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Public Health in South Africa: AIDS and Child Welfare

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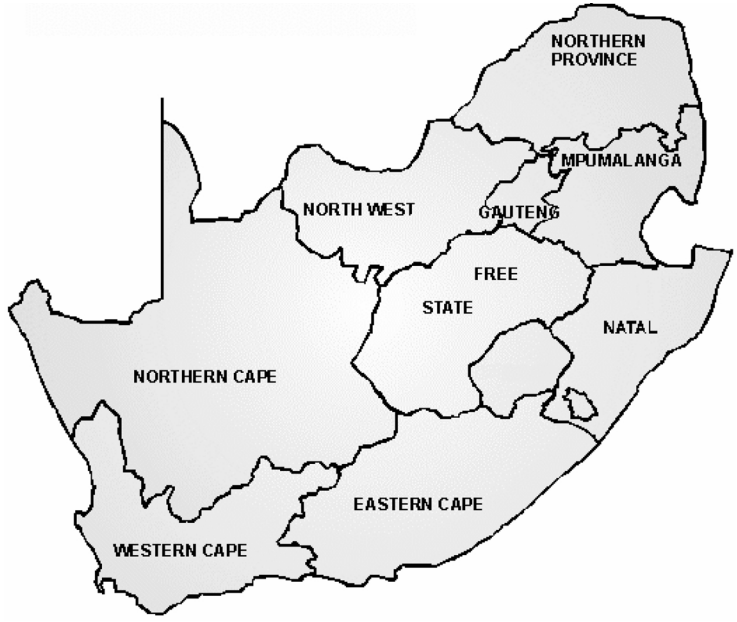
I. Overview of Health in South Africa

A. Health Status

The life expectancy of South Africans is 62.8 years, with the Western Cape and Gauteng both having life expectancy rates of over 65 years and most of the other provinces close to 60 years. The maternal

Figure 1 Provinces of South Africa



mortality rate is estimated at around 150 deaths per 100,000 births, which is very high in relation to developed countries.

Infant mortality rates in 1998 (based on a household demographic and health survey) were 45.4 deaths for every 1,000 live births. The Eastern Cape had the highest infant mortality rate of 61.2 deaths per 1,000. For young children under one year of age, the major causes of death remain preventable disorders such as perinatal conditions, infections including diarrheal disease, and respiratory problems.

In the last decade, there appears to have been a reversal in the child mortality rates and this is illustrated in figure 2 below. The deterioration in these indicators is thought to be directly attributable to the impact of the AIDS epidemic.

The household survey also showed that 80% of all children have received measles immunization with nearly two thirds receiving their full schedule of immunizations by the age of one year.

Other important health status data from this survey show that, on average, the fertility rate is 2.9 children per fertile woman. However, there is a gradient correlating with education. Women with higher education have a fertility rate of 1.9 as opposed to women with no education who have a fertility rate of 4.5. Nearly all women are aware of

Figure 2 Child Mortality Trends

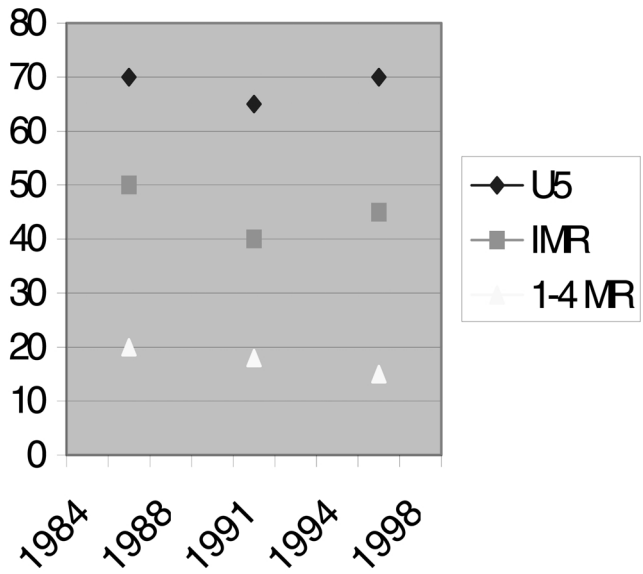


Table 1 Socio-Demographic Indicators by Province

	Population 1997 (millions)	Proportion of Population Percent	Population less than 5 years (1996 %)	Population 65 years and older (1996 %)	Population Urbanized (1996 %)
South Africa	43.1	100	10.9	4.8	53.7
Eastern Cape	7.0	15.5	12.0	5.8	36.6
Free State	3.0	6.5	9.5	4.5	68.6
Gauteng	7.2	18.1	8.9	4.1	97.0
KwaZulu-Natal	9.2	20.7	11.5	4.5	43.1
Mpumalanga	3.1	6.9	11.6	4.1	39.1
Northern Cape	0.8	2.1	10.6	5.0	70.1
Northern	5.5	12.1	13.1	5.2	11.0
North West	3.6	8.3	11.2	4.6	34.9
Western Cape	3.7	9.7	9.6	5.1	88.9

methods of contraception and almost three-quarters of women have used a contraceptive method.

Tuberculosis remains the single most important infectious disease. More than 150 out of every 100,000 people in the general population developed tuberculosis in 1996 and 1997. In some provinces, such as the Northern and Western Cape, the rates were over 500 per 100,000 people. These are among the highest rates in the world. The two diseases, tuberculosis and HIV infection, both affect the immune response and more and more people are likely to be dually infected.

Other important aspects of health status include the large number of non-natural deaths due largely to violence and traffic accidents. In particular, violence against women is an important cause of morbidity. In the 1998 household survey, more than one in ten women reported being beaten by their partner and nearly one in twenty reported having been raped.

II. History of Health Policy in South Africa

A. Public Health Prior to 1994

The first phase, roughly the century prior to 1919, was characterized by increasing organization, institutionalization, and professionalization of health care, due to British influence. Before 1807, there was little structure to the health care system in South Africa. British influence resulted in the construction of numerous military and civilian hospi-

tals. A series of legislation was aimed at regulating the practice of health care and containing the spread of epidemics. Despite these developments, neither uniformity nor coordination of policy was achieved until 1919. The international influenza epidemic of 1917 was the main impetus to further change.

A second phase of health policy development, the period 1919 to 1940, began with the proclamation of the Public Health Act of 1919, which established the first Department of Public Health in an attempt to coordinate health care more effectively at the national level. However, this period saw little substantive and positive evolution in health policy; developments favored exclusion and segregation of sectors of the population and there was a reluctance to take active steps to solve the increasing health problems of the time.

