbating South Africa's skills shortage. Among the highly skilled, the infection rate is forecast to peak at 13.1% in 2005, compared with 22.8% for the skilled and 32.8% for the semi- and unskilled. Annual AIDS-related deaths among the highly skilled are forecast to peak at 1.2 per 100 workers, while deaths among the semi-and unskilled grouping are expected to peak at 3.4 per 100 workers.

*The labour force
will be worst
affected*

Figure 6 PROJECTED AIDS DEATHS PER 100 WORKERS BY SKILLS



Source: ASSA

Figure 7

HIV+ INDIVIDUALS PER 100 WORKERS BY SKILLS LEVEL

	Highly skilled	Skilled	Ratio skilled/ highly skilled	Semi- and unskilled	Ratio semi- and unskilled/ highly skilled
1999	10.2	15.5	1.5	19.9	2.0
2000	11.2	17.5	1.6	22.7	2.0
2001	12.0	19.1	1.6	25.2	2.1
2002	12.6	20.5	1.6	27.4	2.2
2003	12.9	21.5	1.7	29.2	2.3
2004	13.1	22.2	1.7	30.6	2.3
2005	13.0	22.6	1.7	31.6	2.4
2006	12.8	22.8	1.8	32.3	2.5
2007	12.5	22.7	1.8	32.7	2.6
2008	12.1	22.5	1.9	32.8	2.7
2009	11.7	22.1	1.9	32.8	2.8
2010	11.2	21.7	1.9	32.7	2.9
2011	10.8	21.3	2.0	32.5	3.0
2012	10.4	21.0	2.0	32.4	3.1
2013	10.0	20.6	2.1	32.4	3.2
2014	9.6	20.4	2.1	32.4	3.4
2015	9.3	20.2	2.2	32.6	3.5

Source: WEFA

Figure 8

AIDS DEATHS PER 100 WORKERS BY SKILL LEVEL

	Highly skilled	Skilled	Ratio skilled/ highly skilled	Semi- and unskilled	Ratio semi- and unskilled/ highly skilled
1999	0.3	0.4	1.4	0.5	2.0
2000	0.4	0.5	1.4	0.8	2.0
2001	0.5	0.7	1.5	1.0	2.1
2002	0.6	0.9	1.5	1.3	2.2
2003	0.7	1.2	1.5	1.7	2.3
2004	0.9	1.4	1.6	2.1	2.4
2005	1.0	1.6	1.6	2.4	2.4
2006	1.1	1.8	1.6	2.7	2.5
2007	1.1	1.9	1.7	3.0	2.6
2008	1.2	2.0	1.7	3.2	2.7
2009	1.2	2.1	1.8	3.3	2.8
2010	1.2	2.1	1.8	3.4	2.9
2011	1.1	2.1	1.8	3.4	3.0
2012	1.1	2.0	1.9	3.4	3.1
2013	1.0	2.0	1.9	3.4	3.3
2014	1.0	1.9	2.0	3.4	3.4
2015	1.0	1.9	2.0	3.3	3.5

Source: WEFA

THE MACROECONOMIC ASSUMPTIONS

Following on from the demographic analysis, we have attempted to model the possible effect of HIV/AIDS on South Africa's longer term economic prospects. For that purpose, we have formulated assumptions based on the information that is currently publicly available. However, one cannot emphasise enough the deficiencies and gaps in the publicly available data. With this in mind, our analysis tries to identify the main channels through which the epidemic will affect the macroeconomy and highlight the sensitivity of the forecast outcomes to the input assumptions on the patterns of the epidemic. To our knowledge, this macro-modelling exercise has not been performed so far, and we hope that in addition to highlighting potential investment implications, we will add to the public debate on the impact of AIDS more generally. We believe that we have drawn a realistic scenario in our assumptions and have refrained from being unduly alarmist.

As the AIDS epidemic is unfolding, it will place severe costs on the economy. The channels we will be examining are the following:

We have identified seven key impact channels

1. A lower labour force
2. Lower labour productivity through absenteeism and illness
3. Cost pressures for companies through higher benefit payments and replacement costs
4. Lower labour income, as employees bear some of the AIDS-related costs
5. Lower population translating into lower expenditure
6. Increased private sector demand for health services
7. Higher government expenditure on health services.

Rising expenditure on healthcare will not only put pressure on the fiscus, but also on households and companies. Overall household demand will be dampened and reprioritised and household savings squeezed. Absenteeism, productivity losses and higher costs for training skilled personnel will place an additional burden on companies. Some of the higher costs will be passed on to the consumer via higher prices, but some will be absorbed in the companies operating surplus and may well come out of corporate savings. Not surprisingly, our analysis concludes that GDP will be lower under the AIDS scenario than the no-AIDS scenario. Price pressure will pick up and with it pressure on interest rates.

LABOUR SUPPLY AND PRODUCTIVITY

The impact of AIDS will be reflected on the labour supply and productivity. The demographic analysis has shown that the infection rates among the South African workforce are higher than for the population as a whole. We can thus expect the labour force to be disproportionately affected by the epidemic. Here we are trying to model the effect of AIDS-related deaths across the various skills groups on overall labour supply. Any change to the overall labour supply in the economy will affect potential output (which is determined by labour and capital supply as well as technology). With unemployment in excess of 30%, South Africa is currently faced with a surplus labour situation. So, in theory, employees who die of AIDS-related causes can be easily replaced by the available pool of unemployed. However, while South Africa has a large pool of unskilled labour available, it already faces a labour shortage at the skilled and highly skilled level. At the higher skills levels, the replacement of employees who have died is more difficult. Since the withdrawal of one unit of highly skilled labour is expected to have a more negative impact on potential output we propose to make an adjustment to the labour supply numbers that accounts for the importance of skill. Assuming that the average wage is a reasonable proxy for skills, we weigh the units of labour by their wage rate relative to the economy-wide average so as to arrive at a weighted aggregate labour supply.

Labour supply is adversely affected by AIDS deaths ...

Figure 9 THE RATIO OF THE AVERAGE WAGE RATE OF SKILL CLASS TO THE ECONOMY-WIDE AVERAGE WAGE RATE

Highly skilled	Skilled	Semi & unskilled
1.91	1.07	0.65
Source: WEFA's 1997 Social Accounting Matrix		

Figure 9 suggests that highly skilled labour earns on average 1.91x more than the economy-wide average, while semi & unskilled only receives 65%. This set of assumptions generates the following impact on labour supply.

... with the loss of skilled employees weighing more

In the last column of Figure 10 it can be seen that in an AIDS scenario, the labour force is an average 10% lower than in a no-AIDS scenario between 2000-15. Values for the weighted labour supply under the AIDS scenario are shown in column 7. These will feed into the implicit production function of the macroeconometric model to determine forecasts for potential output. Moreover, we add the effect of productivity losses to the forecasts of efficiency units of labour rather than modelling productivity separately.

Figure 10 LABOUR FORCE IN AN AIDS AND NO-AIDS SCENARIO

	1 Highly with AIDS	2 Highly no AIDS	3 Skilled with AIDS	4 Skilled no AIDS	5 Semi & with AIDS	6 Unskilled no AIDS	7 Weighted total with AIDS	8 % difference compared to no-AIDS
2000	2,074,168	2,097,928	3,788,658	3,849,153	11,506,362	11,767,110	17,433,588	-1.6
2001	2,128,591	2,162,204	3,825,218	3,910,797	11,749,814	12,126,135	17,797,313	-2.2
2002	2,182,074	2,228,396	3,859,059	3,976,996	11,954,146	12,480,647	18,127,131	-3.0
2003	2,236,712	2,298,858	3,892,986	4,051,212	12,121,566	12,835,745	18,430,872	-3.9
2004	2,298,042	2,379,208	3,935,103	4,141,758	12,239,118	13,178,368	18,709,092	-5.0
2005	2,363,127	2,466,329	3,978,194	4,240,955	12,319,603	13,518,091	18,963,523	-6.2
2006	2,431,209	2,559,053	4,019,316	4,344,820	12,367,142	13,853,083	19,192,964	-7.5
2007	2,499,390	2,653,904	4,053,264	4,446,679	12,391,904	14,185,945	19,397,491	-8.9
2008	2,571,530	2,754,126	4,087,465	4,552,384	12,402,051	14,516,853	19,594,459	-10.2
2009	2,650,577	2,862,134	4,125,581	4,664,243	12,396,076	14,837,195	19,787,090	-11.5
2010	2,736,277	2,977,240	4,167,731	4,781,276	12,373,991	15,141,414	19,973,804	-12.8
2011	2,827,235	3,097,726	4,212,106	4,900,840	12,340,512	15,430,427	20,155,152	-14.0
2012	2,921,752	3,221,665	4,257,213	5,020,869	12,307,125	15,713,640	20,338,954	-15.1
2013	3,018,388	3,347,484	4,301,252	5,139,218	12,276,051	15,992,473	20,524,060	-16.2
2014	3,115,985	3,473,962	4,343,401	5,254,915	12,249,849	16,269,587	20,711,151	-17.2
2015	3,214,624	3,601,201	4,384,128	5,368,471	12,221,538	16,538,634	20,893,995	-18.1

Source: ASSA 600, version: November 1999 and 1996 Population census, WEFA

Labour supply will also be affected by the anticipated decline in labour productivity due to absenteeism especially once the patient is suffering from full-blown AIDS. We assume that full-blown AIDS spans the last two years of the HIV+ term.

