The Impact of the AIDS Epidemic on South Africa's Children

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Introduction

This chapter highlights the many impacts that HIV and AIDS impose upon South Africa's children. Efforts under way to alleviate these impacts are critically examined. Alternative policies and programmes that could potentially better alleviate the impacts are also discussed.

Initially, the nature of the epidemic and its likely impacts upon the populations of adults and children are examined. The chapter then goes on to discuss the impact of increased illness and death from AIDS on the health, welfare and education of children. Many children are already living in poverty. These areas are examined in terms of household level economic strain and the capacity of the community systems designed to provide services to children to meet these extra demands. Attention is then given to interventions that currently exist in terms of prevention and mitigation. Family, community and, in particular, state responses are outlined and critiqued. This information is used to identify key concerns and areas for action.

Impacts

Population

South Africa has a young population. Out of a total of 44.8 million, 17.3 million, or 39 per cent of the population, were under 18 in 2001. The AIDS epidemic has had many negative implications for South African society, which stem from the illness and eventual death resulting from HIV and AIDS. The identification of impacts needs, therefore, to be placed in the context of the scale of illness and death.

The following section examines the path that the epidemic is expected to follow and the implications this has for illness, death and the population structure.

Modelling results: The projections in this section are based on the ASSA2000 model developed by the Actuarial Society of South Africa. They are reported as at 2002 in Dorrington, Bradshaw and Budlander (2002).

Figure 1 shows the significant impact AIDS is having on the mortality of the South African population. The past trend of falling IMR (infant mortality rate) has been halted and IMR is likely to remain above 50 per 1,000 for the next 10 years. Most paediatric AIDS mortality is likely to occur after the first year of life and there is not only a reversal of a previous downward trend but a significant increase (around 50 per cent over the next 10 years) in the childhood mortality rates (newborn child dying before reaching age five). In 2004 it was estimated to be at its highest level in almost 20 years. But even more startling than this is the impact on adult mortality (as measured by the 45q15, the probability of a fifteen-year-old dying before reaching age 60). This rate is expected to increase by some 150 per cent by 2010, from around 30 per cent to around 80 per cent, implying that without behavioural change, half of all adults can be expected to contract the virus during their lifetimes.

Figure 1. Mortality rates per 1,000 live births

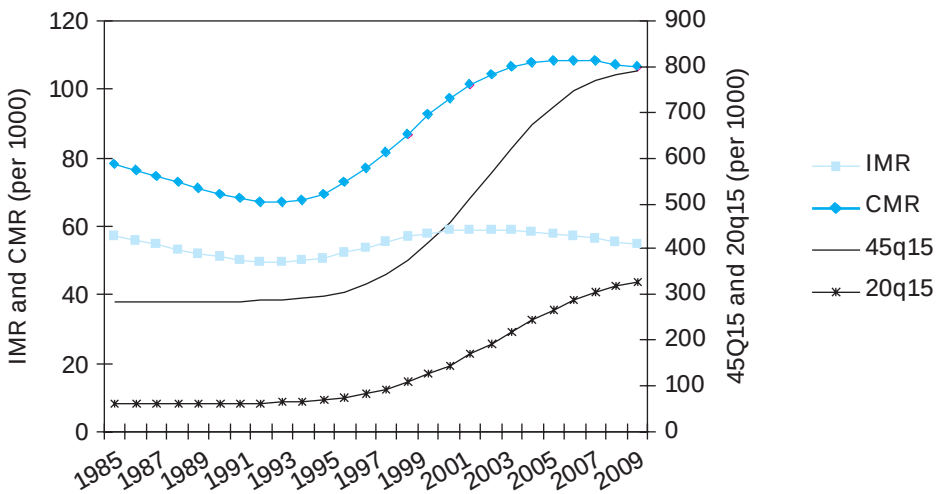


Figure 2 shows that these effects have the consequence of reducing life expectancy at birth in South Africa from over 60 years in the mid-1990s to slightly above 40 years by 2010 (see also table 1).

Figure 2. Impact on life expectancy at birth

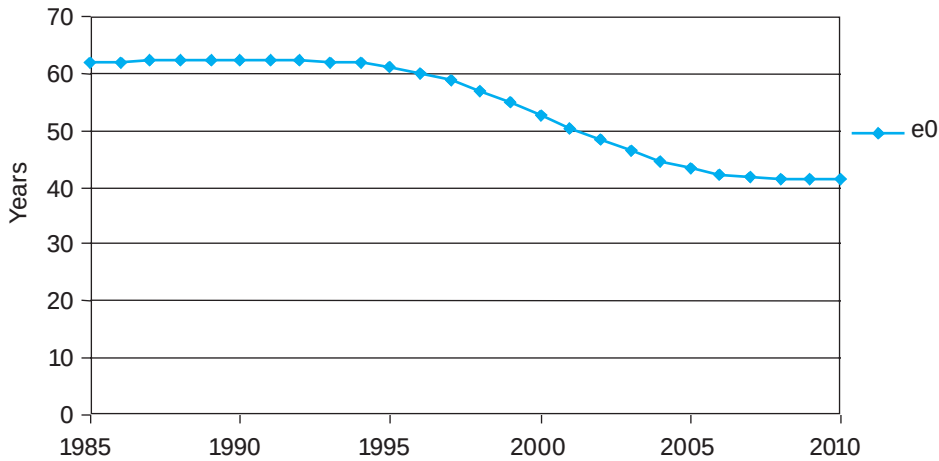


Figure 3 shows that the number of AIDS deaths is expected to exceed the number of deaths by all other causes within the next three years. Included in this figure are the numbers of new infections, showing that although these have already peaked, the number of deaths is only expected to peak in 2010.