The third phase, the years 1940 to 1950, heralded an exciting period in health care in South Africa. Attempts were made to redirect health policy, to rid the prevailing system of its numerous structural deficiencies, and to restructure and reform it in every important respect. During this period, the vision of a unified, comprehensive, and state-funded national health service — based on primary care in the form of a network of comprehensive health centers — was cultivated and even began to be realized. However, these progressive visions of reform were stifled as a result of political change.

The fourth phase, spanning roughly the period 1950 to 1990, commenced with the victory of the National Party in the elections of 1948. This phase was characterized by legislated racial discrimination and segregation, which affected not only the way health services were organized, but also the very health of the people. Health policy development closely mirrored the ideology and social engineering of the white minority government. By the end of this period, there were fourteen national departments of health, one each for the ten homelands/bantustans and another for each of the four "ethnic/population" groups in the rest of South Africa.

The period 1990 to 1994 brought the first serious attempts to effect a significant break with the past. Changes were initiated under increasing pressure from a progressive health sector demanding fundamental reform of the health sector and beyond. This phase was marked by efforts to bring about "de-fragmentation" and deracialization of government structures and health care facilities by attempts to emphasize primary health care; by a more sober and guarded approach to privatization; and, with mounting intensity toward the end, by jockeying for

position in the future health service by health authorities, institutions, and individuals alike. However, the steps toward reform originated and were taken within the framework of a still racially segmented and undemocratic society, which meant that reforms were cosmetic rather than fundamental. Below are some more glaring points:

- Prior to 1994, there was massive inequity in resources available to the private and public sectors. Private sector spending was (and remains) around 60% of total health expenditure while the users of the private sector comprise around 20% of the population. This is equivalent to a six-fold difference in spending. (The inequities of resources between public and private have increased since 1994!)
- The private sector operated almost totally independently, with little government control.
- The public health sector had a number of characteristics which made it inequitable including:
  - —Fragmentation of the organization of health services, i.e., between different homeland governments, provincial governments, central government, and local governments.
  - —Fragmentation between curative and preventive services with additional fragmentation of very centralized, vertically driven programs (e.g., family planning).
  - —Health services oriented toward hospital-based (especially academic/tertiary hospital) curative care.
  - —Racial discrimination in access with many institutions having duplicate facilities and separate entrances for whites and blacks.
  - —Underfunding of services in certain geographic areas, especially rural and peri-urban township areas where the vast majority of blacks lived.

B. Developments since 1994

A number of accomplishments have been achieved since 1994. These include:

- The creation of a national health system, with cooperation between the national and provincial health departments.
- A clearly stated policy of primary health care, accepted with national support.

- The transformation of the public health system from a fragmented, racially divided, hospital-centered service favoring the urban population into an integrated, comprehensive national service driven by the need to redress historical inequities and give priority to providing essential health care to disadvantaged people, especially those living in rural areas.
- Elimination of discriminatory practices and structures in the public health system.
- Expansion of the primary-care infrastructure through building and upgrading clinics.
- Making health care free at the point of delivery for all using the public primary care system.
- Launching a National Drugs Policy and introducing an Essential Drugs List appropriate to the level of care.
- Improving access to health services in disadvantaged communities through the introduction of community service for new South African graduates and employment of over 400 Cuban doctors. Community service is planned to be extended to other health worker categories, e.g., dentists and pharmacists, over the next few years.
- A more rational and equitable distribution of resources based on increasingly sophisticated resource allocation formulas.

III. Some Challenges Facing the Health Sector

As a result of fiscal discipline and the Growth, Employment and Redistribution (GEAR) strategy, there have been absolutely declining health budgets per capita for the past few years. The key component of expenditure, personnel cost, has not been under the control of health services management. The only way to reduce staff costs in the short term has been through voluntary severance packages. This has led to unplanned reduction of services, which has had many negative consequences. Indeed, the management of personnel in the civil service is one of the key economic and social challenges facing the government as a whole.

Another problem relating to the redistribution of resources and the attainment of equity was that the rural and disadvantaged provinces,

which benefited from redistribution, did not have the capacity in the short term to absorb the increases given to them.

The management of health services in the public sector has been extremely centralized in the past. With the change in policy and an emphasis on a decentralized, geographically based, district public health system, there is a far greater need for well-trained, effective health managers. Unfortunately, there is a dearth of such skills in the country.

Planning for and training human resources are the most important areas for a successful public health service. Human resource development will need far greater attention in the future and the country is still waiting for a coherent human resource policy for the health sector. Further, the relationship between the public and private health sectors needs to be better defined and there needs to be greater collaboration between these sectors.

Within the public sector, the role of local government needs greater definition and elaboration. However, the restructuring of local government, culminating in elections for new structures at the end of 2000, will give greater clarity to this unsolved problem.

A. HIV/AIDS and STDs

Estimates by the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicate that the epidemic of HIV in South Africa is one of the fastest growing in the world. Unless a cure is found, the majority of the 3.6 million South Africans already infected with HIV will die

Figure 3 HIV Prevalence, Antenatal Clinic Attendees, 1990 to 1998

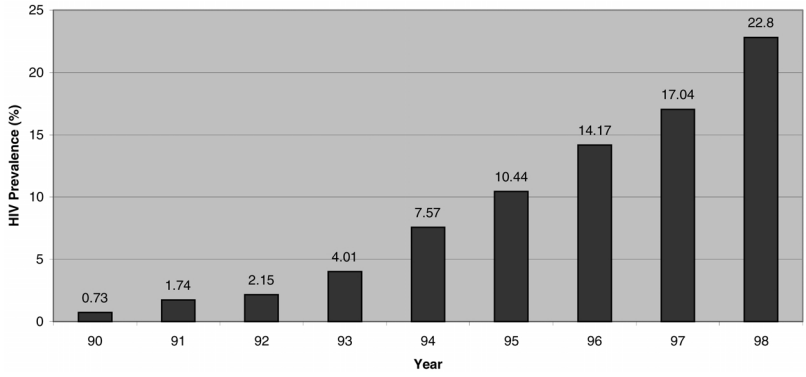


Table 2 HIV Prevalence among Antenatal Attendees by Province, 1997 and 1998

Province	Est. HIV+ 1998	Est. HIV+ 1997	Rate of Increase %
Eastern Cape	15.9	12.6	26.2
Free State	22.8	20.0	14.0
KwaZulu-Natal	32.61	26.9	20.8
Gauteng	22.5	17.1	31.6
Mpumalanga	30.0	22.6	32.8
Northern Cape	9.9	8.6	15.1
Northern Province	11.5	8.2	40.2
North West	21.3	18.1	17.7
Western Cape	5.2	6.3	0
South Africa	22.8	17.01	33.8

within the next ten years. If there is no success with interventions to reduce the spread of HIV, an additional 550,000 persons will become infected each year. This will have a major impact on all aspects of life in South Africa.

