YOUTH & FAMILY DEVELOPMENT

HUMAN SCIENCES RESEARCH COUNCIL

THE STATE OF CHILDREN IN GAUTENG

A REPORT FOR THE OFFICE OF THE PREMIER, GAUTENG PROVINCIAL GOVERNMENT

MAIN REPORT

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Professor Andy Dawes
Principal Investigator

CONTENTS

SUPPLEMENTS TO THE MAIN REPORT

ACRONYMS (For the full report including supplements)

AFP - Acute Flaccid Paralysis

AIDS	- Acquired Immune Deficiency Syndrome
ANC	- Antenatal Care (coverage)
ASSA	- Actuarial Society of South Africa
BCEA	- Basic Conditions of Employment Act
CASE	- Community Agency for Social Enquiry
CAS	- Crime Administration System
CBO	- Community Based Organisation
CBR	- Community-Based Rehabilitation
CCA	- Child Care Act
CDG	- Care Dependency Grant
CIAC	- Crime Information Analysis Centre
CIET	- Community Information and Epidemiological Technologies
CPI	- Consumer Price Index
CJB	- Child Justice Bill
CJP	- Child Justice Project
CPU	- Child Protection Unit of SAPS
CRC	- Convention on the Rights of the Child
CRM	- Child Risk Measure
CYFD	- Child Youth and Family Development
DALY	- Disability-Adjusted Life Years
DHIS	- District Health Information System
DOTS	- Directly Observed Therapy Short Course
DQA	- Developmental Quality Assessment Programme
DSD	- Department of Social Development
DSO	- Decentralised Service Office (of the Gauteng Department of Social Services and Population Development)
DSSPD	- Department of Social Services and Population Development
EA	- Enumerator Area
ECD	- Early Childhood Development
EPI	- Expanded Programme of Immunisation

FBO	- Faith-Based Organisation
FCG	- Family Group Conferencing
FCS	- Family Violence, Child Protection and Sexual Offences Unit of SAPS
GDE	- Gauteng Department of Education
GDP	- Gross Domestic Product
GERTOF	- Gauteng Early Childhood Resource and Training Organisation Forum
GJWSSDF	- Greater Johannesburg Welfare Social Service and Development Forum
GP	- General Practitioner
GPAC	- Gauteng Programme of Action for Children
GYD	- Gauteng Youth Directorate
HAART	- Highly Active Antiretroviral Therapy
Hib	- Haemophilus Influenzae b
HIV	- Human Immunodeficiency Syndrome
HSRC	- Human Sciences Research Council
ICD-10	- International Classification of Diseases- Tenth Edition
IDASA	- Institute for a Democratic Alternative in South Africa
IDP	- Integrated Developmental Plan
IES	- Income and Expenditure Survey
IMC	- Interministerial Committee on Child and Youth Care
IMCI	- Integrated Management of Childhood Illness
IMR	- Infant Mortality Rate
JCWS	- Johannesburg Child Welfare Society
LBW	- Low Birth Weight
LRTI	- Lower Respiratory Tract Infections
MEC	- Member Executive Committee
MOU	- Midwife Obstetric Unit
MRC	- Medical Research Council
MVC	- Motor Vehicle Collision
NACCW	- National Association of Child Care Workers
NCCEMD	- The National Committee on the Confidential Enquiries into Maternal Deaths
NCCS	- National Crime Combating Strategy

NFCS	- National Food Consumption Survey
NGK	- Nederduitse Gereformeerde Kerk
NGO	- Non-Governmental Organisation
NHC/MIS	- National Health Care Management Information System
NICRO	- National Institute for Crime Prevention and Reintegration Organisation
NIMSS	- National Injury Mortality Surveillance System
NMR	- Neonatal Mortality Rate
NPA	- National Prosecuting Authority
NPO	- Nonprofit Organisation
NQF	- National Qualifications Framework
NSCAN	- National Strategy on Child Abuse and Neglect
ODP	- Organisational Developmental Plan
OoP	- Office of the Premier (Gauteng)
ORS	- Oral Rehydration Solution
OSDP	- Office on the Status of Disabled Children
PAG	- Probation Advocacy Group
PHC	- Primary Health Care
PHRU	- Perinatal HIV Research Unit
PMTCT	- Prevention of Mother to Child Transmission
PPIP	- Perinatal Problem Identification Programme
PSNP	- Primary School Nutrition Programme
RAF	- Road Accident Fund
SADHS	- South African Demographic and Health Survey
SAFMH	- South African Federation for Mental Health
SAHRC	- South African Human Rights Commission
SALC	- South African Law Commission
SAMM	-Surveys Analyses Modelling and Mapping
SANCA	-South African National Council on Alcoholism and Drug Dependence
SANCCFW	- South African National Council for Child and Family Welfare
SAPS	- South African Police Services
SAVACG	- South African Vitamin A Collaborative Group

SAYP	- Survey of Activities of Young People
SAYStOP	- South African Young Sex Offenders Programme
SBR	- Still Birth Rate
SID	- Sudden Infant Death Syndrome
SMLC	- Southern Metropolitan Local Council of Johannesburg
SNA	- System of national Accounts
SOCA	- Sexual Offences and Community Affairs Unit of SAPS
Stats SA	- Statistics South Africa
STD	- Sexually Transmitted Disease
STI	- Sexually Transmitted Infection
TB	- Tuberculosis
TMI	- Transvaal Memorial Institute
TOP	- Termination Of Pregnancy
TUS	- Time Use Survey
U5MR	- Under 5 Mortality Rate
UN	- United Nations
UNCRC	- United Nation's Convention on the Rights of the Child
UNDP	- United Nations Development Programme
UNICEF	- United Nations Children's Emergency Fund
UNISA	- University of South Africa
VCT	- Voluntary Counselling and Testing
WHO	- World Health Organisation
WMISSD	- Welfare Management Information Systems Subdirectorate
YES	- Youth Empowerment Scheme

EXECUTIVE SUMMARY

The fundamental purpose of this report is to aid The Office of the Premier in the Gauteng Government (the OoP) by providing a picture of the status of children (under 18 years of age) and services to children in the priority areas below as identified by the OoP:

- Children in Poverty.
- Early Childhood Development.
- Health safety and health care.
- The impact of HIV/AIDS on children.
- Vulnerable children including:
    - *Children awaiting trial*
    - *Child labour*
    - *Commercial sexual exploitation of children.*
- Children with disabilities.
- The girl child.
- Abused and neglected children.
- Children affected by violence.

DATA SELECTION, DATA SOURCES AND LIMITATIONS

The report relies on secondary data analysis and draws on *the most recent data* in each priority area. However, as a function of the nature of the available information, there are limitations in the data reported. The data sources available for this project are fragmented and for the most part do not permit the sort of analysis that would assist best policy practices. Apart from survey and research data, the report draws on administrative data from Gauteng Government. Administrative data was often difficult to obtain, and when obtained it was often not prepared in a manner that permitted analysis.

One of the requirements of the research was to link child status to service needs, and services are located at local level. The health sector has the most information of this kind as will be evident below. However, in most of the other priority areas this is not the case as there is no integration of information on the situation of children and services to children in the province.

Approach to this executive summary

Only main cross cutting findings are presented here. Detailed recommendations in each area will not be presented. The focus will be on the main recommendations for information systems and data collection that arise from all the priority areas.

This executive summary is oriented around two questions:

1. What are the crosscutting findings in priority areas that link to children in poverty?
2. What is the quality of current data for the monitoring of the status of Gauteng children, and what are the foremost data needs?

CHILD POVERTY AND ITS LINKS TO THE MAIN AREAS OF DEPRIVATION AND PROBLEMS AFFLICTING CHILDREN IN GAUTENG

It is well established that conditions associated with poverty have the *most powerful and pervasive impact* on the broadest range of negative child outcomes. Other influences aside, as poverty conditions increase, the risks to prenatal development, neo-natal and child health, child care, exposure to accidents and violence, poor educational preparation and attainment, all increase.

Poverty during the early years may be more damaging than when it occurs later particularly where health and educational outcomes are concerned.

Many of the specific health, rehabilitation and developmental needs of disabled children are not likely to be met in conditions of enduring poverty. In addition, the problems of emotionally vulnerable children are likely to be compounded.

Furthermore, in the area of psychosocial development, the research is clear that child outcomes become worse *in proportion to the number of risks to which children are exposed*.

It is *enduring developmental* contexts that are particularly powerful in shaping long-term child outcomes. It is for this basic reason that *long-term poverty* in particular is associated with a range of negative outcomes for children.

These facts are recognized in the commitment of the Gauteng Provincial Government to poverty eradication as well as to a range of programmes designed to protect children in poverty (particularly in early childhood), and reduce its impact on child health and other outcomes.

While the available data does not always permit an examination of each priority area in relation to the child's poverty status, interpretive links are made where possible.

Key findings on child poverty in Gauteng

Definition: For the purpose of this report, child poverty is defined as children who live in the poorest 40% of households (an income of less than *R4 382.00 per capita per annum).* The information

presented on poverty is based on the Income Expenditure survey conducted by Statistics South Africa in 2000.

There are clear indications that child poverty is a serious problem in the province.

- *More* families are living in poverty now than in 1995.
- Almost *half* of Gauteng *children* (48%) live in poor households.
- An equal proportion of girls and boys are affected.
- *Fifty one percent* of under fives live in poverty,
- *Forty eight percent* of children 6-12 years,
- And *46%* of children 13-17 years live below the poverty line.
- Poorer magisterial districts have the highest concentrations of children.
- The proportion of children living below the poverty line (i.e. earning less than R4 382.00 per capita per annum) is much higher among *Africans* than other groups.

The proportion of children living below poverty line by population group is as follows:

- African 55%
- Coloured 32%
- Indian 15%
- White 3%

Poverty impacts on all areas of development. This is evident in the findings below.

Key indicators: Maternal and child Health

- IMR and U5MR: In 1998, the IMR was *36.3, and* the U5MR was *45.3*[1]. Both figures are better than the national average, and are only surpassed by the Western Cape. *Infant and child mortality rates have increased* in the province over the past five years largely due to the HIV pandemic and possibly deepening poverty.
- MMR: *maternal mortality rates have increased* in the province over the past five years[2]. This is directly related to the HIV pandemic, and is possibly related to deepening poverty.
- Under-nutrition: 20% of 1-9 year olds and 26% of 1-3 year olds are stunted[3].
- Low Vitamin A and iron levels *remain a concern* in some age groups[4].

[1] Department of Health, et al. (1999). South African Demographic and Health Survey 1998. Preliminary.
[2] Pattinson, R. C. (Ed). (2002). Saving Mothers: Second report on Confidential Enquiries into Maternal Deaths in South Africa 1999-2001. Pretoria: Department of Health.
[3] Labadarios, D. (Ed.). (2000). National Food Consumption Survey: Children aged 1-9 years, South Africa, 1999. Pretoria: Department of Health.
[4] South African Vitamin A Consultative Group (SAVAGG). (1996). Anthropometric, vitamin A, iron and immunisation coverage status in children aged 6-71 months in South Africa, 1994. S. Afr. Med J, 86(4), 354-357.

- Immunisation coverage has improved. In 2003 79% of one year olds are immunized in the province[5].
- Diseases: since 1998 the numbers of diarrhoeal and respiratory illnesses in the province have decreased[6]. In 2002 Lower respiratory track infections in children under five accounted for 5% of visits to local council clinics and 59.4 children per 1000 sought treatment for diarrhoea from PHC facilities[7].
- Maternal mortality is a sensitive indicator of the status of women, their access to health care and the adequacy of the health care system in responding to their needs.
- Maternal mortality; during 1999-2001, 17.8% of maternal deaths reported nationally came from Gauteng and in 2000 MMR was 112 per 100 000 births[8]. The high maternal mortality rate generally reflects weakness in the delivery of health care. Specifically, it reflects poor care during pregnancy, insufficiently trained staff, inadequate facilities, and the lack of transport and means of communication.

Key indicators: HIV/AIDS

- Overall HIV prevalence in Gauteng (all ages) is between **14.7%[9] and 16%[10]**
- Prevalence among women attending antenatal clinics:..... **29.8 %[11]**
- Prevalence among Gauteng youth aged 15-24 .....**11.6%[9]**
- Youth living in urban informal areas: ..... **13%[10]**
- Prevalence in 15-49 age group (both sexes): .....**20%[9]**
- Prevalence among women of childbearing age: ..... **25%[10]**

Prevalence rates in this last group are recognised by Unicef to be a *key indicator of risk to children*. They should be monitored regularly. District Health Information System 2002 data -preliminary. 2003

Key indicators: ECD

Early childhood development programmes are an essential strategy to address some of the risks of poverty. However the study found that most children are not getting an ECD service, and that high-risk areas are poorly resourced. For example:

[5] Gauteng Expanded Programme on Immunisation Survey, 2003 (Courtesy: S. Fonn).
[6] Department of Health, et al. (1999). South African Demographic and Health Survey, 1998. Preliminary.
[7] Gauteng Provincial District Health Information System. (2003). 2002 data-preliminary.
[8] Gauteng Provincial Government. Health status of women improving in Gauteng. 8-4-2002.
[9] Shisana, O. & Simbayi, L. (2002). Nelson Mandela/HSRC study of HIV/AIDS: SA national prevalence, behavioural risks and mass media household survey. Cape Town: HSRC
[10] Dorrington, R. et al. (2002). HIV/AIDS profile in the provinces of SA Indicators for 2002. Cape Town: MRC.
[11] Department of Health. (2002). National HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in SA, 2001. Pretoria: Department of Health.

- Children attending ECD**:** In 2000 **24%** of children up to six years in Gauteng were attending a known ECD site. This means that **76%** are not attending and many of these children are likely to be deeply poor and highly vulnerable to health and psychosocial risks[12].
- The proportion of boy and girl children attending ECD services was **50%** in each case, consistent with the population profile[12].
- Population groups and access: white children under 7 years had higher access than other population groups[13].
- Quality and poverty: High-risk poverty areas (*informal urban settlements)* were markedly lower on measures of infrastructure, educational programme and the training and experience of educators than either those in *rural areas or formal urban settlements*. Another variable associated with poorer quality of provision was whether the site was school, community or home-based[12].
- Home based ECD quality: home-based sites account for **60%** of Gauteng's provision. They are *below average* on indicators of educational programme and qualifications and experience of educators[12].
- Feeding in ECD facilities: In 2002/3 the Department of Health identified the feeding of 90 000 children in 1244 crèches as a goal but output figures were not available[14].

In keeping with national policy and Gauteng's policy development processes, the Gauteng Department of Education is phasing in Grade R and is moving towards the establishment of an ECD institute to take forward the operationalisation of an integrated ECD strategy with a focus on children up to five years

- Relative to other provinces, most sites in Gauteng are well developed in terms of infrastructure and staffing ratios.

Key indicators: Disability

- Prevalence: In the absence of the necessary data, it is not possible to assess the prevalence of child disability in Gauteng. Based on international studies prevalence is likely to be between **3.3%** and **6.4%** of children in the province[15].
- Rehabilitation for the disabled: Only **60%** of Health facilities are accessible to people with disabilities[16].

[12] Williams, T. et al. (2001). The Nationwide Audit of ECD provisioning in SA. Pretoria: Department of Education.
[13] Stats SA . (1996). The people of SA: Population. Pretoria.
[14] Gauteng Department of Health. (2002). Annual report 2001/2002.
[15] Community Agency for Social Enquiry (CASE). (1999). "We also count" The extent of moderate and severe reported disability and the nature of the disability experience in South Africa. Pretoria: Department of Health.
[16] Gauteng Provincial Government. Address by premier Mbazima Shilowa at the opening of the Gauteng Provincial Legislature, 2-24-2003.

- Poverty and disability: Children with disabilities are profoundly affected by poverty. The most marginalized disabled children include those children with severe and profound disabilities, and children living in disadvantaged areas with mild to moderate intellectual disabilities. The research indicates that the mildly to moderately intellectually disabled child living in a poor area and the most severely disabled children, are receiving the least amount of care in terms state support, rehabilitation and education.
- Burden on poor families: Poor families carry a huge burden with a disabled child. However, the data suggests that less than half of the disabled children eligible for Care Dependency Grants are actually receiving them.

Key Indicators: Psychiatric disorder

- Prevalence: In the absence of the necessary data, it is not possible to assess the prevalence of psychiatric disorders including mental disability in Gauteng. Based on international studies prevalence is likely to be **14% to 20%** of all children in the province[17].
- Poverty and psychiatric disorder: The risks to children with psychiatric vulnerabilities increases under poverty.
- Tertiary level treatment: for psychiatric disorders in the public sector are extremely limited, and the need for services is likely to be far greater than services available.

Key Indicators: Substance abuse

- Prevalence: In the absence of the necessary data, it is not possible to assess the prevalence of substance abuse in Gauteng. A study conducted in Pretoria (Ladikos, 2000) showed that 23% of children <12 and 34% of 15-16 year old had tried to smoke dagga while another study (Rocha—Silva et al, 1996) showed that 22% of children below 10 years had smoked their first cigarette.
- Tertiary level treatment: for substance abuse are limited.

Key indicators: Child Safety, violence to children and sexual abuse

Sexual Abuse

- Prevalence: Due to problems with data collection, it is not possible to establish the prevalence of child sexual and other forms of abuse. In one study in Gauteng, *20% of females and 13% of males* reported experiencing sexual abuse before the age of 18[18].

[17]Lazarus, R. et al. (1997). Enhancing coping, competency and mastery: a strategy for developing mental health services for children and adolescents in the Vaal and W Rand regions. Technical Report prepared for the Mental Health Directorate: Gauteng Provincial Administration. Paper No TK29. The Centre for Health Policy, Department of Community Health, University of the Witwatersrand.
[18] Community Information Epidemiological Technologies (CIET) Africa. (2000). Beyond victims and villains: the culture of sexual violence in South Johannesburg. Unpublished research report. CIET Africa: Johannesburg.

- *Sexual crimes against children* in Gauteng are likely to be very high indeed and to *exceed the national average*. Gauteng is consistently one of the highest risk provinces for sexual crimes: Rape, Attempted Rape and Indecent Assault on children. SAPS figures for 2001 show that **29 530** sexual crimes to children were reported[19].
- Regional distribution of sexual violence: SAPS units receiving the most cases are (in order of descending frequency) Vaal Rand, Pretoria, Johannesburg, Soweto, and Benoni.
- Commercial exploitation and trafficking: There is minimal data on commercial *sexual exploitation* and *child trafficking.* Prevalence is therefore unknown. This is not unusual given the nature of these crimes.
- Given high levels of poverty coupled with the HIV/AIDS pandemic, girls are likely to become increasingly vulnerable as they loose their caregivers and a source of economic support.

It is not easy to link data on child sexual abuse and violence against children in poverty, however we were able to establish that for the most part, violence against children, other violent crime and poverty *are clustered together in certain magistrates districts.*

While not surprising, it is hoped that the information even in this relatively crude state is an aid to planning protection services and interventions for the many children who will be at risk in these areas.

Vanderbijl Park, Johannesburg and Soweto show the highest rates of child sexual assault and high levels of other violent crime. *Wonderboom, Pretoria, Kempton Park, Benoni and Alberton* are also high-risk areas.

While it is encouraging that the province has expanded its set of Child Protection Units, from the evidence available, some areas in particular seem to be under-served. In addition given the very high rates of sexual crime, it would appear that these units are simply insufficient (See Appendix 4).

Child safety and violence

Poverty is associated with a range of risks to child safety. Fires, burns from stoves and road conditions where children play all contribute.

Causes of child death due to injury in Gauteng vary by age[20]:

- *Ages 1-4 years*: drowning and burns.
- *Ages 5-14 years*: transport related accidents, in particular pedestrian accidents, motor vehicle passenger injuries, and drowning.

[19] Annual report of the National Commissioner of the South African Police Service, 1-04 to 31-03-2002.
[20] MRC-UNISA, Crime Violence Injury Lead Programme. (2001). National Injury Mortality Surveillance System data set. UNISA Institute for Health Sciences.

- *Ages 15-17 years*: homicide (due to firearms or stabbing), and transport-related injuries.

It is clear that *traffic accidents* in which children are involved are a major risk to child safety across ages.

Older children are likely to be victims of what is likely to be neighbourhood, school and gang violence.

Four Ss are appropriate to mention here:

- Safety in the home
- Safety in the school and sports fields
- Safety in the streets
- Safety in the environment (e.g. pollution).

Assertive child safety policies can use the four Ss to develop effective interventions to protect children in these areas.

Key indicators: Child Work and labour

Definition: "*child work* is not the same as *child labour"*. The latter term is reserved for work by a child that harms the child or pose as a serious harm. Unfortunately there are no clear guidelines on where the boundaries between work and labour is situated. For the purpose of this report child labour is defined according to the Department of Labour's definition as "work by children under 18, which is exploitative, hazardous or otherwise inappropriate for their age, detrimental to their schooling, or social, physical, mental, spiritual or moral development".

Poor children are at risk of child labour. The problem is exacerbated by parental unemployment and death. It was not possible to obtain an accurate estimate of working children in the province. Systematic studies are required. The limited data suggests a number of risks to these children that commence with poverty conditions:

- Prevalence[21]: Available surveys suggest that about **3**% *of children are involved in economic activity for more than 3 hours per week and most live in urban areas*. Sixty percent (60%) are over 15 years and 39% of these children are paid for their work. Only a small minority *is under the age of 10 years*.
- Gender[22]: More girls than boys are involved. Many child domestic workers, girls in most instances, are taken from rural areas, especially Lesotho and rural settlements of Gauteng, to households where they are meant to work.
- Causes[23]: Family, friends or neighbours, due to poverty, death of a parent or caregiver, or other effects of HIV/Aids, placed the children in domestic work.

