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Using the Child Support Grant to
Advance the Socio-Economic Rights of
Children Affected by HIV/AIDS in South Africa: A Critical Reflection

Mini-Thesis for Master of Philosophy: Critical Issues in HIV/AIDS and Society

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People like to call us AIDS orphans. But you can call us Dennis, Titha and Stewart.

Throughout the writing of this thesis, this card hung above my desk as a constant reminder that in amongst the data and statistics, lie the hearts and minds of children – who deserve the right to dignity, and consideration as individuals.

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ABSTRACT

South Africa is ten years into a new democracy, and dealing with several public health and human rights challenges. One of the most pressing challenges is HIV/AIDS, which is prevalent in the context of ubiquitous poverty. Part of the post-apartheid reconstruction of the country has been the choice of a Constitution that heralds progressive and justiceable socio-economic rights, especially for children. Notably these include the rights to basic nutrition, shelter, basic health care services and social services, as well as social assistance. However, reality does not yet match Constitutional aspirations and approximately seventy percent of children in South Africa still live in poverty. Many children are also coping with the impact of HIV/AIDS on their households and families.

The Child Support Grant is the government's primary poverty alleviation mechanism targeted at children living at the nexus of poverty and HIV/AIDS. This thesis reflects on the Child Support Grant in terms of a public health and human rights framework, showing that it is fundamentally a good public health policy; and has made significant inroads into alleviating poverty and easing the burden of HIV/AIDS for many children in South Africa. However, this thesis also argues that there are several levels of discrimination within the policy that still need to be addressed. Notably, these include discrimination based on age, as the grant currently leaves approximately 7 million poor children between 14 – 18 years excluded from social assistance. In addition, barriers to accessing the grant are substantial, even for those who are eligible, and need to be addressed through creative and appropriate responses that draw on public health and human rights discourse.

Key Words

HIV/AIDS; poverty; child rights; socio-economic rights; social assistance; Child Support Grant; public health; human rights

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INTRODUCTION

South Africa has recently emerged from forty years of legislated apartheid in which the State directed extreme racial oppression and exploitation at the majority of the population. For many years, the shape of the political economy ensured repression and denial of human rights to black South Africans. With no right to vote, no right to organise politically or otherwise, no right to freedom of expression, severe restrictions on private and public behaviour, and limited mobility and ownership of land, black South Africans were disempowered. South Africa was effectively a police state, where one section of the population (white) patrolled the other (black). Society was stratified on racial lines with the African majority oppressed by a small group of whites; and the working class was divided along colour lines. The long-term impact of apartheid can still be seen today, in the continuing high levels of poverty and social inequality that retain a racial form.

One of the legacies of apartheid was the pattern of disease in the country. Diseases of poverty were common in the poor (and racially divided) areas. However, political priorities dictated that the health system should concern itself with the diseases of the white and wealthy population, and therefore little attention was paid to the African majority¹. There was also no adequate welfare system to cope with widespread poverty among the black population. The welfare system that did exist catered for the white population and was well-administered, but little provision was made for Africans. One of the groups affected by these policies was children, particularly poor black children. These conditions were more extreme in areas of the country supposedly 'independent' i.e. the "Bantustans" or "homelands" set up by the apartheid government for the black population. Duplicate administrations and entrenched inequalities fed into the problems of ill health and poverty.

¹ Racial categories were used by the apartheid government, including African (black), Coloured, Indian, White

When the first democratically elected government of 1994 came into power, it was committed to dismantling the old system and developing a culture of rights in which all citizens could benefit from State provision. The past ten years in South Africa have seen a new democratic and constitutional framework that intends to respect, promote, protect and fulfill human rights, including children's rights. There have been many gains in recognition of, and attempts to protect children's socio-economic rights. However, the outcome of negotiations prior to 1994, which led to democratic elections, was essentially a political compromise, allowing many apartheid-era bureaucrats and systems to remain in place. The legacy of apartheid and years of oppressive state policy, prior to democracy, can still be seen in the struggle to reach poor and vulnerable children. In addition, the global context of western domination and capitalism is hostile to state intervention and welfare assistance, which, it is argued, is greatly needed by many poor and HIV-affected children in South Africa. Ten years after the introduction of democracy, many challenges remain. In addition, changes in the economy have meant that unemployment is a major issue, with more than a third of the economically active population out of work. Poverty levels remain at extremely high levels, and affect food security, infrastructure, housing and access to resources. Poor health and premature mortality are rife among the poor.

In this context, HIV/AIDS is making its mark. South Africa has one of the highest rates of HIV infection in the world. The natural history of HIV/AIDS is such that, while demographic modeling predicts that five million South Africans were infected with HIV in mid-2004 (Dorrington et al, 2004), we have yet to see the full impact of AIDS in terms of illness and death; and the effect this will have on South African political and socio-economic life. HIV/AIDS impacts on children in South Africa in the context of historic and ubiquitous poverty, that already provides many existing public health and human rights challenges. HIV/AIDS is seen by many as one of the most important challenges South Africa is facing, partly because the epidemic has consequences for production and reproduction. Herein lies the interest of the thesis – the impact of HIV/AIDS on poor children, who, it will be argued, are made more vulnerable by the impact of HIV/AIDS.

An important question is what is being done and what can be done to better support children living at the nexus of HIV/AIDS and poverty?

This thesis will look at the impact of HIV/AIDS on children in the context of children's rights in South Africa. While many other public health issues are present in South Africa, HIV/AIDS provides some unique challenges, which will be discussed in this thesis. The challenge for government is to construct and implement appropriate policy that confronts the HIV/AIDS epidemic as one of the crucial public health challenges in South Africa. In the context of inequality and poverty, political tensions continue and the government's policy choices reflect this tension and struggle. An example can be seen in the government's choice of a Reconstruction and Development Plan (RDP) in the early 1990's, advocating state intervention and a comprehensive welfare system; but followed by principles of the Growth, Employment and Redistribution (GEAR) approach of 1996, which shifted towards a neo-liberal market-driven "trickle-down" approach.

This thesis will argue that a market-driven approach has manifestly failed to make a substantial impact on poverty alleviation. It will argue that strong state intervention is needed through welfare measures, to support children living in poverty and affected by HIV/AIDS. Specifically, this thesis will look at the impact of the Child Support Grant, the government's primary poverty alleviation mechanism targeted at children. It will use the public health and human rights framework, developed by Leslie London, to examine the Child Support Grant as a policy instrument that mitigates the impact of HIV/AIDS on children living in poverty in South Africa.

This requires an assessment of the following questions, which this thesis will address: What is the political and socio-economic context in which HIV/AIDS is making an impact? What is the demographic impact of HIV/AIDS? What is unique about the challenge of HIV/AIDS in terms of public health and poverty alleviation? What do we mean when we talk about children, and what is the impact of the epidemic on South Africa's children? What is a public health and human rights framework? How are human rights extended to children in the context of HIV/AIDS and poverty?

These questions are considered in the following chapters. Chapter one considers the challenges evident in the South African historic political context, particularly because of the impact of years of apartheid, that still leave an imprint on socio-economic development. Chapter two examines the epidemiology of HIV/AIDS and its impact on children in South Africa, including an assessment of the relationship between HIV/AIDS and poverty. Chapter three explores notions of childhood and children's rights, in a South African context. This chapter refers to the international background of children's rights, as well as the rights enshrined in the South African Constitution. Chapter four suggests the value of a public health and human rights framework for promoting the well-being of children. Chapter five reflects on the Child Support Grant, the government's primary poverty alleviation mechanism for children affected by HIV/AIDS, in the context of a public health and human rights framework. The existing barriers to accessing the Child Support Grant are reviewed in terms of real life experiences of households involving more than sixty children².

The final chapter of the thesis presents conclusions and recommendations. It argues that the Child Support Grant promotes values intrinsic to a public health and human rights framework. However, recommendations regarding a review of the Child Support Grant policy and the means for implementing child-targeted social grants are suggested, in order to more fully realise the value of this policy in terms of fulfilling public health and human rights requirements.