The HIV prevalence determined in pregnant women attending antenatal services in the public sector is a good indicator of the progress of the epidemic in the general population. Figure 3 shows the progression of the epidemic in South Africa since the inception of this annual survey in 1990. Prevalence has increased from less than 1% in 1990 to almost 23% in 1998.

Table 2 shows that:

- The national HIV prevalence of women attending antenatal clinics in 1998 was almost 23%. This represents an increase of 34% on 1997 figures.
- Prevalence in the provinces continued to rise.
- There is a gradient of infection in the provinces from the Western Cape in the southwest to KwaZulu-Natal in the northeast.

Table 3 shows that:

- HIV prevalence among pregnant women continues to rise, with those age 20–29 having the highest rates.
- Prevalence among pregnant women under 20 years of age has risen by 65%.
- The exceptionally rapid increase of HIV infection in teenage women is a serious cause for concern.

Table 3 HIV Prevalence by Age Group: Antenatal Clinic Attendees, 1997 and 1998

Age group	Est. (HIV+) 1998	Est. (HIV+) 1997	Rate of Increase %
<20	21.0	12.7	65.4
20–24	26.1	19.7	32.5
25–29	26.9	18.2	47.8
30–32	19.1	14.5	31.7
35–39	13.4	9.5	41.1
40–44*	10.5	7.5	40.0
45–49*	10.2	8.8	16.0

Levels of Infection among the General Population

It is estimated that:

- Approximately 3.6 million South Africans were living with HIV at the end of 1998, compared to 2.7 million in 1997.
- One in eight adults (15 to 49 years of age) are infected with HIV, or between 12 and 14 %.
- Current estimates suggest that over 1,500 South Africans are infected with HIV each day or 550,000 per annum.
- Projections into the 21st Century
  Based on modeling of the data without effective interventions:
  —National adult infection levels will be at 5 million by 2002.
  —250,000 South Africans will die of AIDS each year by 2002.
  —500,000 South Africans will die of AIDS each year by 2008.

B. Impact of HIV/AIDS

It is estimated that:

- Average life expectancy will fall from 60 years to 40 years between 1998 and 2008.[1]
- Infant mortality will rise from under 50 per 1,000 to over 60 per 1,000 in the same period.
- Current estimates show that about 25% of children admitted to hospitals for all reasons are HIV infected and in those areas with the highest prevalence rates, this figure exceeds 50%.

The epidemic will result in a large number of orphaned children. In 2005, it is estimated that a million children under the age of 15 years will have lost their mothers to AIDS. The number of AIDS orphans will increase to two million by the year 2010.

The impact of the AIDS epidemic will be most evident in the health sector. In Gauteng, it has been estimated that adult hospital bed needs will increase from 2,000 in 1998 to over 10,000 in 2010, a 600% increase over the next ten years, unless more effective and efficient ways of caring for people with HIV are implemented. There is anecdotal evidence that currently acute medical hospital beds have between 30 and 50% usage for AIDS-related conditions. There is no doubt that HIV will consume a large proportion of future health budgets. In addition to the health sector, the impact of HIV will be most marked in the educational and welfare sectors while it will have a significant impact on the economy, development, and poverty, as well.

Levels of Infection with other Sexually Transmitted Diseases

The interaction between HIV and the other sexually transmitted diseases (STDs) has been known for a number of years. The presence of an STD in an HIV negative partner increases his/her susceptibility to HIV during sexual intercourse with an HIV positive partner, while an HIV positive partner is more infective when s/he has an STD.

As part of the Demographic and Health Survey undertaken by the Department of Health in 1998, men were asked about the symptoms of a STD. 12% of men over 15 years of age reported having the symptoms of a discharge and/or an ulcer during the previous three months. Prevalence was highest in the 15 to 44-year-old age group, although prevalence for all age categories was over 10%. This prevalence is very high.

Knowledge of AIDS and Behavioral Surveillance

Information from the 1998 South African Demographic and Health Survey shows that 97% of women between 15 and 49 years of age have heard of AIDS. However, their knowledge of ways to avoid AIDS was limited, with up to 10% stating that staying with one partner and using a condom during sexual intercourse would not protect them against AIDS. 21% still believed that transmission could take place by sharing public toilets while 38% felt mosquitoes could spread HIV. The impli-

cations of these data are that much more needs to be done in educating the general public.

National AIDS Plan

The South African Nation AIDS plan has three primary objectives and this section gives some details of these objectives and the strategies to achieve them.

- Prevent the Transmission of HIV
  1. Prevent sexual transmission
  2. Prevent transmission through blood
  3. Prevent perinatal transmission
  4. Promote policies and programs which address changes in the socioeconomic conditions predisposing the population to the spread of HIV
- Reduce the Personal and Social Impact of HIV Infection
- Mobilize and Unify National, Provincial, Local and International Resources.

C. Prevent the Transmission of HIV

The prevention of HIV infection still remains the dominant response to the epidemic in South Africa. There are four strategies associated with this objective:

1. The Prevention of Sexual Transmission

In South Africa, as in most countries, the health care approach dominates HIV prevention efforts. This response arises from the World Health Organization's (WHO) individual risk reduction strategy:

- Correct and appropriate information/education
- Health and social support services (such as counseling, testing, STD management, and condom distribution)
- Non-discrimination towards people living with HIV/AIDS.

This response to the epidemic is based on the assumption that risk behavior must be minimized at the individual rather than at the community or societal level. The critical point about this approach is that all three elements have to be accessible to individuals in order for them

to sustain positive behavior change. The provision of information and education is of little benefit if appropriate or accessible support services are not available to facilitate behavior change.

a. Information/Education and Counseling (IEC)

Appropriate counseling remains a very important aspect of prevention, particularly pre- and post-test counseling.

Life Skills Programs in Schools

Given the rapid increase in HIV infection among youth, life skills education in schools is a priority. The National Life Skills Project Committee was established in 1995.