[21] Stats SA (2001). Survey of activities of young people in SA 1999. Country report on children's work-related activities. Pretoria: Commissioned by Department of Labour.

- Work conditions[22]: Most children *work long hours, often without time off, leave or even payment*. Those who did get paid received between R150 and R350 per month.
- Hazardous labour[22]: Almost half working children engaged in work that could be defined as *hazardous.*
- Child trafficking: The Southern African regional office of the International Organisation for Migration has recently completed a study on trafficking for sexual exploitation and shows that children are being trafficked either to be used as sex slaves within Gauteng or sold on to other destinations. Some victims have been reported to be as young as 14 years.

Key indicators: Children in need of care and children in the Justice system

This group normally originates in poor communities in which the risks to development are significant. However, there is no integrated data that enables one to establish their origins.

Child care

Key indicators in the *childcare* area include:

- Numbers of children in care: *Comprehensive data on children in need of care is not available* because several different Departments have responsibility for child found in need of care; service delivery is fragmented; most services are delivered by NGOs, and data collection is not centralized. Where information is available, there are many gaps in the data and the appropriate information has not been collected. It *was not possible*, on the basis of the available Provincial and NGO data to obtain an accurate picture of how many children are being *found in need of care,* what their *origins* are, why they are in care, or *how long* they are in care.
- Service quality: information as to *the nature and intensity of services* being delivered to children in care and their families, and the outcome of such services, is not available

Childcare *services* are of concern. The following are few key points:

- Pressure on services: Services for children in need of care are *becoming overwhelmed by impoverished families applying to foster children* who are related to them and already in their care, in order to gain access to the Foster Care Grant. This trend seems at least in part to be an outcome of the *AIDS pandemic*.
- Impact of HIV/AIDS: The influx of AIDS related cases is diverting the province's scarce social work resources into what is essentially a *social security function*.
- Young children in residential care: Large numbers of *infants and very young ch*ildren are being accommodated in *residential* care. Young children are particularly vulnerable to the damaging consequences of institutionalisation.

[22] Sithabile Child and Youth Centre. July (2002). Child domestic workers in the Gauteng Province of South Africa. Sponsored by UNICEF, Johannesburg.

- Resourcing children's homes: Many *children's homes are functioning on very inadequate re*sources. This places children at serious risk in a number of areas of development. It is also probable that the quality of care abrogates children's rights.

Child Justice

In the *justice syst*em, there are a number of threats to child well-being. Despite the efforts of authorities, children who enter the justice system from poor abusive homes and from the streets may be exposed to secondary abuse in the correctional system.

Major threats to child well being and rights in the justice system include the following:

- Assessments: A very small proportion (15%) of arrested children were *assessed* by a probation officer[23]. This is in contravention of the Probation Services Amendment Act (35 of 2002). Assessments are declining and arrests are increasing
- Awaiting trial: on 28 February 2003 there were 444 children *awaiting trial* in Gauteng prisons[24], often for minor crimes and for months in extremely over-crowded cells with limited access to any support services. This situation is *in contravention of the UN Convention on the Rights of the Child* even though South Africa law permits this practice. This is not necessary, as there is capacity for 923 children in *more child-appropriate facilities* in the province for awaiting trial prisoners[25].
- Sentenced children: 23 % *Children who were sentenced to imprisonment at December 2002* were serving sentences of longer than three years. This is an extremely worrying situation and will place a strain on correctional resources. (see Appendix 3 of this report).
- *Children who are sentenced to imprisonment are receiving long sentences*. Twenty three percent (23%) were serving sentences of longer than three years. This is an extremely worrying trend and will place a further strain on the resources
- Diversion: Where children were assessed, half were diverted out of the correctional system. In nearly 50% of cases where an assessment had been done, *diversion* was recommended by the probation officer[26]. This is a strongly positive trend. However, *not more than 25% of all arrested children are currently diverted* from the criminal justice system[27].
- Diversion seems to work: less than 20% of diverted children re-offend over a three-year period[28].
- Monitoring mechanisms have been established by the Department of Social Development in order to monitor the situation of children in the criminal justice system. It is not clear how effective the system is. Closer attention should be paid to the *efficacy of monitoring structures*

[23] DSSPD. (2002a). Administrative data recorded on the assessment of children.
[24] Department of Correctional Services. Sentenced and unsentenced children in prisons in Gauteng as at the end of February 2003.
[25] DSSPD. (2002b). Administrative data on children awaiting trial.
[26] Assessment Register: Youth Offenders, 2002. Pretoria.
[27] Muntingh, L. M. (2002). Sentenced children admitted to prison 1999-2000. Unpublished report. Cape Town: NICRO.
[28]Muntingh, L. M. (2002). The effectiveness of Diversion-A longitudinal evaluation of cases, 2001. Cape Town: NICRO.

to ensure firstly that the number of children awaiting trial in prison is reduced substantially and further, is in line with the objectives of a more child friendly criminal justice as articulated in the Child Justice Bill.

Key indicators: The girl child

An important finding is that much of the data is not stratified by gender. This will be necessary in future if the well-being of the girl child is to be tracked.

- Child Mortality: we have no information on infant and child mortality rates by gender in Gauteng.
- Nutritional status: There is no information on differences in nutrition between boys and girls.
- Immunisation: There is no information on gender differences.
- Abortion: The rate of abortions among girls 16 and under is not known, nor do we know whether they are at greater risk than other age categories in terms of undergoing illegal abortions. It is important to collect this information.
- Sexual Health: Girl children are disadvantaged in the area of sexual health. They have difficulty in accessing contraceptives and exercising their choice of TOP, therefore, data on teen pregnancy (U5MR is high in infants of teenage mothers), access to family planning is necessary.
- HIV/AIDS: The data is presented in the HIV section above.
- Gender violence: Gender violence, in particular the threat of sexual abuse during school and to and from school is a very serious problem hindering education of girls. Figures on prevalence of different types of gender violence against girls and *how* gender violence impacts on girls' education are sorely needed. We know it occurs, but how does its occurrence impact on the learning environment, on teen pregnancy, and school drop out among girls?
- Sexual molestation: Nearly half of the children reported sexual molestation by their male employers, farm labourers, and relatives or customers of their employers[29].
- Cleaning at schools: This is an emerging developmental rights issue for girls. In Gauteng, 8% of school children do 5 or more hours of cleaning and maintenance at school[30]. Girls are far more likely to be doing this work than boys. Other research in schools also suggests that cleaning is often done during lesson time. Further data on treatment of girls at school is needed.

[29]Sithabile Child and Youth Centre. July (2002). Child domestic workers in the Gauteng Province of South Africa. Sponsored by UNICEF: Johannesburg.

[30] Stats SA (2001). Survey of activities of young people in SA 1999. Country report on children's work-related activities. Pretoria: Commissioned by Department of Labour.

- Missing data in high-risk areas: Child prostitution, childcare, drug work, slavery, work done on the streets by street children and illegal domestic work are some of the main forms of child labour that need to be fought. Unfortunately there are few statistics on these issues and most are likely to be underreported.

OVERALL CROSSCUTTING DATA NEEDS FOR THE MONITORING OF THE SITUATION OF CHILDREN IN GAUTENG

If there is one point that unifies all the contributions to this research, it is the poor quality of information available that can provide data on the status of Gauteng children and services to children (This is less of a problem in the health sector).

All sectors without fail noted the lack of good information on service quality. Clearly a range of services are not monitored, particular examples are children in child care facilities and correctional facilities.

The ECD sector has made strides to develop an ECD site quality-monitoring tool. Other sectors could perhaps learn from this experience.

Regular monitoring and collection of data on the status of children as well as their services is essential if the province is to see to it that children receive the best services that can be afforded within budgetary limits. Monitoring will also ensure that the province is able to report in terms of its obligations under the Bill of Rights and the Convention on the rights of the Child.

However the choice of indicators is critical, and role players will need to agree on which indicators are important in each area before decisions as to measurement are undertaken (see main report).

General Information system and data recommendations

Each expert report provides specific recommendations. Overarching points are made here.

- In virtually every area, there is a need for improvement in the design of administrative information systems in the province. This system needs to integrate information from a number of sources.
- The issue is not just a problem of the correct data. This is of course important, as in many areas there is no data available. Rather it is about the correct data to collect in each area and how to integrate across sectors in order to assist in planning and services monitoring.
- If the effects of poverty on children are to be tracked and understood, it is essential that information systems be designed such that the status of children can be linked to the situation of the child's parents or caregivers and conditions in their neighborhood. Since risks to children vary as a function of the environments they live in, it is essential that the child's address be noted.

- All sectors of government need to decide what priority data on risks to children is collected, and when.
- It is best and cheapest to collect a limited amount of good data in key areas. Regularly collected administrative data can service much of this purpose.
- Data should be collected regularly. The time frames will differ for different priority areas.
- The NGO sector covers a wide range of services, and needs to be part of this process.
- More emphasis needs to be placed on reporting data that provides an indication of the status of girl children.
- Where possible and appropriate, the age groups on which data is collected should be similar across different data sets.

The following were the key information needs noted in priority areas (the girl child is covered in the general recommendations above).

Primary data needs in the health sector:

- An effective and efficient health information system is vital for planning and managing health service delivery. Integration of data systems from health districts, municipalities, provinces, the private sector and the national department work is vital. Further, various governmental systems, such as Home Affairs and Public Services impact on the health system and should also be integrated with that of the health system.
- Lack of accurate national, provincial and local (hospital and clinic) data on the magnitude and causes of child, infant and neonatal morbidity and mortality is limiting advocacy and program planning in child health. Information systems, including birth and death registration, need strengthening. Use of rapid epidemiological assessment tools such as the Preceding Birth Technique on a regular basis in all health districts offers a quick, simple and indirect method to compare child mortality rates among districts.
- A child register (computerised) should be set up at each clinic to assist with the identification and follow-up of children who have missed their follow-up date; developing a strategy to follow-up children who have not returned; and establishing a community network to assist in tracing of children.

Primary data needs in the disability, child psychiatric and drug abuse areas:

- As no provincial level data exists, a system is required that will permit the ongoing collection of data to monitor the prevalence in these populations.
- Psychiatric services for children and adolescents as well as rehabilitation services for youth with drug and alcohol problems are likely to be severely under-supplied. Based on probable prevalence figures, estimates of service needs are necessary for planning.

Primary data needs in the child care and justice sectors

Children in need of care

- The DSSPD plans to improve its information management system. This is a *priority*.
- There is a need for the many identified gaps in data collection to be filled.
- Categories of information currently in use must be thoroughly re-examined.
- NGOs must buy into the information management system and submit their statistics regularly.
- Effective linkages must be put in place with other systems involved in child placements such as the courts.
- Because several different Departments have responsibility for child found in need of care, because service delivery is fragmented, because most services are delivered by NGOs, and because data is not centralized, *comprehensive data on children in need of care is not available*.
- Where information is available, there are many gaps in the data and the appropriate information has not been collected.

Child justice

- *Inter-sectoral monitoring systems* have been established by the Department of Social Development to monitor the situation of children in the criminal justice system. This process needs to be monitored in itself.
- Court data on children found in need of care needs to be strengthened and integrated with welfare services data.
- No data could be obtained regarding the *HIV status* of children in the criminal justice system. This is of concern.
- It was not apparent if any special attention is being given to the specific needs *of girl children* in prison. This requires further investigation.
- The *arrest* of children needs to be monitored closely in order to avoid that children enter the criminal justice system unnecessarily on petty charges.
- Closer attention should be paid to the *efficacy of monitoring structures* to ensure firstly that the number of children awaiting trail in prison is reduced substantially and further, is in line with the objectives of a more child friendly criminal justice as articulated in the Child Justice Bill.

Primary data needs in the area of child safety and abuse.

- The *data quality* on child sexual abuse is *very poor* (both state and NGO data). Different agencies collect different data making estimates of the problem very difficult. Data collection systems must be standardized.
- C*omprehensive and reliable data* specifically *focusing on children* is needed to track injuries and violence.
- Minimal co-ordination occurs at present across the various data sources on child abuse, injury and violence. This results in continued differences in data sets that cannot be matched and therefore cross-validated.
- Centralise various data sets in such a manner that they would be easily accessible to decision-makers, practitioners and researchers.
- Link provincial processes to national data collection and information management strategies, through feeding into those debates and collaborating on national level initiatives, thereby ensuring synergy.
- For children at high risk for abuse, particularly those living *within institutions and the disabled* child, monitoring is essential.
- Commercial sexual exploitation and trafficking of children: As noted, data quality is very poor in this area. Despite the considerable difficulties in gathering data, this is a priority.

Primary data needs in the area of child labour.

- There are serious problems in the data availability on the topic of child labour.
- The province's decision as to what to monitor concerning child labour will need to take into consideration the outcome of the *Programme of Action process currently underwa*y.
- There needs to be a clear distinction in the data between child work and child labour.
- Many of the worst forms of child labour-sex work, drug work and domestic work- are not documented and thus no data is available for use. This gap in data needs to be examined and rectified if possible.
- Data that is Gauteng specific needs to be generated, so that a clear indication of the child labour situation can be attained.

CONCLUSION

There are many challenges ahead. The main message of this report is that poverty continues to present a significant threat to the well being of nearly 50% of children in the province. Poverty is associated with a number of risks including increasing child and maternal mortality, high levels of HIV infection, and danger to children. It is also clear that there are many gaps in the data.

The development of good information systems is itself a challenge, however the investment will be worthwhile and will improve the capacity of the province to monitor the status of children and their services.

Recommendations regarding priority indicators for the province are to be found un supplement 2 of this report.

1. INTRODUCTION

1.1 THE RESEARCH MANDATE

The Office of the Premier in the Gauteng Government (the OoP) contracted with the Child Youth and Family Development Research Programme (CYFD) of the Human Sciences Research Council (HSRC) to produce a status quo report on children and services to children in Gauteng. In line with the contract, and where evidence permits, this report pays particular attention to gender, population group, and regional differentiation in the status of children and services to children in the priority areas below as identified by the OoP:

Children in Poverty.

Early Childhood Development.

Health safety and health care.

The impact of HIV/AIDS on children.

Vulnerable children including:

- Children awaiting trial,
- Child labour,
- Commercial sexual exploitation of children,

Children with disabilities,

The girl child,

Abused and neglected children,

Children affected by violence.

Definition: For the purposes of this report, *a child is defined as a person less than 18 years of age*.

The fundamental purpose of the report is to aid the OoP by identifying areas for action and or intervention. In order to achieve this aim, the report attempts to address the following questions:

3. What is the scope and extent of deprivations and problems afflicting children in Gauteng in each of the priority areas identified by the OoP?
4. What gaps in existing services to children and families are evident in each priority area and how should these be addressed?
5. In which geographical areas of the Province are problems relating to children most concentrated?
6. What groups of children and segments of the population are most vulnerable or at risk?
7. What are the social processes and dynamics that create and reinforce vulnerability?

8. What is the quality of current data for the monitoring of the status of Gauteng children?
9. What are the key indicators that should be considered for monitoring the status of children in the province?

Questions 1, 2, 4, and 6 are covered in each priority area. As data is not available in many instances, question 3 will be dealt with in a limited sense with a discussion of regional poverty distribution. Question 5 is dealt with in the conceptual framework, and question 7 is covered at the end of the report.

The OoP posed two further questions. However, they cannot be addressed satisfactorily in a report of this scope.

- What interventions would be most effective in addressing the vulnerabilities and risks associated with children?

  The appendices address this question to a limited degree. A more complete answer would require a separate and intensive investigation in each priority area.

- What resources, opportunities and constraints exist for addressing these vulnerabilities and risks?

  A satisfactory answer to this question would require a range of information including the full extent of the problem to be addressed, the existing services and existing resource allocation. Only the health sector is able to address this issue to any degree.

1.2 APPROACH TO THE RESEARCH TASK

1.2.1 The priority areas and expert reports

The priority areas identified by the OoP cover a complex range of areas some of which overlap. Experts were commissioned to provide in depth reports on the following areas, each of which may be found in an appendix. Each report provides a comprehensive analysis of the priority area and includes recommendations specific to the topic.

Expert reports:

Appendix 1: Maternal and child Health Status and Services
Appendix 2: Children and adolescents with disabilities
Appendix 3: Children in the justice system
Appendix 4: Sexual abuse of children: the problem and the response
Appendix 5: Child Safety and violence to children
Appendix 6: Working children
Appendix 7: Early Child Development
Appendix 8: Children in need of care

Some comment needs to be made in relation to the specified priority areas and the expert papers as it will be evident that there is not a neat correspondence between them.

Rather than commissioning a specific report on the priority area of *child poverty*, this aspect is dealt with in the main body of this document. The same approach has been taken in regards to *HIV/AIDS*. The effects of the pandemic cut across all the priority areas as will be evident from the expert papers. It was felt to be more constructive therefore, to present a more integrated consideration of HIV/AIDS in the main report. In addition, information on the *Girl Child* has been extracted from the expert accounts and is presented as a separate section of the main report.

1.2.2 Data selection, data sources and limitations

Given the limited time available for this investigation, no primary research was conducted. Secondary data analysis was conducted for certain purposes, however in most instances, existing data is reported without further analysis. The detailed analysis of existing data in each priority area is contained in the topics presented in the appendices (other than poverty and HIV/AIDS which are included in the main body of the report).

The report draws on *the most recent data* in each priority area. However, as a function of the nature of the available information, it is necessary to point out certain major limitations.

- There is no policy to collect data on key indicators of child status and well being on a regular basis and in a manner that permits one to link data in different priority areas at the same point in historical time. As a result the data sources available for this project are fragmented and for the most part do not permit the sort of analysis that would assist best policy practices. For example, we have drawn on the 2001 Income and Expenditure Report (Statistics South Africa – StatsSA) in order to describe Gauteng child poverty. However, that data does not permit reliable sub-regional disaggregation. Therefore, when describing the sub-regional situation (see below), the report relies on Census 1996 data. While very outdated, this was the only course of action possible. Optimally, one would wish to link household level information to a range of child outcomes. In some instances this is possible where specific studies have been conducted. However, there is no provincial level data of this kind.
- Apart from survey and research data, the report draws on administrative data from the Gauteng Government. While in most instances the staff tried their best to assist, administrative data was often difficult to obtain, and when obtained it was often not prepared in a manner that permitted analysis. Where these problems have arisen, they are noted in the appended specialist report.
- One of the requirements of the research was to link child status to service needs, and services are located at local level. The health sector has the most information of this kind as will be evident from Appendix 1. However, in most of the other priority areas this is not the case as there is no integration of information on the situation of children and services to children in the province. In addition, it is evident that apart from the maternal and child health priority area, there is little satisfactory provincial level data, and virtually no sub-regional information that would be of use to the policy planner. It is often only possible to make guestimates of the likely need for services. As an example, child sexual abuse is a very significant concern. We need to know the prevalence of the problem to inform planning. An obvious source of provincial data is the South African Police Service (SAPS). However, it is instructive that the police do not record 'child abuse'. They record certain categories of reported crime to children

(see Appendices 4 & 5). While welfare agencies that deal with child abuse do keep records of incidence, the manner in which they define and count abuse varies. Clearly, this situation makes it very difficult for the authorities to plan on a rational basis.

- While services may be in place, children's rights and needs may not be met if they are of poor quality. Quality audits are required in order to assess the match between needs and rights and service provision. As will be evident, there is very little current data on this issue. Indeed, as is reported in Appendix 8 (children in need of care) for example, there is a particular need to ensure the quality of care given to children in foster care and residential settings. The same applies to children in the justice system (Appendix 3). In both situations children are at risk for abuse and neglect. There was very little information available on which to express an opinion on the quality of services, (other than health) at the time of this report.

While these certainly are limitations, they present an opportunity to suggest some ways in which data collection can be improved to strengthen policy initiatives in the service of children and their rights.

1.2.2.1 Regional level data: The choice of magisterial districts

The OoP requested an analysis of regional differences in the situation of children and services to children. This was only possible to a limited extent simply because the available provincial data seldom permits appropriate levels of disaggregation.

The choice of a sub-regional level analysis is an important but complex matter. In discussion with the OoP this was recognised and it was left to the project team to draw on available information and an appropriate spatial unit. The OoP therefore did not specify the unit of analysis for the study.

Spatial units need to be meaningful and appropriate to the questions being asked. Unless studies have been specifically designed to address questions concerning child well-being under particular conditions in particular geographical areas, one is not likely to find much suitable data in surveys within which information is collected for other purposes such as the measurement of adult poverty, employment and so on.

In this study, census enumerator areas (EAs) were considered as one possible geographic unit, but this solution was rejected. There were several reasons for the decision. First, there is very little child data at EA level. Apart from information on adult household members (not parents) such as income, expenditure education and employment (all important in the assessment of children's situation), no data exists for the other priority areas included in this study at EA level. In addition, state services to children such as health, education, police and so on are positioned in relation to districts that do not necessarily coincide with one another, and are normally larger than EAs. For example, Education and Health districts may not coincide, and police precinct boundaries differ from the others.