² Many of the concepts involved in this research (HIV/AIDS; poverty; epidemiology; public health; childhood; human rights) are interlinked and dependent on one another. The order in which these concepts are explored can vary. This thesis has attempted to use a logical approach to reflect on each of these in turn, with the use of reference to earlier or later chapters.

1. THE CHALLENGES TO POVERTY ALLEVIATION IN THE SOUTH AFRICAN POLITICAL CONTEXT

South Africa has a particular historical context which has greatly affected the different (and unequal) socio-economic experiences of citizen's lives. This chapter outlines the historical context within which the government's current measures to deal with inequality must be considered. A sketch of apartheid's restrictive policies is presented, showing that these still have an impact on children who are marginalized because of years of poor or non-existent service delivery. Following democratic elections in 1994, the State has had to undergo an entire transformation process, on policy and bureaucratic levels, to provide services to all citizens. In the midst of this transformation, HIV/AIDS has struck, and often at those who are already the most vulnerable.

South Africa's history of ubiquitous poverty and high levels of social inequality must be addressed by government in order to promote a decent future for its children. This legacy is the result of a system of racial and colonial capitalism, which deliberately sought to keep the majority poor, so that a small elite might enjoy the comforts of life. For many years, race was a defining factor in people's lives. Prior to 1994 apartheid policies were pursued by an oppressive State. Since 1994, the country has been unraveling the complicated relationship between race, class and socio-economic privilege. Before 1994, race largely determined socio-economic status, access to services, including access to health care and respect for human rights. The levels of care, education and welfare (and resources) provided for children depended on their race, and black children bore the worst of the legislated discrimination. As a result, the legacy of apartheid was entrenched in a social order with which we still battle, despite ten years of democratic rule.

Decades of racial oppression have been deeply ingrained in South African society, dating back to the late 1800's. As early as 1903, the South African Native Affairs Commission recommended a blueprint for segregation between races (Worden, 1994). This was implemented in various acts and measures throughout the first half of the 20th century, in which the political system was characterised by racial exclusion and discrimination,

forming the basis of ruthless exploitation. Apartheid, a government-imposed policy which physically separated the races, was enacted through an oppressive and vice-like clamp over all aspects of life in South Africa, especially after 1948 when the National Party was in power. Legislation and policy were set up to impose these restrictions in areas such as the following (please note, these are examples rather than an exhaustive listing): political expression and franchise (*Representation of Natives Act, 1936*; and *Suppression of Communism Act, 1950*), land ownership (*Natives Land Act, 1913*), urban segregation and housing (*Natives Urban Areas Act, 1923*; and *Group Areas Act, 1950*), conditions of employment and union representation (*Natives Urban Areas Act, 1923*; and *Mines and Works Act, 1911*), labour mobility (*Native Laws Amendment Act, 1937*; and *Black Labour Act, 1964*), sexual behaviour (*Prohibition of Mixed Marriages, 1949*; and *Immorality Act, 1950*); separate educational facilities (*Bantu Education Act, 1953*); separate amenities (*Reservation of Separate Amenities Act, 1953*) and others³.

Welfare for the poor and unemployed was racially exclusive as early as the 1930s (Worden, 1994). While apartheid elicited a strong response from black communities who garnered social capital to fight an oppressive government, there was little government support for welfare provisions for black individuals or communities. Black communities helped one another through mechanisms such as 'stokvels' (funds pooled between households), voluntary associations and burial societies, which were the only forms of economic survival for some (Worden, 1994). Lack of sufficient housing was a problem, particularly in urban areas where black people, driven by poverty in rural areas, came to seek work. As a result, un-serviced 'township' areas had emerged by the mid 1940s (Worden, 1994). No government or municipal services were provided to people living in these areas. Health and welfare services were biased towards white urban areas, in support of apartheid government policies.

In 1927 the Native Administration Act stressed the need for black Africans to be ruled by a distinct system of law and government. In 1959, the apartheid policy of 'separate development' became a reality, with the Promotion of Bantu Self-Government Act

³ See Butler (2004) and Worden (1994) for further discussion of repressive apartheid legislation.

setting up ten distinct, ethnically based “Bantu homelands”, each with some degree of self government and administration. In 1970, homeland citizenship was forced on all Africans, who were supposedly given citizenship and political rights through this system of self-governance (Butler, 2004). This led to forced relocations of Africans, and in most cases people were relocated to “barren areas far removed from employment or adequate resources” (Worden, 1994). With regard to children, the original Child Care Act of 1913 only made provision for white children, and until 1996, many former “homeland” areas set up under apartheid, had no children’s court and therefore no child protection (Sloth-Nielsen, 2001). These backlogs inherited from apartheid inequalities continue to aggravate the conditions of children living in poverty and have an effect on diseases of poverty, for example through inequality in access to proper sanitation, clean water and housing (Radebe, 2004). The current challenges faced by the South African government show that the impact of apartheid policies can still be felt in South African society today, with many poor children unable to reach the state support that they need.

The democratic government elected in 1994 inherited this legacy of separate homelands, with duplicate administrations, entrenched inequality and lack of access to adequate government services or welfare assistance for the poorest and most remote citizens. Wholesale transformation of the state bureaucracy was a necessity, in order to reach the most vulnerable of all of South Africa’s citizens. Part of the transformation of the state bureaucracy has required that officials understand that their duty is to serve and assist the poor, rather than police and obstruct or ignore them, as in the past. South Africa has therefore been coping with vast inequalities and an inherited system of apartheid-based welfare and health mechanisms that do not adequately cater for the needs of all children in South Africa.

Not surprisingly, many citizens viewed the state under the apartheid government, as the oppressive machinery of a colonizing enemy. Despite a new democratic order, notions of an unhelpful and untrustworthy state persist for some, especially at the level of bureaucrats (such as social development officers) with whom the poor must deal in order to receive, for example, social assistance. For the majority who identified with the

African National Congress (ANC) as a liberation movement, there was a belief that once democracy was won, their rights would be secured. However, delivery of socio-economic rights is often a long and uneven process, especially in the context of the historical inequalities evident in South Africa. A necessary part of democracy is the building of robust civil society, that promotes understanding among citizens of a culture of human rights. Citizens need to learn to claim their right to social assistance, among other socio-economic rights. The cases which are used for reflection, later in chapter 5, show that HIV/AIDS and poverty is impacting the least powerful people in the country, not those who would ordinarily clamour for the fulfillment of rights. This places a heavy burden on the State to protect the most vulnerable.

The new system of governance, introduced after 1994, with a new Constitution, and new legislative framework (see chapter 3 below) are an important part of creating an equal and non-discriminatory society. However, implementation of a new order takes time and needs to overcome the hurdles of the past. The difficulties of implementing legislation become apparent through looking at the case of the Child Support Grant, targeting poor children. The uptake rate of the grant has increased substantially since its initial introduction in 1998, thus providing social assistance for many children. Partnerships between government and civil society have played an instrumental role in reaching greater numbers of vulnerable children. However, implementation is still very patchy and approximately 7 million needy children between the ages of 14 – 18 do not receive social assistance that is their right (Cassiem & Kgamphe, in Coetzee & Streak, 2004). Further discussion of barriers and difficulties encountered in implementing the Child Support Grant are discussed in chapter 5.