Figure 3. Comparison of the number of new HIV infections with the number of deaths

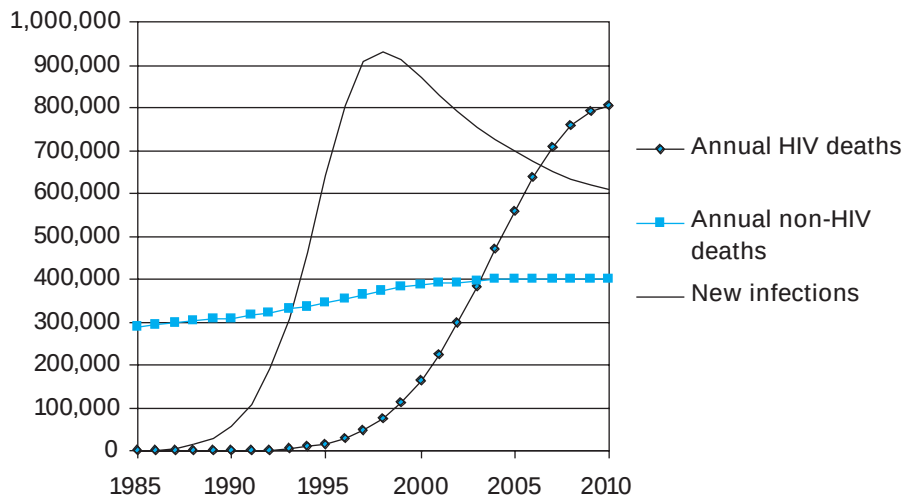


Figure 4. Projected population, number infected, cumulative number of deaths and total number living with HIV

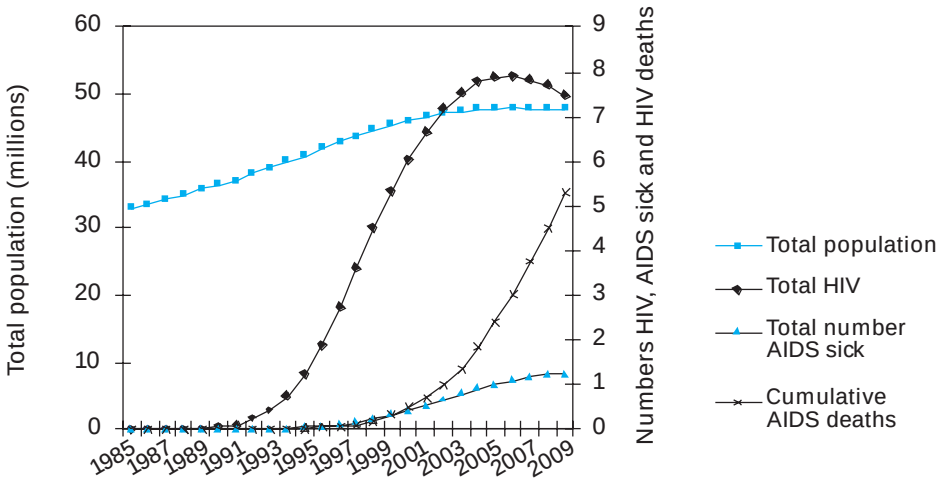


Figure 4 shows that the population growth rate is expected to fall to zero over the next few years and that the South African population is unlikely to exceed 50 million. The number of children under the age of 15 whose mothers have died of AIDS is expected to rise from some 878,000 currently to around 1.4 million by 2010.

It is expected that the number of infected people in the population will peak at between 7 million and 8 million, in contrast with the current estimated number infected of 5.3 million, while the country will have to cater for approximately 1 million people living with HIV. A total of between 5 million and 6 million people will probably have died of AIDS by 2010.

Figure 5. Provincial childhood mortality rates

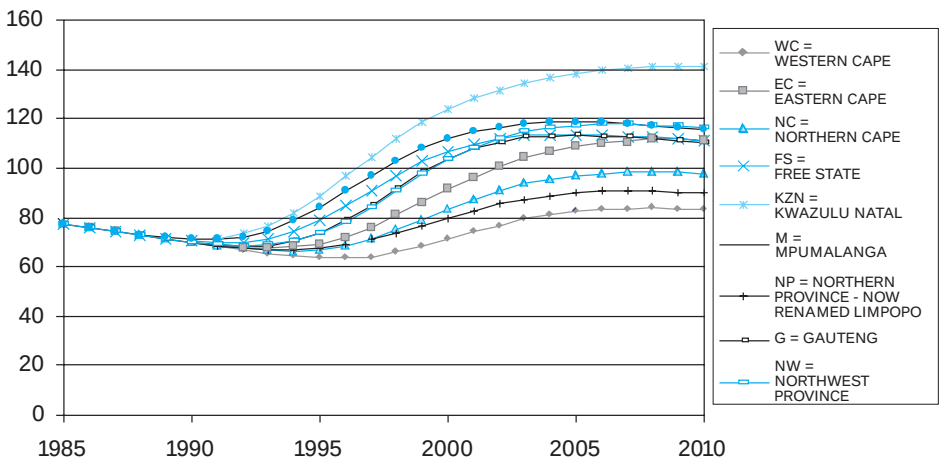


Figure 5 illustrates the impact of the epidemic on childhood mortality (per 1,000) in the nine provinces. In the most severely affected province, KwaZulu-Natal, the child mortality rate is expected to exceed 140 per 1,000, more than double the rate in the late 1980s. Even in the Western Cape, which has the lowest overall prevalence, HIV will reverse the downward trend in child mortality. Adult mortality rates have already increased in all the provinces and this rise is set to continue.

HIV and AIDS are already affecting the size and structure of South Africa's population and the impacts on the population are only in their infancy. High levels of child and adult death will have many follow-on impacts. Table 1 incorporates some health, education and welfare indicators with recent past measures.

Table 1. Health, education and welfare measures (1985–2000)

Health [a]	**1985**	**1990**	**1995**	**2000**
Life expectancy at birth – without AIDS	58	59	63	66
Life expectancy at birth – with AIDS	58	59	55	47
Infant mortality rate (measured – DHS) [b]	0.062	0.052	0.046	0.058
Child mortality rate – without AIDS (estimated ASSA) [b]	0.079	0.071	0.062	0.057
Child mortality rate – with AIDS (measured – DHS) [b]	0.070	0.052	0.058	0.091
DPT3 immunization coverage	75%	72%	72%	76%
Measles immunization coverage	70%	79%	76%	82%
Antenatal care	–	–	89%	94%
Delivery attendance	–	–	82%	84%
Education [c]				
Primary school female gross enrolment	114	120	130	103
Primary school male gross enrolment	116	123	135	109
Secondary school female gross enrolment	52	80	103	
Secondary school male gross enrolment	55	69	88	
Pupil–teacher ratio	34:1	33:1	34:1	33:1
Social welfare [a]				
Maternal or double orphan children	–	–	3.6%	5.2%
Maternal or double orphans from AIDS	–	–	36%	61%

Sources: a) Health and social welfare data supplied by Professor Fabio Zagonari; b) 2000 figures from Dorrington, Bradshaw and Budlander (2002); c) All education data are from UNESCO Institute for Statistics.