Because of these challenges, much thought will need to be given in the future to the most sensible units that are chosen to track the situation of children and child services. This is a policy question for the province because it has significant implications for administrative data collection and management.

For the present study, and after careful consideration, we chose to use the Gauteng *magisterial districts* as our unit *for purposes of spatial mapping of data* on the situation of children and child services. This unit permitted the integration of some information, unfortunately from different points in time. In

addition, we felt that these districts would at least make sense to a range of policy makers and other stakeholders who would be able to recognise them by name. In choosing these units, it is recognised that they may not be the most appropriate for future purposes.

1.3 STRUCTURE OF THE REPORT

The report commences with the presentation of the *conceptual framework* used to inform our analysis and interpretation of the data in the priority areas. The framework stresses the manner in which child development is a function of the interaction between the child's unfolding biological and psychosocial capacities, and the physical and human settings in which she or he grows up. The framework also enables an understanding of children's development in poverty and other high- risk environments.

The second section of the report commences with a discussion of *child poverty* in Gauteng, in order to provide a context for the analysis of some of the main sources of risk to children.

Thereafter, we present the findings in the priority areas based on the expert reports contained in the Appendices. Rather than repeating the extensive commentary provided by each expert, the key findings will be lifted out. For an in depth treatment of each priority area (other than poverty and HIV/AIDS) the reader is referred to the expert reports contained in the appendices.

Subject to the availability of data, the report draws attention to particular clusters of negative child outcomes that may be apparent at different ages in girls and boys and associated with the particular circumstances in which the children are living.

The final section of the report presents recommendations regarding the indicators that need to be collected in order to provide good information to inform policy in the future.

2. CONCEPTUAL FRAMEWORK

2.1. CHILD DEVELOPMENT IN CONTEXT

Huston (1994) notes that policies and programmes designed to improve children's health and well being, need to appreciate the way the settings or contexts within which children grow up influence the child's development at different ages. In this section, we provide a conceptual framework for understanding the relationship between the growing child and the multiple sources of influence on development. We then proceed to apply this framework to the development of children under high poverty and high-risk environments.

First, beyond the critical need to ensure child survival and health, our objective in the policy context is to contribute to the increase of positive child development outcomes. What do we mean by this?

It may be helpful to segment positive outcomes (beyond health and survival) into *five competencies,* or the five Cs: They are:

- Competence,
- Connection,
- Character,
- Confidence, and
- Caring (compassion)

The Cs represents:

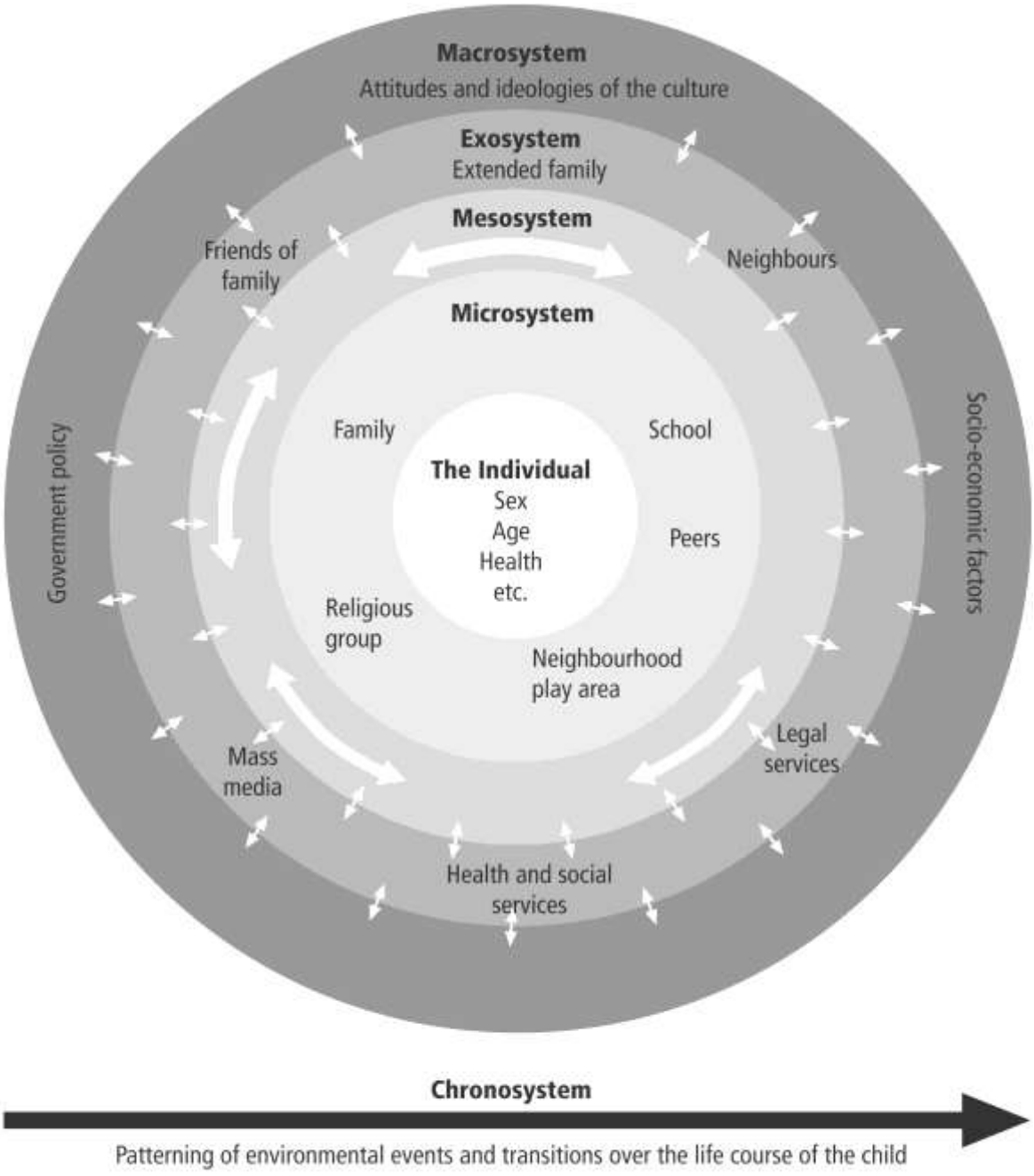
"*Five clusters of individual attributes – for example, intellectual ability and social and behavioural skills; positive bonds with people and institutions; integrity and moral centeredness; positive self-regard, a sense of self efficacy and courage; and humane values, empathy, and a sense of social justice, respectively*." ((Lerner, Fisher & Weinberg, 2002, pp. 16-17).

All these competencies are good indicators of child well being, and all are fundamentally influenced by the child's developmental context.

What do we mean by the child's developmental context? What features of which contexts affect what aspects of the child's development at different ages? These are complex matters, but they are central to the construction of well-informed policies and intervention programmes for children.

Many have found it helpful to approach these issues from an *eco-systemic perspective* originally formulated by Urie Bronfenbrenner (1986) (see Donald, Dawes, & Louw 2001). Ecological models of child-context relationships commonly represent the child as nested within a set of contexts, which influence one another to varying degrees as illustrated in Figure 1.

Figure 1: Child-context relationships



Source: adapted from Cole & Cole (2001)

At the centre of the figure is the child, and the child him- or herself may be viewed as a set of inter-related systems, including biological and psychological subsystems. These subsystems interact with one another. For example, under-nutrition compromises the child's biological system and may cause damage to neurological development. These biological events influence the child's ability to concentrate at school and intellectual development suffers as a result.

The *Microsystem* is the first level of external influence, and refers to contexts in which the child has close contact with another person. These would include a parent-child relationship, the educator–child learning relationship, and the child's relationships with close friends in the neighbourhood.

The different microsystems in which the child is involved may be linked to what is called a *mesosystem*, such that what is learnt in one context may complement or conflict with what occurs elsewhere. This observation has implications for policy and programmes.

Let us take the example of a programme that seeks to reduce aggressive behaviour in foundation phase boys by teaching them non-violent conflict resolution at school. We spend a lot of money on the programme, in the belief that it will make a lasting difference to the children's behaviour. However, we know that at this age the influence of parents is very powerful, and if we do not take that into account in our programming, we may be disappointed in our outcome. For example, if we do nothing to address the harsh discipline used by the parents (that are often associated with child aggression), then the value of the school programme might well be undermined, and we will see little change in the boys' behaviour. This is because the enduring relationships and culture at home are more powerful than the school intervention.

The *exosystem* is a set of external influences and supports that are broader than the more intimate relationships that characterise the lower levels. Note the inclusion of services that potentially support the child and the caregiver.

The outer circle of influence is known as the *macrosystem,* which refers to the political, socio-economic and cultural level of influence on the other components of the ecosystem.

At the political level, we could include the *constitutional provisions* and the *policies* that have been put in place (or need to be put in place) for children. The rights of children enshrined in the South African Constitution provide very significant protections for the child in vulnerable circumstances. These are not just political instruments, but filter through the other two eco-systems to impact eventually on the child. For example, the policy decision banning school corporal punishment is a macrosystem influence designed to increase child protection from violence. Apart from this effect, the policy changes the child's classroom environment and teacher behaviour.

The provision of free health care for young children and the primary school nutrition programme both seek to reduce threats to healthy physical development and improve the child's start in life.

Policy and programming also take place in a *cultural context,* and in Gauteng there are a variety of cultural communities. The beliefs of these communities play a major role in child development particularly when it comes to child rearing and child care. Macrosystem cultural beliefs about childhood provide parents with ideas about such matters as the rights and responsibilities of children, gender socialisation, and how children should be disciplined. In some instances policies will fit well

with prevailing beliefs, in others they will not. Macrosystem beliefs have to taken into account in policy and programming.

2.1.1 Sources of change across development

There is an important point to be made at this stage. It is generally true that *enduring* life conditions and *on-going* negative or positive relationships and conditions have the most powerful influence on child outcomes. For example, the conditions commonly associated with *enduring conditions of poverty* are likely to have more profound effects on a wide range of developmental outcomes than passing or transitory episodes of deprivation (McLoyd, 1998). It is such enduring negative conditions that are associated with the greatest risks to children's development, and which call for prioritisation of policies and interventions.

Furthermore, it is clear that as children *mature with age, they are sensitive to different sources of influence.* While this may appear obvious, depending on the issue that is to be addressed, policy-makers and programme implementation staff need to appreciate the particular sensitivities and capacities of children at different points in their maturation so that policy targeting is appropriate. The importance of maturation and influences at different points in development is captured in the notion of the *chronosystem* in Figure 1.

For example, during infancy the caregiver-child relationship is a potent source of the child's sense of security. By adolescence, peers become an increasing source of influence, in some instances more important than caregivers.

Changes in relationships can also be a function of changes in individual psychological and health states rather than broad developmental shifts. For example, the health status of an HIV+ mother will impact on her emotional availability and thus her capacity to relate to her child. This is likely to have a significant impact on the child's emotional development. A policy implication might be that programmes of support are provided for such caregivers.

Policy and programming may need to take into account changes in the *contexts* within which children develop. For example, many children in South Africa move between different caregivers and households. They also move between town and country for a variety of reasons. Some city families send their children away from the town because they believe the child will be safer in the countryside (Ramphele, 1993; Jones, 1993). Such migrations pose difficult questions for policy and intervention. If migration of this kind is occurring, is the school enrolment system flexible enough to admit this moving population of children at various points in the school year?

Finally, the child's developmental contexts (the mesosystem we referred to earlier) *influence* one another. For example, the developmental setting of the home is influenced by the conditions in the neighbourhood. Negative influences in the neighbourhood or school may have more power than parental values in determining the child's moral development as she spend more time outside the home in middle and later childhood.

In sum, an ecosystemic perspective on child development, together with a *clear understanding of the area of child development* that is of concern, provides a useful conceptual base for the development of policy and programme initiatives. Three general principles may be extracted. These ideas are explored more fully in Donald, Dawes and Louw (2001).

1. Interventions should be informed by knowledge of developmental periods and pathways.
2. As children grow older, different areas of risk emerge, and different risk reduction strategies become appropriate.
3. Where possible, policies and interventions need to be developed at multiple levels. As is emphasised in an ecosystemic conceptualisation, children's development is a product of multiple individual-context relationships that change over time. For example, in very disadvantaged contexts, families, schools and neighbourhoods can all be sources of risk for child development. Optimally, interventions need to consider the relative influence of each source of risk (at different developmental periods), and be shaped accordingly. Multiple level interventions are therefore more likely to be successful.
4. Interventions should combine cultural and developmental sensitivity. Culture, as we have observed, provides an envelope for all contexts within which development occurs. All developmental settings, in which other persons play a mediating role, are infused with elements of the participants' culture. Cultures structure the settings within which the child's activities take place; they determine how children's needs are seen; and they suggest what is or is not acceptable behaviour at different ages and for different genders. Failure to consider these aspects of the local situation is likely to hinder access to communities and reduce policy and programme efficacy. Policies and interventions are likely to be more successful when the target community is taken on board and made part of the solution.

2.2 Poverty and risks to children: Implications for policy and intervention

The priority areas that are the subject of this report cover a wide range of issues, and it is neither sensible nor possible to construct a single conceptual framework that embraces such a diverse set of problems. Each requires its own in depth conceptual understanding.

However, it is possible to construct a framework of how risks affect children in a poverty context. That is the purpose of the current discussion.

It is well established that more than any other factor, the conditions associated with poverty have the *most powerful and pervasive impact* on the broadest range of negative child development outcomes. Other influences aside, as poverty conditions increase, the risks to prenatal development, neo-natal and child health, child care, exposure to accidents and violence, poor educational preparation and attainment all increase (Aber, Gephart, Brooks-Ginn & Connel, 1997; McLoyd, 1998).

Poverty during the early years may be more damaging than when it occurs in later years. Major threats to healthy development include extended periods of food deprivation, which have a negative impact on neurological development, and ultimately on cognitive and educational outcomes. "The dual risk of poverty experienced simultaneously in the family and the surrounding neighbourhood increases children's vulnerability to adverse circumstances." (Shonkoff & Phillips, 2000, p. 394).

Many of the specific health, rehabilitation and developmental needs of disabled children are not likely to be met in conditions of enduring poverty. In addition, the problems of emotionally vulnerable children are likely to be compounded.

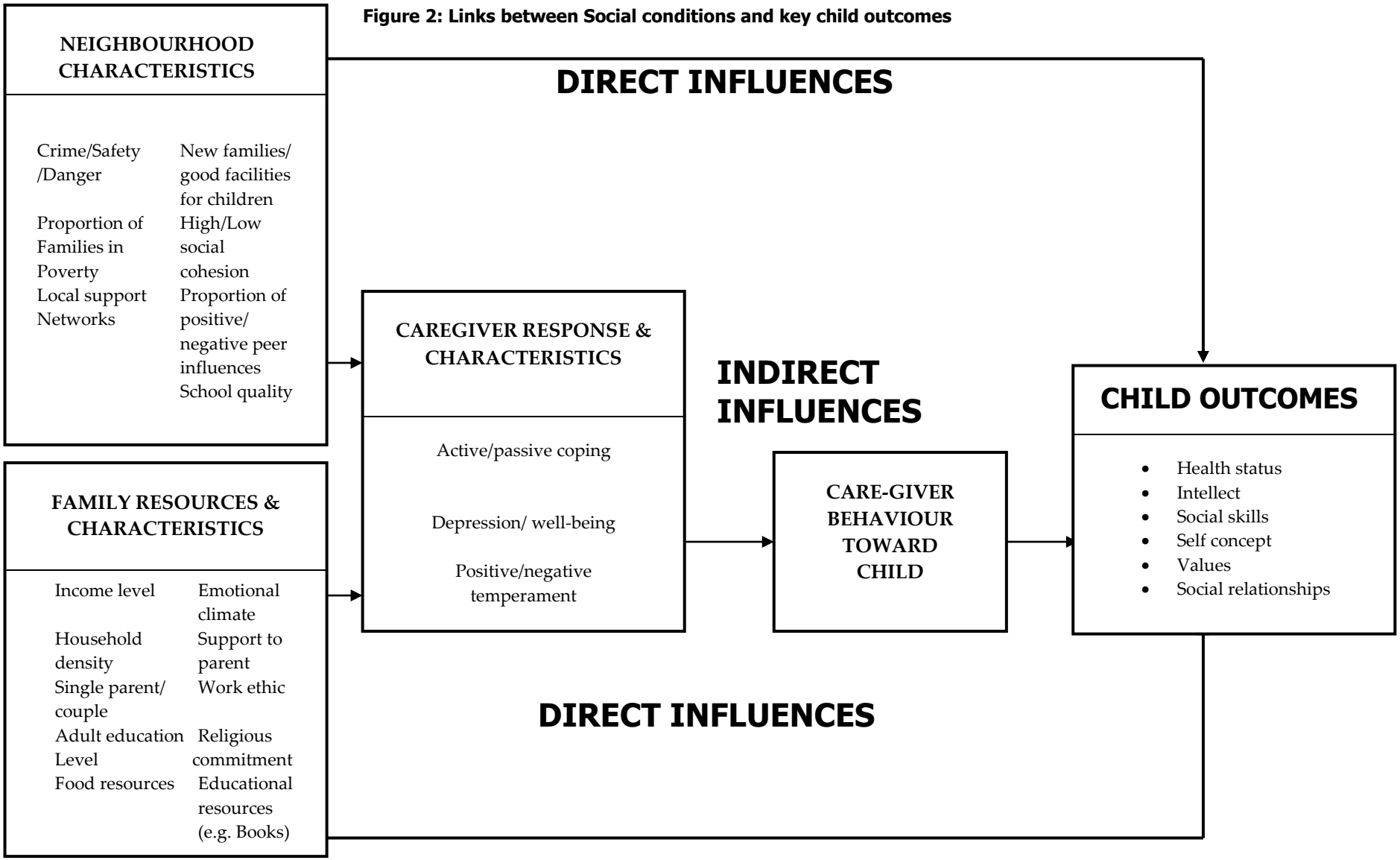
Furthermore, in the area of psychosocial development, the research is clear that child outcomes become worse *in proportion to the number of risks to which children are exposed*. (Maston & Coatsworth, 1998)

We noted above that it is *enduring developmental* contexts that are particularly powerful in shaping long-term child outcomes. It is for this basic reason that *long-term poverty* in particular is associated with a range of negative outcomes for children.

These facts are recognised in the commitment of the Gauteng Provincial Government to poverty eradication as well as to a range of programmes designed to protect children in poverty (particularly in early childhood), and reduce its impact on child health and other outcomes.

Figure 2 below illustrates some links between social conditions such as poverty, at the neighbourhood and family levels of poverty and child outcomes expressed in terms of key child outcomes. International research points increasingly to the *neighbourhood* level as a key location for interventions to prevent risks to children and support families (Shonkoff & Phillips, 2000). This is because children and their *families* are closely connected to *neighbourhood influences*, and they normally experience these influences over extended life periods.

Figure 2: Links between Social conditions and key child outcomes



The figure shows how these two major sources of development have a *direct* influence on children. At the same time, they exert powerful influences on those most responsible for the child's care, thereby affecting how the caregiver behaves with the child (*indirect* influences). Clearly, the influences and outcomes would differ, depending on the *age and sex* of the child.

In principle, and with some modification, the same model could be adapted for a residential child care situation or children's home and a school. For example, in the case of the children's home, the neighbourhood characteristics would still be important, the family resources would now be *institutional resources* and the caregivers would be the *staff* who work with the children.

A framework of this nature has value in its ability to inform interventions with children. It draws our attention to how *different* sources of influence impact on children's development at different points in time and provides guidance concerning the contexts to focus on, for what purpose, at what stage in development.

Research indicates that during the pre-school and primary school years in particular, the impact of a range of related poverty impacts (e.g. economic hardship, poor housing and violence in the neighbourhood), is mediated primarily by family members, particularly primary caregivers and older siblings (Aber *et al.*, 1997).

Because of this finding, it is important to understand how community characteristics influence the well being of those who care for children. The evidence is clear that stressful conditions in the community can undermine the coping capacities of adults (Wandersman & Nation, 1998). This impacts on their ability to create a supportive emotional climate for the children. Nevertheless, even in very poor communities, exposure to at least *some well functioning families can protect children* against the deprivations of their situation. In addition, adults in the community who are less stressed than their neighbours can also offer *support* to nearby caregivers who are living in difficult circumstances, thereby reducing the risks of child neglect and even abuse on the part of stressed caregivers.

These findings suggest that *policies that strengthen social cohesion and support* in communities at *neighbourhood* level is an important way of supporting those who care for children, ultimately protecting them from neglect. This would seem to be particularly important in communities that suffer from high levels of persistent poverty and HIV/AIDS, and those that have high instability caused by in and out *migration*. Some informal settlements would be examples of the latter. In communities affected by *high levels of violence and HIV/AIDS*, children are particularly vulnerable. These areas would be particularly import foci of this sort of intervention.

This brings us to examine conditions that constitute risks to child health and safety beyond the confines of the home.

In South Africa, poor urban communities commonly have a poorly developed road and traffic control infrastructure that almost certainly is *a major contributor to child injury* and mortality due to *pedestrian accidents* (see Appendix 5).

The poorest areas are often characterised by neglect and danger such as physical deterioration, garbage in the streets and dilapidated buildings, as well as social incivilities such drug-dealing and violence on the street. They also include environmental hazards such as waste, and sources of air pollution in communities near industrial zones.