Absenteeism drags down productivity

The proportion of a working year that is lost for a full-blown AIDS patient can range between 0-2 years, according to JT Cuddington (*Modelling the Macroeconomic Effects of AIDS, with an Application to Tanzania*; The World Bank Economic Review, vol.7, no.2). The reason for a proportion higher than 1 is that, in Cuddington's words, 'the loss may be not only in the AIDS victim's labour but also in the labour of others. For example, if a person who gets AIDS stops working immediately and that person's spouse must also stop working to provide full-time care, then the value could be 2'. However, these assumptions are drawn from experience in sub-Saharan Africa excluding South Africa in the early 1990s, where the medical care system may have been less sophisticated than is currently the case in South Africa. It thus seems reasonable to adopt a value lower than 1, such as 0.33, for our purposes. In other words, for every person with full-blown AIDS, four months of person-year equivalent labour supply will be lost. This set of assumptions generates the impact on labour supply (again weighted by skill) shown in Figure 11. The combined effect of the decline in labour supply due to AIDS deaths weighted by skills groups and to productivity losses is fed through to the production function in the WEFA macro model in order to forecast potential output.

Figure 11 LOSS OF LABOUR SUPPLY RESULTING FROM IMPACT OF AIDS ON LABOUR PRODUCTIVITY

	Full blown AIDS highly skilled	Full blown AIDS skilled	Full blown AIDS semi & unskilled	Weighted decline in labour units	AIDS scenario % difference compared to no-AIDS*
2000	13,554	35,941	165,218	57,454	-0.3
2001	17,648	47,058	218,064	75,542	-0.4
2002	22,192	59,509	277,030	95,727	-0.5
2003	26,946	72,652	337,980	116,723	-0.6
2004	31,558	85,495	395,818	136,845	-0.7
2005	35,669	97,007	445,668	154,433	-0.8
2006	38,998	106,352	484,044	168,250	-0.8
2007	41,421	113,169	509,528	177,779	-0.8
2008	43,002	117,604	522,721	183,245	-0.8
2009	43,886	120,048	525,758	185,343	-0.8
2010	44,228	120,949	521,468	184,950	-0.8
2011	44,182	120,760	512,806	182,968	-0.8
2012	43,889	119,890	502,165	180,154	-0.8
2013	43,468	118,688	491,279	177,086	-0.7
2014	43,037	117,480	481,248	174,196	-0.7
2015	42,605	116,273	471,217	171,306	-0.7

* % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

REMUNERATION COST INCREASES

It is expected that employers will need to adjust their contribution to pension, life and medical benefits upwards on account of the AIDS epidemic. In addition there may be indirect cost increases to account for, such as recruitment, additional sickness and compassionate leave, as well as costs of ensuring occupational health and safety standards, loss of turnover and profits due to the impact of AIDS on clients. We calculate the overall change in costs to the employer stemming from higher benefit contributions and other indirect costs according to the economy-wide relative importance of wages as a production input for 45 sectors in the South African economy.

Companies face higher direct and indirect costs ...

As a starting point, we propose to consider work done by the Metropolitan Employee Benefits unit on the cost of AIDS to companies. Metropolitan noted that 'the cost of an average set of benefits is expected to double for many schemes by 2005 and triple by 2010'. Where employers have full responsibility for the provision of benefits, Metropolitan projects that this could add around 15% to the remuneration costs of an average manufacturing company by 2005 and about 30% by 2010. Indirect costs, Metropolitan estimates, could add a further 10% and 15% respectively. We assume that employers are responsible for carrying two-thirds of the wage cost increases while, employees carry one third.

1. Higher wage cost passed on to consumer via PPI

It is conceivable that employers will not be able to pass on the full wage cost increase to customers in the form of higher prices. If we take Metropolitan's assumption for 2005 as a starting point and assume that the proportion of wage cost increases that can be passed on is 50% across all economic activities in South Africa (not just manufacturing), then the initial wage cost increase is 12.5% for that year. A doubling of the 2005 benefits bill, as suggested by Metropolitan, would result in a 22.5% wage bill increase by 2010. We propose to apply linear interpolation between 2000 and 2005 and between 2005 and 2010 and we keep the increase beyond 2010 constant.

... which will feed through to higher prices ...

Moreover, we exclude unskilled labour from the wage cost calculations as it is less likely that this skill category is covered by these benefits and few indirect costs will be incurred. We estimate the cost impact across sectors with an input-output model and then weigh them according to aggregate sectoral intermediate sales to arrive at an approximation for the change in PPI. This latter PPI forecast will feed into the macroeconometric model.

The results of our cost simulation and the estimates effect on PPI are shown in Figure 12.

Figure 12		DIRECT IMPACT OF AIDS ON WAGE COSTS (%)			
	Average Increase in wage bill** (1999 prices)	Initial increase in wage bill***	Employer passing on to customer†	Direct Impact on the economy- wide firm costs	Direct & indirect impact on PPI*
2000		7.1	2.4	0.3	0.7
2001		10.7	3.6	0.5	1.1
2002		14.3	4.8	0.7	1.4
2003		17.9	6.0	0.8	1.8
2004		21.4	7.1	1.0	2.1
2005	25.0	25.0	8.3	1.2	2.5
2006		29.0	9.7	1.4	2.9
2007		33.0	11.0	1.6	3.3
2008		37.0	12.3	1.8	3.7
2009		41.0	13.7	1.9	4.1
2010	45.0	45.0	15.0	2.1	4.5
2011		45.0	15.0	2.1	4.5
2012		45.0	15.0	2.1	4.5
2013		45.0	15.0	2.1	4.5
2014		45.0	15.0	2.1	4.5
2015		45.0	15.0	2.1	4.5

* % difference in index levels between Aids and no-Aids scenario, and not YoY growth rate differences
 ** Metropolitan projection
 *** Skilled and highly skilled only due to AIDs
 † 50% of two thirds of the increase in the wage bill of skilled and highly skilled labour

Source: WEFA

2. Higher wage cost financed from operating surplus

Since we assume that companies will only be able to pass on 50% of the wage cost increases to its customers, the remaining 50% can be assumed to be absorbed by the firm in the form of lower operating surpluses. The impact on gross operating surpluses is weighted by cost exposure across sectors, as in the previous section, and feeds directly into our macroeconomic framework as a reduction of overall gross operating surplus. The results are shown in Figure 13.

... or be absorbed by operating surpluses

Figure 13 DIRECT IMPACT OF AIDS ON OPERATING SURPLUS (%)				
	Average Increase in wage bill (1999 prices)**	Initial increase in wage bill***	Employer absorbing internally†	Direct Impact on economy-wide gross operating surplus *
2000		7.1	2.4	-1.5
2001		10.7	3.6	-2.3
2002		14.3	4.8	-3.1
2003		17.9	6.0	-3.8
2004		21.4	7.1	-4.6
2005	25.0	25.0	8.3	-5.4
2006		29.0	9.7	-6.2
2007		33.0	11.0	-7.1
2008		37.0	12.3	-7.9
2009		41.0	13.7	-8.8
2010	45.0	45.0	15.0	-9.7
2011		45.0	15.0	-9.7
2012		45.0	15.0	-9.7
2013		45.0	15.0	-9.7
2014		45.0	15.0	-9.7
2015		45.0	15.0	-9.7

* Real % difference in levels between AIDs and no-AIDS scenario, and not YoY growth rate differences
** Metropolitan projection
*** Skilled and highly skilled only due to AIDs
† 50% of two thirds of the increase in the wage bill of skilled and highly skilled labour

Source: WEFA

DEMAND CHANGES AMONG HOUSEHOLDS

The AIDS epidemic affects household demand through three distinct channels:

1. lower wage income especially among the skilled and highly skilled who absorb some of the higher healthcare and other benefit schemes;
2. lower overall population numbers which affect the distribution of household income and thus demand;
3. the higher need for healthcare, which diverts fund away from other expenditure categories.

We model each of these effects separately and then aggregate the results.

1. AIDS costs absorbed by employee via lower wage income

We argued above that two thirds of the higher wage bill due to costs related to HIV/AIDS will be borne by the employer who either passes it on through higher prices or absorbs it from the operating surplus. The remaining third of the higher costs may well be borne by the employee (skilled and highly skilled) and translate into lower labour income for these skills groups across sectors. Column 1 in Figure 14 shows the drop in wage income for the skilled and highly skilled, who benefit from health and pension schemes, which could be expected to be as much as 15% by 2010. If translated into a change in wage income for the economy as a whole, the effect is obviously less dramatic. Nevertheless, wage income is still expected to be almost 6% lower than in the no-AIDS scenario by 2010.

Wage income is expected to fall ...

We are trying to assess in addition, what effect the lower wage income for the higher skills groups will have on economy-wide demand patterns. For that purpose, we use a WEFA model based on income distribution patterns from the 1995 October Household Survey (OHS). We first analyse the impact of the lower wage income for the skilled and the highly skilled on household income. The households that are dependent on skilled or highly skilled income earners may be the most adversely affected. We then feed the lower wage income profile by household income classes through the income distribution model to assess the change in demand composition across the various expenditure categories. When we compare the effect of lower wage income to a no-AIDS scenario, we observe that the drop in wage income does affect all expenditure categories. However, demand for services, durables and savings suffer the most under these conditions. We incorporate this first order effect of lower wage incomes in the macro-model.