Social epidemiology

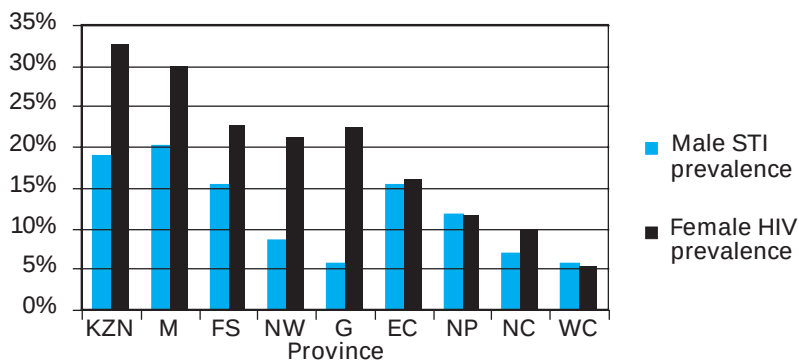
Bio-medical factors: The most significant bio-medical factor driving the epidemic in South Africa is the high prevalence of sexually transmitted infections (STIs). Genital sores and ulcers caused by these STIs greatly increase the risk of HIV transmission, and there is thus a significant correlation between levels of STI and HIV prevalence.

Levels of STI treatment are low for a number of reasons. Firstly, many STIs (particularly those affecting women) are asymptomatic, and even when symptoms occur, they may not be recognized as being due to infection. A second problem is that even when symptoms occur, individuals will often not seek treatment, either because treatment is inaccessible or because the infection is not regarded as being serious. To aggravate the situation further, treatment is often ineffective.

The relationship between HIV prevalence and STI prevalence is demonstrated in figure 6. HIV prevalence levels among pregnant women, estimated from the 1998 antenatal clinic survey (Department of Health 1999a), are compared with percentages of men reporting having had painful urination, penile discharge or genital sores in the last three months from the South Africa Demographic and Health Survey (Department of Health 1999b), in each of the nine provinces. With the exception of Gauteng and the Northwest, there is a pattern of high HIV prevalence in provinces with high STI prevalence, and lower HIV prevalence in provinces with low STI prevalence.

Knowledge and belief about HIV and STIs: Although a large number of public HIV awareness and education programmes have been launched in South Africa, there remains a significant proportion of the population that – due to illiteracy, geographical isolation or misinformation – is still ignorant of the basic facts of HIV.

Figure 6: Comparison of STI and HIV prevalence levels (1998)



Source: Department of Health 1999a and 1999b.

Sexual abuse and the status of women: In 1998 South Africa had the highest per capita rate of reported rape in the world (115.6 for every 100,000 of the population), and – on the common but highly debatable assumption that only one in every 20 rape cases are reported – close to 1 million acts of rape occur in South Africa every year (Rape Crisis Cape Town 2001). Marital rape is particularly underreported, with many relationships being characterized by violence and sexual abuse. Vundule et al. (2001) found, in a study of black teenagers attending antenatal clinics in Cape Town, that 72 per cent of girls reported having been forced to have sex at some stage, and 11 per cent reported having been raped. The South African National Youth Survey (Kaiser Family Foundation 2001) also found that 39 per cent of sexually experienced girls had been forced to have sex, and 33 per cent reported being afraid of saying no to sex. In many cases, therefore, women have limited control over their sexual activity, and are thus more vulnerable to HIV infection.

Migration patterns: South Africa has experienced high levels of political and economic migration in recent decades, both between its provinces and between itself and its neighbouring states. Migration increases the extent of sexual networking, and thus facilitates the swift spread of the HIV epidemic. This is demonstrated in a study of a rural community in KwaZulu-Natal: people who had recently changed place of residence were three times more likely to be HIV-positive than those who had not (Abdool Karim et al. 1992). It is therefore a concern that, in some rural areas, rates of migrant employment for those between the ages of 19 and 49 are as high as 60 per cent of males and a third of females (Lurie et al. 1997).

Health impacts

Perhaps the most startling evidence of the impact is the effect that the HIV pandemic is expected to have on child health indicators, the morbidity and mortality of women and young adults, and the number of children who will be orphaned. Increased morbidity and mortality in young adults reduces the pool of caregivers and breadwinners, leaving an increasing number of children in conditions of poverty and neglect. The 'orphan epidemic' in South Africa is a crisis in its own right with 3 million orphans expected within the next 10 years. Children orphaned by AIDS are arguably the most vulnerable children in our society, struggling not only to survive, but also to do so within the context of open discrimination.

The impact of HIV on child health is being reflected in a reversal of the gains achieved in improving child health indicators over the 1980s and first half of the 1990s. Trends in improvement in infant mortality obtained through successful child survival programmes over the past 15 years have been reversed, and predictions are that if the transmission of HIV from mother to child is not prevented, child mortality rates will increase to over 100 per 1,000. Few events impact as severely on the health and well-being of a child as the death of his or her mother. The

maternal mortality rate in South Africa is 150 per 100,000 live births. In 1999, non-pregnancy-related infection was the leading cause of maternal mortality and 30 per cent of these deaths were AIDS- related. In most provinces, AIDS has emerged as the major contributory cause of maternal deaths. The implications for the health of children will be widespread, but some will be particularly vulnerable.

Three groups of children are particularly vulnerable:

1) Children living in households where one or more family members is HIV-positive.

2) Children orphaned by AIDS.

3) Children who are HIV-positive.

Child health and well-being in infected households

Poor health among children living in HIV-infected families is common. This is believed to be a consequence of HIV itself (in the case of MTCT), increased exposure to opportunistic infections, disease-related poverty and psychosocial factors that impact on caregiving practices and child well-being (Piwoz and Preble 2000). Children living in households with HIV-infected persons are more exposed to opportunistic infections, such as TB and pneumonia. With caregivers sporadically sick or absent, the child is less likely to get the medical attention he or she needs and more likely to have repeat infections.