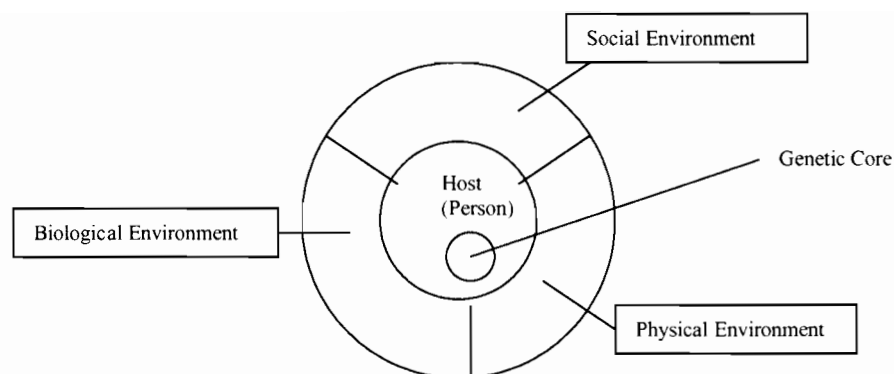
2. THE EPIDEMIOLOGY OF HIV/AIDS AND ITS IMPACT ON CHILDREN IN SOUTH AFRICA

This chapter considers the epidemiology of HIV/AIDS in South Africa and its impact on children living in poverty. Epidemiology can be defined as the “study of the distribution and determinants of diseases and injuries in human populations ... concerned with the frequencies and types of illnesses in groups of people and with the factors that influence their distribution” (Mausner & Kramer, 1985). First, the interaction between poverty and health (and HIV/AIDS specifically) is discussed. This is followed by an outline of the general epidemiology of disease and a brief outline of the different stages of HIV/AIDS. The unique aspects of HIV/AIDS are also explored, particularly in the context of poverty; as well as the vulnerability of different risk groups. Finally, the ways in which HIV/AIDS impacts on children at different stages of development is explored.

HIV/AIDS and poverty

HIV has been said to “change the contours and dynamics of poverty” through the impact it is having on demographic and socio-economic aspects of life (Drimie, 2002). Recent research has shown that South African life expectancy in 2004 was approximately 48 years for men, and 52 years for women. The Infant Mortality Rate was approximately 56 per 1000, and there are a total of 1.1 million maternal orphans under 18 years old, 250,000 of whom were newly orphaned in 2004. It is estimated that approximately half a million South Africans were in need of antiretroviral treatment, but by October 2004, only 19,500 were receiving anti-retrovirals through the public sector (Dorrington et al, 2004).

The health of individuals in a community is substantially affected by the environment in which they live. The interaction between a person and their environment can be seen in the following diagram of Mausner & Kramer, which shows the wheel model of people-environment interactions.



- Mausner & Kramer, 1985-

Here, the social, physical and biological environment interact dynamically with the core genetics and health of the person. The health of individuals, households, and communities should not be considered outside of context. In a country such as South Africa, poverty is one of the major societal determinants of health (Werner & Sanders, 1997) and has substantial impact on the social, physical and biological environment.

In the 2001 report on the Special Session of the General Assembly on HIV/AIDS (UNGASS), the United Nations Secretary-General said:

“It [HIV/AIDS] changes family composition and the way communities operate, affecting food security and de-stabilising traditional support systems. By eroding the knowledge base of society and weakening production sectors, it destroys social capital. By inhibiting public and private sector development and cutting across all sectors of society, it weakens national institutions. By eventually impairing economic growth, the epidemic has an impact on investment, trade and national security, leading to still more widespread and extreme poverty” (cited in Drimie, 2002).

Bonnel (in Sogaula et al, 2002) discusses other economic impacts of HIV/AIDS. These include declining school attendance rates; rising medical costs; limited economic opportunities for women; and a decline in infrastructural investment. Reflecting on the potential impact that HIV/AIDS can have on the political, social and economic life of a country, the South African Human Rights commission has placed HIV/AIDS at the core of South Africa’s economic and social rights dilemmas (Radebe, 2004). Those infected with HIV are usually the sexually active of the population, also the economically active

adult population. The loss of this section of a country's population impacts on the livelihood of households and communities and ultimately the economic productivity of a country. HIV/AIDS has seen an increase in grandmothers caring for their grandchildren with no financial or other support from their children who have died (Drimie, 2002).

While older generations in Africa have traditionally cared for their grandchildren, they are generally supported by the economically active parents of the children, who in the cases of those affected by HIV/AIDS, are too sick to work, or have died.

Drimie (2002) explains the potential cyclical nature of the relationship between HIV and poverty:

“the experience of HIV/AIDS by poor individuals, households and communities is likely to lead to an intensification of poverty, push some non-poor into poverty and some of the very poor into destitution. In turn, poverty can accelerate the onset of HIV/AIDS and tends to exacerbate the impact of the epidemic.”

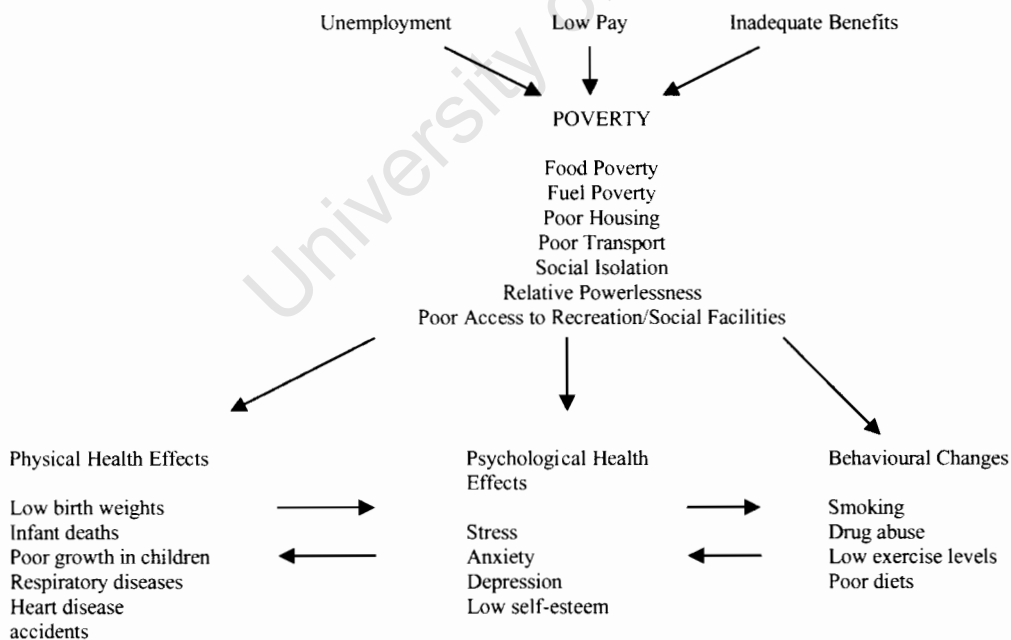
Poverty is a complex phenomenon and different levels of poverty have diverse impacts on people across South Africa. It is difficult to formulate one policy to suit everyone's needs. That said, similarities in health and access to healthcare can be drawn between people who struggle in poverty. In terms of access to healthcare which impacts substantially on the levels of health, Goudge and Govender (2000) and (Drimie, 2002) highlight the disadvantages of poverty, because poor people:

- spend a higher proportion of their income on health to obtain the same level of health care;
- have lower health status because of poorer living conditions;
- tend to depend on their physical ability as a source of income, which is compromised when they are ill;
- are less likely to have health insurance;
- are often provided with insufficient information to make cost-effective decisions about healthcare;
- are likely to be malnourished and have general poor health
- those who are HIV positive, are more likely to become sick and die faster than the wealthy

- are vulnerable to HIV because they live in an environment of poverty, an environment of risk.

These conditions highlight the relationship between poverty and ill health, including HIV/AIDS. The severity of the impact of HIV/AIDS is exacerbated by the fact that there is no cure; neither is there a vaccination. The poor are particularly affected, because it is a disease that currently requires careful medical management and healthcare, some of which is unavailable, or very costly and time consuming for those with fewer resources. As a result, poverty further magnifies the difficulties encountered for the HIV positive and AIDS sick.

The extent of the HIV/AIDS epidemic is both a symptom of, and a contributor to, growing poverty in South Africa, which means that it is difficult to tackle one without the other⁴. Examples of the reciprocal relationship between poverty and ill health, and their impacts on families and children can be seen in the following diagram.