Figure 14 CHANGE IN DEMAND ASSOCIATED WITH THE LOWER LABOUR INCOME IN THE AIDS SCENARIO (%)

	Ch in wage Inc of skilled and highly skilled labour*	Ch in economy- wide wage income*	Ch in demand for residential buildings*	Ch in demand for durables*	Ch in demand for semi- durables	Ch in demand for non-durables*	Ch in demand for services*	Ch in savings*
2000	-2.4	-1.5	-0.9	-1.3	-1.2	-0.6	-1.1	-1.4
2001	-3.6	-2.2	-1.3	-2.0	-1.8	-1.0	-1.8	-2.1
2002	-4.8	-2.9	-1.8	-2.8	-2.4	-1.3	-2.8	-3.1
2003	-6.0	-3.7	-2.2	-3.5	-3.0	-1.6	-3.4	-3.9
2004	-7.1	-4.4	-2.6	-4.2	-3.5	-1.9	-4.2	-4.8
2005	-8.3	-5.1	-3.1	-5.0	-4.2	-2.3	-5.1	-5.7
2006	-9.7	-6.0	-3.7	-5.8	-4.9	-2.7	-6.0	-6.7
2007	-11.0	-6.8	-4.3	-6.7	-5.7	-3.1	-6.8	-7.7
2008	-12.3	-7.6	-4.8	-7.6	-6.5	-3.5	-7.7	-8.7
2009	-13.7	-8.4	-5.3	-8.9	-8.1	-4.1	-8.9	-10.4
2010	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2011	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2012	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2013	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2014	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6
2015	-15.0	-9.2	-5.7	-9.2	-8.0	-4.2	-9.3	-10.6

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

2. Lower population resulting in changing household demand

The wage income effect on household demand cannot be seen in isolation, however. The population developments noted in the first part of the report will have some implications for consumption patterns as well. One can probably assume that the epidemic does not initially affect the distribution of income among earners in the context of a labour surplus economy, as each time an income earner dies he/she is replaced by another. However, the epidemic will affect income distribution within households, as it will result in a decrease in the number of individuals per household while total economy-wide income earned remains constant. The effect of this is an initial increase in per capita income of households. Note, this does not translate into higher disposable incomes, as will be explained later.

*... but lower
population numbers
might initially raise
household incomes*

In order to determine the potential effect of the falling population on household demand, we employ again the WEFA income distribution model. We isolate the population impact of AIDS on income distribution by separately running an AIDS and no-AIDS scenario and compare the resulting income distributions of the two scenarios. All other economic variables are kept constant, ie, it is only population growth that differs. A comparison of consumption patterns then reveals that as income per household moves up under the AIDS scenario, one can expect a shift away from non- and semi-durables towards durables and services as the latter constitute a higher proportion of high-income household expenditure. For the

same reason one could also expect a lower demand for residential buildings, which by 2009, could be almost 2.5% lower than in the no-AIDS scenario.

Figure 15 CHANGE IN DEMAND ASSOCIATED WITH THE LOWER POPULATION IN THE AIDS SCENARIO

(%)	Residential*	Durables*	Semi-durables*	Non-durables*	Services*	Savings*
2000	-0.2	0.0	-0.1	-0.3	0.0	0.0
2001	-0.2	0.0	-0.1	-0.4	0.0	0.1
2002	-0.3	0.2	-0.1	-0.5	0.4	0.4
2003	-0.5	0.2	-0.1	-0.7	0.4	0.6
2004	-0.7	0.3	-0.2	-1.1	0.7	0.9
2005	-1.0	0.4	-0.4	-1.5	1.0	1.2
2006	-1.3	0.5	-0.5	-1.9	1.3	1.6
2007	-1.6	0.6	-0.6	-2.4	1.6	1.9
2008	-2.0	0.8	-0.7	-3.0	1.8	2.3
2009	-2.2	0.8	-0.8	-3.3	2.1	2.6
2010	-2.4	0.9	-0.9	-3.6	2.3	2.8
2011	-2.6	1.0	-1.0	-3.9	2.5	3.1
2012	-2.8	1.1	-1.0	-4.2	2.7	3.4
2013	-3.0	1.2	-1.1	-4.5	3.0	3.6
2014	-3.2	1.3	-1.2	-4.8	3.2	3.9
2015	-3.4	1.4	-1.3	-5.1	3.4	4.2

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

3. Increased demand for health services

The demand picture would be incomplete without taking into account a higher demand for health care. Presumably, part of the higher wage costs, which are either passed on by the employers eventually resulting in a higher PPI, or they are absorbed by the employers as lower operating surplus or by employees as lower labour income, are used to contract in a range of health and other services. We assume that at least 25% of the higher cost to the private sector (employer and employees) will be spent on health-related services. As a result, we find that demand for health services could be over 11% higher by 2010 than in a no-AIDS scenario.

Demand will shift to health services

Figure 16 CHANGE IN DEMAND FOR HEALTH AND RELATED SERVICES ASSOCIATED WITH HIGHER WAGE COSTS

%ch in demand for health related services*	
2000	1.8
2001	2.7
2002	3.6
2003	4.5
2004	5.4
2005	6.3
2006	7.3
2007	8.3
2008	9.4
2009	10.4
2010	11.4
2011	11.4
2012	11.4
2013	11.4
2014	11.4
2015	11.4

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences

Source: WEFA

We add this higher demand for health services to the change in demand from services resulting from the previous assumptions (lower wage income and lower population). The net effect of all three demand-assumptions is shown below and will be used in the macroeconomic model. We find that the net impact on household demand of the three effects described above is negative. All expenditure categories are expected to be down with the exception of services, which are boosted by the higher demand for health-related services. Maybe not surprisingly, it is the spending on semi-durables and durables as well as residential buildings that suffer the most. The fall in demand for savings trails behind, probably as a result of the already low household savings rate.

Figure 17 NET CHANGE IN HOUSEHOLD DEMAND						
	%ch in demand for residential*	%ch in demand for durables*	%ch in demand for semi-durables*	%ch in demand for non-durables*	%ch in demand for services*	%ch in demand for savings*
2000	-1.1	-1.3	-1.2	-0.9	0.6	-1.3
2001	-1.6	-2.0	-1.9	-1.3	1.0	-2.0
2002	-2.1	-2.6	-2.5	-1.8	1.2	-2.7
2003	-2.7	-3.3	-3.2	-2.4	1.5	-3.3
2004	-3.3	-3.9	-3.8	-3.0	1.9	-3.9
2005	-4.1	-4.6	-4.6	-3.8	2.3	-4.5
2006	-5.0	-5.3	-5.4	-4.6	2.7	-5.1
2007	-5.9	-6.1	-6.3	-5.6	3.1	-5.7
2008	-6.8	-6.8	-7.2	-6.5	3.5	-6.4
2009	-7.5	-8.0	-8.9	-7.3	3.6	-7.9
2010	-8.1	-8.3	-8.9	-7.8	4.4	-7.8
2011	-8.3	-8.2	-9.0	-8.1	4.6	-7.5
2012	-8.5	-8.1	-9.1	-8.4	4.8	-7.3
2013	-8.7	-8.0	-9.1	-8.7	5.0	-7.0
2014	-8.9	-7.9	-9.2	-9.0	5.3	-6.7
2015	-9.1	-7.8	-9.3	-9.3	5.5	-6.5

* % difference in constant price levels of AIDS and no-AIDS scenarios; not YoY growth rate differentials

Source: WEFA

HIGHER GOVERNMENT EXPENDITURE

The medical costs for treatment of AIDS discussed in the previous sections relate to the highly skilled and skilled labour force. Medical costs of other AIDS patients are assumed to be carried by the public sector. Given the number of patients with full-blown AIDS for the economically active (by skill class) and non-economically active population we can proceed by calculating the costs to the public sector. Conservative official estimates being muted are that the public sector currently spends between R3,000 and R4,500 per AIDS patient per year. This would result in annual increases in health spending in excess of R4bn by 2008.

While we use this number in our analysis, it is important to note that there are no reliable estimates available. Additionally, it is also naïve to assume, as we do, that the pattern of AIDS-related government expenditure will not change over the next 15 years. However, in the absence of reliable data and projections we have little choice but to assume a constant cost profile. As mentioned before, the significance of this analysis lies in identifying the potential ripple effects of certain assumptions.

The results are shown in Figure 18.

Medical costs are expected to push up the deficit

Figure 18 DIRECT IMPACT OF AIDS ON GOVERNMENT CURRENT EXPENDITURE				
	Full blown AIDS total population (1)	Full blown AIDS highly skilled & skilled (2)	Full blown AIDS for which govt responsible (1-2)	Government health expenditure at R3,750 per patient per year (Rm)
2000	447,550	49,494	398,056	1,493
2001	569,686	64,706	504,980	1,894
2002	702,310	81,702	620,608	2,327
2003	837,075	99,598	737,477	2,766
2004	963,768	117,053	846,715	3,175
2005	1,072,597	132,676	939,921	3,525
2006	1,156,543	145,350	1,011,193	3,792
2007	1,212,802	154,589	1,058,212	3,968
2008	1,242,806	160,605	1,082,201	4,058
2009	1,251,038	163,934	1,087,104	4,077
2010	1,243,376	165,177	1,078,199	4,043
2011	1,225,693	164,941	1,060,751	3,978
2012	1,202,978	163,779	1,039,199	3,897
2013	1,179,002	162,156	1,016,846	3,813
2014	1,156,343	160,517	995,825	3,734
2015	1,133,683	158,878	974,805	3,656

Source: WEFA

There are several ways in which this expenditure can be financed.

- Expenditure switching within the health department or by sacrificing other current expenditure.
- Expenditure switching by forfeiting public sector capital expenditure.
- Higher budget deficit.