Children orphaned by AIDS: South Africa already has 500,000 maternal orphans caused by AIDS, yet the 'orphan epidemic' is still in its infancy and over the next few years is expected to grow to devastating proportions. In most parts of the industrialized world, no more than 1 per cent of the child population is orphaned. In low- and middle-income countries this figure was around 2.5 per cent before the AIDS pandemic (Loening-Voysey and Wilson 2001). If one combines all other causes of maternal death with the AIDS pandemic, 11 per cent of children under the age of 15 years in South Africa are orphans and this figure is expected to rise to almost 17 per cent by 2010 (SA National Council for Child and Family Welfare 1999). By 2015, children orphaned by AIDS will constitute between 9 per cent and 12 per cent of South Africa's total population.

Children infected with HIV: As of end-2003 there were an estimated 230,000 children 0–14 years old who were infected with HIV (UNAIDS 2004). The majority acquire HIV from their infected mothers during pregnancy, at the time of delivery, or after birth through breastfeeding; 60 per cent of these children will not live beyond their fifth birthday, but 40 per cent of them will, and the majority of these children will join the 60 to 70 per cent of children in South Africa who live in conditions of extreme poverty.

Fifteen to 18-year-olds fall within the age category most vulnerable to HIV infection through sexual contact. Within this group, girls are particularly vulnerable to infection. Physiological, cultural and social factors contribute to their vulnerability and girls between the ages of 5 and 14 years are over eight times more likely to be infected through sexual abuse than their male counterparts (Shell 2000). In sub-Saharan Africa, the rate of HIV infection in teenage girls is five times higher than the rate of infection in teenage boys (Mpanju-Shumbusho 2001). The reason for the lower differential between teenage boys and girls is that the male/female difference in risk is not as marked for older teenagers as it is for younger children.

Education impacts

The process of education and learning is the key to social, cultural and political participation, personal and community economic empowerment and national development. Its output is the human capital that constitutes the nation's primary wealth and potential for growth.

One third of all HIV-positive persons in South Africa were infected during their school years, while a further third were infected within two years of leaving school. This confirms schools as a high-risk environment.

In 2000, 12 million students were enrolled in South African public schools. However, it is estimated that less than a quarter of children five to seven years of age were enrolled in early childhood education programmes. Many children living in poverty are denied access to basic education because they cannot afford to pay school fees or purchase school uniforms. Over 1.2 million school-age children do not attend school. The HIV epidemic is exacerbating these trends.

The impact of HIV in the home and on education: The incidence of HIV in the home can be expected to further reduce access to education. This will occur due to increased economic hardship, family care and other household or agrarian duties, the need to find employment, declining health due to deteriorating nutrition and other opportunistic infections, and the effects of personal trauma associated with grief, stress and added responsibility. The child in an affected household, with an infected parent to consider and even care for, will be exposed to a variety of impacts that together may reduce or even preclude access to schooling, either temporarily or permanently.

Gender inequity and access: South Africa has had, and to an extent continues to have, a unique level of gender equity in its schooling system, relative to its sub-Saharan neighbours. One obvious implication of the epidemic is that girls will be more affected than boys, so the balance will be upset. There are a number of reasons for this, including the fact that, in the event of economic hardship and deprivation, girls are more likely to be withdrawn from school than boys, and more likely to be held back to provide care both for the infected party and for siblings.

Girls are also more likely than boys to become the victims of sexual exploitation and may be driven to this course as a means of personal survival and household support. There is also likely to be a decline in the number of girls matriculating and a consequent drop in the gross number of matriculants.

Welfare impacts

The impacts on health and education are significant; there are, however, many other ways in which HIV will affect children. Numbers of children in South Africa already live in poverty, in situations that violate many of their basic rights. HIV will serve only to worsen their plight. The following section examines the impacts of the epidemic, focusing on poverty and the impact on children who have been orphaned or who are living with HIV-infected adults.

Poverty: Of the 17.3 million children in South Africa, about 12 million are classified as living in poverty, according to household income indicators. Estimates of the child poverty rate in South Africa vary between 60 per cent (May et al. 1998) and 72 per cent (Haarmann 1999). These estimates are based on income poverty lines and only the Haarmann study looks at household spending per child as opposed to household income. Such figures provide a baseline for looking at broad trends but not for assessing children's quality of life. There is a critical lack of data on child poverty trends and causal factors in South Africa.

Poverty, unemployment and inequality are increasing in South Africa. Income distribution is among the most unequal in the world. In 1996, almost 57 per cent of the population were living in poverty, and of these, two thirds were black Africans. Racial inequalities persist; white South Africans' per capita income is almost nine times higher than that of black South Africans.

Food insecurity regularly affects 30 per cent of households where children live. The majority of South African children live in overcrowded homes with pit latrines. Water supply in rural areas remains variable.

Children orphaned by AIDS: There have been many international and national studies looking at the 'orphan problem'. Most concentrate on the issue of scale, the crisis of unmanageability, the imperative of community-based care. Few look at the impact of being orphaned on individual children, or on children and adults in the households into which they are 'absorbed'. Studies have examined the wide range of socioeconomic impacts experienced by children and families in poor, HIV-affected families (Whiteside 1998). These point to the all-encompassing breakdown that can begin with the diagnosis or the suspicion of HIV infection in a family.

Child-headed households: There is very limited information on child-headed households in South Africa. Households may be headed by employed adult siblings of

orphans, by school-going older siblings, by children looking after each other with adult support from another household, or by children caring for a dying parent with no adult support. As the adult mortality rate peaks, there are likely to be many more households of this nature. The Durban-based Children's Rights Centre stresses the need for more reliable information on the whereabouts and situation of orphaned children, in order to assess vulnerability and need for support. When a child becomes a caregiver for an adult infected with HIV, his or her childhood is effectively sacrificed. Already some NGOs and CBOs find themselves offering training and support to children who are fulfilling adult roles at the expense of their own security and development.

Violence, child abuse and neglect: Violence, abuse and neglect of children are on the increase in South Africa. Domestic violence is common among HIV-infected families and has become one of the major stumbling blocks to disclosure among married women in South Africa. The fear of disclosure makes it difficult for women to make informed decisions. They are therefore forced into continued childbearing and breastfeeding that may significantly compromise the health of their children.

Sexual and physical abuse of children increased by 117 per cent between 1993 and 1996. In 1998 there were approximately 34,000 reports of crimes against children, including rape, incest, kidnapping, etc (ACESS 2001). The reported cases of children being victims of abuse, neglect and other forms of violence have increased dramatically since the late 1990s, when data were last made available. There are no official national data on the number of children who are victims of commercial sexual exploitation.