⁴ The links between poverty and ill health have been well documented elsewhere and will only be briefly discussed here. For further reading on poverty, inequality and health, see Leon & Walt (2001); and Werner & Sanders (1997).

It can be seen that societal or environmental factors such as unemployment or low pay, contribute to the poverty in a household (increasing food, fuel, housing, transport poverty; as well as social and emotional isolation). This in turn affects individual's and household's physical and psychological health (leading to diseases or stress and anxiety), which can impact on behaviour and physical health. In such a condition, individuals and households are compromised in terms of their capacity to find employment or get better paying work. Thus the cycle of poverty and ill-health feeds into itself.

In a society like South Africa that is grappling with very high levels of unemployment and ubiquitous poverty, a rapidly spreading HIV/AIDS epidemic can be seen as a potential catastrophe. It can deepen poverty and undermine the country's already limited capacity to deal with existing social and economic challenges.

Epidemiology of HIV/AIDS

In order to explore the relationship between HIV/AIDS and poverty further, it is useful to develop an understanding of the natural history of a disease such as HIV/AIDS within which to frame the course of the disease and its impact. Using the framework of epidemiologists, Mausner & Kramer (1985), the first stage of a disease is the *Stage of Susceptibility*, in which there are a number of risk factors that favour the occurrence of HIV. Biological risk factors increasing susceptibility would for example, include the presence of sexually transmitted diseases that make a person vulnerable to HIV transmission. Behavioural risk factors also influence susceptibility, such as lack of consistent use of condoms. Sociological risk factors could include the inability to negotiate safe sex because of unequal power and gender relations. Environmental risk factors could include the poverty levels experienced by the individual who engages in transactional sex for food or money, and has no power to negotiate the use of condoms which would protect them from HIV transmission.

The second stage of the natural history of a disease is the *Stage of Presymptomatic Disease*, where the disease has taken root in the body, but without visible symptoms.

HIV/AIDS is particularly dangerous because of this long ‘incubation’ period, where no AIDS symptoms are manifesting. The infected person doesn’t appear ill and is therefore unaware of the consequences of their risky behaviour that increases the chances of re-infection, and of infecting others with HIV. The stigma and denialism surrounding HIV/AIDS in South Africa may also make it difficult for people to consider the possibility of HIV infection, as this would force them to acknowledge the disease which they may prefer to deny.

The third stage of the disease is the *Stage of Clinical Disease* where recognizable signs or symptoms become apparent. With HIV/AIDS, this could be when one has begun to display AIDS-associated symptoms. However, diseases that commonly strike HIV infected people whose immune systems are compromised, such as tuberculosis, pneumonia and others, can also be attributed to causes other than HIV, allowing further denial in individuals, families and communities.

The final stage is the *Stage of Disability* where the person is permanently disabled as a result of the disease. Although disability has different definitions, Mausner & Kramer (1985) identify this as a limitation of their “psychosocial role as parent, wage earner, and member of his [sic] community”. With HIV/AIDS, this stage can be contained or restricted for some people, through the use of anti-retrovirals, if they are appropriately administered. While anti-retroviral therapy (ART) can prolong and improve the quality of life of those infected with HIV, it is not a cure for HIV/AIDS. Anti-retrovirals are slowly becoming available through the public health system in South Africa⁵, mitigating the potential impact of earlier deaths of for instance, parents, whose children would otherwise be orphaned. However, since there is no cure and no vaccine for HIV, we will be dealing with AIDS-related deaths and the far reaching consequences for many years to come.

⁵ The South African government committed to providing 53,000 people with anti-retroviral therapy by March 2005. By December 2004, 19,500 people were receiving treatment through the public sector.

The Actuarial Society of South Africa (ASSA) uses World Health Organisation (WHO) stages of HIV/AIDS in predicting the numbers of people in South Africa at different stages of HIV/AIDS infection. Taken from Dorrington et al (2004), the ASSA projections for mid-2004 were as follows:

WHO stage 1: Acute HIV infection (Presymptomatic Disease)	- 1,476 000 people
WHO stage 2: Early disease (Clinical Disease)	- 1,098 000 people
WHO stage 3: Late disease (Stage of Disability)	- 1,671 000 people
WHO stage 4: AIDS (Stage of Disability)	- 534 000 people incl. those on treatment & those who have discontinued treatment
Receiving antiretroviral treatment	- 19,500 people in public sector
Discontinued treatment	- Projection not given

In addition, Dorrington et al (2004) project that South Africa has 211,000 HIV positive children aged 0 – 14 years, and an additional 33,000 more were at stage 4, either on treatment or having discontinued treatment.

Vulnerability in Different Groups

As seen above, HIV/AIDS is a long drawn-out infection, sometimes taking many years from infection to the onset of AIDS, and several more until death. The epidemic is in different stages in different parts of the country. Various groups are at different stages of risk and infection and therefore need to be managed differently⁶.

Some of the groups for which there is a differential impact of HIV/AIDS in South Africa are geographically defined. The most populous province, Kwazulu-Natal, is also the province with the highest HIV prevalence rates, and has been for some time (Department of Health, 2001). The government caters for these differences primarily in government budgetary allocations, which allow for flexibility within a national policy framework, and reflect known prevalence rates in different provinces. Therefore, Kwazulu Natal receives the largest share (22%) of the conditional grant for anti-retroviral treatment in 2004/5; while the Northern Cape receives the smallest (4%). These funds are allocated to provinces according to need, which is based on provincial analysis of the following

⁶ A discussion of public health measures of primary, secondary and tertiary prevention that would be used at different stages follows in the next chapter.

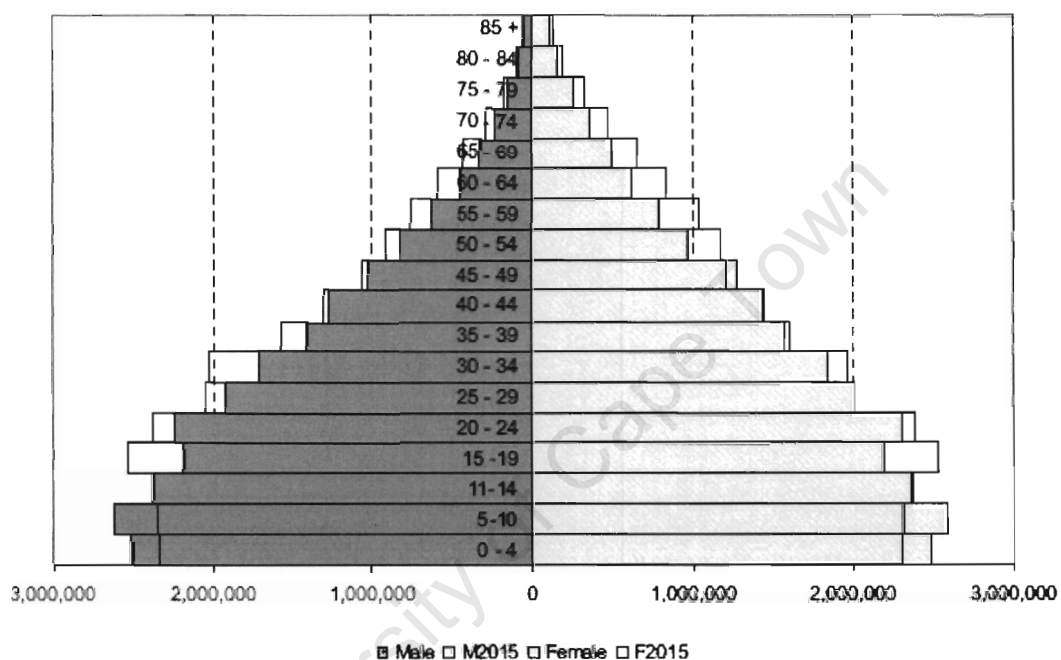
surveys and estimates: the 2001 Antenatal HIV Prevalence Survey; estimated share of HIV positive births; share of reported rapes; and estimated share of AIDS cases (Division of Revenue Bill, in Hickey, 2004).