The first two options are difficult to model at the macro level. Unless a significant channel can be established that handles the long-term macroeconomic effect of lower current expenditure on, say, housing and education to off-set the higher expenditure on health on macro level productivity, the net macro effect is relatively small as it involves compositional changes. Similarly, forfeiting public sector capital expenditure has a long-term productivity effect, but this requires an independent modelling exercise that is based on a wide range of macroeconomic assumptions. At this stage the most practical approach is to ignore macro effects of expenditure switching and to focus on higher budget deficits as our baseline scenario. The higher health spending by the government is thus used as an assumption in the macro-modelling, which will then have economy-wide demand and crowding-out effects.

SUMMARY OF ASSUMPTIONS

The assumptions discussed above can be summarised in Figure 19 and are fed into the WEFA long term macroeconometric model.

Figure 19 SUMMARY OF MACROECONOMIC AIDS ASSUMPTIONS

	%ch in demand for residential* (%)	%ch in demand for durables* (%)	%ch in demand for semi- durables* (%)	%ch in demand for non- durables* (%)	%ch in demand for services* (%)	%ch in savings* (%)	%ch in labour supply* (%)	%ch in PPI* (%)	%ch in GOS* # (%)	Abs ch in govt curr exp (Rm)
2000	-1.1	-1.3	-1.2	-0.9	0.6	-1.3	-1.8	0.7	-1.5	1,493
2001	-1.6	-2.0	-1.9	-1.3	1.0	-2.0	-2.5	1.1	-2.2	1,894
2002	-2.1	-2.6	-2.5	-1.8	1.2	-2.7	-3.4	1.4	-2.9	2,327
2003	-2.7	-3.3	-3.2	-2.4	1.5	-3.3	-4.6	1.8	-3.7	2,766
2004	-3.3	-3.9	-3.8	-3.0	1.9	-3.9	-6.1	2.1	-4.4	3,175
2005	-4.1	-4.6	-4.6	-3.8	2.3	-4.5	-7.7	2.5	-5.1	3,525
2006	-5.0	-5.3	-5.4	-4.6	2.7	-5.1	-9.6	2.9	-6.0	3,792
2007	-5.9	-6.1	-6.3	-5.6	3.1	-5.7	-11.6	3.3	-6.8	3,968
2008	-6.8	-6.8	-7.2	-6.5	3.5	-6.4	-13.7	3.7	-7.6	4,058
200	-7.5	-8.0	-8.9	-7.3	3.6	-7.9	-15.6	4.1	-8.4	4,077
2010	-8.1	-8.3	-8.9	-7.8	4.4	-7.8	-17.6	4.5	-9.2	4,043
2011	-8.3	-8.2	-9.0	-8.1	4.6	-7.5	-19.5	4.5	-9.2	3,978
2012	-8.5	-8.1	-9.1	-8.4	4.8	-7.3	-21.4	4.5	-9.2	3,897
2013	-8.7	-8.0	-9.1	-8.7	5.0	-7.0	-23.2	4.5	-9.2	3,813
2014	-8.9	-7.9	-9.2	-9.0	5.3	-6.7	-25.0	4.5	-9.2	3,734
2015	-9.1	-7.8	-9.3	-9.3	5.5	-6.5	-26.7	4.5	-9.2	3,656

* Real % difference in levels between AIDS and no-AIDS scenario, and not YoY growth rate differences
Gross operating surplus
Source: WEFA

In summary, compared with a no-AIDS scenario, an AIDS scenario will be characterised by a lower population and labour supply. This will have a negative effect on demand, although unemployment may also decline. The initial effect of lower demand in our assumptions is reflected in the lower expenditure on all categories other than services, which incorporates higher health spending.

THE METHODOLOGY AND THE MODEL USED

The net impact of the often counterbalancing effects of the AIDS epidemic were explored with WEFA's annual macroeconomic modelling framework.

Our first step was to create a no-AIDS reference scenario, which is characterised by higher population and a higher labour force. We used the ASSA model's demographic forecasts for population and labour force (see first sections of the report) and to add estimated AIDS deaths back into the population and labour force numbers and adjust for fertility and mortality changes.

The model itself was designed primarily for the purposes of long-term (up to 20 year) forecasts of the South African economy. A forecast of the level of economic activity as measured by gross domestic product (GDP) is driven by two basic components: the first is the rate of use of existing resources and technologies. This component is the focus of short-run macroeconomic fluctuations. Such projections primarily involve forecasting changes in the level of aggregate demand and the subsequent split between output changes and price changes given the current economic environment. The second component is the rate of expansion of the country's resource and technology base of the economy, which is the focus of long-run economic growth (aggregate supply) analysis.

WEFA's long-term macromodel is a blend of these two approaches. In the first few years of the outlook period, the results are dominated by aggregate demand projections, since both the resource and technology bases are relatively constant. The second part of the long-term forecast, which comprises the period 2002 to 2015, is dominated by supply factors such as population growth, labour force participation and productivity growth. Fiscal policy, monetary policy, regional trade and the projected degree of international economic integration are also incorporated into the long-term forecast.

There are two basic types of long-term scenarios: trend and cycle. The WEFA long-term forecast is a trend forecast. The principal characteristic of a trend scenario is the absence of any business cycle. It is not our belief that business cycles will never occur. Rather, the perspective is that business cycle turning points, far into the future, are virtually impossible to predict accurately. Historically, cycles have often been generated by random events, such as oil shocks, wars and natural disasters.

A trend scenario assumes that the real economy grows at historical averages in relation to population growth and other factors, as indicated previously. A trend forecast does not represent the economy as growing at a 'full employment' path, but rather as growing with a certain amount of slack. In a sense, the trend forecast represents the average growth of the economy over the business cycles. The advantage of a trend forecast is that it reflects supply factors. The reason a trend forecast is used in business planning is that it allows a business to comprehend how the evolution of the economy will affect it without the noise of the business cycle obscuring the fundamentals of growth.

The broad structure of the model may be described as that of a full supply-demand econometric model which is derived from economic theory on the one hand and will have the flexibility to incorporate short-run adjustments and technological constraints on the other. These supply elements consist of a measure of potential output which, in conjunction with the expenditure-determined total output, provides a measure of economy-wide capacity utilisation. The latter then serves as a variable supply constraint in the determination of imports, investment, prices and wages.

The model was estimated with Ordinary Least Squares (except for some equations where Cochrane-Orcutt adjustments were used), using annual data. The period of estimation varied between 1960 to 1998 depending on data availability and other concerns. The model consists of 90 equations, of which 23 are behavioural equations and 67 technical relations and identities. Some 49 variables are treated as assumptions.

The model consists of the following sectors:

1. The demand side

- private consumption expenditure
- investment (fixed and inventory)
- imports, exports and the balance of payments
- government sector

2. The supply side.

3. Employment, potential output and capacity utilisation.

4. Prices and wages.

5. Monetary sector.

RESULTS OF THE MACRO-MODELLING

With the assumptions and the modelling framework in place we can now turn our attention to the results. The results are summarised by means of deviations from the no-AIDS baseline.

Figure 20 THE IMPACT OF AIDS ON GDP AND COMPONENTS OF CONSUMPTION EXPENDITURE

	Real GDP*	Growth	Real household disposable inc*	Growth	Real % consumption expenditure*	Growth
	(%)	(% point diff)**	(%)	(% point diff)**	(%)	(% point diff)**
2000	0.7		-1.0		-0.6	
2001	-1.0	-0.3	-1.3	-0.4	-0.8	-0.3
2002	-1.2	-0.2	-1.7	-0.5	-1.2	-0.4
2003	-1.4	-0.2	-2.1	-0.4	-1.5	-0.3
2004	-1.6	-0.2	-2.4	-0.4	-1.9	-0.4
2005	-1.9	-0.3	-2.8	-0.4	-2.4	-0.5
2006-2010	-3.1	-0.4	-4.4	-0.6	-4.7	-0.8
2011-2015	-4.7	-0.3	-5.8	-0.2	-8.4	-0.8

* Real % difference between AIDS and no-AIDS scenarios, not YoY growth rate differences

** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

Given the assumptions that we have outlined above, AIDS is expected to have a negative impact on GDP. In 2006-2010, constant price GDP in the AIDS scenario will be an annual average 3.1% lower than in the no-AIDS baseline; in 2011-15, it is expected to be 4.7% lower on an annual average basis. In constant 1995 terms, GDP would be R12.5bn below its no-AIDS level by 2005 and R41bn by 2015. GDP growth rates are expected to be 0.4 percentage points lower in 2006-10 and 0.3 percentage points in 2011-15. This is mainly the result of the lower household income assumption, which translates into lower disposable incomes and lower consumption expenditure, as can be seen in the remaining columns of Figure 20. In constant 1995 rand terms, this would also mean that real disposable income would be R20bn lower by 2005 and R40bn lower by 2015 than in the no-AIDS scenario. The higher anticipated demand for health services is insufficient to pull consumption growth back into the positive category – but at least it helps to dampen the negative effect. It is important to note that, on average over the period, the decline in consumption expenditure is less than the decline in disposable income, so that household savings will be declining in the AIDS scenario.

GDP and growth will be lower due to lower consumption ...

Capacity utilisation is helped by the lower labour supply and labour productivity. This reduces the gap between potential and actual output and induces firms to invest more in capital. As a result, total fixed investment in constant rand terms and its YoY real growth relative to the no-AIDS baseline is only marginally affected, as the drop in demand for residential buildings that we assume following the income and expenditure analysis is counterbalanced by the switching of some firms to more capital intensive production methods. In fact, as can be seen in Figure 21, column 5, GDFI can even be expected to increase as a percentage of GDP.