- By the end of 1998, two teachers in every secondary school throughout the country had been trained in life skills education.
- The focus has now shifted to primary schools, with pilot training of teachers in the Free State, Gauteng, North West and Northern Provinces.
- Most activities occur in "pockets" and are not generalized to the whole province and the implementation of the program is slow in rural areas.
- Conservative elements in certain schools have delayed implementation. The question of condom promotion and availability in schools continues to be controversial.
- There are concerns that teachers are not ideally placed to conduct life skills education and that it should be implemented through a peer-based approach.

b. Barrier Methods

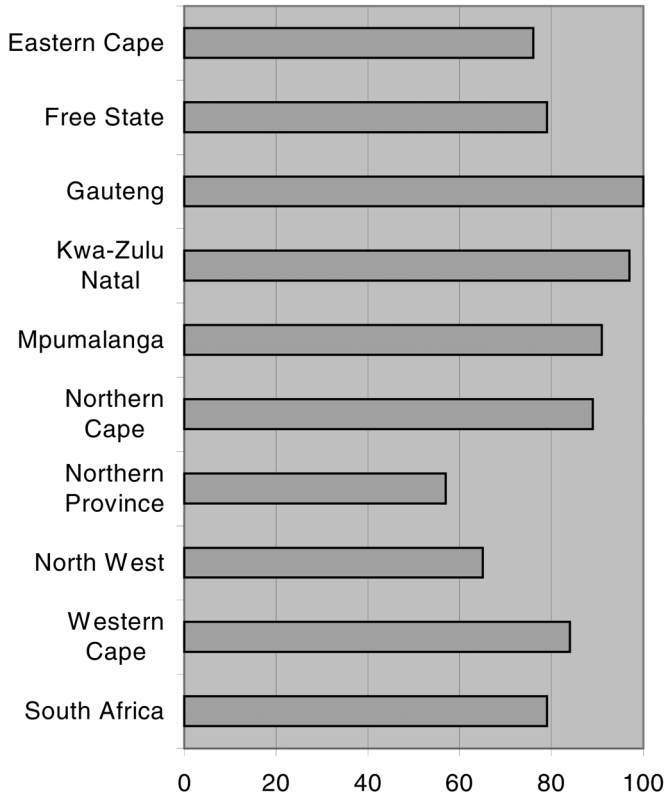
Access to and utilization of condoms is a critical factor in controlling the spread of HIV.

- There has been a rapid increase in demand for condoms from 1.2 million per month in 1995 to 15 million per month in early 1999.
- In 1998, the government purchased 160 million condoms, up from 140 million in 1997.

The single biggest challenge is persuading individuals to use condoms consistently. The survey conducted in 1998 suggests that adolescents and adults have still not internalized the risks of unprotected sexual intercourse. While gender programs have been very good at persuading women to use condoms, their successes have been considerably limited by the attitude of men toward condom use.

Figure 4 shows the availability of condoms in a sample of primary care clinics in the nine provinces.

Figure 4 Percent of clinics with condoms in their waiting rooms



Sexually Transmitted Disease (STD) Management and Control

- STD management and control is the most advanced of all the HIV prevention strategies.
- Extensive training in STD management has taken place in all provinces to implement policy guidelines.

- All provinces surveyed reflected very few problems with service delivery. In Gauteng, for example, over 80% of 300 clinics are delivering on policy.
- This is not the case with private medical practitioners. Studies show that the quality of care in the private sector and in the workplace is poor.
- A "best practice" model for STD control is the Lesedi Project, in a mining community, where the presumptive treatment of STDs in sex workers has led to a significant decrease in STDs among miners who work in the area. The project estimates that the intervention has reduced HIV infections by 46%.

c. Protection of the Rights of People with HIV/AIDS

- In its approach to HIV prevention, the WHO has included non-discrimination toward those most at risk and those infected. The decision was prompted by field experience showing that fear of discrimination led those most likely to be infected to avoid participating in prevention programs. A number of laws that protect the rights of people living with HIV/AIDS were enacted and promulgated during 1998/99. The Employment Equity Act (Act 55 of 1998) eliminates unfair discrimination in any employment policy or practice. HIV is explicitly listed as a ground of non-discrimination. The Medical Schemes Act prohibits discrimination against members or prospective members on the grounds of pregnancy, disability, or state of health.
- Despite this progress in legal and policy formulation around human rights, there is still discrimination and human rights abuse of infected and affected persons. This is evidenced by the murder of Gugu Dlamini in KwaZulu-Natal in December 1998 after she disclosed her HIV status on a public platform.

2. The Prevention of Transmission through Blood

Since the mid-1980s, the supply of blood products in South Africa has been safe. With the rapid escalation of the epidemic placing pressure on blood transfusion services to keep blood products safe, increasingly stringent screening of donors has taken place.

Between 25 and 35% of babies born to HIV positive mothers are infected. A short course of AZT to pregnant mothers shortly before birth and to the babies after birth reduces transmission by up to 50%. However to provide AZT to every prospective mother would require a great deal of logistical expertise and would also require extra staff time over and above the cost of the medicine. The provision of drugs to pregnant mothers has been one of the major public debates raging over the past year and at the time of this writing the issue has not yet been resolved.

There is, however, a growing ethical concern related to the health care provider's obligations to ensure the respective survival rights of mother and baby, and this, coupled with the dilemmas of caring for the orphan infants, is receiving considerable attention.

D. Reduce the Personal and Social Impact of HIV Infection

As the HIV epidemic develops in South Africa, there is a rapid increase in the number of people who are becoming symptomatic and dying. There are three main strategies to lessen the impact:

- The provision of counseling, care, and social support for persons with HIV/AIDS, their families, and the community
- The provision of social welfare services for persons with HIV/AIDS, their families, and the community
- The reduction of the macro-social economic consequences of HIV/AIDS.

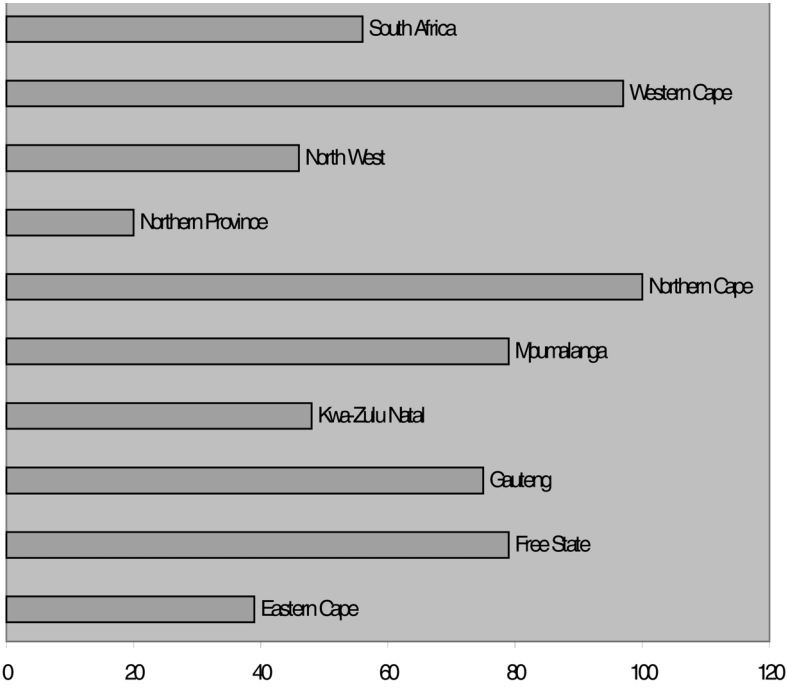
1. The Provision of Counseling, Care, and Support

The appropriate treatment and support for people with HIV infection have not been given priority in South Africa. There is a need for the documentation of best practices and guidelines on implementation.