Rates of child neglect and abuse are high in these areas (see appendices 4 and 5). In addition to the threats they pose to adult and child safety, they also provide opportunities for youth to be socialised into violent and deviant sub-cultures, particularly as they move into adolescence.

Dangerous neighbourhoods also encourage harsher parenting as adults desperately strive to protect their children from outside influences. Apart from the health risks, dangerous and decayed areas are "*socially toxic*" to child development (Garbarino, 1995).

Therefore, while poverty conditions call for interventions to protect, support and better serve the developmental needs of individual children and vulnerable groups of children such as girls and the disabled, *the ecosystemic orientation points to a range of the critical policy implications that go beyond interventions that touch more immediately on the family and the child*.

Interventions to improve the infrastructure, safety and overall quality of poverty environments is likely to go a long way toward reducing risks to children and improving the quality of life for all community members. There are of course many challenges, not least the necessity for close collaboration between several sectors of government and local communities.

Resilience in spite of adversity

However, as is well known, while many children growing up in difficult circumstances do show negative outcomes in health and behaviour, significant proportions do not. Why is this?

It is well established that there is variation in the situations in which equally poor children grow up. Contemporary research shows that in cases where children do well despite their considerable adversities, they have *sources of protection that build resilience*.

Resilience:

"generally refers to those factors and processes that interrupt the trajectory from risk to problem behaviours or psychopathology and thereby result in adaptive outcomes even in the presence of adversity" (Zimmerman & Arunkumar, 1994, p. 4)

Factors that promote resilience and protect children from negative outcomes, include capacities that are part of the child's physical and psychological makeup, as well as features of the social ecology in which the child is involved. The key factors that have been identified are (after Donald, Lazarus, & Lolwana, 2002):

- Child characteristics: good health, effective communication and problem solving skills; secure attachment bonds and a positive self concept; a sense of positive direction in life. Clearly these children possess the 5 competencies alluded to above:

- The care context: Long-term supportive characteristics of the child's family or care situation (including for example a residential children's home), and caregivers who are emotionally resilient themselves; a consistent caregiving context that encourages social and intellectual competence, and which has a consistent value system that is evident in daily life.
- Formal and informal support networks to which the child and the caregivers are connected: An example of the former would be positive role models provided in religious structures or sports groups, and in the case of the latter, one example would be supportive friends.

Resilience is determined "by the balance between the *stresses* and *risks* children are exposed to on the one hand and the protective factors that might be operating for them on the other." (Donald, Lazarus, & Lolwana, 2002, p. 222).

Knowledge of the factors that are associated with resilience under difficult circumstances provides *useful entry points for interventions* to improve the situation of children. The detail would be determined by the priority area under consideration. However, the protective factors outlined above provide a general framework that cuts across many threats to child well being in high risk environments. Moreover, it is evident once more that the local community or neighbourhood is an important unit on which to focus.

The intention of the conceptual section of the report has been to provide a framework that will be of use as a basic tool for understanding the broad parameters of child development in context. We have noted the many sources and levels of influence on development during childhood and adolescence. We have pointed to some of the main ways in which poverty conditions impact on development at the level of the family and the local community. Finally, we have provided some broad pointers for intervention, bearing in mind that particular problems will require purpose designed strategies. The picture is complex, and there are no simple answers to addressing the situation of children in poverty.

While the focus has been on children in poverty, it is essential to remember that children in more privileged communities suffer adversity and also need support. Children from wealthy backgrounds are subject to sexual abuse. They may be exposed to domestic violence, and suffer serious drug problems, disabilities and other challenges. While one would assume that they have access to more supportive resources than the poor, this may not always be the case.

With these principles in mind, and hopefully armed with a set of ideas about intervention, we proceed to the key findings of the desk and secondary research undertaken to assess the current status of children in Gauteng.

3. THE STATE OF GAUTENG CHILDREN: CHILD STATUS, SERVICES AND NEEDS

3.1 CHILDREN AND POVERTY IN GAUTENG

The definition of poverty is a complex matter. However defined, it is recognised that the measurement of child poverty needs to go well beyond a focus on income available to support a reasonable standard of living and promote positive child development. Currently many experts favour a 'Capability' model of poverty, in which *income is seen as a means to the achievement of survival and beyond survival human development goals*. On this basis, four categories of poverty have been distinguished (Cassiem, Perry, Sadan & Streak, 2000, p. viii):

- Insufficient income.
- Lack of human development opportunities.
- Feelings of physical and economic insecurity.
- Lack of an ability to participate in family and community life – a sense of social exclusion.

According to Cassiem *et al.* (2000, p. ix), this approach "matches the ideas on child well-being and poverty" contained in the Convention on the Rights of the Child and South Africa's National Programme of Action for Children (NPA). These are captured in four groups of rights together with implied deprivations:

- Survival rights: a child's rights to an adequate standard of living, including shelter, and nutrition, as well as access to medical services;
- Development rights: a child's right to education, play and leisure, cultural activities, as well as to information and freedom of thought, conscience and religion;
- Protection rights: a child's right to be protected against all forms of exploitation and cruelty, arbitrary separation from family and abuse in the criminal justice system; and
- Participation rights: a child's right to express opinions and to have a say in matters affecting his or her life. "

In order to assess the extent to which poverty constrains the achievement of these rights within the family or child care unit, each group of rights should ideally be *linked to indicators of child poverty at household level*. It would be desirable to have provincial level data within which children can be specifically linked to their caregivers. Unfortunately, this is not the case in data available for Gauteng (or other provinces). That is why the priority areas have had to be reported separately. In this section therefore we report specifically on the most

recent available information on children in poverty in the province. Thereafter, the report maps out poverty distribution and certain associated risks.

At root, income poverty determines the achievement *of survival rights*. Useful indicators of this poverty dimension include *household expenditure*. While this approach assists in estimating 'pooled household income', the extent to which such pooling does or does not benefit the children usually cannot be assessed. In our view it is more desirable to examine the link between family or caregiver expenditure and child outcomes, but this is very difficult to determine in most household surveys. As is well-known, in South Africa, definitions of 'family' are highly variable.

Existing income and expenditure surveys for Gauteng are not designed to enable one to separate out families and expenditure on their children from *household* expenditure on children. Of course, many households contain more than one 'family'.

3.1.1 Choice of data source

Bearing these limitations in mind, the Income and Expenditure Survey (IES) conducted by Statistics South Africa in 2000 was used to assess the level of child poverty in the province. The main purposes of that survey were: to investigate patterns of household consumption; show the earnings and the spending capacity of South African households; and to determine the weights for the Consumer Price Index (CPI) during the survey period.

The IES was chosen as it is the most recent and comprehensive nationally representative survey of household income and expenditure available. It covers the period 1st November 1999 to 31 October 2000.

The sample consisted of 30 000 households from across the country. A representative sample of households throughout Gauteng Province were surveyed, including urban and rural areas. Households surveyed included 13 523 persons, of whom 9 362 were adults and 4 161 were children. As the sample is representative, the data presented may be considered an accurate reflection of the situation in the province.

3.1.2 The Definition of Relative Poverty used for the purposes of this report

In line with World Bank practice and in keeping with several other South African studies this report has used a *relative* rather than an *absolute* definition of income poverty. In this definition and for the purposes of this report:

Children living in poverty are those children living in the poorest 40% of households in the Province.

The cut off line of 40% does not mean that those above this level do not experience economic hardship. It is used so that the current study is in accord with one of the major approaches used by the World Bank and is common local practice (Cassiem *et al.*, 2000).

Income and Expenditure surveys have found that people generally understate their income. (Woolard, personal communication). For that reason, in this report, we have focused on *expenditure* data. Level of income has estimated from total expenditure. In the 1995 Income and Expenditure Survey (IES), the poorest 40 % of households were those with an *income* of

less than R3 143 per capita per annum. Due to the unreliability of household income reporting (see above), income in this model is estimated on the basis of household expenditure. Included in the expenditure calculation is the proportion of total household expenditure on education and food.

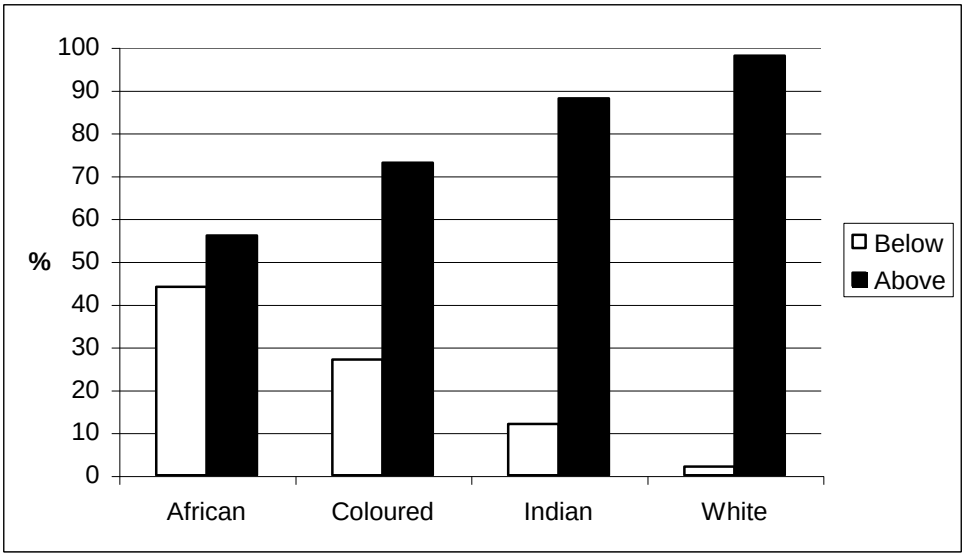
For the purposes of the current report, the 1995 value was inflated by a factor of 1.39427 to put it in 2000 prices to **achieve a figure of R4 382.00** (inflation factor between the two years).

3.1.3 Adults in poverty in Gauteng

Thirty eight percent of Gauteng adults (38%) live *below* the provincial poverty line of R4 382.00 per annum. Forty seven percent (47%) of this group are men and 53% are women. The proportion of people living in rural areas in Gauteng is insignificant (2%). Therefore, no distribution of poverty by rural urban status was undertaken.

Figure 3 shows the proportion of adults living below the poverty line by population group. While it is encouraging that the majority of all groups are above the line, it is clear that Africans are by far the most affected, with the greatest proportion (44%) of this group living below the line.

Figure 3: Proportion of adults living below poverty line by population group



Children' survival and development opportunities are determined in fundamental ways by their parent's income. However, in the IES, it is not possible to link children to specific adult parents or guardians. *Household* adults are the units. For present purposes, in order to calculate the proportion of children living in poverty, we have had to rely on adult income data. Having extracted households living below the poverty line (on the basis of estimated adult income), the children in those households were counted.

3.1.4 Children in poverty in Gauteng

Almost *half* of Gauteng children (48%) live in poor households. An equal proportion of girls and boys is affected. As we have noted above, deep long-term poverty during early

childhood poses significant risks to development. The evidence in figure 5 shows that the youngest age group (0-5 years) has the largest proportion of children in poverty (51%), while 48% of children 6-12 years and 46% of children 13-17 years *live below the poverty line*.

Figure 4: Proportion of children living below the poverty line by age

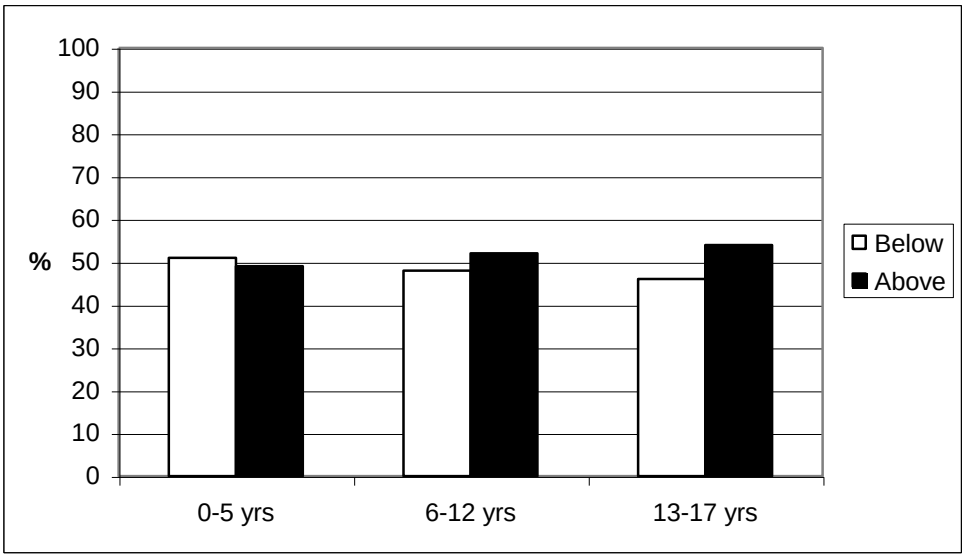


Figure 5: Proportion of Gauteng children living below the poverty line by population group

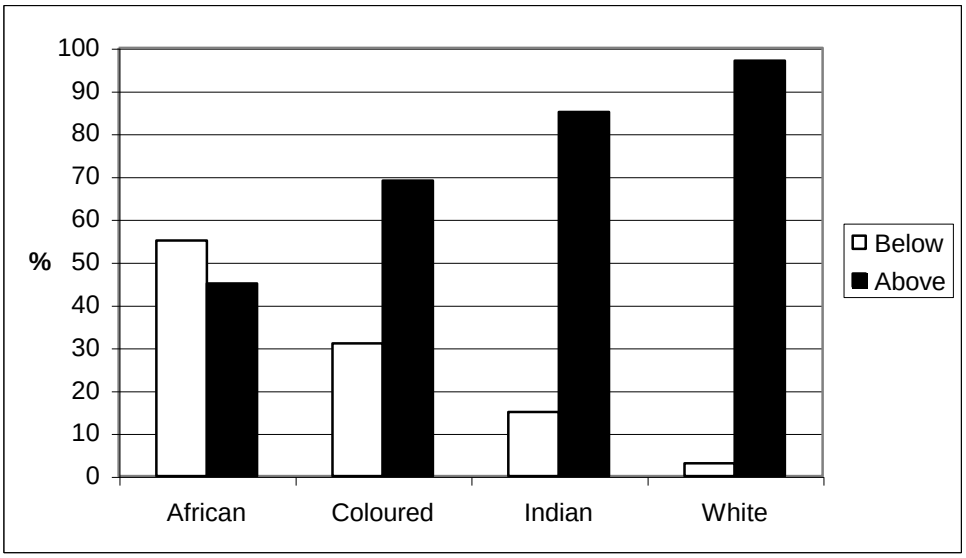


Figure six shows that the proportion of children living below the poverty line is clearly much higher among African, than other groups.

In sum, according to the IES data, nearly half of Gauteng children live in the poorest 40% of households. The vast majority are African and the youngest age groups are most vulnerable (see also the ECD Appendix to this report). It should be noted that proportionally more poor than wealthy households have children, and this fact contributes to the child poverty distribution.

In addition, it would appear that despite the best efforts of the Gauteng government, poverty (and of course child poverty) has grown *significantly* in Gauteng since 1995. According to Woolard (2001), relative poverty rates for children 0 – 6 years in Gauteng, show a 13.6% increase from 24.2 % in 1995 to 37.8% in 1999 (based on October Household Survey data). This was the largest increase in the child poverty rate in South Africa.

This is a very serious situation. Increasing adult and child poverty, no doubt brought about by a mix of causes, will lead to a range of negative outcomes for children. It will also reduce the ability of the province to improve the achievement of children's rights. Apart from their costs to individual children, the costs to the province in the provision of increased services, and loss of human capital as the development of successive generations is compromised, will be substantial.

While we do not have good child well being trend data for the province, there are indications in the appendices to this report that suggest that in some areas at least, the situation for children is getting worse, despite the wealth of the province. For example, the Infant Mortality Rate in Gauteng increased in the period 1998 to 2002 by 27%. This is almost exclusively the consequence of increased deaths from vertically acquired HIV infections. At Chris Hani Baragwanath Hospital, more than 70% of deaths occurred in HIV positive children. Further, the nutritional status of admitted children worsened and over 60% of children who died were malnourished.

There are also indications from the NGO sector that child abuse is increasing. Abuse and neglect go hand in hand with deepening poverty.

Poverty reduction remains a key provincial strategy.

Finally, it would be desirable to have provincial level data within which children can be specifically linked to their caregiver's income, education levels, employment status and food consumption patterns and expenditure on the children. However, for links to be demonstrated, the appropriate research needs to have been conducted, and this is unfortunately not the case in data available for Gauteng. The situation is probably a function of the fact that surveys have not been designed with a focus on children. This is a clear need in the province and nationally.

3.1.5 Regional Distribution of Risks to Children in Gauteng

A key question posed by the Office the Premier, was: "*In which geographical areas of the Province are problems relating to children most concentrated*?"

There is not sufficient data to answer this question in anything other than a limited manner. As noted in the conceptual discussion, poverty constitutes the most pervasive risk to development, and for that reason can act as a proxy for many risks to children. For that reason we have chosen to describe the distribution of poverty, a key risk area to children (sexual assault) and selected services. Expert reports comment where possible on regional issues.

Three maps are included below in order to illustrate regional distribution of certain risks to children. They are based on information held by the HSRC Surveys, Analyses Modelling and Mapping GIS unit (SAMM). It is necessary to note that the data utilised for these maps is based on a mix of sources, collected at different points in time. Thus due to the lack of other data for this purpose, the poverty data used for the compilation of Maps 1 and 2 is based on the 1996 Census and is therefore somewhat out of date. As in all data accessed thus far, mapping of this kind depends fundamentally on the available information.

Map 1: The distribution of household poverty in Gauteng

With these cautions in mind, Map 1 provides a picture of the distribution of poverty across magisterial districts, the proportion of children in each district, and the unemployment rate in that district.

Heidelberg and Bronkhorstspruit had the highest poverty rates in the province at the time the data was collected. A number of other districts had poverty rates in which 30-50% of households were below the poverty line and associated high levels of unemployment.

What is most important perhaps is that *the poorer areas have the highest concentrations of children, indicating where the needs are greatest.* It is not known whether this pattern fits the contemporary situation, but it is very likely.

Map 2: Health and Social Services in relation to poverty in Gauteng

Map 2 takes the analysis further to show links between poverty and key services – primary health clinics, social grant payout points and Provincial Child Welfare Services. Unfortunately, the system does not have the addresses of the NGO services. Their inclusion would greatly aid planning in the future as it is this sector that carries most of the responsibility for service delivery. This is a very preliminary attempt at analysis and would need to be taken much further with the appropriate data to hand.

It would appear that in the years for which data is available, services are most numerous in the most populous urban areas, but it may be the case that they are not necessarily best distributed in terms of need. The map suggests that the two poorest regions have relatively few services. Clearly, this may be a function of population and the figures may be out of date. However, it is worth following up to check whether child services in particular are insufficient in relation to need. (See Appendices 1, 2 and 8).

What is evident is that in areas of high poverty (and high risk to children) with high proportions of children (see Map 1), state child welfare services are few and far between (for example Bronkhorstspruit and Cullinan).

Map 3: The distribution sexual crimes to children in Gauteng

Map 3 uses South African Police Service data to map one of the areas of highest concern to the province, sexual crimes to children (see also Appendices 4 and 5). The map shows the extent to which other violent crime coincides with sexual violence, and the state services to affected children are indicated.

Vanderbijl Park, Johannesburg and Soweto show the highest rates of child sexual assault. They are also characterised by high levels of other violent crime. Wonderboom, Pretoria,

Kempton Park, Benoni and Alberton are also high risk areas. Clearly, it would not be the entire district that is a hot spot, and the OoP would have to take this analysis down to smaller geographical units within these areas in order to determine where the most serious problems are occurring. The SAPS data should permit this.

While it is encouraging that the province has expanded its set of Child Protection Units (CPU), from the evidence present in the maps, some areas in particular seem to be under-served. In addition, given the very high rates of sexual crime, it would appear that there are simply an insufficient number of these units (See Appendix 4).

For example, there is no CPU in Vanderbijl Park, which has a very high rate of sexual crime and other violence. It may be that the Vereeniging CPU can cope with both districts but this is very unlikely. The map suggests that there are other areas that might also benefit from a CPU (e.g. Wonderboom and Kempton Park). In addition, it has to be asked whether the protection facilities in the inner cities of Johannesburg and Soweto are sufficient given the very high rates of abuse in these areas. While there is a fair distribution of magistrate's courts, not all have the ability to deal sensitively with child matters (see Appendix 8).

For the most part, the three maps show that violence to children, other violent crime and poverty are clustered together in certain districts. While not surprising, it is hoped that the information even in this relatively crude state is an aid to planning protection services and interventions for the many children who will be at risk in these areas.

3.2 MATERNAL AND CHILD HEALTH STATUS AND SERVICES

3.2.1. What is the scope and extent of deprivations and problems afflicting children in this priority area, and what groups of children and segments of the population are most vulnerable or at risk?

The discussion in this section is based on a summary of the findings contained in Appendix 1, the data sources are also contained in the appendix.

Infant and child mortality rates in Gauteng have increased by over 25% between 1998 and 2002 (Department of Health, MRC and Macro International, 1999) and dire predictions of a doubling of mortality rates within five years are likely to materialise unless significant interventions are instituted. In 2001, lower respiratory tract infections became the leading cause of death among infants and young children in the province. It is probable that HIV/AIDS is the primary cause.