... while investment holds up fairly well

Figure 21 THE IMPACT OF AIDS ON SELECTED INVESTMENT DEMAND COMPONENTS OF GDP

	Real fixed inv: residential* (%)	Growth (% point diff)**	GDFI* (%)	Growth (% point diff)**	GDFI/GDP (% point diff)**	Capacity utilisation (% point diff)**	Inventories (diff in levels) (Rm)
2000	-1.1		-1.3		-0.2	-0.1	-2,245
2001	-1.5	-0.4	-1.4	-0.1	-0.1	-0.2	-130
2002	-2.2	-0.7	-1.3	0.1	-0.1	-0.1	-698
2003	-2.6	-0.4	-1.1	0.2	0.0	-0.1	-935
2004	-3.3	-0.7	-1.0	0.2	0.0	0.0	-852
2005	-4.1	-0.8	-0.9	0.1	0.1	0.1	-1,116
2006-2010	-6.6	-0.9	-1.2	-0.1	0.3	0.0	-4,014
2011-2015	-8.7	-0.2	-1.1	0.0	0.7	0.0	-4,676

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences

** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

The decline in the demand for labour, is expected to be faster than the slowdown in GDP. However, with the supply of labour falling even more, the unemployment rate is set to decline marginally in the AIDS scenario.

Government current expenditure in constant rand prices as well as in terms of YoY growth is expected to drop less than GDP because of the additional expenditure on health and related services which is set to rise with more AIDS patients. However, government current revenue will decline with economic activity. Consequently, AIDS will create pressure on the budget deficit on two fronts: higher health expenditure and lower revenues which is not counterbalanced sufficiently by expenditure declines linked to lower economic activity. We have here assumed a flexible budget deficit. If we were to assume stringent fiscal discipline in line with the medium-term budget framework, government expenditure would have to decline more or less in line with government revenue, which will cause GDP to decline even more than is forecast in our baseline case. This, in turn, would cause government revenue to decline further, dragging down GDP with it – a process that can be referred to as the pro-cyclical effects of fiscal discipline. The flexible budget deficit, which we assume in our baseline case, prevents this downward spiral, at the expense of a higher public sector borrowing requirement (about 1% higher as a percentage of GDP than the no-AIDS scenario) and lower government savings (see Figure 22).

The fiscal deficit deteriorates not only due to higher expenditure but also lower revenue

Figure 22 THE IMPACT OF AIDS ON GOVERNMENT FINANCES

	Government consump expen* (%)	Growth (% point diff)**	Government revenue* (%)	Growth (% point diff)**	Public sector deficit/GDP (% point diff)**
2000	-1.3		-0.7		-0.2
2001	-1.2	0.1	-0.8	-0.2	-0.3
2002	-1.2	0.1	-0.9	-0.3	-0.3
2003	-1.1	0.1	-1.2	-0.2	-0.4
2004	-1.0	0.1	-1.4	-0.2	-0.5
2005	-1.0	0.1	-1.6	-0.2	-0.6
2006-2010	-1.1	-0.1	-2.6	-0.4	-0.8
2011-2015	-2.0	-0.2	-4.1	-0.2	-0.9

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences

** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

As described above, the AIDS epidemic will result in lower disposable incomes that are not matched fully by lower consumption expenditure. This will have a negative effect on household savings, as presented in the table below. Public sector savings will also be adversely affected by the higher public sector borrowing requirement. Furthermore, corporate savings will suffer as some of the higher wage bill faced by employers will be financed out of the operating surplus and savings. Total domestic savings as a percentage of GDP is thus forecast to be on average about 2 percentage points lower than in a no-AIDS scenario. This means that South Africa's savings rate is unlikely to top the 20% of GDP level required to accelerate trend growth. This highlights an important potential problem area for the South African economy: as domestic savings are already low and presenting a real capital constraint to the economy, any further deterioration in the formation of savings will lower the country's investment potential.

Domestic savings will suffer across the board ...

In our analysis, some of the decline in savings (in constant rand terms) will be matched by lower real investment. The switching of companies away from labour towards more capital-intensive means of production will be more than compensated by a reduction in demand for residential buildings, leaving overall investment lower. Nevertheless, the remainder of the fall in savings will have to be made up by foreign savings – most likely in the form of foreign loans and a widening current account deficit. If foreign funding is unavailable, however, to plug the savings-investment gap, the higher investment demand will translate into heightened upward pressure on interest rates, further slowing the economy.

... and will need to be made up by foreign savings -

Figure 23 THE IMPACT OF AIDS ON COMPONENTS OF DOMESTIC SAVINGS						
	Private* (%)	Public* (%)	Corporate* (%)	Total domestic savings* (% point diff)**	GDS/GDP (%)	Total savings = Investment (%)
2000	-7.4	-5.8	-27.8	-10.4	-1.4	-3.7
2001	-16.1	-9.2	-17.7	-10.4	-1.5	-1.4
2002	-33.3	-11.1	-3.7	-7.7	-1.1	-1.7
2003	-31.7	-13.7	-4.6	-9.9	-1.3	-1.7
2004	-32.4	-16.5	-2.7	-11.1	-1.5	-1.5
2005	-30.6	-19.1	-1.7	-12.2	-1.7	-1.5
2006-2010	-32.9	-23.2	-2.9	-14.8	-2.1	-2.3
2011-2015	-23.6	-22.7	-7.1	-15.0	-2.2	-1.9

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences
 ** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

Following on from the need for foreign savings in the form of foreign currency loans, resultant higher net factor payments will lead to a widening current account deficit. This is despite an expected improvement in the trade balance. With lower domestic activity, producers are diverted to international markets, while imports will decline on account of lower domestic demand. On average over our forecast horizon, the current-account deficit as percentage of GDP would be about 2 percentage points higher than in a no-AIDS case. This would push the overall current-account deficit closer to 3% of GDP – a less comfortable deficit level than the present 1-1.5%.

... which will lead to a higher current-account deficit

Figure 24 THE IMPACT OF AIDS ON SELECTED TRADE AND THE CURRENT ACCOUNT

	Exports*	Growth	Imports*	Growth	Current account/ GDP
	(%)	(% point diff)**	(%)	(% point diff)**	(% point diff)**
2000	0.1		-0.4		-1.4
2001	0.2	0.1	0.0	0.4	-1.0
2002	0.2	0.1	-0.1	-0.2	-1.2
2003	0.3	0.1	0.1	0.2	-1.4
2004	0.4	0.1	0.1	0.0	-1.7
2005	0.4	0.1	0.0	-0.1	-1.7
2006-2010	0.6	0.1	-1.1	-0.3	-2.4
2011-2015	0.8	0.0	-3.1	-0.5	-2.4

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences

** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

The upward pressures on the PPI are largely responsible for an anticipated increase in the overall CPI inflation rate by an annual average 0.4 percentage points in 2006-2010 compared to the no-AIDS baseline. The overall effect on the CPI has been muted by the slowdown in domestic demand. Nevertheless, given the policy focus on inflation targeting, the higher CPI will translate into some upward pressure on interest rates. We would expect the prime lending rate to be less than 0.5 percentage points higher per year. But this slightly higher interest rate outlook is also one of the reasons why investment is slowing.

A higher CPI will put some pressure on interest rates and the exchange rate

The higher CPI profile will also have some negative repercussions for the nominal exchange rate. If we assume the real effective exchange rate constant throughout the period of observation, we would expect the nominal trade weighted rand exchange rate to depreciate pretty much in line with inflation differentials.

Figure 25 THE IMPACT OF AIDS ON SELECTED FINANCIAL VARIABLES AND EMPLOYMENT

	CPI*	Inflation rate	Prime Interest rate	Trade weighted nominal exchange rate*	Employment*	Unemployment rate
	(%)	(% point diff)**	(% point diff)**	(%)	(%)	(% point diff)**
2000	0.4		-0.2	-0.4	-1.1	-0.2
2001	0.7	0.7	0.0	-0.7	-1.5	-0.3
2002	1.3	0.2	0.0	-1.3	-2.1	-0.3
2003	1.4	0.4	0.0	-1.4	-2.8	-0.4
2004	1.9	0.3	0.1	-1.8	-3.7	-0.5
2005	2.2	0.4	0.2	-2.1	-4.7	-0.6
2006-2010	3.2	0.4	0.3	-3.0	-8.3	-0.9
2011-2015	4.3	-0.1	0.6	-3.9	-14.1	-1.2

* Real % difference between AIDS and no-AIDS scenario, not YoY growth rate differences

** Difference between the YoY rates in the AIDS and no-AIDS scenario

Source: WEFA

SECTORAL RISK EXPOSURE

Given the absence of any requirement of disclosure, very little actual information is available dealing with company or sectoral infection profiles and response strategies. From our analysis, however, we can identify two key areas of risk to sectors due to AIDS:

1. An exposure of sectors to infection risk
2. An exposure of sectors to higher skills groups and thus higher costs associated with AIDS

We propose to combine the two issues into a sector risk ranking. First, we calculated sectoral infection rates and ranked these. Secondly, we compiled the percentage of the total wage bill of highly skilled and skilled workers and ranked those. We applied a weighting of the ranks of 60% for the exposure to infections and 40% for the exposure to remuneration for the higher skilled. The final ranking gives us a sectoral rating that reflects the relative risk exposure to the AIDS epidemic.

We compiled a sectoral risk ranking

SECTORAL INFECTION RATES

From our demographic modelling, we were able to overlay our forecasts of population and age groups as well as skill levels on sectoral data from the population census to arrive at infection rates and AIDS death variables for selected sectors in the South African economy. It is important to bear in mind that the calculation of sectoral infection and death rates is a very mechanical process and should be viewed as a framework for assessing relative rather than absolute sectoral risk exposure to the AIDS epidemic.