One controversial issue is the current move by government to make AIDS a notifiable disease. This notification is to be anonymous and to be used for tracking and planning purposes only. It is also to inform caregivers. From a monitoring point of view, such notification information is likely to be inaccurate, as persons with HIV will be reluctant to divulge their status until there is a climate of nondiscrimination and acceptance.

Figure 5 shows the availability of HIV testing in primary care facilities. That only around three out of every five clinics have testing facilities is indicative of the great strides that still have to be taken in coming to grips with this epidemic.

Figure 5 Percent of clinics which offer HIV testing, 1998, by province



2. The Provision of Social Welfare Services

Many studies show the potential impact of the epidemic, particularly in terms of social welfare services.

Two issues are particularly important at a local level:

- The intensification of poverty as a result of AIDS-related mortality and morbidity
- The problem of how to cope with the increasing numbers of orphans.

E. Mobilize and Unify National, Provincial, Local and International Resources

This objective is the least developed of the three outlined in the AIDS Plan.

The NACOSA Plan emphasizes three strategies to achieve this objective:

1. Mobilize commitment, support, and resources
2. Strengthen national, provincial, and local capacities to respond to HIV/AIDS
3. Strengthen international efforts in the Southern African region

1. Mobilize Commitment, Support, and Resources

There are three interventions associated with this strategy:

a. Promote common intersectoral strategies and coordination
b. Ensure financing through mobilizing provincial, national, and international funds
c. Promote community involvement and coordination with NGOs.

Intersectoral Strategies and Coordination

Intersectoral strategies and coordination are essential components in mobilizing commitment, support, and resources. South Africa has not mobilized on a scale sufficient to create a critical mass of action in the face of the epidemic. There are, however, a number of encouraging developments at a national level. One of these measures is the establishment of the Inter-Ministerial Committee (IMC) at the end of 1997, which created a platform for ministries to strategize and mobilize collectively. Early in 1998, the IMC developed the Government AIDS Action Plan for South Africa (GAAP) to mobilize South Africans in controlling the epidemic. This plan is intended to address two critical weaknesses hindering the expanded response to the epidemic — the lack of political commitment and limited intersectoral collaboration. The plan provides a strategic framework that is adaptable to different regions, communities, and circumstances. Planning will happen on a sectoral basis with consolidation of plans to be discussed at annual National AIDS Summits. Deputy President Mbeki launched the plan in October 1998 and called on all South Africans to join in a "Partnership

against AIDS." Sectoral pledges were made (e.g., from business, trade unions, and youth). This has been followed by the mass mobilization phase of the plan, using key calendar dates and activities to promote partnership building. For example, on World AIDS Day, all cabinet ministers were highly visible around the country pledging their support for the AIDS effort. There is strong evidence to suggest that the mobilization campaign has caught the attention of South Africans and that AIDS is widely spoken about.

One of the key roles of the Beyond Awareness Campaign in the AIDS Action Plan is to provide tools for action that any program to combat AIDS can use. Items such as the red ribbon and guidelines on developing programs, pamphlets, and posters are readily obtainable from a central AIDS Action office. In addition, the promotion of the red ribbon has achieved much success in increasing the profile of the program to combat the epidemic in South Africa.

Although the amount of funds mobilized and utilized in controlling HIV in South Africa has never been quantified, it is known to be large. Funds are mobilized from many different sources. It is, however, the larger donor amounts (e.g., United States Agency for International Development, the European Union, and the Department for International Development) that tend to be quantified. With the exception of Gauteng, all provinces report very little financial support from their respective governments. This reflects limited political commitment on the part of most provinces.

2. Strengthen National, Provincial, and Local Capacities to Respond to HIV/AIDS

This strategy poses many challenges. While the demands of the epidemic have increased substantially, there has not been a simultaneous strengthening of the AIDS programs. The net result is an HIV/AIDS response that is still relatively uncoordinated and lacking in vision, strategy, and management.

The role of national and provincial AIDS programs is to coordinate the implementation of the response. This is an extremely difficult task. The difficulties of these programs include:

- The low status of AIDS programs in many provinces and the subsequent absence of a visible presence at a district level.

- The lack of human resources within programs. In some provinces, there is only one person responsible for HIV/AIDS. In others, there is a heavy reliance on secondary staff. This reflects a lack of true commitment to control the epidemic.
- AIDS programs, both nationally and provincially, engaged in implementation at the expense of coordination and management.
- The inability of programs to advise politicians on appropriate policy.
- The lack of planning for local implementation despite this being the thrust of national health and development policy.
- Provincial coordinators lacking management skills.

The AIDS program in Gauteng stands out in contrast to all the other provincial programs. Political commitment in Gauteng started with an impact assessment of the HIV/AIDS epidemic on Gauteng as a province and on the government as an employer. This study was carried out under the auspices of an interdepartmental committee. It was a very effective way to begin the process of gaining political commitment. Through this process, the AIDS program in Gauteng became an interdepartmental initiative, with Health as the lead ministry. The benefits to the program have been significant. The AIDS program reports directly to the cabinet and derives its budget from an allocation from each ministry. This is the reason for the budget of R40 million in 1998. Despite its many challenges, the program is structured and funded in such a way that it can provide strategic leadership to the HIV/AIDS effort in the province. In large measure, this has been made possible by political commitment that is translated into a strong resource base for provincial action.

Little information is collected to measure and monitor the epidemic in South Africa. Indicators used generally relate to input or output such as number of condoms distributed, teachers trained in life skills education, and number of HIV/AIDS events held. There are few measures that monitor the impact of programs and interventions. In addition, the prevalence of HIV will only begin to decline sometime after interventions are successful. Thus, intermediate indicators are required such as the prevalence of high-risk behavior and of STDs in the general population and in sub-populations.

A number of conclusions can be drawn regarding the attempts at combating HIV/AIDS.

- The first is to translate political commitment into strong national and provincial AIDS programs.
- The second is to harness the skills and expertise within civil society through the establishment of intersectoral management committees to work alongside government AIDS programs. Not only will this provide an added dimension to strategic thinking, but it will also broaden the response from a government to a country response.
- The third is to learn from what has worked. The epidemic has reached the stage where large numbers of people now have symptomatic HIV infection.