Given the differential impact of HIV/AIDS across these geographical areas, it has been suggested that there is opportunity for policy to address these differences creatively. An example could be the use of pilot programmes in Kwazulu-Natal, that could be tested for effectiveness, and then rolled out to reach other provinces in time to address the impact of the later stages of the epidemic in those provinces. For example, the cycle of HIV/AIDS has thus far, had a particularly large lag time between peak HIV prevalence, and maximum number of orphans, viz. 7 – 10 years or more (Hunter & Williamson, in Bray, 2003). Thus strategies for dealing with HIV related orphanhood could be tested in Kwazulu-Natal and then adapted for use in other provinces such as the Western Cape, where the HIV/AIDS prevalence curve is still rising. However, public health experts argue that the Western Cape province has been much more proactive than some other provinces, and used provincial administrative discretion to pilot their own prevention and treatment programmes. These differences in strategies have stirred debate among public health experts about the value of provincial autonomy in dealing with HIV/AIDS prevention and treatment.

Within a recent South African demographic survey, Dorrington et al (2004) found that the 15-24 year age group was the highest risk category, contributing the largest numbers of new infections, particularly in the case of young women. Empowerment of young women is considered crucial in slowing the incidence of infection in this age category (Dorrington et al, 2004). Prevalence throughout South Africa is highest for women aged 15 to 34, while it is higher for men in the older ages. Children's infection rates have been slowed by the introduction of the Prevention of Mother to Child Transmission (PMTCT). The introduction of a public anti-retroviral programme has also altered the projections of future HIV infections and deaths, and has been said to play a particularly important role in the future outcome of the epidemic – by 2010, it is predicted there will be about 381

000 AIDS deaths per annum rather than the 495 000 deaths, if no anti-retroviral programme was in place (Dorrington et al, 2004).

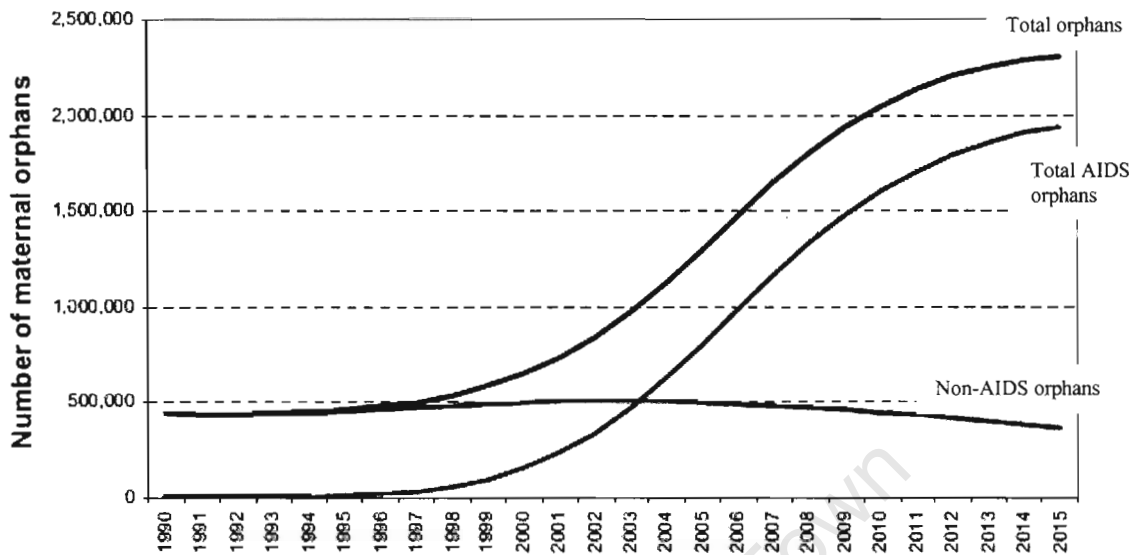
A look at the current and projected population pyramid below (with projects for 2015) indicates that between 2004 and 2015, from age 20 upwards, the population will consist of more women than men in every age group.



Source: Dorrington, Bradshaw, Johnson, Budlender (2004)

The prediction of the impact of AIDS can be seen in the middle age groups, where numbers are smaller than they would otherwise have been. Dorrington et al (2004) assume that this will have implications for dependency rates, as the middle population group is traditionally the economically active group, and therefore expected to support children and older adults. This gap also accounts for higher orphan rates projected below.

Dorrington et al’s (2004) projections of maternal orphans under the age of 18 years in South Africa can be seen in the graph below.



Starting in the early 1990's, there were fewer than 500 000 maternal orphans under the age of 18 years in South Africa. By 2004, this number had increased to over 1.2 million, with half of these (600 000) orphaned as a result of AIDS. The number of non-AIDS orphans is projected to drop from 2004, but the number children orphaned by HIV/AIDS is set to increase.

It is important to realise that while demographic studies provide analysis of the current and projected HIV prevalence, orphanhood and other impact rates, these will vary in different areas, and will also change as the epidemic progresses. Bray (2003) attributes these changes to factors such as saturation of the epidemic in high risk groups, and changing mortality and fertility among the infected. Strategies and policies to deal with these differences also therefore need to be flexible.

Unique aspects of the impact of HIV/AIDS

While the epidemiology and impact of HIV/AIDS can be compared with other diseases, some of the characteristics of AIDS-related illness and death appear to be different to other illnesses. Further research needs to be conducted about the unique impact of

HIV/AIDS illness and death on children. Some of the known differences are outlined here, drawing on the research of Sogaula et al (2002) in the Eastern Cape, and commentary from Bray (2003).

Communities in South Africa are familiar with dealing with orphans under normal circumstances⁷. However, rising deaths from AIDS among adults are leading to changes in orphan rates. The question this situation poses is whether orphanhood for those affected by HIV/AIDS is qualitatively different than for those orphaned for other reasons. Bray (2003) discusses this at length, and concludes that “to date, the most dependable evidence we have of the impact of AIDS-related orphanhood is that it deepens poverty in already poor households, and that orphaned children may find themselves playing a greater role in the struggle to maintain household livelihoods.” Part of orphanhood relating to HIV/AIDS is that children have to take on the role of caring for their sick parents prior to death, whose illnesses tend to last longer than with non-HIV related deaths (Crampin, in Bray, 2003). Thus, these children are vulnerable in much the same way as a child who has already lost a parent (hence the term “orphanhood”), but with the additional strain of caring for a sick parent or family member (Bray, 2003). Home-based care is not always available to those in need, and again, stigma has been shown to play a part in impacting on people’s ability to ask for assistance or use services that would highlight their vulnerability and HIV infection (Daniels, in Bray, 2003). This is particularly pertinent for people who cannot afford to pay for private medical or hospice care. The psychological impact on children who have to care for terminally ill parents appears to be severe, as is the impact on children’s development. They can be drawn away from school for long periods, to care for the sick at home (UNAIDS, 2004). Bray (2003) and Giese et al (2003) also mention that many parents or carers struggle to talk about death with children, making the psychological and physical preparation for death difficult.

Another feature of the HIV/AIDS epidemic is that there is a strong likelihood of multiple adult deaths in an AIDS-infected household, since partners (e.g. mother and father) are

⁷ See the following chapter for more on definitions of orphanhood and child-headed households.

likely to have infected one another. This effectively eliminates an integral part the economically active section of the household, on whom households (and children specifically) depend for economic support. This leaves the household in a state of deeper poverty. At the same time, HIV/AIDS brings increased costs of transportation to medical facilities and multiple funeral expenses at a time when the household income is already compromised because of unemployed and ill adults. Bray (2003) concludes that the impact of HIV/AIDS on children is “much more negative amongst those who are already socially and economically disadvantaged”. Finally, stigmatization surrounding HIV/AIDS and particularly AIDS-related illnesses can lead the community to further isolate the family in need.