Infection risk is one factor

No special assumptions have been made to adjust the risk profile of any population group, skill group or sector. For example, mineworkers have not been assigned a higher HIV+ infection rate because they may or may not be more exposed to the 'PRO' group as noted in Figure 3. Similarly, no special assumptions have been made in respect of transport or health workers.

Figure 26 HIV+ PER 100 WORKERS				
	2000	2005	2010	2015
Agriculture, forestry and fishing	17.3	23.2	23.2	21.8
Mining	24.1	29.3	26.4	24.4
Consumer manufacturing	17.3	23.0	22.9	21.3
Forestry products	15.2	20.2	19.8	18.6
Chemicals	16.6	21.6	20.7	19.3
Metals	15.0	19.9	19.3	17.8
Machinery	15.9	21.2	20.8	19.5
Construction	18.2	23.9	23.4	22.1
Retail	16.2	21.3	20.7	19.3
Catering and accommodation	17.9	23.0	22.2	20.8
Transport and storage	18.5	23.5	22.0	20.2
Communication	12.1	16.5	16.3	15.3
Finance and insurance	8.9	12.4	12.5	11.7
Business services	11.9	15.6	15.1	14.3
Health	14.9	20.0	19.0	16.6
General government	17.2	24.5	26.0	26.1

Source: WEFA

Figure 27

AIDS DEATHS PER 100 WORKERS

	2000	2005	2010	2015
Agriculture, forestry and fishing	0.6	1.7	2.4	2.2
Mining	0.8	2.5	3.0	2.7
Consumer manufacturing	0.6	1.8	2.5	2.4
Forestry products	0.5	1.6	2.1	2.0
Chemicals	0.6	1.8	2.4	2.2
Metals	0.5	1.6	2.1	2.0
Machinery	0.5	1.6	2.1	1.9
Construction	0.5	1.7	2.2	2.1
Retail	0.6	1.8	2.3	2.1
Catering and accommodation	0.6	2.0	2.5	2.3
Transport and storage	0.4	1.3	1.7	1.7
Communication	0.3	0.9	1.2	1.2
Finance and insurance	0.4	1.1	1.5	1.4
Business services	0.6	1.9	2.5	2.2
Health	0.4	1.3	1.7	1.6
General government	0.4	1.0	1.4	1.4

Source: WEFA

Figure 28

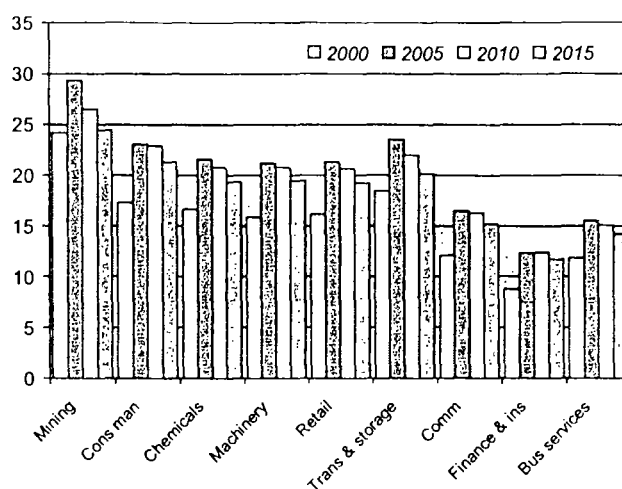
AIDS DEATHS PER 100 NORMAL DEATHS

	2000	2005	2010	2015
Agriculture, forestry and fishing	103.9	342.4	489.0	503.9
Mining	174.7	560.3	741.2	759.2
Consumer manufacturing	164.9	545.2	804.3	867.2
Forestry products	125.5	415.5	596.0	636.6
Chemicals	130.6	432.9	605.9	632.5
Metals	123.5	417.6	612.2	658.4
Machinery	116.6	389.2	542.3	563.6
Construction	142.7	470.5	662.7	694.6
Retail	188.9	605.6	836.2	876.4
Catering and accommodation	128.5	424.4	584.8	601.9
Transport and storage	117.4	403.5	598.8	652.6
Communication	93.8	322.8	484.0	528.4
Finance and insurance	99.4	324.4	454.3	479.6
Business services	162.8	557.5	784.6	788.8
Health	96.1	323.5	457.5	471.9
General government	74.3	191.0	239.1	229.1

Source: WEFA

Figure 29

HIV+ PER 100 WORKERS FOR SELECTED SECTORS AND YEARS



Source: WEFA

The figures above highlight the risk exposure of the mining sector, where infections peak at above 29% and deaths at 3 out of 100 workers. The reason is that mine workers are mainly black, male and generally fall into those age groups that are relatively more at risk. The possibility that mine workers are more in contact with high risk groups such as PRO is not accounted for at this stage. As a result, the actual infection rates in the mining sector are likely to be even higher.

The mining sector is followed closely by the general government sector, where infections peak at over 26%. Agriculture, manufacturing, machinery, construction, retail, catering and accommodation and transport and storage are all expected to record infection rate peaks above 20%. However, even sectors such as finance and insurance or business services, which draw on a high proportion of skilled and highly skilled employees, are still expected to face infection rates in excess of 10%. The ranking of sectors by infection rate is given below.

Figure 30

HIV+ PER 100 WORKERS

	2000	Rank
Finance and insurance	8.9	1
Business services	11.9	2
Communication	12.1	3
Health	14.9	4
Metals	15.0	5
Forestry products	15.2	6
Machinery	15.9	7
Retail	16.2	8
Chemicals	16.6	9
General government	17.2	10
Consumer manufacturing	17.3	11
Agriculture, forestry and fishing	17.3	12
Catering and accommodation	17.9	13
Construction	18.2	14
Transport and storage	18.5	15
Mining	24.1	16

Source: WEFA

SECTORAL REMUNERATION COSTS

If we look at the composition of sectoral wage bills, we find, not surprisingly, that service industries, such as finance and business services, are the most skills-intensive, while mining and manufacturing feature at the opposite end of the spectrum.

Potential wage costs are another consideration

Figure 31 % OF SKILLED & HIGHLY SKILLED OF WAGE BILL		
	1997	Rank
Agriculture, forestry and fishing	15.2	1
Mining	34.5	2
Construction	36.5	3
Consumer manufacturing	42.9	4
Metals	50.7	5
Machinery	56.2	6
Chemicals	65.7	7
Forestry products	65.8	8
Transport and storage	78.1	9
Retail	81.7	10
Communication	85.9	11
Catering and accommodation	88.8	12
General government	91.1	13
Health	97.2	14
Business services	98.2	15
Finance and insurance	98.8	16

Source: WEFA; OHS 1995, Population Census 1996

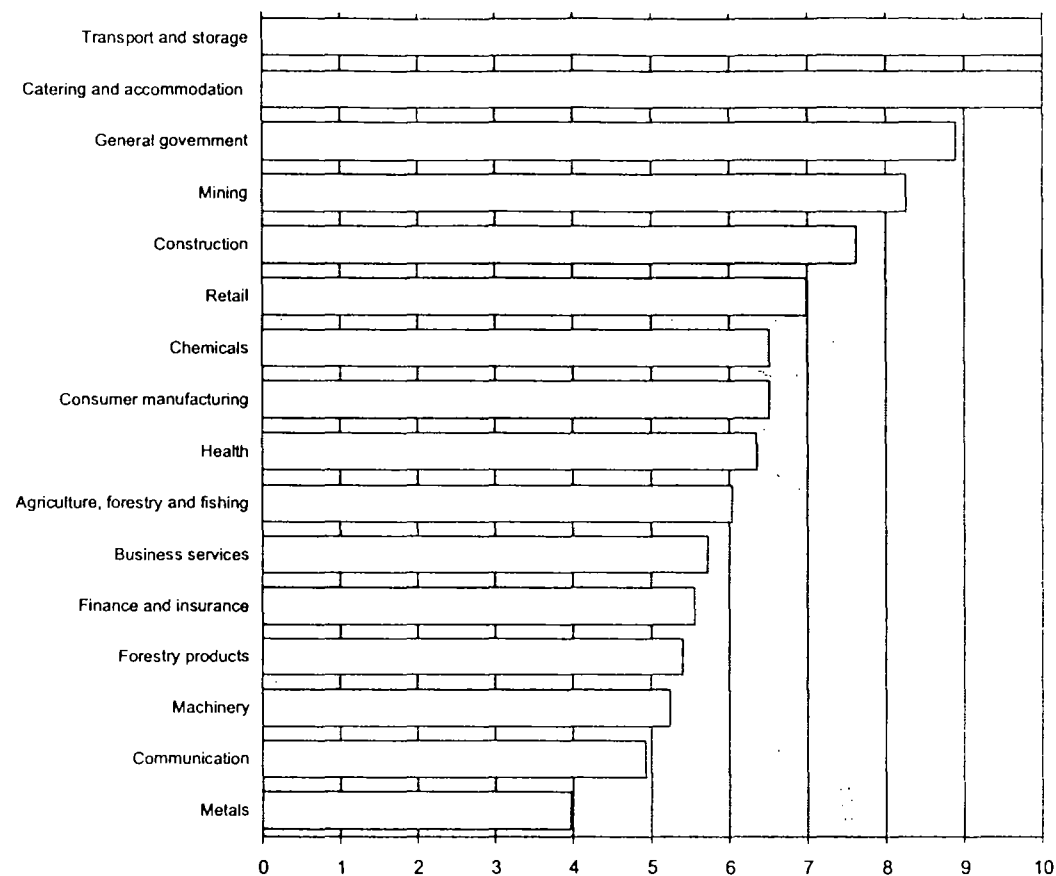
COMPOSITE SECTOR RISK RANKING

If we combine the two rankings with a 60:40 weighting, we find that the transport and storage industry, as well as the catering and accommodation sector, are most exposed to the AIDS risk. Not only are these sectors' infection rates high, they are also more reliant on a skilled workforce than mining or agriculture, say, whose infection rates are also very high. Finance and insurance and business services, which face the lowest infection risk, feature in the middle field in the composite ranking, as their high dependence on skills is likely to lead to higher remuneration costs in the form of rising benefit and retraining payments. While this ranking should provide a useful reference framework for relative sector risk exposure, it is important to emphasise that no sector can afford to be complacent in light of the AIDS epidemic. The effect will be felt across all sectors – just to varying degrees.