According to the South African Police Services, 15,650 child rape cases were reported between January and September 2002. Of these, 5,859 concerned children between 0–11 years and 9,791 children between 11–17 years. The South African National Council for Child and Family Welfare (1999) has found that children most affected by abuse are between the ages of 10 and 14 years old. There is increasing concern that the age of children committing sexual offences is also decreasing.

Abandonment/children on the streets: Abandonment happens at two levels. The first is the abandonment of the family by a caregiver/breadwinner. It is commonplace to hear of women whose partners or husbands abandoned them when they disclosed their HIV status. The second is the abandonment of the child. The South African National Council for Child and Family Welfare (1999) reported a 67 per cent increase in the number of children abandoned in South Africa. This is corroborated by reports of an increase in the numbers of children being abandoned in hospital wards across the country.

There is a general lack of data on the number of street children in South Africa. Experts believe that the number of children living on streets is increasing gradually due to poverty and HIV.

Household impacts

The HIV epidemic results in many impacts, the majority of which affect children directly or indirectly. Few, however, are as serious and affect children more than the impact felt at the household level. Data from a household survey conducted in Free State province from 2001 to 2003 is presented and discussed below (Booysen et al. 2003). The study involved a detailed household questionnaire that was administered in two areas, one rural and one urban. In each area, households containing an HIV-positive adult were sampled and balanced by households not directly affected. The sample of affected households was selected based on referrals from home-based care organizations in the area. The non-affected households were randomly selected from each area and screened for negative signs of HIV infection with the use of a questionnaire. However, the sampling of non-affected households only attempted to select those not affected by HIV-related illness at the time of the interview and did not attempt to screen them in terms of the other ways in which they were indirectly affected by the epidemic (e.g. having to give shelter to orphaned children or having to care for friends and family members in neighbouring households).

Household size and structure: Although affected households appear to be larger, suggesting a greater supply of labour, dependency ratios are also greater, implying that households affected by HIV in fact have a smaller supply of labour than non-affected households, with a larger proportion of the household consisting of children and elderly persons.

Table 2. Supply of household labour and unemployment levels

	Urban Affected	Urban Non-affected	Rural Affected	Rural Non-affected	Total	Total Affected	Total Non-affected
Average household size	5.6	4.6	4.5	4.1	4.7	5.1	4.3
Dependency ratio	36.5	32.0	34.3	34.0	34.2	35.4	33.0
Sample size (n)	101	100	101	104	406	202	204
Household composition (%):							
Nuclear family	73.8	83.2	72.2	80.9	77.5	73.0	82.0
Extended family	24.4	15.9	27.3	18.6	21.5	25.9	17.2
Non-related persons	2.2	1.0	0.0	0.3	0.8	1.1	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average unemployment rate (%):							
- Narrow	55.2	48.8	70.1	61.0	57.8	61.6	54.3
- Broad	57.9	50.0	72.5	62.8	59.9	64.2	55.8

In addition, morbidity and mortality occur more often in affected households than in non-affected households; in 73 per cent of affected households one or more members

had experienced chronic illness in the past month, while 20 per cent had lost one household member in the six months before the interview. In non-affected households, only 20 per cent of households were affected by morbidity and 1 per cent by mortality.

Table 3. Income and composition of income

	Urban Affected	Urban Non-affected	Rural Affected	Rural Non-affected	Total	Total Affected	Total Non-affected
Average monthly household income (Rands)	1630	2692	948	1596	1727	1296	2147
Average monthly per capita income (Rands)	335	741	232	417	434	285	580
Average monthly adult equivalent income (Rands)	614	1211	397	694	734	508	954
Sample size (n)	99	100	95	99	393	194	199
Composition of income (%):							
Employment income	58.4	67.4	31.1	41.4	49.8	45.0	54.5
Non-employment income	33.9	24.7	40.9	30.8	32.4	37.3	27.7
Remittance income	7.6	7.8	21.7	25.4	15.5	14.5	16.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: the sample sizes differ from the interviewed samples in table 2 because data were not available for all households.

Income and expenditure: HIV infections are concentrated among members of the economically productive age group (15 to 49 years). Infection often leads to the loss of earners within the household. As expected, affected households were found to have lower incomes than non-affected households, measured at the household or individual level or in adult equivalent terms. The fact that affected households were generally larger than non-affected households means that fewer resources were being shared among a larger number of persons. Per capita and adult equivalent income in affected households represented between 50 per cent and 60 per cent of the levels of income in non-affected households.

There were also significant differences in the income composition of affected and non-affected households. Affected households were more dependent on non-employment sources of income (consisting primarily of government grants) and a lower proportion of their income was derived from employment. This is understandable, given that affected households face higher dependency ratios, are more subject to morbidity and mortality and face higher unemployment levels.

Average monthly household expenditure, per capita monthly expenditure and adult equivalent monthly expenditure were lower in the affected group of households than

in the non-affected group. Although differences are not particularly pronounced in terms of total household expenditure, the fact that affected households have more members means that per capita and adult equivalent expenditure is 30–40 per cent less than the levels of expenditure in non-affected households.

The survey also found differences in patterns of expenditure. In the case of illness, a larger proportion of household resources are allocated to spending on food, health care and household maintenance, while a smaller share goes to education, clothing, personal items and durables. Transport and rent differences are very small. Households affected by death in turn spend relatively more of their available resources on food, health care, clothing and rent and a smaller share on education, household maintenance, transport and personal items, compared to households where no death has occurred. The differences in the share of durables in total regular household expenditure are fairly small.

Table 4. Expenditure patterns in households affected by morbidity and mortality

	Morbidity		Mortality	
	Illness	No illness	Death	No death
Composition of regular expenditure (%):				
Food	51.8	48.0	52.1	49.5
Education	1.8	4.6	1.9	3.5
Health care	4.7	3.0	5.1	3.7
Household maintenance	21.0	19.5	17.7	20.5
Transport	7.2	7.1	6.4	7.2
Clothing	1.9	2.9	4.3	2.3
Rent	1.6	1.4	2.0	1.4
Personal items	2.9	3.7	2.2	3.4
Durables	7.1	9.8	8.4	8.6
Total	100.0	100.0	100.0	100.0

Coping financially: Households generally have three alternatives in terms of coping with changes in income and expenditure, i.e. to borrow money, to utilize savings, or to sell assets. The most frequent responses seem to be borrowing, followed by the utilization of savings and the sale of assets.