While this is not an exhaustive list, it gives some indication of the characteristics that have been found in studies of the relationship between HIV/AIDS and poverty. Therefore it can be argued that children who live in extreme poverty are more susceptible to the impact of HIV/AIDS; and children who are affected by HIV/AIDS are more likely to be impoverished (Sogaula et al, 2002).

The Impact of HIV/AIDS on children of different ages

Another area where the differential impact of HIV/AIDS can be felt, is among children of different ages. In South Africa “child mortality has had an upward trend since 1990, which is likely to be associated with the HIV/AIDS epidemic” (Government, 2001). The figures estimating children who are affected or infected with HIV appear alarming. UNAIDS estimates that worldwide every day, about 1,700 children become infected with HIV - some are infected during pregnancy, others during delivery or early in life (UNAIDS, 2004). The figures for Southern and Sub-Saharan Africa are also alarming. Ainsworth, in Sogaula et al (2002) estimates that maternal infection rates for newborns in Southern Africa are as high as 30-40%. Sogaula et al (2002) report on a study showing that approximately 80% of all HIV-infected children in Sub-Saharan Africa die by the age of five, with diarrhea being the most common cause of death. From these figures and those of Dorrington et al (2004) cited earlier, it appears that children in South Africa are

substantially affected by HIV/AIDS, whether they are HIV positive themselves, or affected by those around them who are ill.

The development of a child's potential can be threatened at various stages, if the impact of HIV/AIDS undermines their access to social services, healthcare and education (UNAIDS, 2004) as well as their social and economic roles in a family setting. The biological risk factors impacting on children's health only appear to have a long term negative developmental impact when combined with conditions of chronic poverty (Richter, 1994), in which many children in South Africa live. In addition to dealing with illnesses associated with HIV and AIDS, children who lose their parents become vulnerable in a variety of other ways. The death of a mother has shown to increase the probability of the death of her children (Goudge & Govender, 2000) because the mother is often the "gatekeeper" to household food security and protection of children (Sogaula, 2002). In losing a parent, children can lose a breadwinner, and sometimes lose their home. Children who find themselves responsible for bringing in family income can be required to stop attending school in order to work to earn. Girl children are often relied upon to do more household duties, and at times care for members of the family who are sick (Government, 2001). Thus, the achievement of children's rights to education and to development can be further compromised in the context of HIV/AIDS. A recent study of poverty in South Africa found that while individuals don't always make a direct link between AIDS and poverty, they do make a strong link between poverty and the "social burdens associated with the epidemic" (Afrobarometer, 2004).

It is those who are already marginalized who often struggle the most. A recent survey of South African households affected by HIV/AIDS reported that almost half of the households who participated had insufficient access to food (Steinberg in Giese et al, 2003) and Barnett & Whiteside (2002) (in Giese et al, 2003) argue that "AIDS affected households tend to be poorer, consuming less food and with smaller disposable incomes; it is hardly surprising that children in these households are usually less well nourished and have a greater chance of being stunted or wasted".

From infancy through to 18 years old, a child goes through various stages of development, requiring different kinds of support and protection. The needs of an infant vary from those of an adolescent. Physical, cognitive and emotional differences characterise different stages of development, and shape children's responses to things such as illness or death of a parent, and resultant household changes. The needs of children at different ages are therefore different, as is their capacity to care for themselves and others. These differences should inform policy and community responses for supporting and protecting children at their different stages of development.

Malnutrition poses a severe threat for children living in poverty, where adequate nutrition is hard to come by. Soon after the introduction of a democratic government in South Africa, infant mortality rates began declining, largely because of the provision of free health care for women and young children. However, these advances have begun to be significantly eroded by the HIV/AIDS epidemic (Radebe, 2004). The Department of Health states that "children who are infected should be given the best possibility of remaining well for as long as possible through appropriate interventions and should also be made comfortable and free from distress in the terminal stages of their illness" (Department of Health, in Giese et al, 2003). This is particularly difficult to fulfill for children living in poverty, who often lack appropriate access to food and healthcare.

Even if not infected themselves, children who are *affected* by HIV/AIDS are considered susceptible to early death, or survival under conditions that impair their nutritional and health status (Population Council, 2000). Early childhood is the most rapid period of development in a human life and a child's right of access to food, water, shelter and health care are particularly important at this stage.

In middle childhood, when a child would usually go to primary school in South Africa, children face different developmental challenges to those of an infant or young child. They may have to deal with abandonment issues, struggling over the loss of parents, separation from siblings, stigmatization and isolation when faced with AIDS deaths in the family (Sogaula et al, 2002). A child's right to education (Constitution, section 29(a))

should not be compromised at this stage - it is important that children attend school in order to learn and develop important skills. However, in this stage of middle childhood, household poverty, age and relationship with their parent/carer have been shown to affect school attendance, and therefore development (UNAIDS, 2004).

Adolescence poses alternative challenges as children progress in physical and sexual maturation, and some progress towards economic independence. Important life skills should have been taught to children by this stage, especially regarding knowledge about HIV prevention, as sexual maturity is imminent. Again, children's right to education can be threatened. It is often at this time in their lives that children can be taken out of school to care for the sick or, as AIDS claims the lives of the economically active adults in the household, children are forced out to work, to retain some level of income (Population Council, 2000). A South African study conducted by Booysen and Arntz (cited in Bray, 2003) found a statistically significant difference between children in households affected by HIV, who didn't attend school, as opposed to children in non-affected households, who did attend school. In Zimbabwe, it was found that young girls are particularly vulnerable to being kept from school. A study by Whiteside (2002), showed that 76 percent of children in South Africa who were removed from school to look after sick family members or orphans were girls. Thus an adolescent's role in the family and the household changes, as more adult roles of responsibility for supporting the family can be expected. These economic pressures, along with household poverty and related hopelessness can drive adolescents to risky behaviour, and possibly risky sexual behaviour which may make them more susceptible to HIV infection (UNAIDS, 2004). Such risky sexual behaviour may stem from economic needs (trading sex for goods or food; or inability to negotiate safe sex because of a need for income), or hopelessness about the future and therefore little concern about their own sexual health or protection. Boys and girls are also affected differently, particularly in adolescence. This is a particularly vulnerable stage of childhood, where children's rights need to be protected even more vigilantly because they are on the brink of recognised adulthood, and at a stage of development where they make choices regarding education, a career, their

sexuality, that will determine much of the rest of their lives, including the sexual practices they choose that will or will not make them vulnerable to HIV transmission.

It can be concluded that HIV/AIDS poses a potential threat to children's rights to education, nutrition, protection, and access to healthcare at different stages of their lives. The next chapter will consider children's rights and notions of childhood, both in an international context, and in South Africa. How do we define children and children's rights? How are children being protected from the impact of HIV/AIDS? How is the South Africa government dealing with these complex and differentiated challenges? It is to these questions that we now turn.

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3. WHAT IS CHILDHOOD, AND THE CONTEXT OF CHILDREN'S RIGHTS IN SOUTH AFRICA?

Exploring Definitions of Childhood in an International Context

This chapter explores definitions of childhood and children's rights as they originated in the international context, and how this differs in some developing country contexts, including South Africa. The socio-economic rights accorded to children are also outlined, with commentary on the difficulty of interpreting these rights and making them a reality for children. The chapter also considers orphanhood, which has been a feature of African life for some time, and child headed households in South Africa, about which little research has been done so far. Finally, this chapter will consider the value of a public health and human rights framework for assessing the advancement of children's socio-economic rights.

International concepts of children's rights and childhood were influenced by the post Second World War era. Legal and social work professions had an important role to play in defining childhood and children's rights, and both of these originally focused on individual situations and underestimated the broader socio-economic context within which individuals existed (Boyden, 1997). Over time however, social, economic and environmental factors have come to be recognised as more important than individual and biological considerations, for better health in children (Hall & Elliman, 2003). The concepts of 'childhood' which began the international discourse about children's rights therefore originated in developed countries such as the United States and the United Kingdom (Boyden, 1997). These norms of children's rights and childhood have been applied to many developing countries and set up as 'universal standards'.