The HIV pandemic has affected the lives of all South Africans. It is clear from the data presented that its capricious effects extend to disrupting the lives of the most vulnerable members of society. The provision of nevirapine by all hospitals and more than 90% of midwife obstetric units in the province by early 2003 is a positive step in that direction (see 2.1.2.1 appendix 1).

On a negative note, the prevention of opportunistic infections, particularly pneumocystis pneumonia has progressed slowly. Similarly, provision of routine and special care for

children infected and affected by HIV has been patchy and uncoordinated. Inequities in health provision have been exaggerated by the HIV pandemic. The provision of antiretroviral therapy to children and their parents in the public sector, while offering many logistical obstacles and of direct relevance to a minority of children, is nevertheless likely to have a major positive impact on the health of Gauteng's children and on service provision in the region.

There have been important successes in the realisation of health for all the province's children. Greater numbers of children are being immunised for example, 79% of one-year olds in the province are now fully immunized largely due to the Expanded Programme on Immunisation (Gauteng provincial government, 4-4-2003). The benefits of this are already being realised- the province was certified polio-free in 2002, measles is likely to be eradicated in Gauteng in 2003 and the burden of liver, lung and meningeal infections is decreasing thanks to the benefits of the hepatitis and Hib vaccines, now routinely provided to all infants. There has been a reduction in diarrhoeal morbidity and deaths in the province, and fewer visits were made to primary health care centres for lower respiratory tract infections in the past two years.

In contrast, there is little evidence of an improvement in the anthropometric status of children in the province over the past decade. In reality, under-nutrition and severe malnutrition rates have worsened, no doubt associated with unemployment, poverty the HIV pandemic. Despite improving cure rates for tuberculosis the epidemic continues unabated. The persistent segregation of promotive and curative care at primary care level disadvantages children the most, while a misunderstanding of the "supermarket" concept of health care delivery has resulted in the loss of a focussed concentration on children's health at many clinics in the province. Fiscal constraints continue to stress hospital systems attempting to provide appropriate care to increasing numbers of chronically ill and dying children.

Programmes that focus on the health of children are expanding and being implemented in many parts of the province. These include provision of kangaroo mother care to low birth weight and premature newborns; promotion of breastfeeding through the Baby Friendly hospital initiative; training of health professionals to enable them to practise the Integrated Management of Childhood Illness (IMCI) strategy within primary health care centres and increased attention on ensuring optimal growth of young children through growth monitoring, food fortification and supplementation, and improved food security at schools and homes; and increasing access to social security grants for poor children.

The health of pregnant women and mothers has also been influenced by competing forces. Improved access to antenatal care, prompter diagnosis and treatment of infections such as syphilis and better understanding of major causes of maternal deaths (and an adequate response to preventing these) has positively affected the health of mothers-to-be in Gauteng. However, these gains have been upset by the negative consequences of HIV- increased illnesses during pregnancy, including TB, and higher maternal and foetal mortality. The overall result is deterioration in perinatal health care indicators such as the perinatal mortality rate and the perinatal care index over the past four years in Gauteng.

While there has been some progress in Gauteng, it is disturbing that not a single of the **National** 14 child health goals norms set by the Primary Health care strategy for 2000, have been met by 2003. It could be argued that these goals represented ideals and were never expected to be achievable. Table 1 presents the 2000 National goals and *suggests* targets for Gauteng province for 2008 based on the data in this report.

Table 1: National Year 2000 Goals, Objectives and Indicators and suggested target goals for Gauteng province for 2008.

National Year 2000 Goals, Objectives and Indicators	Gauteng 2008 Goals, Objectives and Indicators*
Reduce the infant and under-5 mortality rate by 30% and reduce disparities in mortality between population groups.	Maintain the infant and under-5 mortality at end-2002 levels and reduce disparities in mortality between population groups.
Reduce mortality due to diarrhoea, measles and acute respiratory infections in children by 50%, 70% and 30% respectively.	Reduce mortality due to diarrhoea and acute respiratory infections in children by 50% and 30%. Eradicate measles by 2003.
Increase full immunisation coverage among children of one year of age against diphtheria, pertussis, Hib, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to at least 80% in all districts and 90% nationally.	Increase full immunisation coverage among children of one year of age against diphtheria, pertussis, Hib, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to at least 90% in all districts in the province
Eradicate poliomyelitis by 2002.	Eradicate poliomyelitis by 2003.
Increase regular growth monitoring to reach 75% of children <2 years	Increase regular growth monitoring to reach 50% of children <2 years
Increase the proportion of mothers who breast-feed their babies exclusively for 4-6 months, and who breast-feed their babies at 12 months	Increase the proportion of mothers who breast-feed their babies exclusively for 4 months to 25%, and who breast-feed their babies at 12 months to 90% (if HIV negative)
Reduce the prevalence of under weight-for-age among children <5 years to 10%.	Reduce the prevalence of under weight-for-age among children <5 years to 5%.
Reduce the prevalence of stunting among children <5 years to 20%.	Reduce the prevalence of stunting among children <5 years to 15%.
Reduce the prevalence of severe malnutrition among children <5 years to 1%.	Reduce the prevalence of severe malnutrition among children <5 years to 1%.
Eliminate micro nutrient deficiency disorders.	Reduce marginal Vitamin A status to <10% in children < 5 years of age Reduce iron deficiency anaemia to < 5 % in children 6-24 months of age Reduce iodine deficiency in schools to <3% having children with low iodine levels.
All children treated at the clinic are treated according to IMCI Guidelines.	All children treated at the clinic are treated according to IMCI Guidelines.
Every clinic has at least two staff members, who have had the locally adapted IMCI training, based on the WHO/UNICEF Guidelines.	Every clinic has at least two staff members, who have had the locally adapted IMCI training, based on the WHO/UNICEF Guidelines.
Every clinic has a rehydration corner.	Every clinic has a rehydration corner.
A supervisor, who also evaluates the degree of community involvement in planning and implementing care, undertakes a six monthly assessment of quality of care.	A supervisor, who also evaluates the degree of community involvement in planning and implementing care, undertakes a six monthly assessment of quality of care.

* Gauteng 2008 goals set using end-2002 Gauteng indices and statistics as baseline

3.2.2 What gaps in existing services to children and families are evident in the priority area and how should these be addressed (recommendations)?

3.2.2.1 Main service gaps identified in this area are the following:

- A comprehensive service for children born to HIV infected mothers, including antiretroviral prophylaxis to prevent MTCT of HIV, support for mother's infant feeding choice, provision of cotrimoxazole prophylaxis for the first year of life, growth monitoring and nutritional advice and support including food supplementation if the child is failing to thrive, and antiretroviral therapy for children with low CD4 counts.
- Improved care of ill and pre-term newborns at regional hospitals. Need for training in neonatal resuscitation, use of standard protocols, and increased availability of and accessibility to neonatal intensive care facilities.

3.2.2.2 Primary recommendations

- Reduction in poverty is essential to sustainable reduction in child mortality, under nutrition, infectious diseases and many other indicators.
- The need for an effective and efficient health information system is vital for planning and managing health service delivery. Integration of data systems from health districts, municipalities, provinces, the private sector and the national department work is vital. Further, various governmental systems, such as Home Affairs and Public Services impact on the health system and should also be integrated with that of the health system. Priorities for child health are the expansion of the NHC/MIS to all clinics and hospitals and strengthening of the vital registration system of births and deaths and the implementation of page two of the birth registration form.
- Lack of accurate national, provincial and local (hospital and clinic) data on the magnitude and causes of child, infant and neonatal morbidity and mortality is limiting advocacy and program planning in child health.
- Monthly mortality and morbidity audits at health facilities (clinic and hospitals) and reporting of deaths on a standardised form (similar to the PPIP) can contribute to defining the extent of the problem.
- Morbidity and mortality rates can be decreased by strategic health interventions. Examples include resources being allocated to support the IMCI strategy, guideline development on standards of care for common paediatric problems and provision of prophylaxis and treatment for children with HIV.
- The availability of affordable, good quality drugs and the training of health providers in the rational use of drugs has to be ensured. The use of the Essential Drugs Lists and the training of health providers in procurement and rational prescription must be strengthened.
- Accessible, child-friendly services, achieved by integration of services, social mobilisation, education and training, and research need to be championed.

- The need to increase the number of district (community) hospital beds whilst significantly reducing the numbers of tertiary beds has to be balanced by the recognition that many existing district and regional paediatric services are offering sub-optimal paediatric care, and that the needs of children may be best served by maintaining services in academic paediatric centres while fostering the development of district hospital care.
- Prioritise paediatric services in the province This may require that any budgetary cut in hospital finances specifically describe the predicted impact of this measure on children's health care.
- The preschool child, especially the very young (< 2 years of age), should be the prime target group for nutritional intervention, and the mother for nutrition education.
- Antenatal care needs to be started at an earlier gestational age. Twenty five per cent of serious problems during pregnancy occur before 20 weeks.
- Opportunities for immunisations should be created by offering evening or weekend clinics. Hospitals and GPs should be provided more freely with vaccines by the local authority.

3.3 CHILDREN AFFECTED BY HIV/AIDS

Given the major concern about this priority area, the discussion in this section is more extensive than elsewhere in the main report. The complexity of the issue actually requires its own large-scale investigation.

3.3.1 What is the scope and extent of deprivations and problems afflicting children in this priority area, and what groups of children and segments of the population are most vulnerable or at risk?

In order to assist in all spheres of planning, it is necessary to have an understanding of the nature and the impact of the epidemic. The main objective of this section of the report is to present the most recent data on the impact of HIV/AIDS in Gauteng and its probable impact on children and risks to children. Data from different sources is utilised, and it should be noted that not all sources are comparable because they have examined different populations at different points in time, and with different methodologies.

The information in this section is taken mainly from four studies, which viewed together can provide an adequate picture of the situation regarding HIV in South Africa and in Gauteng province.

It should be noted that there is some variation in prevalence figures reported in different studies. In what follows, we have drawn mainly on the Nelson Mandela/HSRC study of HIV/AIDS conducted in 2002, and the work of Dorrington, Bradshaw and Budlender (2002). The former is the first national non-clinic survey of HIV/AIDS prevalence. While in many

respects a robust study, due to high rates of non-response to certain critical tests, the results should be treated with some caution.

3.3.1.1 Overall HIV prevalence in Gauteng (all ages)

According to a recent provincially representative study, the overall prevalence of HIV in the province in 2002 was estimated to be **14.7%,** the second highest in the country (Nelson Mandela/HSRC study of HIV/AIDS, 2003). The estimate provided by Dorrington *et al* (2002), puts the provincial figure a little higher at **16%.**

33.1.2 Prevalence among women attending antenatal clinics

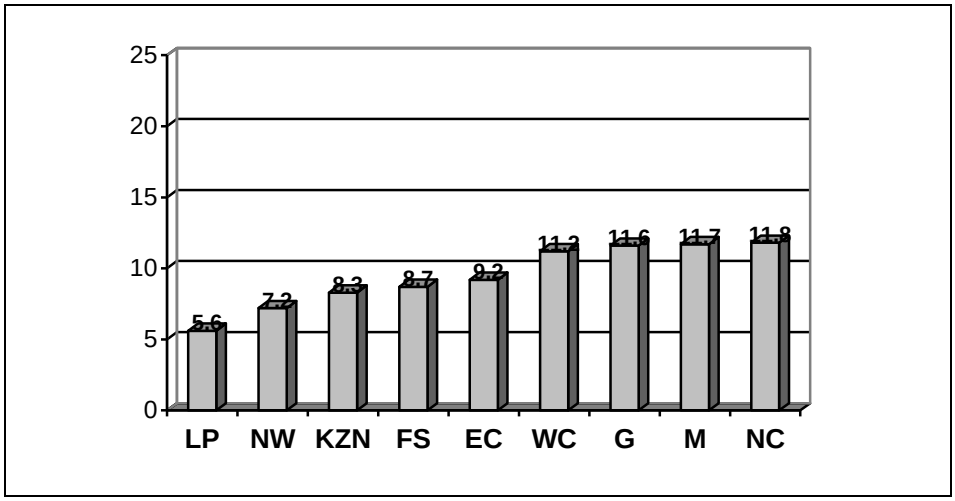
HIV prevalence is the estimate of the percentage of people in a particular group who are infected. Provincially representative data from the National HIV and Syphilis sero-prevalence survey of women attending public antenatal clinics indicates that in Gauteng the estimated prevalence in this population in 2001 was at **29.8 %** (Department of Health, 2002).

3.3.1.3 Prevalence among Gauteng youth aged 15-24

The Nelson Mandela/HSRC study of HIV/AIDS reported a prevalence rate of 11.6% for Gauteng province. The province was amongst the highest in prevalence in this population nationally. Comparative provincial rates from this study are shown in Figure 7 below. The study also showed that youth living in urban informal areas have significantly higher HIV prevalence than youth living in urban formal areas. In their study, Dorrington et al. (2002) set the figure at 13%.

Female youth in this age band are much more vulnerable than men. The ***prevalence for women is 19.8% and for men it is 5.9%*** (Dorrington *et al.*, 2002).

Figure 6: HIV prevalence among persons aged 15-24 by province, South Africa 2002



Source: Nelson Mandela/HSRC study of HIV/AIDS. South African National prevalence, behavioural risks and mass media household survey (2002).

3.3.1.4 Prevalence in the 15-49 age group

The Nelson Mandela/HSRC study found that *among the sexually active 15-49 age group (both sexes), Gauteng has a prevalence rate of* **20%,** which was the second highest HIV prevalence in

this group across all provinces. However, Dorington *et al* (2002) estimate the prevalence among *women of childbearing age (15-49) specifically to be higher at* ***25%.***

Prevalence rates in this group (15-49) are recognised by Unicef to be a *key indicator of risk to children*. They should be monitored regularly.

3.3.1.5 Infections among Gauteng babies:

The Actuarial Society of South Africa (ASSA) model provides a rigorous set of current figures for the number of infants infected with AIDS in the province and South Africa. Gauteng province accounts for 176 272 of babies born uninfected during this period, while 10 500 were infected at birth and 3 123 infected through mother's milk (See Table 2 for SA estimates).

Table 2: Births and infections Jan 1 – Dec 31, 2002

Births	Gauteng	SA
Uninfected births	176 272	1 098 476
HIV+ births	10 500	69 213
Infected by mothers milk	3 123	20 162

Source: Dorrington, R.; Bradshaw, D. & Budlender, D (2002, p.4)

3.3.2 The trajectory of the HIV/AIDS profile Gauteng Province

3.3.2.1 Course of the illness and its impact

The lives of children are *increasingly* affected by the infection of their caregivers as the condition progresses. Four stages are recognised. In stages *one* and *two* the patient is relatively asymptomatic, and other than as a consequence of stigma, household members would not be significantly affected by the person's declining physical and emotional capacity. This becomes much more evident in stage *three*, when the patient would be suffering from weight loss and bouts of illness from opportunistic infections, and stage *four* when full blown AIDS presents as the last stage of HIV infection.

The situation for all those infected in Gauteng, July 2002 was as follows (Dorrington *et al*., 2002):

- Stage 1: 54%
- Stage 2: 21%
- Stage 3: 29%
- Stage 4: 7% had full-blown AIDS.

People in stage four usually do not survive more than a year after becoming AIDS sick, if they do not receive treatment.

3.3.2.2 The epidemic may have peaked

The figures presented in this section are based on Dorrington and colleagues (2002). The figures presented are estimates from 1st January to 31st December 2002.

- The epidemic is considered to be entering a mature stage. The *worst-case scenario* estimates that there are ***6.5 million HIV infected people*** *in South Africa today*.

- In Gauteng, there are likely to be about **1.4 million** infected people today.
- The number of new infections peaked, in about 1998 and has begun to decrease. These findings confirm the observation that the rapid growth of the South African epidemic may be slowing down (Makubalo, Simelela, Mulumba & Levin, 2000). Of course the peak in orphans occurs much later in the cycle.

3.3.3 AIDS-related deaths and orphans

An accurate figure for HIV/AIDS related deaths is problematic because HIV/AIDS is normally not recorded on a death certificate. In the case of hospitalised children it is easier to track patterns. For example, *the death rate among under 5 year old children has doubled* in Gauteng since 1998, and most of this change is attributed to HIV/AIDS (see Appendix 1). This pattern should improve with the supply of antiretroviral medication to infected pregnant women.

However, recent evidence indicates strongly that the increase in mortality for relatively young adults is due to AIDS. In 2000, 40% of deaths in the 15 to 49 years group are believed to be AIDS related, and between 5 and 7 million people in South Africa will die of AIDS by 2010 (Dorrington, Bourne, Bradshaw, Laubscher, & Timaeus, 2001 cited in Wilson, Giese, Meintjes, Croke & Chamberlain, 2002, p. 6).

The literature defines 'orphans' as children under the age of 15 years who have lost a mother to AIDS. Using this definition (and in the absence of adult treatment), the orphan population is expected to peak at between two and three million children by 2015. "If the definition of 'orphan' is broadened to include all children (under the age of 18 years) who have lost one or both parents, the figure is expected to be substantially greater, at 5.7 million. Due to the dependency between paternal and maternal mortality (linked to the fact that HIV is a sexually transmitted disease), we are likely to see a dramatic increase in the proportion of the orphan population that are double orphans (having lost both parents)." (Wilson, Giese, Meintjes, Croke & Chamberlain, 2002)

The evidence is clear that:

- *The number of people dying from AIDS each year has begun to increase substantially*.
- Without intervention to reduce mortality, it will peak in about 2010, resulting in *increasing numbers of children who are orphaned*.
    - The number of maternal orphans who are under 15 years of age will peak in about 2015.
    - The desegregation of deaths by gender is particularly relevant when considering the impact of HIV on children
    - The death of a female caregiver commonly results in significantly more severe social, emotional and economic consequences for the child than is the case with a male parental death (Wilson *et al.*, 2002).

3.3.3.1 How many children are likely to be orphaned by HIV/AIDS?

Table 3 indicates the estimated numbers of children under 15 years who have lost their mother due to AIDS and other causes for each year in Gauteng province over the period 1991 to 2010. The growth rate in the non-HIV orphan population will actually decline as a function of the death of parents who have HIV. In contrast, the share of orphans due to HIV increases exponentially over the period.

Table 3: Maternal orphans under 15 years, Gauteng

Year	Total orphans	Total AIDS orphans	Total non-AIDS orphans
1991	45 228	18	45 210
1992	46 083	49	46 034
1993	47 289	125	47 164
1994	48 801	302	48 499
1995	50 638	682	49 956
1996	52 903	1 446	51 457
1997	55 814	2 886	52 928
1998	59 801	5 451	54 350
1999	65 389	9 726	55 663
2000	73 111	16 384	56 727
2001	83 432	26 107	57 326
2002	96 816	39 506	57 310
2003	113 727	57 013	56 714
2004	134 417	78 764	55 653
2005	158 699	104 449	54 251
2006	185 793	133 204	52 589
2007	213 979	163 399	50 580
2008	241 775	193 352	48 423
2009	267 668	221 326	46 341
2010	289 727	245 470	44 257

Source: Dorrington, R.; Bradshaw, D. & Budlender, D (2002, p. 15)

Children orphaned by AIDS face particular challenges. Most of the factors rendering them vulnerable are *poverty* related. Poverty is inevitably deepened by caregiver illness and then death. Shisana, Richter and Chandiwana (2002) summarise the effects:

Economic Impact

- The death of a caregiver and breadwinner can lead to children leaving school in order to fend for themselves.

Migration:

- Migration occurs within and between rural and urban areas. The Henry J. Kaiser Family Foundation and Health Systems Trust (2002) study (not a representative sample) conducted in rural and urban areas of Gauteng showed that caregiver illness or death has resulted in 12% of affected households sending children to live elsewhere. This occurred most in urban areas.
- A third of these displaced children were sent to live with another parent, 35% were sent to a grandparent, 2% to children's homes and 2% of household didn't know of

the whereabouts of the non-resident children (Henry J. Kaiser Family Foundation & Health Systems Trust, 2002).

- Often girls or young adults are sent to help out in other households and most are encouraged to fend for themselves by working or becoming street children.

Changes in caregiver and family composition:

- Siblings may be split up, a factor which has been found to be a predictor of emotional distress in children and adolescents affected by HIV/AIDS.

New responsibilities and work for children:

- Orphans often have new responsibilities including work such as domestic chores, caring for the sick and old and subsistence agriculture. (UNICEF, 2000 cited in Shisana *et al*., 2002).

Education:

- Children in households affected by HIV/AIDS may leave school for various reasons. The Henry J. Kaiser Family Foundation and Health Systems Trust (2002) study found that:
- Four percent (4%) of children had left school as a result of having to care for an AIDS sick person.
- The situation is worse for Girl children who are more likely than boys to drop out of school. Five percent (5%) of boys in contrast to 10% of girls were out of school because attendance competed with other duties. Girls drop out of the education system at a variety of ages for several reasons: no money for school fees, caring for the sick, and pregnancy. In addition, stigmatisation may prompt affected children to remain away from school rather than endure being isolated and excluded at school.

Loss of home and assets:

- Children may suffer the loss of their home through the sale of land and assert stripping by relatives, sale of livestock etc.