The purpose for which the households borrow money also suggests that the HIV epidemic plays a role in causing households to take on increasing levels of debt. The majority of responses by affected households indicate that the money is used to pay for funerals and medical expenses, whereas most non-affected households indicate that the money is spent on education, durables and clothing.

Impacts on children: The impacts outlined above have numerous implications for the children living within the two types of households. Two specific issues related to the impact of HIV on children were briefly explored in more detail. Firstly, the extent to which the school enrolment of children in affected and non-affected households may differ. A distinction was made between children aged 7–13 (primary school), aged 14–18 (secondary school) and aged 7–18 years (all children of school age). The second issue explored is of orphaned children, which should give an indication of the extent of the problem, not only in affected households but also in non-affected households, which may also provide shelter to orphaned children. In addition, school enrolment of orphans was compared across affected and non-affected households, while the characteristics of those households sheltering orphans were also explored.

Children orphaned by AIDS: On average, 8 per cent of children aged 15 years and under lost their mother, 28 per cent their mother or father and 3 per cent both mother and father. This suggests a relatively high incidence of paternal orphanhood. An almost equal number of orphans are male and female.

Table 5. Number of orphaned children

	Urban Affected		Urban Non-affected		Rural Affected		Rural Non-affected		Total		Total Affected		Total Non-Affected		P value
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	
Total children aged fifteen or under	214	100	149	100	165	100	153	100	681	100	379	100	302	100	
Children who lost their mother	29	14	7	5	11	7	7	5	54	8	40	11	14	5	<0.001
- Male	11	38	5	71	7	64	4	57	27	50	18	45	9	64	<0.001
- Female	18	62	2	27	4	36	3	43	27	50	22	55	5	36	<0.001
Children who lost one parent	56	26	24	16	51	31	57	37	188	28	107	28	81	27	<0.001
- Male	22	39	10	42	24	47	29	51	85	45	46	43	39	48	<0.001
- Female	34	61	14	58	27	53	28	49	103	55	61	57	42	52	<0.001
Children who lost both parents	12	6	3	2	4	2	4	2.6	23	3	16	4	7	2	<0.001
- Male	4	33	3	100	3	75	2	50	12	52	7	44	5	71	0.007
- Female	8	67	0	0	1	25	2	50	11	48	9	56	2	29	0.004

A significantly larger percentage of children in affected households lost their mother or both parents when compared to non-affected households. The percentage of children in affected households who lost either parent is only slightly higher

than that in non-affected households. Hence, the results indicate that, although a larger number of orphans are to be found in affected households, non-affected households also shelter a number of orphans. This is understandable, insofar as the extended family often absorbs orphaned children.

Orphaned children are sheltered primarily by households that are headed by females, with 76 per cent of orphans living in female-headed affected households and 89 per cent being cared for in non-affected households led by women. A large proportion of those caring for orphans were running households on their own: of the non-affected households, 68 per cent were headed by widows or widowers, and 18 per cent by those who were divorced or separated. There was a similar case for affected households that shelter orphans: 65 per cent were headed by widows or widowers, and 21 per cent by married persons. The fact that some affected households already sheltered orphans means that, apart from having to care for older affected members, they also had to take responsibility for the children of deceased members of their extended family.

Table 6. Demographic characteristics of households sheltering children who have lost at least one parent

	Urban Affected		Urban Non-affected		Rural Affected		Rural Non-affected		Total		Total Affected		Total Non-Affected		P value
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	
Number of children who lost at least one parent	56	100	24	100	52	100	57	100	189	100	108	100	81	100	
Gender of household head:															
Male	16	29	2	8	10	19	7	12	35	19	26	24	9	11	<0.001
Female	40	71	22	92	42	81	50	88	154	82	82	76	72	89	<0.001
Marital status of household head:															
Married (civil)	19	34	1	4	4	8	1	2	25	13	23	21	2	3	<0.001
Married (traditional)	0	0	0	0	3	6	4	7	7	4	3	3	4	5	0.008
Widow/widower	29	52	18	75	41	79	37	65	125	66	70	65	55	68	<0.001
Divorced/separated	4	7	3	13	0	0	12	21	19	10	4	4	15	19	<0.001
Never married	4	7	2	8	4	8	3	5	13	7	8	7	5	6	0.005
Average household size	7.8		7.0		5.6		5.6		6.1		6.2		6.0		
Average age of household head	55.1		45.8		56.5		55.2		54.3		55.8		52.4		

Conclusions: The devastating impact that HIV infection and the ensuing illness and death have on members of affected households is starkly illustrated. These households face a shrinking supply of labour and income at the same time as the need for both increases. Children in these households face many risks. Expenditure on food, clothing and education falls, placing the health and rights of children at risk. After the death of a parent, children are faced with great uncertainty. It is at the household level where many of the impacts discussed in this chapter begin and it is at this level where many of the responses should focus.

Responses

The impacts outlined in the proceeding sections have not occurred without response. Individuals, communities, FBOs, NGOs, businesses and government have responded in various ways. To review all of these would be a major paper in itself. This study focuses on government response.

Prior to 2002, the response of the national and provincial governments in terms of policies, resources committed and services delivered to respond to HIV were very limited. However, due to a concerted public campaign by civil society, primarily around the issue of treatment of people living with HIV (PLHIV), many more resources have been committed to ameliorating the impacts of the epidemic. These resources have primarily been allocated towards health, but significant funding increases to education and welfare programmes have also occurred, as table 7 indicates.

Table 7. National budget allocations to HIV and AIDS, 2001/02–2006/07, Rand millions

Department	2001 /02	2002 /03	2003 /04	2004 /05	2005 /06	2006 /07	Total (6 Years)
Health	265	459	766	1,212	1,545	2,008	4,765
Social welfare	14	51	70	78	85	89	252
Education	62	133	131	128	136	144	409
Science	0	2	5	19	30	26	76
Total	343	646	973	1,439	1,797	2,268	5,504
Real terms	395	677	973	1,365	1,616	1,939	4,920
Real growth rate	49%	71%	44%	40%	18%	20%	26%

Source: Hickey 2004, p. 6.

With slowly increasing resources early in this decade, service delivery difficulties were experienced and take-up rates of national government money by the provinces was problematic. This resulted, for example, in the Eastern Cape in 2000/01 only spending 26 per cent of their allocated HIV funds. These vastly increased amounts of resources indicated in table 7 will cause a major logistical problem in delivering services to those infected and affected by HIV.