Approaches to children's rights developed in the international arena are often applied to social and economic contexts where concepts of childhood are very different. Thus the 'universal' concepts associated with respecting, promoting, protecting and fulfilling children's rights and required care for children, need to be interrogated for their

applicability to children's lives in developing countries. Internationally respected treaties set out, among other things, to protect children from a variety of forms of maltreatment. With differing socio-economic and cultural norms and values however, many children live in circumstances that do not fit the model assumed by international children's rights treaties. "International children's rights lawyers largely ignore the evidence that the conception of rights is intimately tied up with cultural values and the outlook of any given society" (Boyden, 1997).

Some theorists argue that children deserve to be protected and nurtured because they are "seen as weaker, less developed, with less judgement, less able to take responsibility; therefore to be protected, controlled, circumscribed" (Burman, 1998). An alternative view of children is that they are valuable resources for our future and should be encouraged to participate in society. Knutsson (1997) argues that the most important issues with regard to children is understanding their inherent lack of power, and their dependence on others (parents or carers; and the state) for material, physical and emotional growth. Lack of understanding children's needs and making provision for them, can have a negative impact on their growth and development. By extension, it will have an impact on the development of an important resource i.e. future citizens and decision makers. Some research indicates that people without quality care in their early years struggle to stay in school and can turn to crime. This in turn negatively impacts on society (Population Council, 2000).

The first 'universal ideal' regarding children's rights was the Declaration of the Rights of the Child, established by those who had seen children suffering in the context of war (Boyden, 1997). Several international instruments followed, which have further refined the rights bestowed on children, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966); the UN Convention on the Rights of the Child (CRC, 1989) and the African Charter on the Rights and Welfare of the Child (1990). These are legally binding instruments for States who choose to ratify them. South Africa has ratified all of the above, except for the ICESCR. However, many of the rights enshrined in the ICESCR can arguably be found in the South African Constitution.

Article 11 of the ICESCR highlights “the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions” (ICESCR, 1976).

The UN Convention on the Rights of the Child (CRC), considered the primary international treaty protecting children and the gold standard for children’s rights, was ratified by South Africa in 1995. Article 26 of the CRC highlights the right of children to social security as follows: “State parties shall recognise for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realisation of this right in accordance with their national law.” (CRC, 1989) In addition, article 27 states that every child has the right “to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development.” (CRC, 1989). The UN Committee on the Rights of the Child, which enforces the CRC, has explicitly stated that HIV/AIDS impacts on the lives of children to such an extent that it affects their civil, political, economic, social and cultural rights⁸.

The African Charter on the Rights and Welfare of the Child was the first comprehensive regional charter on Children’s Rights, drawn up by the Organisation for African Unity (now the African Union). It refers to the child’s right to survival, protection and development, and places particular emphasis on healthcare for children: “State parties must see to the provision of necessary medical assistance and healthcare for all children, with particular emphasis on the development of primary healthcare” (African Charter, in Taylor, 2002). South Africa ratified this charter in January 2000.

The Convention on the Rights of the Child has been criticized for being drafted by a group that was “predominantly Western in its orientation”. According to these critics, “greater account should have been taken of the cultural diversity and economic realities of developing countries” (Newman-Black, in Boyden, 1997). The African Charter on the

⁸ For more discussion on the rights of children affected by HIV/AIDS, see General Comment No. 3 (2003): HIV/AIDS and the rights of the child (CRC, 2003).

Rights and Welfare of the Child, emanating in Africa attempts to view children's rights through an African perspective⁹.

Of particular interest, is the difference in definitions of 'childhood' between international documents originating in developed countries, such as the UN Convention on the Rights of the Child, and those originating in developing countries, such as the African Charter. Many international documents take the concepts and definitions surrounding childhood as universal givens. They assume that an understanding of childhood is based on agreed and fixed norms. The norms surrounding 'childhood' however, are complicated, and different in different parts of the world. Some countries view children as dependent until their late teens, while other countries expect children to be independent from an early age. In Peru, a significant group of children aged 6 – 14 are heads of households and some are principal family breadwinners; there have been similar reports from India (Boyden, 1997). With the increase of HIV/AIDS in South Africa, child-headed households have become a more common phenomenon (Sloth-Nielsen, 2004); although the actual numbers are unclear (see further discussion below).

Interestingly, the African Charter states very clearly that "for the purposes of this Charter, a child means every human being below the age of 18 years" (African Charter, 1990). This definition is not ambiguous and leaves no room for limitations. The CRC however, includes the option that children are those under 18 years old "unless majority is attained earlier". Gose (2002) argues that contrary to expectation, the CRC is more flexible and adaptable to African contexts than the African Charter, whose definition of children appears discordant with African culture and tradition. Ncube (in Gose, 2002) contends that childhood in the African context has less to do with age, and more to do with the capacity to do things that are normally reserved for adults (e.g. initiation ceremonies, or marriage) and thus, the African Charter's definition of childhood, solely determined by age, appears to clash with African cultural tradition (Gose, 2002). The South African Constitution has adopted a similar position as the African Charter, in defining children as

⁹ For further deliberation, see Gose (2002), who discusses at length, the differences between the CRC and the African Charter on the Rights and Welfare of the Child.

those under the age of 18 years old. Perhaps this apparent ‘discord’ with African culture can be attributed to an attempt to benefit children in Africa in terms of being able to claim a certain set of rights, with the margin of error in favour of those who are still vulnerable until they are 18 years old.

An example of influence from developed countries in international treaties that have been adopted in developing countries is the divergent focus on the definitions of family responsibility. In some developing countries such as South Africa, customary law expects the extended family to take on parental responsibilities, and this is an accepted community practice. However, international instruments generally confer these responsibilities on parents alone, and do not recognise the role of the extended family (Boyden, 1997). The CRC confers obligations on “parents”, while the African Charter confers primary responsibilities on parents but also makes room for “other persons responsible for the child” who have the “primary responsibility for the upbringing and development of the child” (African Charter, 1990). This flexibility allows for situations where children are cared for by extended family or community networks, which is common in Africa (Gose, 2002). This has important implications for the care and welfare of children, and the obligations of communities, particularly in the context of HIV/AIDS, where social capital can be harnessed to care for children in need.

Child labour is another area where international treaties have not always taken into account the realities of developing countries. The International Labour Office (ILO) used to advocate for eradication of child labour, but has since recognised that the grinding poverty levels in developing countries make this an impossible goal (Boyden, 1997). The ILO has thus begun to pursue policies that only prohibit *damaging* or *hazardous* work for children, and have a much more open attitude to family-related labour (Boyden, 1997). The African Charter’s provisions for child labour appear to be largely based on the wording of the CRC. The African Charter recognises that children are considered as a resource for families, particularly in terms of direct labour for work on family farms such as planting and harvesting subsistence crops, as well as for domestic work such as cooking, washing, fetching water or caring for younger children (Gose, 2002). This

'labour' is seen as an important part of childhood, as there is a shared understanding of the relationship between parents who care for their children, and children who are obligated to contribute to household work (Gose, 2002). Bray (2003) has noted that in South Africa, "the participation of children in everyday household chores is viewed as a function of their roles as members of a household and family, as part of their duty to their seniors and as an opportunity to learn skills required in adulthood."

The South African Constitution, which lays the framework for a human rights approach to children's development, has attempted to recognise that it may be necessary for children to work, but that children's basic rights should be protected at the same time. This can be seen in section 28 (e) and (f) of the Constitution, where children have the right "to be protected from exploitative labour practices; and not to be required or permitted to perform work or provide services that are inappropriate for a person of that child's age; or place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development." Following on from this, the South African Department of Labour adopted the following definition: "Child labour is work by children under 18 which is exploitative, hazardous or otherwise inappropriate for their age, detrimental to their schooling, or their social, physical, mental, spiritual or moral development. The term 'work' is not limited to work for gain but includes chores or household activities in the child's household, where such work is exploitative, hazardous, inappropriate for their age or detrimental to their development" (Bray, 2003(b)). Using less absolute definitions which categorise unacceptable forms of work, as "exploitative" or "inappropriate" recognise that there may be times when it is appropriate for children to work. This protection of children who work is particularly important in the context of HIV/AIDS, in the light of a recent study by Rau (in Bray, 2003) which concluded that "children orphaned through HIV/AIDS are more likely to enter the workforce, to be exploited in the workforce and to become infected by HIV than other children".