Health and nutrition:

Poverty exacerbates the HIV infection rate and is associated with malnutrition.

Psycho-social impact:

Children who have lost caregivers often suffer from stress related to death, illness, insecurity and stigmatisation, which may have a significant impact on their psychological functioning. Other stressors include; separation form siblings, loss of home, dropping out of school, increased workload and social isolation.

Increased vulnerability to sexual abuse:

"Apart from other social economic impacts, children affected by AIDS are themselves highly vulnerable to HIV infection (due to) early onset of sexual activity, commercial sex exploitation and abuse. All of which may be precipitated by

economic need, peer pressure, lack of supervision, exploitation and rape" (Shisana, *et al*., 2002, p8).

The dimensions discussed above are interdependent and have combined impacts on children. All these findings have important implications for policy and programming.

3.3.4 What gaps in existing services to children and families are evident in the priority area and how should these be addressed?

The Gauteng provincial government has developed an AIDS strategy, which is consistent with the National AIDS strategy. The Gauteng AIDS programme is co-ordinated by AIDS Unit based in the provincial Health department (Gauteng provincial government, 2000-2001). The key components of the strategy include, mobilisation, prevention, care and inter-sectoral action (Modiba *et al*., 2002). The care policy was developed around the notion of a continuum of care and it includes the following:

- Support for people with AIDS (in communities, support groups, counselling)
- Care services: medical (clinics, hospitals, TB) and palliative (home care and terminal/respite care facilities). Families and orphans: social support grants.
- Referral systems: Modiba *et al.* (2002) sought to examine whether care and support services for people with HIV/AIDS are being provided at primary health care (PHC) clinics, to examine the quality of the services and the extent to which services are being utilised. The study focused on testing and counselling. The situation of services to children was not included.
- We were not able to locate any systematic studies of the level of care rendered to children affected by HIV/AIDS in the province. This is clearly a priority research need.

3.3.5 Key recommendations for the identification and monitoring of children rendered vulnerable by HIV/AIDS

The recommendations suggested draw on evidence from a range of other literature (Dorrington *et al*. 2001; Department of Social development, 2000; HIV/AIDS/STD strategic plan for South Africa 2000-2005, 2000; Shisana *et al*., 2002; Wilson *et al*., 2002). The topic of support for HIV affected children warrants an extensive report on its own. Only a few essential points are made here. Wilson and colleagues outline a set of key recommendations. Their excellent focused report on policy recommendations for orphans and vulnerable children *is well worth consulting*. We draw extensively on their report, and parts are quoted in full below (italics ours; their pages 4-5):

3.3.5.1 Principles

- "Any approach to addressing the needs of vulnerable children should be *grounded in needs and rights based paradigms*."

- "While orphans, and in particular children orphaned by AIDS, do face some unique or additional challenges, many of the factors rendering them vulnerable are poverty related and shared by children living in poverty who are not orphans."
- (A) service response (is needed) that is *sensitive to this and to the potentially harmful consequences of directing support inappropriately at particular groups* of children, at the exclusion of others, within contexts of widespread and severe poverty."
- "Identification, support and monitoring of vulnerable children (should) be *integrated into existing programmes and standard practice*. In order to achieve this without placing unrealistic additional burdens on service providers, we recommend a focus on *strengthening the roles that various service providers are best placed to fulfil* in terms of their existing functions. "

3.3.5.2 Maximise opportunities for the identification reporting and monitoring of vulnerable children and equip the relevant people to do this properly:

Wilson and colleagues note:

- "With limited capacity for home visits and outreach services ….. contact with children and their caregivers should be viewed as *crucial opportunities to identify, support (or refer) and monitor potentially vulnerable children*." (p.27).
- "Many service providers come into contact with children and their caregivers without using the opportunity that this presents, to identify, refer, support and / or monitor children who may be especially vulnerable." (p.27).
- "The *school* provides an opportunity for adults to notice changes in the child's behaviour or repeated and prolonged absenteeism. If the child drops out of school and no follow up home visit or enquiries are made, as is often the case, this opportunity is lost." (p.27)
- "When an adult tests HIV-positive at a *health care facility*, the opportunity presents itself for health workers to enquire about dependents and, at the very least, to refer the patient to agencies rendering social or financial support."

Wilson and colleagues have developed a framework that provides a list of role players who to a greater or lesser extent might be involved in identification, reporting and monitoring of vulnerable children (below). Of course identification and monitoring systems will only work if these role players are trained to see signs of vulnerability, and make it possible for children to discuss their problems. The presence of stigma, particularly in schools, is a major consideration:

- Children and youth (in all instances)
- Caregivers looking after children and youth
- Representatives from government departments (e.g. health, education, welfare, justice, social development, agriculture, home affairs), including different levels of government.

- Service providers such as health workers, teachers, social workers, magistrates, community volunteers, counsellors, pre-school / crèche workers etc.
- Representatives from non-governmental and community based organisations
- Representatives from other relevant groups e.g. women's groups, street committees, support groups, traditional leaders forums, unions etc.
- Representatives from religious organisations
- Local business people

3.3.5.3 Provide those charged with the identification of vulnerable children with good referral networks

Wilson and colleagues note that:

- "Identification is unhelpful if not linked to some form of support or referral. For this reason, networking and collaboration between role-players are critically important. If a teacher or a nurse identifies a child as being in distress, s/he needs to know who to refer the child to, what information would be required by that person and what procedures need to be followed to complete the referral process." (Wilson *et al*., 2002, p. 33).

3.3.5.4 Reduce barriers to service access

- "User fee exemptions, free or subsidised transportation, extended clinic and social services operating hours and mobile services are some of the possible ways of addressing major barriers to service access." (Wilson *et al.*, 2002, p. 33).

3.3.5.5 Monitor children who have been supported

- "Monitoring of children who have received support (e.g. fostering) is necessary to ensure that *the support provided is sufficient and appropriate* - interventions to address vulnerability sometimes place children in situations that lead to other forms of vulnerability." (Wilson *et al.*, 2002, p. 34).

3.3.5.6 Strengthen systems for the monitoring of children placed in care.

- The increase in the proportion of children rendered vulnerable by HIV/AIDS will become particularly apparent within the next few years. As is pointed out in Appendix 8 (Children in need of care), the current childcare monitoring systems in the province are simply not functioning well enough to provide sufficient protection for children placed in care. Indeed, they may be resulting in further abuse to children.
- The fundamental reason is *resource constraints*. There is no doubt that social services, particularly those in the NGO responsible for child care (foster care supervision and residential home supervision) will have to be substantially strengthened. This will definitely have budgetary implications.

3.3.5.7 Improve collection of data

- There are currently no representative data for the province on children living with infected parents. The beginnings of such data could very easily be collected from

antenatal clinics without any cost. Simply record the number, sex, age and population group of the children of the infected pregnant mother. This will also provide an index of future orphan hood.

- Figures (albeit somewhat coarse) on orphan hood could usefully be collected from school administrative data by recording whether or not the enrolled child's parents are alive, and who cares for them. This would be easier at primary school level.
- There is currently no data available on the number of child headed households in Gauteng. This is a much more complex matter, and accurate figures are unlikely to be obtainable other than through close studies of circumscribed areas of the province. However, some indication could be obtained from the monitoring and identification authorities noted above. Schools and clinic administrative data in particular could also be adjusted to track this issue.

3.4 CHILDREN AND ADOLESCENTS WITH DISABILITIES AND PSYCHIATRIC DISORDERS

3.4.1 What is the scope and extent of deprivations and problems afflicting children in this priority area, and what groups of children and segments of the population are most vulnerable or at risk?

3.4.1.1 Children with disabilities

The South African government has recognised the rights of children with disabilities and, through progressive legislation, has committed itself to abolishing discrimination against these children. A disabled child's right to special care, education and training is also protected in the Convention of the Rights of the Child. The White Paper on an Integrated National Disability Strategy (1997) recommends the development of national policy guidelines for the provision of equitable educational and rehabilitation services for all children with disabilities. The rights of the disabled child is further reinforced in the Education White Paper 6 (2001) on Special Needs Education which outlines a 20-year plan providing for all learners to have access to education through a policy of inclusion.

The wide discrepancy between existing legislation and policies and the actual implementation of these policies results in the fact that children with disabilities are not enjoying the rights and services to which they are entitled.

- Available data suggests that *more than half of disabled children of school going age in Gauteng are not attending school* whilst less than half of the disabled children eligible for Care Dependency Grants are actually receiving them. Only 40% of disabled children who require rehabilitation actually receive it (Anderson, Phohole, Ijsselmuiden, 2002).
- The most marginalised disabled children include those with severe and profound disabilities, and children living in *disadvantaged* areas with mild to moderate intellectual disabilities. The mildly to moderately intellectually disabled child living

in a poor area and the most severely disabled children are receiving the least amount of care in terms of state support, rehabilitation and education.

- This investigation has revealed that data regarding the prevalence of disability in Gauteng is limited. No provincially representative prevalence studies specifically focused on children and adolescents with disabilities have been conducted in the province.
- From the limited data available, it is possible to provide a crude estimate of child disability. It is likely to lie somewhere between 3.3 and 6.4% of the child population (a lower limit of 75 734 and an upper limit of 146 878 children) (Community Agency for Social Enquiry, 1999). This figure is of limited use as a health service indicator, or for planning services because it gives no indication of the categories or the severity of the impairments, and the age and sex distribution of affected children is not known.
- However, given the poverty situation and its risks to children, the upper figure would be of use as a broad estimate of the population requiring disability services.

3.4.1.2 Psychiatric disorders in children and adolescents

- There are no figures available on the extent of psychiatric illness in children and adolescents in Gauteng. However, the prevalence of psychiatric disorders in South African children (excluding mental handicap) has been estimated to be around 14–20% (Lazarus, Dartnall & Sibeko, 1997). It is probable given the risks of poverty to emotional well being the upper figure is useful for service planning purposes. When the most recent census is available, it would be useful to develop probable numbers of Gauteng children with psychiatric disorders. Epidemiological surveys are very expensive, and this rough method will provide a fair indication of need (Dawes, Robertson & colleagues, 1997).
- An analysis of referrals to the Child, Adolescent and Family Unit at Transvaal Memorial Institute (TMI) in 1995 revealed that the top five diagnoses referred to the Unit were behaviour problems (21%), attention deficit disorder (15%), emotional problems (8%), and learning problems (6%). Seven (7%) percent of children had been sexually abused (Lazarus, Dartnall & Sibeko, 1997).
- A similar analysis at the Soweto Community Mental Health Service showed a very different profile – here the five most common diagnoses were sexual abuse (24%), learning problems (23%), mental handicap (15%), depression (11%) and attention deficit disorder (9%). One reason put forward for the differences observed between these two services was the lack of educational resources available for children with learning problems and intellectual disabilities in Soweto and thus a high rate of referrals to the Mental Health services by the school health services. It is also possible that the poverty profile in the Soweto group is different to TMI (Lazarus, Dartnall & Sibeko, 1997).

3.4.2 Recommendations: What gaps in existing services to children and families are evident in the priority area and how should these be addressed?

Detailed comments are presented in Appendix 2. The main recommendations include:

- The establishment of a data base of information relating to the prevalence, type and severity of disability in Gauteng.
- Assess the extent of abuse of disabled children.
- Strengthening and expanding district rehabilitation services for the disabled child.
- Introduction of a transport subsidy for disabled children.
- An education drive to inform all service providers on the type of support and level of care needed by disabled children.
- The appointment of disability management officers in all departments to develop capacity and ensure compliance with, and implementation of, existing legislation; and proactive planning to anticipate the increased demand for services.
- Psychiatric services for children and adolescents as well as rehabilitation services for youth with drug and alcohol problems are likely to be severely under-supplied. Based on probable prevalence figures, estimates of service needs are necessary for planning.

3.5 VULNERABLE CHILDREN

This section of the report groups *main findings and recommendations* on children in the particularly vulnerable circumstances below. Detailed evidence and recommendations are contained in the relevant appendices.

- Children in the Justice system (Appendix 3);
- Children in need of care in terms of the Child Care Act (Appendix 8);
- Adolescents whose behaviour places them at risk for a range of health and psychosocial problems (no appendix for this area).
- Working children (Appendix 6) including sexually exploited children.

3.5.1 Children in the Justice system

In this section of the report we present the main findings and recommendations that arise out of an examination of child arrests, awaiting trial incarcerations, and assessment, sentencing and diversion practices.

3.5.1.1 What is the scope and extent of deprivations problem and service difficulties afflicting children in trouble with the law?

Children are placed at risk by being arrested, improperly assessed, not diverted and not rehabilitated where possible, and where they are incarcerated in facilities that are not appropriate to their age.

Arrests

Gauteng is ranked second behind the Western Cape on the number of arrests of children per year.

- It is estimated that a total of 38 600 children would have been arrested in the province in 2002 (SAPS, 2002).
- Between 1999 and 2002, the number of children arrested increased at an average of 24.95% per year. The increase could be a function of the rollout of the SAPS CAS system or other factors such as increased policing. Alternatively, there may be an increase in children who need to steal in order to survive due to increasing poverty and HIV/AIDS orphan hood.

Crimes: What were children arrested for?

Based on the Assessment register, Youth offenders Pretoria, (2002):

- 51.4% of the children were charged with theft and theft related offences (excluding housebreaking). Violent crime contributed a very low proportion of offences.
- The next most common offences were robbery (9%), followed by housebreaking and theft, and the possession of dagga (7%).

Children in prison

As of 28 February 2003 there were 444 children awaiting trial in Gauteng prisons, often for months in extremely over-crowded cells with limited access to any support services. This is a contravention of the UN Convention on the Rights of the Child even though South African law permits the practice (Department of Correctional Services, 2003).

- There are children being held illegally in contravention of s 29 of the Correctional Services Amendment Act of 1996. A small number of children were tracked that were being held in contravention of the legal requirements.
- *A significant proportion of children who are sentenced to imprisonment are receiving long sentences*. Twenty three percent (23%) were serving sentences of longer than three years. This is an extremely worrying situation, and will place a further strain on the resources.
- The total number of children in police custody as of 31 December 2002 was 299 aged between 7 and 17 years (Department of Correctional services, 2002).
- Very few girls are in prison. The average number of sentenced male children in 2001 for Gauteng province was 298 and 4 for female children (Department of Correctional Services, 2002).
- There is no data on the HIV status of children in the criminal justice system.
- There is no data collected on whether special protection is given to child victims testifying in court in line with the Criminal Procedure Act, therefore it is not know how extensive the intermediary system is currently being used.

Assessment, diversion and rehabilitation:

Table 4: Number of children assessed in Gauteng

Category of service	1999	2000	2001	2002
Assessments	7 085	5 856	7 049	5 823
Pre-trial reports	50	41	46	198
Pre-sentence reports	2 212	2 127	2 259	2 928
Supervision	32	21	43	435

Source: DSSPD (2002)

The Child Justice Bill [49 of 2002] in Chapter 4 (see s 22 and s 23) is specific on what the probation officer has to make recommendations on (s 23(7)(a-d)):

a) The prospects of diversion.

b) The possible release of the child into the care of a parent or an appropriate adult, if the child is in detention.

c) The placement, where applicable, of a child in a particular place of safety, secure care facility or prison.

d) The transfer of the matter to a children's court stating reasons for such recommendation.

The Probation Services Amendment Act [35 of 2002] (s4(b)) requires that *every* child must be assessed before first court appearance.

- In contravention of the Act, only 15% of arrested children were assessed by a probation officer.
- *The number of children assessed should be increasing* in proportion to the number of children arrested. It is not.
- Only 25% of arrested children are diverted from the criminal justice system.

3.5.1.2 Recommendations: What gaps in data collection and services to children and families are evident in the child justice area and how should these be addressed?

- *Do not allow children arrested on petty charges to enter the criminal justice system:* The arrest of children needs to be monitored closely in order to prevent this situation.
- *Awaiting trial capacity must be utilised and expanded*: Gauteng province has the resources and the ability to accommodate all children awaiting trial in institutions other than prisons. There is capacity for 923 children in more child-appropriate facilities.
- *Comply with the CRC*: The detention of children should remain a measure of last resort as spelt out in the UNCRC.
- *Assess all arrested children in accordance with the law*: The assessment of children by a probation officer within 48 hours of arrest is a key gate keeping measure to ensure that children's interest are served by the criminal justice system and that they are not victimised through unnecessary detention in prisons and police cells whilst awaiting trial.

- *Efficiencies and the strain on staffing will have to be addressed*: This is necessary for assessment and diversion to be carried out in terms of the relevant Acts, and for children's rights to be protected.
- *Extend diversion programmes*: Children who participate in diversion programmes apparently benefit as less than two out ten re-offend over a three-year period. The high compliance rate with diversion conditions and the apparent success of diversion programmes in curbing recidivism are evident and lends further support to promoting diversion in the Gauteng criminal justice process.
- *Data: Monitor children awaiting trial and in sentenced custody to improve safety:* Ensure that decision-making in the criminal justice process is in line with the objectives of a more child friendly criminal justice as articulated in the Child Justice Bill.

It is not possible to know how accurate the department's figures are. An independent audit would be necessary. The data quality in some aspects of this area is acceptable (e.g. numbers of children arrested, assessed and incarcerated). However:

- Improve administrative data management in order to promote ease of data extraction from government. For this study, it was very difficult to extract the relevant data from government departments.
- *Data: There is no easily extractable data on the home circumstances of children in the system and where they live*. This is a priority given deepening poverty and the AIDS pandemic, and would assist primary prevention efforts to keep children out of the system. The data may be there (not certain), but it is not easily available.
- *Data: The service quality monitoring systems and data collection in this area need specific attention*. At present it is not possible to monitor the well being of children in any of the sectors of the justice system. This is necessary to protect children and their rights.

3.5.2 Children found to be in need of care (Appendix 8)

3.5.2.1 What is the scope and extent of deprivations problems and service difficulties afflicting children in need of care, and what segments of the population are most vulnerable or at risk?

The child justice area is closely linked to the discussion of children in need of care for two reasons:

1. In both areas, children are likely to have contact with the law, and many will pass through the court system at some stage.
2. Second, it is well known that the ranks of children in the justice system are over-represented by children who are very poor, have been neglected, abandoned and institutionalised (Rutter, Taylor, & Herzov, 1994).

This section of the report deals with children who are alleged to be "in need of care" in terms of Section 14 of the Child Care Act 74 of 1983. It includes in its ambit those whose cases are closed without their having been found to be in need of care, as well as those who are confirmed by the courts as being in need of care and are placed in substitute care in terms of Section 15 of the Act. The section covers:

- The provision and functioning of places of safety, foster care, children's homes and schools of industry and adoptions.
- The functioning of children's courts
- Social work services in all areas

The implication of HIV/AIDS for the service network is dealt with in the section on HIV/AIDS.

Given data limitations (see below), it was only possible to examine general trends, and to identify some areas of special concern and some broad strategies whereby these might be addressed.

The numbers and situation of children found in need of care:

- Numbers of children in care: The figures are not known as there is no provincially centralised record of how many children are being found in need of care annually. There was apparently a practice some years ago in terms of which, every court on a monthly basis submitted particulars of all orders issued to the DSSPD. However, this is no longer the case for some courts and the details that are still being submitted are no longer being collated. Efforts were therefore made to obtain some idea of the numbers of children being dealt with in children's court inquiries in the province from the Department of Justice and from the larger NGO networks.

- Children's court enquiries: *Some 4 878 children's court inquiries' cases were opened in 2001* (Child Justice Project, 2002). This figure applies to cases dealt with, and given that a single case will often involve more than one child from the same family, it does not reflect the actual number of children involved.
- Some 8 323 children alleged to be in need of care were taken through the system by Child and Family Welfare Societies between April 1999 and March 2000 (SA National Council for child and family welfare, 2003).
- About 1 500 children are served by organisations affiliated to the NG Church serve annually (based on 2001-2 and 2002-3 financial years for different components of the NGK-aligned service network (Christian Social Councils and NG Welfare offices).

No racial, age or gender analysis is available for children found in need of care in the province.

However, the South African National Council for Child and Family Welfare (SANCCFW) provided the following breakdown for children on the caseloads of its affiliates from January to December 2000: Black 49%, Coloured 27%, Indian 11%, White 13%. This may not accurately reflect the balance in services to children in need of care, as some of these children may be being assisted through non-statutory services, or may not be assisted at all.

NGK Welfare, whose constituent organisations serve the West Rand and the Vaal Triangle, had the following breakdown for its statutory services for the 2002-2003 financial year: Black 33.5%, Coloured 19%, Asian 0%, White 47.5%.

The NG Church's Christian Social Council (North) estimates that children in its statutory services are approximately: Black 50%, White 50%, clearly very untargeted in relation to the probable needs in the two populations.

The Christian Social Councils serving Johannesburg and the East Rand have statutory caseloads with roughly the following composition: Black 45%, Coloured 10%, White 45%.

Reasons for being found in need of care:

This matter cannot be addressed as there is no provincial system in place for keeping track of the reasons why children are being found in need of care. However, interviews revealed possible trends, all possibly linked to the heightened risk to children posed by deepening poverty, and loss of caregivers. The true situation would require a separate study.