The National HIV/AIDS and STD Programme was operationalized in 1995 by the National AIDS Directorate in the Department of Health (mainly concerned with policy) and nine Provincial HIV/AIDS Programmes (mainly concerned with programme delivery). In addition, a number of NGOs were either funded or sub-contracted to run projects or to provide services.

HIV/AIDS and STD Strategic Plan for South Africa 2000–2005

Early in 2000, an HIV/AIDS and STD Strategic Plan (2000–2005) was developed. It stated that all stakeholders would use this document for planning. In 2000, a target of R10 per person per year was set as the resource standard, making a total of R400 million per year for the whole country. Political pressure resulted in this very modest target being surpassed.

The strategic plan is designed not only for the health sector, but rather to guide the country's response as a whole. It is meant as a framework, and it was envisaged that it would be used as a basis for the development of strategic and operational plans for government departments and other organizations.

The primary goals of the plan are to:

- Reduce the number of new HIV infections (especially among young people).
- Reduce the impact of HIV on individuals, families and communities.

Its objectives are described as follows:

- Establish and implement integrated community-based care and support programmes for children infected and affected by HIV.
- Improve access to VCT services for 12.5 per cent of the population aged 15–49, over three years, focusing on young people and rural communities.
- Implement the life skills and HIV education programme in 20 per cent of primary and secondary schools in the first year, a further 40 per cent the next year, and 40 per cent in year three, ensuring 100 per cent coverage by 2002/03.
- Mobilize communities through community-based HIV awareness programmes.

The National Integrated Plan (NIP) for children infected and affected by HIV/AIDS (2002)

The Government's mitigation attempts for children are being led by NIP and this in turn is guided by the broader HIV/AIDS and STD Strategic Plan for South Africa 2000–2005.

The aim of NIP is: 'To ensure access to an appropriate and effective integrated system of prevention, care, and support services for children infected and affected by HIV/AIDS'. NIP combines the efforts of three key government departments, Education, Health and Social Development, and focuses their efforts on expanding access to the following key programmes areas:

- Life skills education
- Home/community-based care and support
- Voluntary counselling and testing (VCT)
- Poverty relief.

Health responses

The health sector response is primarily around a variety of health interventions including:

- VCT
- Prevention of mother-to-child transmission (PMTCT) of HIV
- Provision of antiretroviral drugs (ARV).

Education response

In South Africa, education consumes almost a quarter of the national budget and employs or enrols almost a third of the country's population. Moreover, educator salaries account for well over 90 per cent of the education budget, confirming that the HIV impact in this sector is of strategic and budgetary significance.

The main HIV activities are life skills and HIV education in primary and secondary schools.

Life skills programme: In 1999 the National Cabinet approved funds amounting to R450 million for an integrated response to the epidemic, focusing on children and young people. In 2000/1, R75 million was allocated to the strategy – 57 per cent of which was for life skills education.

In 1997, 840 master trainers and 9,034 secondary school teachers were trained in life skills and HIV, and quantities of materials were purchased to resource the schools. This programme was managed by the Department of Health – only recently has the Department of Education taken over as the lead department. The roll-out of this programme is planned to potentially reach 21,304 primary schools and 8,497,388 primary school learners. The effectiveness of these interventions has not yet been fully evaluated. Such an evaluation would allow the refinement and appropriate supplementation of the intervention to increase effectiveness.

In support of the life skills programme, a youth programme (the South African AIDS Youth Programme or SAYP) has been established, which targets young people through social mechanisms and youth organizations. In the area of life skills programmes for young people, the challenge remains to utilize peer education on a large scale as an effective way to influence adolescent sexual behaviour. Discrete projects, for both in- and out-of-school young people, offer hope of success, but these have not been rolled out on any large scale.

Welfare response

Family/community response: The main measures to reduce the impact of HIV on children have clearly been taken by individuals and households, who have absorbed nearly all of the country's orphans into their extended families and cared at home for those dying of HIV-related illnesses. While community workers in different parts of the country see some remaining capacity for absorbing orphans, the support structures on which extended family or community fostering depends are already under severe strain.

Civil society response: The various elements of civil society are attempting to respond to the problems faced by HIV-affected and infected children by:

- Mobilizing caregivers in the community to support affected children.
- Providing training and support to caregivers.
- Assisting caregivers and children to access services and social grants to which they are entitled.
- Lobbying and fundraising around the additional needs of children affected by HIV and poverty.

The first task is central to the survival and well-being of the child, but its achievement is increasingly dependent on organizations delivering in all the other areas. Many community-based projects have started out with a specific HIV focus but have developed a holistic approach, given the spectrum of crises facing HIV-affected children. Confronted by huge gaps in service delivery, they are often overstretched in terms of the range of HIV-affected children's needs – from food security to medication, education to foster care.

Government welfare policies for children: Most of the welfare burden of HIV has been shouldered by individuals, families and communities. At present, there are three welfare grants available to children. These are the child support grant, the care dependency grant and the foster grant that are paid by provincial social development departments through their social security budgets.

The **Child Support Grant** in 2004 was R170 per child per month. The maximum yearly household income for assistance was R13,200. Children under the age of 11

years are eligible, although this is being extended to 14 years. Because HIV is throwing increasing numbers of children below the income poverty line, the epidemic is making growing numbers of children eligible for the grant.

The **Foster Grant** was R530 per child per month in 2004. There is also a means test for eligibility. The annual income of the foster parent must not exceed twice the annual foster child grant. Only children who have been placed in the care of foster parents by a court of law are eligible for the grant. Each foster parent or parents can access grants for a maximum of six children. Increasing numbers of children will become eligible for this grant as courts place the rising numbers of children affected by HIV in foster care.

The **Child Dependency Grant** was R740 per child per month in 2004. The means test for this grant is that the combined annual income of the family, after deductions, must not exceed R48,000 per annum. This grant is for children with severe mental or physical disabilities who require permanent home care. But there is no specific provision for children with chronic illnesses, including AIDS.

Table 8 shows that considerable efforts have been made to increase the number of beneficiaries, although for those living in rural areas without transport or the requisite identification documents, access is still problematic.

Table 8. Number of beneficiaries of child-specific grants

	Number of beneficiaries		
	March 2000	March 2001	July 2003
Foster Grant	49,088	52,642	–
Care Dependency Grant	23,705	31,452	3,394,757
Child Support Grant	201,968	757,728	–

Source: Department of Social Development database.