It is clear that South Africa is facing a catastrophic epidemic. The window of opportunity to prevent a large-scale epidemic has passed. The country now has to contend with the social and economic effects of large numbers of HIV-infected and affected people. The control of this epidemic will only be achieved through sustained action in a well managed program that is based on interventions that have been shown to work and in a programme in which all South Africans can participate.

IV. Child Health and Welfare

A large proportion of South Africa's population is comprised of infants, young people under the age of 18 years, and women of childbearing age. Many of these people live in the rural areas, where widespread poverty still prevails. In these areas, poor maternal and child health is exacerbated by inadequate social, economic, and physical infrastructure, limited access to appropriate services, and a scarcity of all those resources required to promote and maintain child well-being.

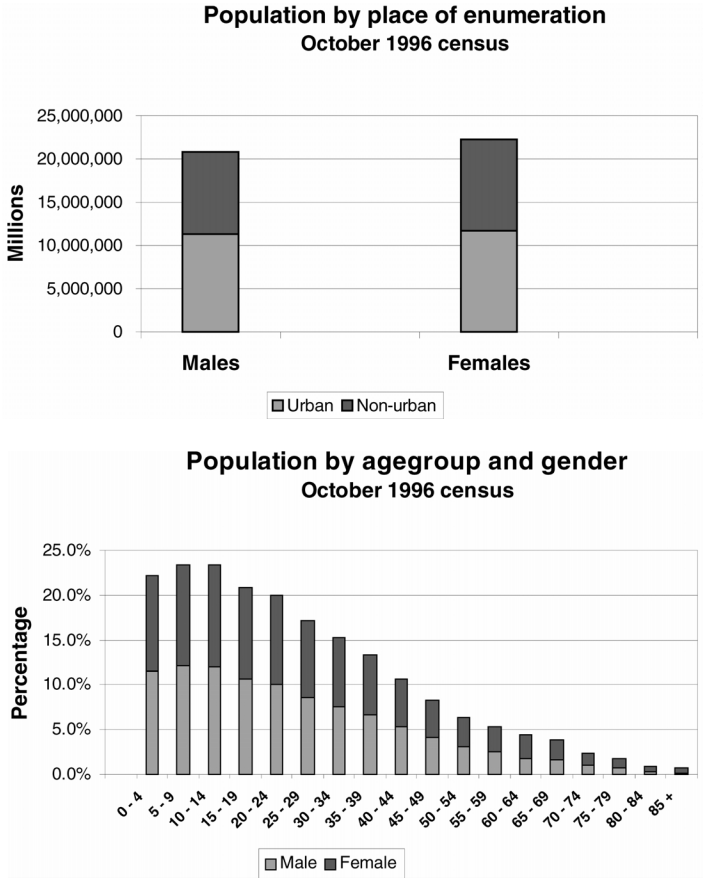
Until 1994, when the new democratic government came into power, there was no comprehensive policy to promote and protect the overall well-being of children. For child health in particular, there was no explicit health policy for this large, vulnerable sector.

Recognizing that children need special consideration in social and economic development policy, the new democratic government took several steps to address the legacy of neglect. The Reconstruction and Development Programme (RDP) made specific reference to policies and programs for children, the most significant of which were declaration of free basic health care for children under six years and pregnant women, and an elementary school-based nutrition program. Although

subsequent evaluation revealed some limitations, these programs provided a firm foundation for development of child-focused activity by government, while giving a clear indication of the seriousness of government's intention to address the plight of children.

In 1995, the newly-elected parliament ratified the Convention on the Rights of the Child, and, in the following year, included a dedicated component entrenching child rights in the new South African Constitution. Government followed this up by developing a National Plan of Action for Children as a framework to guide the realization of child rights by institutions of both the state and civil society.

Figure 6



Source: Statistics South Africa. 1996 Census in Brief (1999).

A. Framework for a National Program of Action for Children

The framework, based on the Convention on the Rights of the Child, defined the policy areas related to promotion and protection of child rights and child well-being, and identified the sectors (both governmental and non-governmental) with responsibility for each policy area. It was designed to guide child-focused actions by government and civil society, while at the same time providing a basis for evaluating such actions with respect to their compliance with the dictates of the Convention. Thus, within a period of less than two years, the new government had created a rights-based framework with which every governmental department was requested to comply through development of child-oriented policies and programs.

Within this framework, civil society defined its own contribution to implementation of child rights. Following years of advocacy for children through activities such as campaigns for their release from detention in the apartheid repression, pressuring government to adopt the Convention on the Rights of the Child in the face of widespread abuse of their rights, and providing alternative services for children with special needs when government failed to acknowledge such need, the national child rights movement has now achieved recognized partnership with the new government.

B. Response by the Health Sector

The fragmentation that characterized South Africa during the apartheid years was very apparent in the health sector. This situation, along with the failure to recognize children as a group worthy of special consideration in comprehensive policy and programming, presented the new government with an opportunity for substantive redress within the framework of its obligation to meet the requirements of the Convention on the Rights of the Child. Recognizing the right to adequate health care as fundamental, policies for children promoted equitable access through provision of free health care for young children under six years old, and the development of a "package" of essential health care services for every child in South Africa. Evaluation of the free care policy showed broad appreciation for its intent, but both health care providers and the beneficiaries expressed concerns about its implementation. Key among these was the inappropriate use of hospital services, seen to be aggravated by declaring free

Table 4 Summary of Sectors Responsible for Implementing the NPA

Policy Area	Sector(s) with Lead Responsibility	Supporting Sectors
Nutrition	Agriculture, Health	Labor, Land Affairs, Posts, Telecommunications and Broadcasting, RDP, South African Communication Services, Trade and Industry, Water Affairs and Forestry, Welfare and Population Development
Child and Maternal Health	Health	Agriculture, Education, Environmental Affairs and Tourism, Housing, RDP, South African Communication Services, Water Affairs and Forestry and Welfare and Population Development
Water and Sanitation	Housing, Water Affairs and Forestry, Constitutional Development	Agriculture, Environmental Affairs and Tourism, Health, Home Affairs, Education, Land Affairs, Public Works and RDP
Early Childhood Development and School Education	Education and Welfare and Population Development	Agriculture, Arts and Culture, Environmental Affairs and Tourism, Health, Housing, Labor, Mineral and Energy Affairs, Posts, Telecommunications and Broadcasting, RDP, South African Communication Services, Sports and Recreation, and Water Affairs and Forestry
Social Welfare Development (Family Environment, Out-of-Home Care and Social Security)	Welfare and Population Development	Arts and Culture, Science and Technology, Education, Health, Justice, Labor, Posts, Telecommunications and Broadcasting, RDP, South African Communication Services, South African Police Services, Sports and Recreation
Leisure and Cultural Activities	Arts and Culture, Science and Technology and Sport and Recreation	Education, Environmental Affairs and Tourism, Housing and RDP
Child Protection Measures	Correctional Services, Justice, South African Police Service, Safety and Security and Welfare and Population Development	Agriculture, Arts and Culture, Science and Technology, Education, Foreign Affairs, Health, Home Affairs, Labor, RDP, Safety and Security, Sports and Recreation and the President's Office

access to this level of care. Since this time, the policy has been modified, enabling free care only at the primary level, and at other levels on referral.