- The Commissioner of Child Welfare for Pretoria: the bulk of the cases involved child abandonment and orphan hood (increasing in recent years).
- The Commissioner of Child Welfare in Johannesburg: case loads have increased with 100 more cases in 2002 than in 2001, and the figures for the year to date already showed an increase of 130.
- In all areas, NGOs report an upsurge of cases in which the children are in the care of poverty-stricken relatives, mainly grandmothers, who are seeking to access the state

  Foster Care Grant. Many of these children are orphans, owing in many cases, it is believed, to AIDS.
- Physical and sexual abuse of children and domestic violence in general were cited as major reasons for children being found in need of care.

Regional indicators

- According to Johannesburg Child Welfare society case records, in Laudium many cases of children are reportedly beyond the control of their parents and engaging in high-risk behaviour such as absenteeism from school and drug abuse. This finding is not however based on a systematic comparison of all JCWS areas of operation, and the extent of child control problems in other regions is not established.
- Very severe alcoholism and associated child neglect were being found to a disproportionate degree in cases among families in historically "Coloured" residential areas, and also in Alexandra in Johannesburg. Rampant unemployment was also seen as a factor. A trend recently noted in the Johannesburg CBD was for older children to be left in flats or shacks by foreign mothers who returned to neighbouring states, having expressed the intention to return but failing to do so.

Provision and functioning of places of safety, foster care, children's homes and schools of industry and adoptions: findings and recommendations:

- *The province has fairly substantial infrastructure* for responding to children in need of care, and a considerable number of structures providing social work services.

However, not all of these are physically close to those served (or need to be served), and a lack of affordable public transport exacerbates this problem.

- Available substitute care vacancies are often not appropriate for children in need of placement. There is a need to investigate ways in which these resources can be capacitated to deal with children who are currently being marginalised or inadequately served.
- Services to these children are an intersectoral responsibility and the contributions of all the relevant government departments need to be clearly identified and systematically strengthened. The Gauteng Programme of Action for Children (GPAC) is a key mechanism for this purpose and provides a mechanism, linked to a national framework, within which the necessary planning and resources can be directed.
- Large numbers of infants and very young children are being accommodated in residential care. This group is known to be particularly vulnerable to the damaging consequences of institutionalisation. Existing foster care and adoption service provision and the associated social work services should be strengthened inter alia with these children in mind.
- Many children's homes are functioning on very inadequate resources and the quality of care provided is uneven and in at least some cases inadequate. These facilities have been disadvantaged by successive shifts in government financing policy which have had a detrimental effect on them. A just and realistic formula for financing must be found.
- *Schools of industry are functioning far below capacity* and various concerns, albeit vague, have been raised regarding their functioning. It may be time to consider afresh the role which they can best play in the provincial service network and whether they might be structured differently.
- Social work and allied services are overstretched to the point where their ability to carry out even their most essential functions is open to question. They are a key factor in determining whether children in need of care are properly served and whether the services designed for them achieve what is intended for them.
- *Caseloads are at levels where effective services are, in a large proportion of cases, not possible*. The following are among the many negative consequences of this situation: (a) Children are tending not to move through the care system as intended, but to remain there for long periods, often in placements which are not appropriate for them. (b) Children urgently in need of placement cannot be accommodated. (c) Children are at risk of secondary abuse due to the mismanagement of their cases.
- Many personnel at work in the province's network of services for children in need of care lack the appropriate skills for the work at hand. This is another factor placing children at risk of secondary abuse. Provision for initial and ongoing training is required at all levels. A haemorrhaging of skills and experience is occurring

throughout this network, with extremely serious consequences for the children and families served. Salaries and working conditions of all personnel serving children in need of care, especially those in the NGO sector, require urgent attention to halt the loss of human resource capacity which is taking place in these services, and to bring about sufficient stability to make meaningful services possible.

- *Services to children in need of care are extremely fragmented.* This has implications for coordination, monitoring, quality control and economies of scale. The extent to which the government's responsibility for services in terms of the Child Care Act has been delegated to NGOs, without a commensurate allocation of resources to these bodies, is a matter for concern. There are historical reasons for the fragmentation of these services, and the involvement of so many community initiatives adds much capacity and value to the resource network. *However it is suggested that the distribution of statutory services between the DSSPD and its NGO partners be re-examined, and that alternative models be explored*.
- The provincial government depends heavily on NGOs for the delivery of services to children in need of care; however, provision for the financing of these services is to all accounts seriously inadequate. At present, the delivery of services which are mandated by the Child Care Act and therefore a government responsibility is being financed through partial, discretionary subsidies, which increasingly are being viewed as inappropriate for this purpose.
- There is a clear need for a financing policy which sets a proper balance between the different levels of service needed by children and families, and which directs appropriate funding to each level. Government's obligation to provide for the effective implementation of the Child Care Act, and an acceptable framework for the outsourcing of the required services to NGOs where appropriate, should be reflected in such a policy. Costing models which take into account the numbers of children to be served, the fundamental tasks involved in acceptable service delivery, and the human and other resources which are required to implement these, appear to be absent. It is urgent that such models be developed and properly utilised in the provincial and national budgeting processes.
- Services for children in need of care are becoming overwhelmed by impoverished families applying to foster children who are related to them and already in their care, in order to gain access to the Foster Care Grant. This trend seems at least in part to be an outcome of the AIDS pandemic. It is urgent that an approach be found whereby long-term kinship care can be separated from formal foster care, and financial assistance along with broad-based supportive activities be directed to the families in question, without further crippling the province's limited capacity to respond to cases of physical and sexual abuse, neglect and abandonment of children.
- *Existing foster care and adoption provision need to be very substantially expanded* and strengthened, and for existing residential care provision to be properly resourced in

order to play carefully selected roles in relation to children affected by HIV and AIDS.

- The position of unregistered children's facilities in the province, which has been identified as needing attention for a number of reasons, should be assessed in the light inter alia of these needs.

The functioning of children's courts:

Gauteng has 24 magistrates' courts, mainly located in urban centres. Most of these have decentralised offices in outlying areas. However, the children's courts function only from the 24 district offices. Various difficulties are reported by social workers in dealing with particular courts. Difficulties that compromise child well being and rights include:

- *Many parts of the court infrastructure are under great pressure.* At least some of the children's courts in the province are seriously overloaded and not all are equipped to deal appropriately with children. There are also deficits in other sectors including policing, health and education which all have essential roles in relation to children in need of care.
- *Where courts are dysfunctional due to overload, there is a long wait for cases* to be heard, no doubt causing considerable on-going distress to the children, and reducing the time that social workers can spend on other urgent tasks.
- *The Soshanguve court in particular does not appear to be functioning*, and cases which should be managed there are being referred to the Pretoria court, resulting in confusion and inconvenience.
- Commissioners of child welfare have a great deal of discretion and each court operates in its own way. *Policies are not applied consistently*.
- *Some Commissioners appear to lack the experience* to deal sensitively with children's situations and needs.
- *Compulsory specialised training* for children's court personnel is therefore required.

3.5.2.2 *Recommendations: What gaps in data collection and services to children and families are evident in the child care area and how should these be addressed*

- *Improve the central administrative data system* so as to link information on children where possible across the different sectors. This would provide an excellent tool for describing the status of and tracking this group of vulnerable children. However, the categories of information currently in use should be thoroughly re-examined. NGOs need to buy into the system and submit their statistics regularly. Effective linkages need to be put in place with other systems such as those operated by the courts.
- *Future plans:* DSSPD has plans in place for improving its information management system and this should be treated as a priority. There is a real opportunity to design a good model.

- Key status of children indicators to be collected: Numbers of children being found in need of care; where are they being placed; the origins of the children; the reasons they are being placed in statutory care; and how long they are in care.
- Key indicators of service quality need to be collected. Precise information as to the nature and intensity of services being delivered to children and their families, and the outcome of such services.

3.5.3 What is the scope and extent of adolescent risk behaviour in the province? (no appendix for this area)

High-risk behaviour among children and adolescents such as alcohol and substance abuse, unplanned pregnancies and unprotected sexual activities, is a major concern in South African today (Visser, 2003). The negative impact that alcohol, tobacco, and drug related behaviour might have on health, economic growth, social relationships, community life, emotional and spiritual well being is widely acknowledged (Rocha-Silva, de Miranda, & Erasmus, 1996).

While the bulk of the report focuses on young children and children in poverty in particular, it was felt appropriate to include a few findings on teen risk behaviour in the province. While these problems cut across all social classes, children who have had a difficult in life and who come into contact with the welfare and justice systems, are more at risk.

Clearly, a full report would be needed to inform policy. For this reason we do not include a lengthy set of recommendations and focus on the situation as revealed in a few studies.

3.5.3.1 Tobacco:

It is of concern that increasing numbers of adolescents are using tobacco products and that many are starting to smoke at earlier ages. In this context, research that focuses on the impact of tobacco use among young children is of fundamental importance.

By the age of 16, 41.5% of Johannesburg youth had tried smoking, and 12.2% were regular smokers. The influence of peers is clear. Factors associated with ever having smoked were: friends smoking, being 18 years or older, being in Std 9, not feeling close to ones parents and being male. Students who had smoked were 7.5 times more likely to have tried dagga than those who had never smoked, and 7 times more likely to use dagga regularly (Guthrie, Shung-King, Steyn & Mathambo, 2000). Clearly, there is a link between these two behaviours, but one should not assume a causal relationship.

A survey of prevalence of alcohol, tobacco and other drug intake among 10 to 21-year-old Soweto found youth that the majority started smoking between 14 and 17 years of age, while 20% started very young, before 10 years of age (Rocha-Silva, de Miranda and Erasmus, 1996).

3.5.3.2 Alcohol and other drugs

Substance abuse is recognised as one of the greatest health and social problems in South Africa. Between 34% and 55% of young persons report current drinking of alcohol (Visser, 2003). Ladikos (2000) found that with a sample of high school learners from Pretoria, the

majority of the learners (62%) had consumed alcohol on a few occasions and almost 40% stated getting drunk occasionally in the course of a typical month. One third of the respondents in the Ladikos study admitted to having smoked dagga, 23% of them under the age of 12, and 34% being 15 and 16 year olds. One quarter of respondents revealed they had inhaled substances such as glue, petrol and thinners, 27% had swallowed, eaten or drunk mandrax, ecstasy, Lysergic acid diethylamide (LSD) etc. and 22% had smoked crack or cocaine and mandrax.

High school learners are not the only children who are exposed to alcohol and other illegal substances. Visser (2003) studied alcohol and drug use among primary school learners. To understand the alcohol and dagga behaviour of the learners, questions were asked about their behaviour and acceptance of the behaviour (Table 5).

Table 5: Alcohol Use

Responses	Yes	No	Don't know	Not completed
Did you ever drink alcohol?	126 (27%)	301 (65%)	22 (5%)	11 (2%)
Did you drink alcohol in the past 30 days to get drunk?	63 (14%)	355 (77%)	32 (7%)	10 (2%)
Is it acceptable for a person your age to drink alcohol?	10 (2%)	400 (87%)	37 (8%)	13 (3%)
Will a person who uses alcohol for a long time become ill?	233 (51%)	71 (15%)	136 (30%)	20 (4%)

(Visser, M; 2003:60)

Alcohol is a known substance to many primary school learners. However, the same study showed that dagga is not a major drug of use by primary school learners, neither was use of solvents.

Over the counter medicines may become a problem for the learners because 13% indicated they use them. However, the question could have been interpreted incorrectly that they used them as medicine and not as a drug to get intoxicated, despite the fact that it was specified in the question that they use it "to get high".

3.5.3.3 Risky Sexual behaviour

A growing body of evidence points to the complexity of sexual behaviour (Eaton, Flisher & Aaro, 2003). Sexual behaviour is one of the most important high-risk behaviours as it is related to teenage pregnancy and the transmission of HIV.

Data on sexual behaviour is variable across studies. This is not surprising given the sensitive nature of the subject. Visser (2003) examined the sexual behaviour of *primary school learners* in the Pretoria Metropolitan area and found that **24%** were sexually active and that many regarded their friends as sexually active as well. Forty-six percent said some of their friends were sexually active. This sets a social climate that no doubt influences their behaviour. Despite this climate, **77%** said that it is not appropriate for learners of their age to be sexually

active. It is not clear whether or not those who said they were active are part of this group. It is disturbing that in this group of primary school children, knowledge of the transmission of HIV was poor. Alarmingly many of the learners do not have accurate knowledge about the transmission of HIV and many of them might be at risk of contracting the virus.

AIDS is not the only consequence of sexual intercourse, for teenage pregnancies commonly occur to women who are still at school. Thirty-five percent of women under the age of 20 are or have been pregnant, or have a child (Jewkes, Vundule, Maforah & Jordaan, 2001).

The most common prevention approach utilised in schools relies on teaching the learners the factual information about high-risk behaviour and the dangers thereof. Yet, as is seen in the data, the learners know what is unacceptable but still act differently. Thus, preventative programmes should rather focus on personal development and other ecological factors in their lives, such as the provision of a social network and social support (Visser, 2003).

3.5.3.4 Recommendations: What gaps in data collection and services to children with high risk behaviour, and how should these be addressed?

The Gauteng Provincial Government established the Gauteng Programme of Action for Children (GPAC) to give priority to a sustained and coordinated effort by government and civil society stakeholders in improving the lives of our children.

Special projects for young women and men include peer education, youth specific HIV education, and the development of life skills. There are 23 clinics in the province that offer adolescent-friendly services. Attention is also given to addressing teenage pregnancy. There are also programmes that focus on domestic violence, sexual abuse and assault at schools.

There is, however, only one fully state funded rehabilitation programme for young people with drug and alcohol problems in the province. The Magalies Oord Rehabilitation Centre currently operates from a house, in which 22 boys can be housed, between the ages of 9 and 18. Girls were initially also taken in, but the male dominated environment was also not conducive to them staying in the house. The programme focuses on developing life skills and settling them into a routine that is healthy. The centre will be relocating to a bigger venue and will then be able to accommodate 100 children (including girls) (telephonic interview with Mrs. Mokoena, Magalies Oord).

There are 32 other non-specialist shelters across Gauteng, that are subsidised by the government, to which children of all ages are admitted if they are destitute, have been abused, have alcohol or drug dependence problems, or are faced with any other problems.

The South African National Council on Alcoholism and Drug Dependence (SANCA) has 14 alcohol and drug centres in Gauteng catering for both inpatients and outpatients. Satellite clinics exist in rural and informal settlements as well. Horizon Alcohol and Drug Centre is one such centre catering for inpatients between the ages of 14 and 18. Their adolescent programme runs over 6 weeks, where the first two weeks involves a detoxification. The programme is based on life skills improvement and incorporates the children's parents in various counseling settings. An outpatient programme is also run in the neighbouring township of Daveyton, where the children are met once a week over a

period of ten weeks. The center receives funding privately, from donors, medical aid and a subsidy from the government. The subsidy is mainly used for children in Daveyton who cannot afford to pay for the services provided, or any other children who need to be sponsored during the inpatient programme (telephonic interview with Erica: Horizon). Unfortunately actual data on the number of admissions per year, and the number of individuals on the waiting list was not available.

It is clear that there are a certain services available to youth who exhibit high risk behaviour. While there are no prevalence studies for the province, a fair estimate can be gained from more focused studies on adolescent risk behaviour. Another indicator of service needs is the length of the waiting list for admission to these centres. It is highly probable that needs far outweigh available services in the drug and alcohol area.

3.5.4 What is the scope and extent of deprivations problems and service difficulties afflicting working children and sexually exploited children in Gauteng (Appendix 6)?

Poor children are at risk for child labour. The problem is exacerbated by parental unemployment and death.

'Child work' is not the same as 'child labour'. The latter term is reserved for work by a child that harms the child or poses a serious risk of harm. Unfortunately, there are no clear guidelines on where the boundary between work and labour is situated.

In 1998, the Department of Labour facilitated the formulation of the country's first Child Labour Action Programme and defined child labour as:

'*work by children under 18 which is exploitative, hazardous or otherwise inappropriate for their age, detrimental to their schooling, or social, physical, mental, spiritual or moral development*.'

The Department of Labour is currently leading a further, inter-departmental and consultative process to develop a new Programme of Action around child labour. The process will, hopefully, result in a document and programme which will provide further guidance on the distinction between child work and child labour. In the interim, one place we can look to, to find a definition of child labour is the law. There are several sources here.

In South African law:

The Constitution states that

- children under 18 years should be protected against exploitative labour practices and work that is hazardous or harmful to their education, health or well-being, physical or mental health or spiritual, moral or social development.

The Basic Conditions of Employment Act (BCEA) 75 of 1997:

- prohibits employment of children who are younger than 15 years or have not completed compulsory schooling. For children aged 15-17 years, the Act says that the work must be appropriate for their age and not place them at physical or any other type of risk.

The Child Care Act (CCA) 74 of 1983

- has a general prohibition of work, which is similar to that of the BCEA. However, the clause is wider than that of the BCEA in that it outlaws provision of work as well as direct employment.

Laws that define and provide for different forms of sexual exploitation of children, including exploiting children for purposes of pornography include:

- The *Sexual Offences Act*, the *Child Care Act* and the *Films and Publication Act*.

International conventions, which have been ratified by South Africa, provide a second source of law.

- The Internationl Labour Organisation Minimum Age Convention states that children should not engage in economic work before they are 15 years old, but that children aged 12 and over may do so if the work is light and unlikely to be harmful.
- The African Charter on the Rights and Welfare of the Child, Article 15 states that children should be protected from economic exploitation. However, it acknowledges that children have responsibilities towards their families.
- The Worst Forms of Child Labour Convention Article 3 identifies the worst forms as including slavery, child prostitution, using a child for illegal activities, and work, which is likely to harm the health, safety or morals of children. The Convention states that each country will need to decide what is hazardous, in consultation with organised employers and labour. Countries, which have ratified this Convention, which include South Africa, are required to address these worst forms as a matter of urgency.

The primary source of quantitative information on child labour used in this study is the Survey of Activities of Young People (SAYP), conducted by Statistics South Africa in 1999 (see Appendix 6). The use of the word 'activities' rather than 'labour', or even 'work' in the survey's name recognised the lack of agreement as to what constituted 'labour'. The intention was to describe what children were doing, as a basis for further discussion as to what constitutes child labour in the South African context. The other source is the Time Use Survey (TUS) conducted by Statistics South Africa in 2000 (see Appendix 6). The TUS covered people from 10 years and upwards. It was a relatively small survey, which asked detailed information about how people spent the previous day.

While both surveys are representative of the province, sample sizes are limited. It was therefore not possible to obtain an accurate estimate of working children in the province. Systematic studies are required. The avialable data suggests the following:

- Prevalence: At least **3**% *percent of children are involved in economic activity and most live in urban areas* (most Gauteng children live in urban areas). Many of the children were paid employees and others self-employed, however, there were those who worked without pay in family businesses. Only a small minority of working children *are under the age of 10 years*.

- Gender: Marginally more girls than boys are more involved. Many child domestic workers, girls in most instances, are taken from rural areas, especially Lesotho and rural settlements of Gauteng, and taken to households where they are meant to work.
- Causes of placement in domestic work: Family, friends or neighbours, due to poverty, death of a parent or caregiver, or other effects of HIV/Aids, placed the children in domestic work.
- Work conditions in domestic work: Most children in this category *work long hours, often without time off, leave or even payment*. Those who did get paid received between R150 and R350 per month. Nearly half of the children reported *sexual molestation* by their male employers, farm labourers, and relatives or customers of their employer
- Hazardous labour: Almost half of the children engaged in work reported *working in hazardous conditions.*
- Child trafficking: The Southern African regional office of the International Organisation for Migration has recently completed a study on trafficking for sexual exploitation and shows that children are being trafficked either to be used as sex slaves within Gauteng or sold on to other destinations. Some victims have been reported to be as young as 14 years.

3.5.4.1 Recommendations: What gaps in data collection and services to working and sexually exploited children are evident in the child care area and how should these be addressed?

Improve the data:

- The intention was that a child labour module would be added on to Statistics South Africa's standard household surveys on a two-yearly basis. It is now four years since the last SAYP, yet there have been no such add-on modules.
- While a household survey would assist in capturing some forms of labour, clearly it will not capture those that are often most hazardous. Work in housework, or even in family businesses, will also be difficult to monitor.
- *Access to fuel and water* should provide some indication of the need for children to collect fuel and water, but will not provide a clear indication of whether they or others (adult women) do this task.
- *Estimates of HIV prevalence and of AIDS orphans* will provide an indicator of one of the factors that is likely to force children into work or labour. However, these indicators do not provide evidence of child labour itself.
- In respect of 'economic' labour as outlawed by the BCEA, since 1999 the national Department of Labour has organised training of labour inspectors on implementation of child labour laws. The Gauteng North office reported that they had done a number of inspections in respect of child labour between January and December 2002. *None of these resulted in prosecutions*, and the Department did not provide any breakdowns, for example in respect of sector, region or age of the child.

However, the Department presumably does have some information about each case that could be used for monitoring purposes. It would also be useful to know the reason why prosecution did not result in each case. (The Gauteng South office did not provide data, despite being asked).

The province's decision as to what to monitor will need to take into consideration the outcome of the Programme of Action process currently underway. In the interim, the report on the Gauteng provincial workshop, which formed part of the consultations, gives some indications as to what participants considered priority areas.