Recommendations for action

Efforts to mitigate the impact of HIV on children require the involvement of many sectors of government, civil society and communities. To draw together and coordinate such a response, strong and committed leadership is essential.

Health

In general, in South Africa, levels of awareness of HIV and AIDS are high (though some myths and misconceptions persist). There is, however, little evidence of behaviour change. This is indicative of the complex nature of perceived vulnerability and the lack, particularly for young people and other vulnerable groups, of any real self-sufficiency in sexual decision-making.

That stated, how has South Africa responded to the prevention challenges? Among the significant prevention achievements in the period from 1997 to 2004 are: the life skills programme, mass media campaigns, the STI programme and the condom programme.

Life skills programmes for youth: One life skills product that has been successfully and extensively used is Stepping Stones, a workshop series designed to promote sexual and reproductive health. It addresses questions of gender, sexual health, HIV and AIDS, gender violence, communication and relationship skills. In doing so, it recognizes that sexual relationships are always situated within a broader context of relationships with sexual partners, families and the community or society in which people live. These influences substantially determine how people behave.

Mass media campaigns: The Beyond Awareness communication campaign, recognizing that the levels of awareness around HIV and AIDS were in fact high, took the debate to a more personal level, encouraging people to confront their vulnerability, and linking them to resources such as the AIDS Helpline, operated by Life Line.

Beyond Awareness II was a multimedia communication campaign that was conducted in two phases over a three-year period (1998–2000). The objectives of the campaign were to:

- Intensify communication of key messages around the HIV epidemic directed primarily at young people.
- Develop and distribute communications resources to support action around HIV and AIDS.
- Promote social action through targeted projects. Specifically these included the AIDS Memorial Quilt Project, a Tertiary Institutions Project and a Media Workers Project.
- Build capacity among HIV communicators and strategists through conducting key research.
- Conduct appropriate behavioural research in support of HIV communication and evaluate various aspects of the campaign.

STI management: As discussed earlier, the presence of an STI dramatically increases the likelihood of HIV infection. The STI programme remains one of the pillars of the National AIDS Programme by ensuring consistent supplies of drugs, promoting awareness and health-seeking activities, and training health care providers in both the public and private sectors. Support materials have been produced on STIs and their links with HIV.

Condom programme: The Department of Health has prioritized condom distribution through a systematic annual procurement programme, supported by

distribution through clinics and other sites (71 per cent of condom users report that they obtain supplies from clinics or community health centres). Access to barrier methods, primarily male condoms, has been greatly improved despite some problems with quality control. Some 250 million condoms were distributed free in 2002.

Despite improved access, there are still significant barriers to condom use in certain areas, particularly for young people. A survey conducted by Condom Concepts and Latex Surgical Products highlighted that young adults do not trust free condoms and think they are of inferior quality.

Prevention of mother-to-child transmission (PMTCT) of HIV: The need to introduce a PMTCT programme in South Africa was first recognized in 1988, when a proposed programme was costed on behalf of the Department of Health. The total cost for introducing this programme – including supplementary staff, staff training, test kits, drugs at a discounted price and milk formula – in all antenatal clinics in the public sector throughout the country was R80 million. The Department considered this figure excessive and the proposal was not pursued.

Planning for the implementation of a national PMTCT programme was at an advanced stage in 2002. The programme was to have been introduced in at least two sites in all nine provinces as a two-year pilot project to resolve funding and logistical problems before the widespread introduction of the programme throughout the country. The programme incorporated VCT to identify HIV-positive women, antenatal interventions, modified midwifery practices and treatment with nevirapine, followed after the birth by medical support for mother and child, free milk substitutes for six months, vitamin supplements and prophylaxis for opportunistic infections. However, as of end-2004, this programme was still awaiting Government support and funding for full implementation.

Treatment and care of HIV-infected children: No objectives exist in the national strategic plan specifically related to the treatment of HIV-positive children. However, children are included as recipients of care and treatment strategies. Provincial and national guidelines have been developed on the management of HIV-infected children as well as on the use of ARV drugs, but further training and improved support services and infrastructure are needed if they are to be followed at all levels.

Such training and health system upgrading would also be beneficial for supporting home-based models of care. Home-based care has been found to be very effective in reducing the rate of hospitalization and length of stay in hospital, decreasing the impact of HIV on primary health care services, lowering costs, supporting the family and increasing compliance with treatment regimes (Johnson et al. 2001).

Education

According to the South African Population Census, in 1996 there were an estimated 1.3 million children between the ages of 7 and 18 out of school, with the provinces of the Eastern Cape and KwaZulu-Natal the worst affected. There is, however, no information on the reasons for this figure, which equates to more than 10 per cent of the enrolled school population. Thus, the advent of AIDS-related morbidity and mortality will build on already high levels of voluntary or enforced exclusion, aggravating the impact on education, and contributing to the decline in enrolments, transition rates and output from the system.

Overall Government education response: For the public education system to survive as an effective delivery mechanism for teaching and learning, it is vital that its administrators take a long-term view of the impact of HIV, which will inevitably exacerbate the existing high attrition rates for educators and managers. Consequent conditions and service ratios may therefore condemn declining cohorts of learners to deteriorating quality and standards of achievement for the foreseeable future.

Clearly, an adequate response to the challenge of AIDS requires both a systemic and sustainable management effort, together with development of appropriate curricula, and relevant sexual and reproductive health education materials, in order to effect behaviour change.

Welfare

Government responses: The South African Government has committed line ministries to providing a continuum of care for vulnerable children and expresses commitment to integrating HIV care and support across sectors. Further coordination is now needed at national, provincial and grassroots level. Government policy with regard to the care of children orphaned by AIDS, according to former Deputy Director of HIV/AIDS in the Department of Social Services and Population, Sakina Mohammed, is to concentrate on "empowering the community to take care of orphans". It is felt that institutions are a short-term solution with long-term negative implications for child welfare. The state has placed a moratorium on setting up new homes and is concentrating instead on foster care. Ninety four per cent of institutional places for children have been closed, and it is hoped that the funds saved will soon be allocated to support foster care. Nevertheless, despite the Government's moratorium, new institutions are appearing with the support of FBOs, NGOs and the private sector. Effort needs to be made to redirect funds and energy to the support and development of community-based models of care, so that children are not left on their own to care for their sick parents.

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