Transport, catering and accommodation are most exposed to AIDS risk

Figure 32

COMPOSITE RANKING AFTER SORTING



Source: WEFA

SUMMARY AND CONCLUSION

The AIDS epidemic is expected to lead to a stagnation in population growth within the next 10 years. Infection rates are expected to peak at almost 17% for the population as a whole and at a massive 26% for the economically active population. That means South Africa's workforce is disproportionately affected by the epidemic. With an official unemployment rate in excess of 30%, South Africa faces a labour surplus situation, which should mean that every person dying from AIDS-related illnesses should be replaced without much problem, leaving the production process and total income intact. However, the reality is not quite as straightforward. Most of the unemployed are unskilled or only semi-skilled. While most of the infections and deaths occur in this segment of the workforce, skilled and highly skilled groups are expected to be notably affected as well, with infection rates peaking at well above 20% and 10% respectively. The epidemic will thus exacerbate the existing skills shortage within the economy.

The AIDS epidemic will exacerbate South Africa's skills shortage

The cost of the epidemic will be borne by companies, households and government:

- The costs to companies will be significant, as higher health and other insurance benefits as well as higher training and replacement costs will add to the remuneration bill. Some of these higher costs will be passed on to consumers in the form of higher PPI inflation. But given the limited pricing power of companies, some of the higher costs will be absorbed by operating profits and come out of company savings.
- Household incomes will also be affected by higher health and insurance costs which are likely to result in lower take-home pay. This is in addition to the effect of a lower number of people in employment. The net effect is negative for disposable income, consumption demand and savings.
- Government will have to finance the health costs not covered by the private medical insurances. Unless current expenditure is switched from other categories to health spending or capital spending is cut, the higher health spending will add to the fiscal deficit, the public sector borrowing requirement and exacerbate government dissavings.

The net effect of the AIDS epidemic will be negative for growth. In our analysis, where we employed very conservative assumptions about costs to companies and government as well as the drop in household income, we found that the average annual trend rate of GDP growth over the next 15 years is likely to be 0.3-0.4 percentage points below the rate in a no-AIDS scenario.

The net effect will be negative for growth

There are some vicious cycles at work when analysing the economic effects of the AIDS epidemic: The most important is related to the savings constraint. The costs of the disease will almost certainly drain household, corporate and government savings. This will exacerbate the country's savings-investment constraint. Even if companies decided to invest further in technology and reduce their dependence on labour, the reduction in their operating profits as well as savings will leave them with much less room to manoeuvre.

One possibility is to draw in foreign savings to plug the savings-investment gap. However, a heightened perception of country risk associated with the AIDS epidemic is unlikely to encourage the inflow of foreign capital. The majority of capital inflows would thus have to be in the form of foreign loans. These would not only push up the country's foreign debt exposure, but also lead to a notable widening in the current-account deficit due to associated higher outflows of net factor payments. In the absence of foreign savings, the domestic savings-investment imbalance would force interest rates notably higher, further slowing economic growth and reining back investment demand.

The savings constraint will worsen ...

Another possibility is for the government to stick to its tight fiscal deficit targets and reduce expenditure in line with the lower revenue generated due to lower economic activity.

However, this in itself would set off a vicious spiral, as lower expenditure would exacerbate the fall in domestic demand and GDP, leading to even lower revenue generation, forcing the government to spend even less, etc.

The savings-investment imbalance could thus exacerbate the outlook for the South African economy under the AIDS scenario.

Even in our baseline case, the likely worsening of the country's growth, inflation and interest rate outlook will adversely affect the country's investment profile and hamper equity and bond market performance. Investors will start to look more carefully at sectoral exposure to the AIDS risk. As a result, we will probably face mounting claims for a disclosure of company infection profiles and coping strategies. While this area is clearly very sensitive, any improvement in information provision would advance the quality of analysis of the epidemic and thus help policy formulation and implementation.

... dampening the outlook for the markets

In the absence of reliable data and information, we propose to look at risk exposure of sectors in terms of two factors – firstly, their reliance on a workforce that has a high infection risk and, secondly, their reliance on skilled workers, the replacement of whom in case of illness and death is much higher than of the unskilled. If we aggregate those two factors, we find that transport and storage and catering and accommodation are the most exposed to the AIDS risk, while machinery, communication and metals fare relatively better. An important finding is, however, that service industries, such as finance and business services, rank in the middle field, as their reliance on skilled personnel makes them more vulnerable to a rising remuneration bill. Overall, no company can ignore the potential impact of the AIDS epidemic. Company management does have choices that will influence the future impact of the epidemic – as does government.

Sector risk assessments will become important

So far, no clear strategies have been forthcoming from either; but they are urgently needed in order to mitigate the destructive effect of the epidemic on all parts of the economy and society.

- The government needs to formulate a clear AIDS strategy that will allow domestic institutions and international development agencies to channel funds into the fight of the epidemic in South Africa. An explicit strategy would also ideally provide the public with more up-to-date and complete data on the spreading of the epidemic and allow better prognosis and response strategy from the private sector. Information creates a better understanding of the epidemic. In the absence of it, foreign investors, in particular, will remain deterred by the uncertainty surrounding the effects of the disease on the economy.
- The government should also move faster to dismantle structural obstacles to foreign investment in order to avoid a worsening of the savings-investment constraints.
- The government also has choices regarding the provision of AIDS drugs, especially to pregnant mothers in order to reduce the risk of mother-to-child transmission.
- At public as well as private sector level, the focus needs to be on education, increased access to condoms and the treatment of sexually transmitted diseases.

But most importantly, a clear AIDS strategy from the government is needed

Given the abundance of policy choices and the limited availability of data, modelling the effect of AIDS on the macroeconomy remains a moving target. However, we believe that, given the limitations of data availability, we have modelled a realistic scenario. Furthermore, we have established a framework of analysis that allows us to incorporate changes to the demographic outlook, government policy, household expenditure patterns as well as company responses in the future.

INTRODUCTION

This perspective does not set out to offer a complete analysis of equity investment over the period analysed for the economic impact of HIV/AIDS in the accompanying report. Rather, it hopes to remind readers of where the various equity sectors lie in terms of size and earnings momentum and, most importantly, to sensitize readers to the external and internal impacts which HIV/AIDS can be expected to bring about on the profit and valuation drivers.

To this end, we have taken the outputs from the AIDS analysis regarding sectoral impacts, and used these as inputs to make subjective calls on the internal and external impacts. This required adjustment for the sectors' operating positioning and their relative market positioning: this not only takes into account the high or low infection strata of the SA market itself, but also to what extent a company might have exposure to low-HIV foreign markets.

The top-down nature of both the HIV/AIDS analysis and this equity perspective hopefully flag sectors and companies which require further micro-analysis.

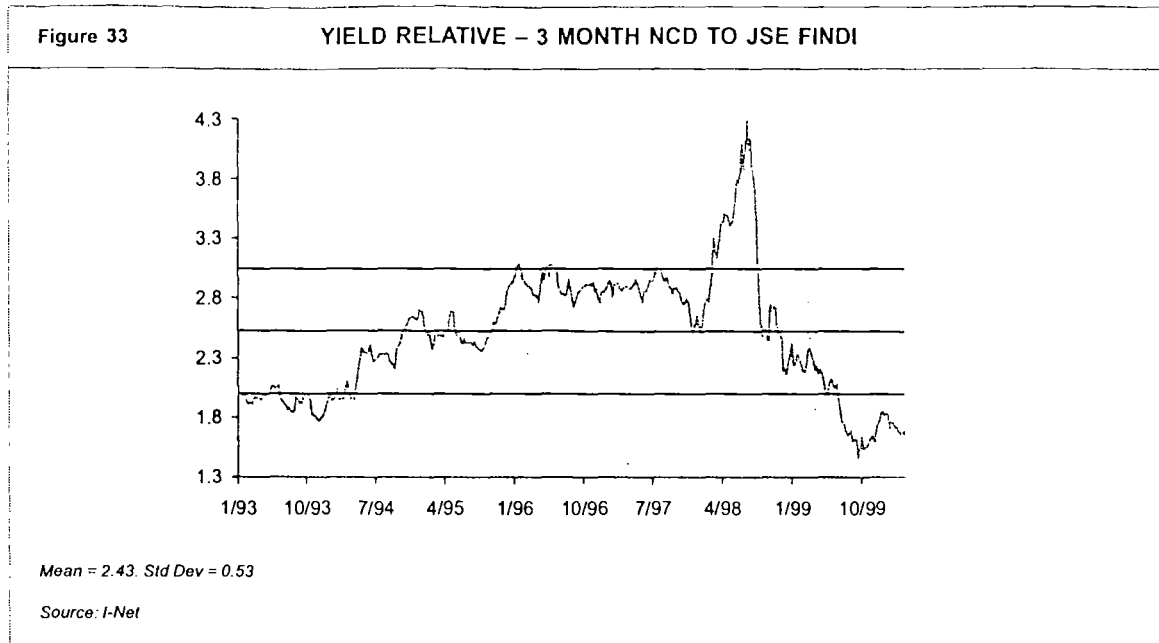
SA MACRO ENVIRONMENT

Equities appear on the surface to offer a good value proposition now, with SA in an economic upswing. Real GDP growth, which bottomed at 0.6% in 1998, is now accelerating through 1.2% in 1999 to 3.3% for 2000. Consumption is in the vanguard, with real retail sales growth set to rise to 5% in 2000 from 1% in 1999, and the broader real PCE growth to rise to 3.5% (from 0.7%). The upswing will see a strong increase in growth of imports (to +6% from -7%), but the economy is sufficiently robust to afford this, with the current account deficit rising to R11bn (1.2% of GDP) in 2000, but then stabilising at around 1% of GDP thanks to improving terms of trade. The vigorous growth in the economy is unlikely to translate into inflationary pressure as capacity utilisation and industry pricing pressure are low – we anticipate core inflation at around 6% next year. In spite of this, interest rates are unlikely to come down from current levels as formal, tight inflation targets have been introduced.