The feedback on an exercise which explored the extent to which different hypothetical cases of children working were acceptable at of different ages highlights the difficulties in defining child labour. One case involved a child on a voluntary basis helping their mother during holidays to do domestic work in the employer's home. All participants felt this was not acceptable for a child of six years. However, some felt that it could be 'developmental' for children aged 13 years and older if done voluntarily. All agreed it was not child labour. In respect of a child delivering newspapers in the morning before school, for pocket money, most participants felt it was acceptable for a child of 13 years or older as long as the streets were not hazardous and the activity did not affect schoolwork. A similar attitude was expressed towards a child buying snacks at the supermarket and selling them between 4 and 6 each afternoon in order to save up to buy a bicycle.

In a later exercise, participants were asked to rank different types of child work in terms of the number of children involved, and the extent of the hazard. The workshops final ranking was as follows (Table 6):

Table 6: Gauteng consultation ranking of child labour priorities*

Type of child labour	Votes
Commercial sexual exploitation	11
Recruitment of children in one place for work far away	10
Begging	9
Commercial agriculture	7
Unpaid domestic work in child's home, parents & grandparents absent	7
Collecting of fuel and / or water	5
Subsistence agriculture	4
Unpaid work family businesses.	2
Retail (ordinary shops / informal stalls)	2
Collecting / catching food to eat or for sale	2
Domestic work for payment (cash or kind)	1

* Domestic chores, school maintenance, and children in performing arts received no 'votes' in the ranking.

3.6. THE GIRL CHILD

Concern for the status and well being of the more vulnerable groups within society necessitates a focus on female children. Key areas of concern are: 1) ensuring survival rights

in terms of health particularly sexual health, 2) development rights, particularly early childhood development and equal education for girls both in early and later childhood; and 3) protection rights - safety of girls, in particular protecting them from violence and sexual abuse, disability and sexual abuse, and child labour and trafficking. Drawing from expert reports on the status of children in Gauteng written for this report and *Children in 2001: A Report on the State of the Nation's Children*, this section provides an overview of the current status of the girl child in Gauteng while also pointing to gaps in information and existing knowledge on their welfare.

3.6.1 Girls survival rights

Although overall provincial statistics from the SADHS (Department of Health and colleagues, 1999) showing infant mortality and U5MR in the province to be 36.3 and 45.6/1000 live births is better than the national average, we have no information on infant and child mortality rates by gender in Gauteng. However, overall infant and mortality rates have increased over 25% between 1998 and 2002 and this may double in the next five years, principally as a result of the HIV/AIDS pandemic (see Appendix l).

There is no information on differences in nutrition between boys and girls or on immunisation, but 80% of all one year olds have been immunised.

In terms of sexual health, 82% of eligible women make use of contraceptive services in Gauteng. However, there are no figures for teenager in particular making use of these services nor is there data on service accessibility for young people. Provincial Health administrative information systems should be able to extract this data. This is important if the province is to monitor sexual health services to the under 18s.

Nevertheless, market research and the HSRC survey conducted in 2002 (Shisana, & Simbayi, 2002) show that condom use is increasing among youth. Statistics suggest that STI's are decreasing among young women and there has been a reduction in syphilis of 83% over the past three years. However, there are no available figures for STI's among children.

According to Appendix 1 in this report, abortion related deaths have decreased in Gauteng since legalisation of abortion. The rate of abortions among girls 16 and under is not known, nor do we know whether they are at greater risk than other age categories in terms of undergoing illegal abortions. It is important to collect this information.

While a recent study conducted by the HSRC (Shisana, & Simbayi, 2002) on HIV prevalence among children (2-14 years) finds a prevalence rate of 5.6%, prevalence for children could not be disaggregated at provincial level because of insufficient numbers. Nevertheless, overall prevalence is high in Gauteng (20.3%), with 28.4% in urban informal areas, suggesting that children are at risk of being affected and infected by HIV/AIDS. Girls are particularly vulnerable because of sexual abuse, early sexual debut and also may have to take on more of the burden of care of sick relatives than their male counterparts. Girls in the 15-19 year age bracket, nationally, have a higher HIV prevalence rate at 7% than boys at 4%. However, the study did not present figures for male and female at provincial level. We also have no figures on VCT uptake among girls in general nor at antenatal clinics. What is clear

from expert reports (See Appendix 1) is that HIV is likely to have a significant impact on the health and well being of the population and in particular women.

The extent of female genital mutilation is not known. The national report on the state of the nation's children (2001) suggests that it does possibly occur more in rural areas. Nevertheless, the report recommends that this be investigated further.

3.6.1.1 Data quality

Provincial health records are not up to date, inaccessible, incomplete and sometimes inappropriately categorised. More emphasis needs to be placed on reporting data that provides an indication of the status of female children's health, particularly in relation to sexual health and more especially HIV.

3.6.2 Girls developmental rights

3.6.2.1 Early Childhood Development (ECD)

Detailed comment on ECD is to be found in Appendix 7. Data presented is largely based on the nationwide audit of ECD conducted by the Department of Education (2001) and Stats SA survey (1996). Enrolment in preschool in Gauteng is at 50% for girl children and 50% for boy children. These figures are consistent with the population profile in which 50.4% are female and 49.6% are male. These proportions do not change with age and appear to be the general pattern in ECD services in South Africa. This is the general pattern in terms of access to ECD services in South Africa. Care of children who do not make use of ECD services is of concern. Service organisations report that children are cared for by mothers, grandmother and older unemployed siblings. They report that increasing numbers of children are in the care of other children both because of AIDS and parents seeking employment. Some report that children are locked up and left alone particularly girls if there is no one to care for them. Although these are anecdotal reports, such impressions are nevertheless of concern particularly in relation to the vulnerability of girl children to sexual abuse.

This report did not call for data on broader school enrolments, dropouts and outcomes, all of which are important in order to monitor the situation of both girls and boys.

3.6.3 Girls' protection rights

3.6.3.1 Child Safety, violence and abuse

This comment is drawn from Appendices 4, 5, and 6. Gender violence, in particular the threat of sexual abuse during school and to and from school is a very serious problem hindering education of girls (*protection rights* are covered below). While several qualitative studies exist, i.e. "Scared at School" (Human Rights Watch, 2001) and "A Study of School Responses to Gender Violence" (Brookes, 2001), figures on prevalence of different types of gender violence against girls and *how* gender violence impacts on girls' education is sorely needed (See further discussion under protection rights). We know it occurs, but how does its occurrence for example impact on the learning environment, on teen pregnancy, and school drop out among girls.

Cleaning at schools is also an emerging developmental rights issue for girls. In Gauteng, 8% of school children do five or more hours of cleaning and maintenance at school. Girls are far more likely to be doing this work than boys. Other research in schools also suggests that cleaning is often done during lesson time (Brookes, 2001). Further data on treatment of girls at school is needed.

Currently no statistics on type and prevalence of sexual abuse are available at provincial level (see Appendices 4 and 5). As has been noted elsewhere in this report, SAPS records do not categorise child sexual abuse as an independent category. Sexual crime categories such as rape and attempted rape are utilised and girls in Gauteng appear to be at significant risk - Gauteng is above the national average in reporting of sexual crimes.

Without statistics at provincial level and categorisation of child sexual abuse, we are not able to tell whether child sexual abuse is increasing or decreasing. Data from service providers strongly suggest that child sexual abuse is increasing. They also suggest that one of the consequences of the sexual assault of teenagers and younger children is that HIV prevalence is also increasing. There is, however, no accurate data on this matter.

Both girls and boys are equally affected by sexual crimes at younger ages (Higson-Smith & Thacker, 2003). However, retrospective survey data is clear that teenage girls are more vulnerable. By 18 years of age, 20% of girls are affected while 13% of boys suffer some form of sexual abuse (Higson-Smith & Thacker, 2003). At one of the largest NGO service providers in Johannesburg, *The Teddy Bear Clinic*, 85% of clients are female.

Schools should be protective and developmental resources. However, as noted above, some schools are in fact a particular danger area for girls. However, there is insufficient data to determine the size of the problem of sexual abuse in schools.

Schools are also not well equipped to handle sexual abuse cases. School based programmes are an essential component of combating child sexual abuse and much is being done by the Department of Education to introduce awareness and life skills programmes for learners. However, such programmes are often not adequately developed, with teachers still not being sufficiently skilled in the recognition, reporting and containment of child sexual abuse cases.

Training of schools and communities to work on these issues together is also an area that could be explored.

Awareness of girls' rights and children's rights is increasing, but needs more translation into action. Continued work on public awareness of child sexual abuse and building the capacity of non-offending adults' to recognise and report cases is essential. Follow up within a reasonable time and feedback are also essential for encouraging reporting of cases.

3.6.3.2 The justice system (Appendix 3)

Girls constitute by far the majority of victims of sexual offenses (See also Appendix 4). A number of sexual offence courts have been established in Gauteng, and there are preliminary indications regarding their effectiveness. The province has the most specialised services for

abuse survivors in the country, but these are not evenly distributed in the region. They concentrate in the Johannesburg area, and much more needs to be done for children who don't have access. Treatment services in specific areas in the province outlined in the report on sexual abuse (Appendix 4) need staff and capacity building.

Experts recommend standard protocols for categorizing and reporting cases should be developed, as well as standard case records and integrated data sets, and all agencies involved in sexual abuse need to provide ongoing and systematic reporting of sexual abuse crimes.

Specific focus needs to be placed on the vulnerability of disabled children, both boys and girls, to sexual abuse. Currently, no figures exist for this vulnerable group. More work needs to be done on how to prevent the abuse of disabled children and the difficult prosecution of offenders.

Girls within the criminal justice system may also be vulnerable to abuse. However, most children are diverted from the criminal justice procedures, and of those awaiting trial, there are approximately 22 boys awaiting trial in prison for every one female child.

The number of female children being held awaiting trial is very low, but it should be noted that Gauteng has the highest number of female children awaiting trial in prisons compared to other provinces. It is clear that there are very few female sentenced children, between 4 and 6 females for every 280 male children. Only a very small percentage of female children are ever held in prison sentenced or unsentenced (Department of Correctional Services, 2003).

3.6.3.3 Working children (child labour)

Protection of children from labour is also another key issue for girls but also for boys. Child prostitution, drug work, slavery, work done on the streets by street children and illegal domestic work are some of the main forms of child labour that need to be fought. Unfortunately, there are few statistics on these issues and most are likely to be underreported.

The little data we have, shows that just over half (54%) of the children doing economic work for three or more hours in Gauteng were girls and that 8% of children attending school did cleaning and school maintenance for five hours or more per week. Girls were markedly more likely to do such work at schools than boys in Gauteng.

Small focused studies of groups in Gauteng show that for some girls between 12 and 17 years, the combination of household work and paid work resulted in excessive hours. Cases of children being placed in domestic work as a result of poverty and death or other effects due to HIV/AIDS are reported. There is some evidence that trafficking of children for domestic work occurs. In most of these cases, children are unpaid or receive intermittent compensation. Those who received regular payment, received between R150 and R350 per month. Eighty five percent (85%) of these cases report sexual assault either before or during the period of their employment.

The southern African regional office of the International Organisation for Migration has recently completed a study on trafficking for sexual exploitation and shows that children are being trafficked either to be used as sex slaves within Gauteng or sold on to other destinations. Some victims have been reported to be as young as 14 years.

Although girls are particularly vulnerable, boys are increasingly becoming vulnerable to sexual abuse and exploitation. Moreover, death by non-natural causes are far higher in boys who are more likely to be victims of homicide, commit suicide and or die in transport accidents than girls.

3.6.4 Recommendations: What gaps in data collection and services are evident in situation of the girl child. How should these be addressed?

- *There is so little disaggregated data on girl children* for the province as a whole that this is a primary problem in need of resolution.
- *The most specialised services for child sexual abuse survivors are concentrated in the Johannesburg area*, and treatment services need to be expanded to high-risk areas (see Map 3).
- *Child abuse protocols must be standardised* across agencies.
- Disabled children, both boys and girls to sexual require special protection.
- More statistics are needed on hazardous working conditions for children, long working hours, household chores, childcare and cleaning at school.
- School sexual harassment and anti-violence policies must be strengthened, and action must be seen to be taken against offenders.

<u>Child justice</u>

- *Inter-sectoral monitoring systems* have been established by the Department of Social Development to monitor the situation of children in the criminal justice system. This process needs to be monitored in itself.
- Court data on children found in need of care needs to be strengthened and integrated with welfare services data.
- No data could be obtained regarding the *HIV status* of children in the criminal justice system. This is of concern.
- It was not apparent if any special attention is being to address the specific needs *of girl children* in prison. This requires further investigation.
- The *arrest* of children needs to be monitored closely in order to avoid that children enter the criminal justice system unnecessarily on petty charges.
- Closer attention should be paid to the *efficacy of monitoring structures* to ensure firstly that the number of children awaiting trail in prison is reduced substantially and

further, is in line with the objectives of a more child friendly criminal justice as articulated in the Child Justice Bill.

4.2.5 Primary data needs in the area of child safety and abuse.

- The *data quality* on child sexual abuse is *very poor* (both state and NGO data). Different agencies collect different data making estimates of the problem very difficult. Data collection systems must be standardised.
- C*omprehensive and reliable data* specifically *focusing on children* is needed to track injuries and violence.
- Minimal co-ordination occurs at present across the various data sources on child abuse, injury and violence. This results in continued differences in data sets that cannot be matched and therefore cross-validated.
- Centralise various data sets in such a manner that they would be easily accessible to decision-makers, practitioners and researchers.
- Link provincial processes to national data collection and information management strategies, through feeding into those debates and collaborating on national level initiatives, thereby ensuring synergy.
- For children at high risk for abuse, particularly those living *within institutions and the disabled* child, monitoring is essential.
- Commercial sexual exploitation and trafficking of children: As noted, data quality is very poor in this area. Despite the considerable difficulties in gathering data, this is a priority.

4.2.6 Primary data needs in the area of child labour.

- There are serious problems in the data availability on the topic of child labour.
- The province's decision as to what to monitor concerning child labour will need to take into consideration the outcome of the *Programme of Action process currently underwa*y.
- There needs to be a clear distinction in the data between child work and child labour.
- Many of the worst forms of child labour-sex work, drug work and domestic work-are not documented and thus no data is available for use. This gap in data needs to be examined and rectified if possible.

Data that is Gauteng specific needs to be generated, so that a clear indication of the child labour situation can be attained.

4. CONCLUSIONS

The key recommendations contained in the expert reports are covered in the proceeding sections. More detail is to be found in each appendix.

Rather than repeating that information here, we will present some basic recommendations regarding the collection of data so as to ensure a more rigorous long term approach to the monitoring of the situation of children in the province. Specific recommendations regarding priority indicators of child well being for the province are presented in a supplement to this main report.

4.1 Overall crosscutting data needs for the monitoring of the situation of children in Gauteng.

If there is one point that unifies all the contributions to this research, it is the poor quality of information available that can provide data on the status of Gauteng children and services to children. (This is less of a problem in the health sector).

All sectors without fail noted the lack of good information on service quality. Clearly a range of services are not monitored, particular examples are children in child care facilities and correctional facilities.

Despite our ratification of the Convention on the Rights of the Child (CRC) and the rights granted to children under Section 28 and other sections of the Constitution of the Republic, Gauteng is not unique in its data gaps. There is no national state policy (or practice) to routinely survey issues of specific importance to child development outcomes and child monitoring. As things stand, no provinces have sufficiently developed and integrated child information systems and data collection strategies to permit reasonably accurate and sufficiently disaggregated descriptions of the state of children.

We conclude with general recommendations for strengthening data collection, followed by some key priority area recommendations.

4.1.1 General information system and data recommendations

Each expert report provides specific information recommendations. Overarching points are made here.

- In virtually every area, there is a need for improvement in the design of administrative information systems in the province. This system needs to integrate information from a number of sources.
- The issue is not just a problem of the correct data. This is of course important, as in many areas there is no data. Rather it is about the correct data to collect in each area and how to integrate across sectors in order to assist in planning and services monitoring.

- If the effects of poverty on children are to be tracked and understood, it is essential that information systems be designed such that the status of children can be linked to the situation of the child's parents or caregivers. Since risks to children vary as a function of the environments they live in, it is essential that the child's address be noted.
- All sectors of government need to decide *together* what priority data on risks to children is collected, and when.
- It is best and cheapest to collect a limited amount of good data in key areas. Administrative child data is routinely collected by government departments at all levels, and regularly collected administrative data can service much of this purpose.
- In some areas the data may be available but not accessible. Building a good child information system for the province on the back of the existing systems (where feasible) is likely to be a cost efficient option.
- Data should be collected regularly. The time frames will differ for different priority areas.
- The NGO sector covers a wide range of services, and needs to be part of this process.
- All data should be gender disaggregated. In particular, more emphasis needs to be placed on reporting data that provides an indication of the status of girl children.
- Where possible and appropriate, the age groups on which data is collected should be similar across different data sets.
- While provincial level data is appropriate for a broad picture of the situation of children, it *is not appropriate for monitoring the child's situation closer to sites of intervention*. One may not need national surveys for such purposes, but locally targeted studies would be a minimum requirement to provide more fine-grained data for policy and programme decisions, and for the monitoring of particular categories of children at risk. Finally, the appropriateness of data collection methods and their reliability and validity for different purposes also needs to be established.
- As is evident in this report, in most surveys conducted by statutory agencies, children are very seldom the focus.
- Surveys conducted at household level normally do not permit one to link children to their parents (the Census does permit this). This is a significant problem to overcome, but it would bear fruit were the province to achieve such an outcome. This could be done in collaboration with those who collect regular economic data for policy purposes, for example, Statistics South Africa.
- The information from these various sources is not integrated at a single point for easy access by a variety of stakeholders and decision-makers. In addition, different methods and surveys may collect data *using different questions to tap the same construct* (e.g. child labour). Also, *different approaches to the desegregation of data by age or*

geographical region are evident. The latter problem is particularly problematic as programmes to improve the situation of children are implemented at local level.

- In addition to survey methods, it is essential that child-centred qualitative methods (appropriate to children's developmental stage and experience), are employed with both adults and children in order to explore their accounts of how policies and services that affect family material resources also affect them. *Children have the right to partici*pate and this would be one way of involving them. This approach also provides an opportunity to generate indicators based on the child's perspective and concerns.
- Children themselves need to be included as participants in surveys. It is most commonly the practice for adults to respond on behalf of children, and it is well known that the accounts of children and adults often differ – particularly in sensitive areas such as sexuality.

The following were the key information needs noted in priority areas (the girl child is covered in the general recommendations above).

4.1.2 Primary data needs in the health sector:

- An effective and efficient health information system is vital for planning and managing health service delivery. Integration of data systems from health districts, municipalities, provinces, the private sector and the national department work is vital. Further, various governmental systems, such as Home Affairs and Public Services, impact on the health system and should also be integrated with that of the health system.
- Lack of accurate national, provincial and local (hospital and clinic) data on the magnitude and causes of child, infant and neonatal morbidity and mortality is limiting advocacy and program planning in child health. Information systems, including birth and death registration, need strengthening. Use of rapid epidemiological assessment tools such as the Preceding Birth Technique on a regular basis in all health districts offers a quick, simple and indirect method to compare child mortality rates among districts.
- A child register (computerised) should be set up at each clinic to assist with the identification and follow-up of children who have missed their follow-up date; developing a strategy to follow-up children who have not returned; and establishing a community network to assist in tracing of children.

4.1.3 Primary data needs in the disability, child psychiatric and drug abuse areas:

- As no provincial level data exists, a system is required that will permit the ongoing collection of data to monitor the prevalence in these populations.
- Prevalence surveys are very expensive. It is appropriate to work with findings from other parts of the world. Given the high risk poverty context within which so many Gauteng grow up, one can assume that the prevalence of disability and child

psychiatric disorders will be at the high end of the prevalence estimates established in other countries.

4.1.4 Primary data needs in the child care and justice sectors

Children in need of care

- The DSSPD plans to improve its information management system. This is a *priority*.
- There is a need for the many identified gaps in data collection to be filled.
- Categories of information currently in use must be thoroughly re-examined.
- NGOs must buy into the information management system and submit their statistics regularly.
- Effective linkages must be put in place with other systems involved in child placements such as the courts.
- Because several different Departments have responsibility for child found in need of care, because service delivery is fragmented, because most services are delivered by NGOs, and because data is not centralised, *comprehensive data on children in need of care is not available*.
- Where information is available, there are many gaps in the data and the appropriate information has not been collected.

Child justice

- *Inter-sectoral monitoring systems* have been established by the Department of Social Development to monitor the situation of children in the criminal justice system. This process needs to be monitored in itself.
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- Data that is Gauteng specific needs to be generated, so that a clear indication of the child labour situation can be attained.

The main message of this report is that poverty continues to present a significant threat to the well being of nearly 50% of children in the province. As is well established, poverty is associated with a number of risks to child well-being. This is clear from the data assembled for the current report.

It is also evident that there are many gaps in current information systems on child well-being in the province, and the data quality is problematic in many instances. The development of good information systems will be a worthwhile investment and will improve the capacity of the province to monitor the status of children, their developmental contexts and their services.

4.2. Supplements to the Main Report.

A summary of the main findings of this research is presented in the first supplement to this Report. A conceptual framework for indicators and their collection is presented thereafter. Finally, appendices with detailed findings in each of the areas researched for this project are presented as separate supplements.

5. REFERENCES

Note on referencing:

1. Supplements and Appendices contain references and data sources for specific priority areas. Unless cited in this section of the report they are not included here.
2. Data sources for each priority area are contained in the relevant appendix. The exception is HIV/AIDS sources which are contained here.

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