1. The Right to Basic Health Care

The draft Health Bill stipulates "the right of access of all South Africans to a basic package of health care." While the strategy of ensuring health care for all children through a set of basic interventions is

worthy in its intent, careful consideration needs to be given to the foundations of the chosen approach and its implementation in practice.

An example is the adoption of the World Health Organization initiated program of Integrated Management of Childhood Illnesses. Based on the assumption that the deaths and disease affecting the majority of the world's children are caused by a small number of preventable disorders, viz., malnutrition, diarrhea, respiratory infections, and the childhood diseases preventable by immunization, the program proposes a core set of preventive and curative strategies to address these conditions. Missing from the "basic package" are interventions to address tuberculosis and HIV/AIDS—a serious omission in a country where both these conditions have reached epidemic proportions.

This has resulted in the development of complementary packages to target these serious problems, and the approach could herald a cascade of separate packages—each developed for a new priority—leaving the children as vulnerable to piecemeal interventions as they were before.

But the right to health care extends beyond the primary level and beyond office hours, and an important consideration is finding a balance between ensuring essential services for all children and providing special services for those who need additional care. The latter includes after-hours care and care for children with chronic illnesses.

Providing Health Care "After-Hours"

A recent evaluation of after-hours health care services for children in the public sector illustrates the pitfalls of ignoring the special needs of children in a system of comprehensive primary care.[2] Focusing on the primary care facilities in greater Cape Town, the study found that children with common illnesses, like respiratory illness, had to share space—and a queue—with adults traumatized by gunshot and stab injuries. These children also had difficulties of access when being referred to another level for emergency or specialist care, a situation which was further compromised in daytime hours by the contractual obligations of their employed caregivers.

Comprehensive care should be available for 24 hours a day, and the challenge of providing such services, to both adults and children, remains a problem.

Care of Children with Chronic Diseases

Conditions like diabetes, epilepsy, and asthma constitute the second component of the "double burden" of ill health borne by children in developing countries. While the burden of the first component comprises the preventable conditions associated with poverty, the burden of the second component is largely linked to societal transition, rapid urbanization, and changes in lifestyle.

There are no national estimates of the burden of ill health associated with chronic conditions, but estimates of some marker conditions provide an indication of the extent of the problem. In the Western Cape, one in ten children is estimated to have asthma, and studies on deaths from asthma also show that the proportion of child deaths is increasing.

Another chronic condition that needs attention is mental illness. Mental health care for children has been low on the national list of priorities, with grossly inadequate services. Widespread under-diagnosed postnatal depression has serious implications for infant mental health, while for older children, the burgeoning problem of substance abuse is a major cause of morbidity and mortality.

In general, chronic illness of childhood is worthy of special consideration in both budgetary allocations and service provision, and is an area that is sorely in need of policies and plans.

Specialist Services

In the face of declining health care budgets, the services that have suffered greatly are those delivered by expensive tertiary care institutions. A case study from the Red Cross Children's Hospital in the Western Cape illustrates the dilemmas linked with finding the right balance. This is the only hospital in the country solely dedicated to the care of children. Serving more than 200,000 ambulatory patients and 25,000 in-patients per annum, the hospital provides unique specialist and sub-specialist services to children at a provincial, national, and regional level. Over the past five years, the number of beds has been reduced by 22%, and in the past year, the budget has declined by 30%.

As the hospital has been affected by indiscriminate budget cuts to tertiary hospitals across the board, those who advocate for children and their rights regard the notion of children enjoying a "first call" with serious skepticism.

Table 5 Extent of Child Under-Nutrition by Province in South Africa: Anthropometric Status of Children 6–72 months

Province	% Wasting	% Stunting	%Underweight
Eastern Cape	3.2	28.8	11.4
Free State	4.5	28.7	13.6
Gauteng	1.2	11.5	5.6
Kwazulu-Natal	0.7	15.6	4.2
Mpumalanga	2.5	22.8	15.6
Northern Cape	1.7	34.2	12.6
Northern Province	3.8	20.4	7.3
North West	4.5	24.7	13.2
Western Cape	1.3	11.6	7.0
South Africa	2.6	22.9	9.3

Source: The South African Vitamin A Consultative Group, 1995

2. The Child Health Budget

To ensure realization, the basic right to health care has to be followed by a basic set of resources, and crude estimates of health expenditure in South Africa show that of the 10% of gross domestic product spent on health, about 22% is dedicated to child health promotion and nutrition. Within this pool of about R50m (1997 estimate), the bulk of the money is concentrated in the urban areas of wealthier provinces, with the larger proportion expended on tertiary care.

There have been proposals that expenditure be targeted at marginalized communities in greater need of care, and that priority funding be given to primary and secondary level services. Such drastic action, without any consideration for the overall funding of health care for children at all levels, could have disastrous consequences.

3. The Right to Basic Nutrition

Malnutrition among South African children is still a serious problem. A national survey of preschool children, undertaken in 1995, showed that one in every four suffers from chronic undernutrition, which results from lack of food. (See Table 5.)

This survey also showed that one in every three South Africans has Vitamin A deficiency, increasing their vulnerability to serious complications of infections such as diarrhea and pneumonia. Provinces with especially high rates of Vitamin A deficiency are the Northern province and KwaZulu-Natal.

Widespread undernutrition is a major risk factor for child deaths and disease, especially from infections. The introduction of an integrated and comprehensive national nutrition policy and program was a timely and essential response to ensuring a child's right to adequate nutrition, to survival, and to development. Underpinned by a radical shift from addressing nutritional problems through a welfare approach to one rooted in social and economic development, the program includes a wide range of components, from ensuring household food security and income generation to breastfeeding promotion to food supplementation.

One important intervention to address this problem is the primary school nutrition program, which has been in operation since 1994. By 1996, the former program reached nearly one million children in schools in areas of need — out of a target of 8 million. This example illustrates the size of the task needed to make a real difference to child nutrition.

4. The Right to Safety and Protection

The international media captured the flagrant violations of children's rights to safety and protection from abuse in the 1970s and 1980s. While the climate has changed, the events of those years has resulted in a culture of violence that is given expression through continued use of corporal punishment in schools, sexual and other forms of physical nonaccidental injury, and the burgeoning problem of firearm-related injuries.