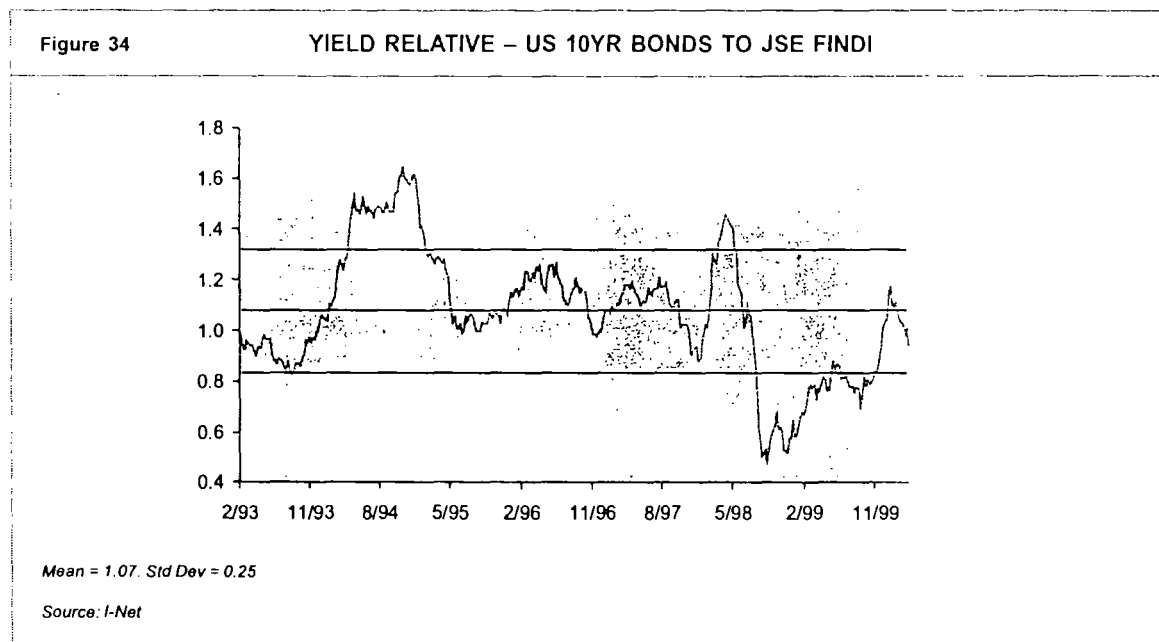
This is the one- to two-year view, however, and the broad investment negative for SA of the HIV/AIDS pandemic leads to a far less bullish investment view over a 5-15 year timeframe. We believe that AIDS will almost neutralise the birth-rate-driven population increase of 2% which would otherwise prevail in SA, and have a corresponding dampening effect on the economy – especially on the sectors exposed to domestic consumption. Many SA businesses also trade in the adjoining sub-Saharan region of Africa and this region carries some two thirds of the world's HIV infected people. The recent past has seen high margin add-ons to SA companies in the retail, beverage and food sectors and this sweetener to earnings faces clear pressure from HIV.

SA EQUITY MARKET LEVELS

In the SA framework (ie, relative to the SA interest market), the JSE looks 'cheap' again after its recent pullback, with the FINDI index at a yield relative of 1.64x, and with stronger near-term economic and corporate earnings backdrops.



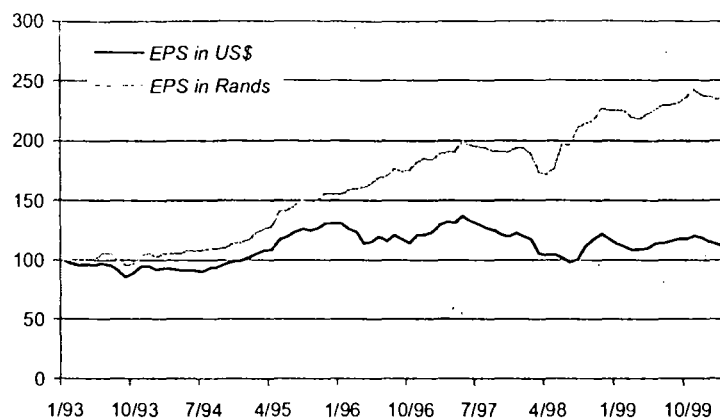
From a US perspective, however, we note a totally different picture relative to US treasuries, Figure 34.



Here we see a yield relative of 1.0x – but equities should cost more because of the growth. Establishing the growth (in US\$ terms), which our equities have actually delivered (the black line in Figure 35), shows a very modest increase – up only 12% in the eight years plotted.

Figure 35

EARNINGS GROWTH



Source: I-Net

Figure 35 clearly shows the dull dollar growth, with the R/\$ cracks in 1996, and 1997/98 lowering the end growth and adding volatility – both reasons not to overpay for the JSE's equity performance. The negative impact on the economy from AIDS reinforces the cautious stance.

SECTOR DYNAMICS UNDER THE AIDS SCENARIO

SA's equity market has a high commodity weighting, with a third of the market capitalisation being resource-based companies. In the nature of commodity businesses (ie, price takers) many of the relevant share prices have been at historically high levels in 1999/2000, anticipating strong demand for these resources from the (consensus forecast) global economic upswing. The market is now trying to establish the duration rather than the fact of the world growth upcycle, before these stocks revisit their highs. Labour use in these businesses is intensive, but predominantly un- and semi-skilled. The capital intensity of mineshafts, refining plants, and process plants is obviously not itself vulnerable to AIDS, and the high availability of unskilled labour in the region also shields these businesses. From a demand perspective, these export-driven businesses have a further shield from the domestic economic impact of AIDS in the form of demand from HIV-remote economies.

The larger proportion of the SA equity market is the FINDI (or Financial and Industrial) universe, however. Internal performance is more important for these companies which are less exposed to external price determination, so our key investment screens are volume growth, pricing power (ie, segment leadership), and cost control. Achieved together, these three would certainly flag out-performance. Our categorisation of the FINDI sub-sectors according to their longer term potential is shown below. We have also shown the expected impact of (or vulnerability to) HIV/AIDS in terms of internal company risk and external customer or market risk. High impact indicates a negative view on the investment case for that sector.

Figure 36

KEY INVESTMENT SCREENS

Sun-sector	Volume growth	Pricing power	Cost control	HIV/A impact - internal	Relative HIV/AIDS impact - customers
Banks	Medium	High	High	Medium	High
Insurance	Medium	Medium	High	Medium	Medium
Fin. Services	Low (med nearterm)	Low	Low	Medium	Low
Food/Pckg.	Low	Low	Medium	Medium	High
Beverage	Low	High	High	Medium	Medium
Hotel&Leisure	High	Low	Medium	High	Medium
Retail	Medium	Low	Medium	High	High
Tobacco	High	High	High	Medium	Low
Transport	Medium	Medium	High	High	Medium
Services	High	Medium	Medium	Medium	Medium
Info Tech	High	High	Medium	Low	Low
Telecom	High	High	High	Low	High

Source: ING Barings

The bottom-up earnings growth, which we forecast by FINDI sector for the next two years, is set out in Figure 37, together with expected longer term growth. The magnitude of sectoral AIDS impact, which we believe should be brought into investment thinking is shown in the last column.

Figure 37

SECTORAL PERFORMANCE FORECASTS AND AIDS RISK SCREEN

Sector	Market cap (Rm)	%CAGR in EPS (now - 2 yrs out)	% CAGR in EPS (long term)	HIV/AIDS impact on long term rating
Banks	183,971	23.7	18	High
Insurance	116,034	22.7	19	Medium
Fin services	36,400	26.1	17	Medium
Ind resources	44,180	18.3	12	Low
Food/pckg	38,435	16.2	13	High
Bev/hotel leisure	50,363	9.5	13	High
Retail	44,519	20.7	13	High
Divers ind	148,811	15.4	16	Medium
Info tech	95,925	38.6	30	Low
Telecom	42,073	32.0	25	Medium
Mining resources	346,876	19.7	14	Low

Source: ING Barings

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ING BARINGS

LONDON

ING Barings Limited
60 London Wall,
London EC2M 5TQ, UK
Tel: 44 20 7767 1000
Fax: 44 20 7767 7777
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HONG KONG

ING Baring Securities (Hong Kong) Limited
39/F One International Finance Centre,
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