The reporting rate for crimes against children is increasing, and from 1994 to 1998, the number of reported child rapes doubled from 7,559 to more than 15,000. In a twelve-month period between 1997 and 1998, the Red Cross Hospital recorded almost 7,000 admissions for trauma-related injuries, most from falls, motor vehicle accidents, and burns.

The health services are seriously engaged in efforts to address these problems, and legislation has been given special attention by the policy-makers. The Child Care Act (being drafted at present) aims to provide equity of access to welfare support for children, while the national child abuse protocol provides clear guidelines for the prevention and management of the terrible problem. The Schools Act now prohibits the use of corporal punishment but there have been calls for its rein-

statement, especially from crowded, under-resourced schools, where alternative forms of discipline are difficult to implement.

Hence, the real solution lies in addressing the crux of the problem: a culture of violence that is deeply entrenched in the psycho-social and economic fabric of South African society.

Two other groups in need of special consideration are children in prison, and those who are on the streets. For the former group, little attention has been paid to development of policies or programs for their general care in prison. Reports indicate that the situation is in need of urgent attention. The extent of the problem of children on the streets has defied assessment, but their large and increasing numbers have drawn the attention of nongovernmental organizations and other agents of civil society to their plight.

5. Children with Special Needs

Child disability is the most serious contributor to the burden of disease for South African children. Based on crude measures of the extent of the problem, an estimated half a million children are in need of disability services. Ensuring children's rights to protection in special circumstances includes development of strategies to prevent disabilities arising from causes such as birth-related events, services to diagnose and manage the medium-term health outcomes of disability, and a coordinated rehabilitation response from health, welfare, and education authorities.

The National Integrated Disability Strategy, launched by the Office of the President in 1996, estimated that in 1997, almost 70% of disabled children of school age were not at school. Today, for those who are at school, very little budgetary provision has been made for special education, with only 1% of all South African schools being equipped as "special" schools. Policy for special education has shifted to encourage mainstreaming, with variable results (and with particular problems experienced in historically disadvantaged schools).

The disability strategy emphasizes a developmental and integrated approach to the broader needs of the disabled child. Among these, access to financial support remains a critical component, and one that eludes many needy children. While caregivers are entitled to apply for assistance, administrative inefficiency often obstructs the award of social assistance.

One concern is that free health care has not been consistently extended to include rehabilitation or assistive devices, and disabled children who are unable to go to school are also denied other social benefits, like school meals.

Child disability presents a special set of challenges for health, education, and welfare authorities, and demands acceleration of the good intentions proposed in national policies and plans.

6. Environment and Health

The scope of attention to ensuring the right of children to a healthy environment has been expanded from a narrow focus on water and sanitation to include other environmental threats such as tobacco smoke, lead, and nuclear emissions.

More than 70% of South African unborn babies are exposed to environmental tobacco smoke, more than 80% of young children in greater Johannesburg have unacceptably high blood lead levels, and studies of the impact of nuclear waste on birth defects have just commenced.

V. Future Challenges

A. Harmonizing Customary Law with National Legislation and the Requirements of the Convention

In customary law, there is no clear definition of the end of childhood or the start of adulthood. This progression is not determined by chronological age, but rather by maturity, initiation, marriage, and other traditional practices. This has implications for recognition of marriages, as stipulated in national legislation, as well as for other legal transactions involving adults (over the age of eighteen years). Other areas of potential conflict reside in the areas of succession, legitimacy, custody, and transfer of parental rights.

The definition of *child* in South African law needs more attention, as various definitions are applied in different settings.

B. Reducing all Forms of Abuse of Children, including Corporal Punishment and Humiliation

There is no doubt that the widespread flagrant physical and sexual abuse of children needs attention, and plans for a national strategy are

underway. More subtle expressions of abuse are of major concern, as the greater proportion of South African society accepts smacking and humiliating children as acceptable forms of discipline. Campaigns to end such forms of abuse against children have had far less success than the bigger campaigns against serious forms of abuse, but these need to be encouraged as one facet of changing fundamental societal practices that are prejudicial to children.

C. Ensuring that National Programs and Policies are in the Best Interests of Children

Of increasing concern are the apparent contradictions between government-initiated social development programs, such as the National Programme of Action for Children (NPA), and the new macroeconomic policies, which have resulted in decreased social spending.

The latter, the Growth, Employment and Redistribution Strategy (GEAR), has placed significant strain on the safety net for children, especially those who remain vulnerable to economic risk. Under these circumstances, child advocates continue to focus on the need for the best interests of the child to be given prime consideration in all areas of governance, in national legislation, and in the national budget.

In the new government, coordination of the NPA is undertaken from the President's office, as a unit called the Office of the Status of the Child. It reports directly to a Cabinet committee responsible for all social issues. Although this has elevated the stature of the NPA, true elevation can only be achieved when children get similar recognition in the budget.

D. Introducing Comprehensive Child Legislation

The adoption of a single piece of legislation to promote and protect the well-being of children is underway in South Africa. The new legislation being drafted by the South African Law Commission will include defining children's legal status, measures to protect them from abuse and sexual offenses, incorporation of customary and religious law, and protection of children in special circumstances (such as work, homelessness, provision of care).

Within each of these provisions, there are special considerations related to the narrower responsibilities of the health sector, and these need further elaboration.

E. Promoting Children's Rights to Participation and Having their Views Respected

One fundamental premise is children's rights to participation. In countries such as the United Kingdom, special attention is being paid to ensuring children's rights in interactions with their health care providers. Accelerating the realization of people's right to participation in the health care process has been assisted by inclusion of a patients' Bill of Rights in the Draft Health Bill, and children need special attention in this regard.

Acknowledging the importance of the views and opinions of children—in matters of their health, their education, their welfare, and the state of society — can go a long way to creating a society that truly places the interests of children first.

The rights of children have been firmly entrenched in the South African Constitution, and policies to give effect to these rights are also well developed. Analysis of the status of children shows the multifactorial nature of their vulnerability, and highlights the needs for intersectoral action, supported by adequate resources from central government coffers.

Implementation of actions is underway, but is in danger of deteriorating once more into piecemeal interventions. Developing a better understanding of children in poverty, and especially in the multicultural South African society, could be an important step in the development of holistic, effective interventions.

Monitoring the impact of these actions on the overall health and well-being of the children will guide future efforts to close the loop in meeting child health needs through a rights-based approach. ◉

Notes

1. The trends in the AIDS epidemic continue to worsen with over four million people in South Africa estimated to be currently infected with HIV. In the *World Health Report 2000*, "Health Systems: Improving Performance," the World Health Organisation estimates that the current life expectancy at birth is 47.3.

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