Legally, the South African Constitution defines a child as anyone under the age of 18 years. Yet, as has been mentioned above, childhood means different things at different times. Cultural rites of passage often signify passing into adulthood before legal

recognition before the law. However, it is only at 18 years old that a person is legally recognised as an adult, no longer a child, and therefore no longer protected by the children's rights of section 27 in the South Africa Constitution (see below for further discussion of children's rights as defined by the Constitution).

Orphanhood and Child Headed Households

While orphanhood is often recognised as a characteristic of HIV/AIDS, Clark (2000) and Bray (2003) argue that orphans have long been part of the African landscape, due to disease, war, natural disasters or mass relocation. Historically, these incidences have been sporadic and short-term problems, however with the advent of HIV/AIDS, orphanhood appears to be a more long-term issue (Bray, 2003). In the past, individuals, families and communities have survived with particular coping strategies, many of which are relevant to scenarios in which HIV/AIDS is present. It is not only children whose parents have died, but also children who are living with ill parents or caregivers, who are considered vulnerable in ways similar to children who have no carers. Thus, the process of orphanhood begins long before the death of a parent (Giese et al, 2003).

The words "orphan" and "orphanhood" are often used without much elaboration on the meaning behind these terms. International agencies tend to categorise different types of orphans such as "maternal orphans", 'paternal orphans' and 'double orphans' (Giese et al, 2003). Bray (2003) highlights that a common understanding of 'orphan' in many African languages is one of a child who is destitute or without care (such as a child living on the street), rather than a child who is parentless, as is the common understanding of 'orphan' in the English language. Therefore, defining orphanhood on the basis of the death of a parent is irrelevant in many African contexts, where "the definition of an orphan tends to be linked to the absence of social rather than biological parenting."(Giese et al, 2003)¹⁰.

¹⁰ Further research is required into the impact of externally imposed definitions of orphanhood.

Bray (2003) points to the fact that the rules of apartheid imposed particular arrangements for family living, such as mothers who lived in urban areas to earn an income to support their children and families, who lived in rural areas and were not allowed to join them at their workplace. Bozalek (in Clark, 2000) notes that less than 40 percent of South African families live in a 'nuclear family' setting where parents are the only carers for their biological children. Thus childcare has long been a fluid arrangement between parents, grandparents and community members, often without formal arrangements (Jones, in Bray, 2003).

In past times, "a prolonged period of training and protection in the early years of a person's life was a luxury many societies were not able to afford for any of their members. Today this luxury is most commonly denied to the poor" (Burman, 1998). Many children today, who are living in the context of HIV and poverty, are forced early into adult decision making roles, through work, or caring for those who are ill and affected by HIV/Aids. This is particularly pertinent for the eldest siblings in households where parents or caregivers are ill.

Child headed households need to be considered with special care regarding realisation of their rights as children. Children sometimes become heads of households when a parent dies, or becomes terminally ill as a result of HIV/AIDS. Thus, the eldest child in the house takes over the responsibility of caring for younger siblings and maintaining the household. Effectively they take over the role of parent in working to get food, clothing and shelter and caring for family members (Sloth-Nielsen, 2004). Very little research has been conducted on child headed households in South Africa thus far, and therefore little is known about their coping strategies. Shisana and Simbayi (in Bray, 2003) cite a study which found that 3% of households in South Africa were headed by someone aged 12-18 years old. The Nelson Mandela Children's Foundation research of 2001 found that the main problems facing children in child headed households had to do with poverty and lack of access to services, including school (in Bray, 2003)¹¹.

¹¹ Further research is required to understand and support the coping strategies of children living in child headed households.

The existence of child headed households is not in itself harmful to children, since it allows for continuity of relationships and the social environment, at a tumultuous time of loss for the children concerned, and enables the remaining family members to stay together (Bray, 2003). However, there are particular challenges that are faced by child headed households, impacting on the realisation of their socio-economic rights, including: difficulties in accessing and securing food and shelter; education for themselves and siblings; protection from abuse (sexual and otherwise); protection from child labour and prostitution; retaining their physical home in the context of rules of inheritance (customary law supports the principle of primogeniture where only a male qualifies as an heir); and to accessing income support (Sloth-Nielsen, 2004). Without appropriate documentation, children younger than 16 years old are unable to apply for a Child Support Grant for their siblings (Sloth-Nielsen, 2004). This means that despite assuming adult responsibility for the care of younger children, they are unable to access social assistance from the government.

Social assistance (or lack thereof) impacts indirectly on other socio-economic rights, all of which can be compromised for children living in child headed households, because of current policy restrictions not allowing them to access grants without the help of an adult. However, this study respects and refers to research has shown that children are often able to access *care* from adults in their community, but it is *income* that is lacking (Giese et al, 2003). Social assistance needs to be made available to child-headed households, and the Child Support Grant would be a legitimate avenue for this, recognising the adult responsibilities that have been thrust on children (i.e. people younger than 18 years old). As is explored later in chapter 5, the barriers to accessing the Child Support Grant for those who have a legitimate claim under current policy stipulations, are in some cases insurmountable. These barriers would be even more difficult to overcome for children heading up households and in need of social assistance for themselves and their siblings, especially since the current rules for distribution of the Child Support Grant only recognises adults as carers of children.

More recognition needs to be given to the inevitable reality that children are also carers of children. Sloth-Nielsen (2004) argues that the Child Support Grant has “the potential to be an enormous source of financial support to children living in child headed households”, however cites the following as difficulties in getting access to the grant: scarcity of social development officials; uncertainty among officials about eligibility criteria for the grant; lengthy delays between application times and receiving the monthly income; lack of transport for department officials to work in remote areas, and the high cost of transport for poor people to get to existing departmental offices; documentation difficulties, such as accessing birth and death certificates; termination of a grant when a caregiver dies and a re-application process ensues. She argues that the key barrier for child headed households is that of age – that children younger than 16 years old are unable to apply for a Child Support Grant for their siblings (Sloth-Nielsen, 2004). Age related barriers will be discussed further in chapter 5. This chapter will now consider what, in the light of these multiple needs, has been done to protect and advance children’s rights in recent years.

Children’s Socio-economic Rights in South Africa

The Children’s Rights framework in South Africa has been progressively developed since 1994, when democracy provided the context for a new system that would work towards respecting, promoting, protecting, and fulfilling the rights of children. Great strides have been taken in terms of a domestic Constitutional framework, which both endorses and is supported by international treaties discussed earlier such as the UN Convention on the Rights of the Child; and the African Charter on the Rights and Welfare of the Child. Domestic legislation and policies have also been developed, to give content to these rights.

The Constitution was drawn up as part of a widely consultative process involving a variety of sectors in South African society, and provides socio-economic rights for everyone in section 27. Everyone has the right to have access to-

- a) health care services, including reproductive health care

- b) sufficient food and water
- c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

South Africa has been commended for including these socio-economic rights in its Constitution, as this makes them justiceable, and therefore enforceable through the Constitutional Court. The difficulties faced by the State in having to deliver on socio-economic rights, in the context of great need and scarce resources, is recognised in what is commonly termed the ‘progressive realisation’ clause. This can be found in section 27 (2) which says that “the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.” The Courts (and society) must therefore consider the fact that it is impossible to deliver on all of these rights immediately. Thus it is acknowledged that it will take some time to roll out delivery of services linked to rights, to the many poverty stricken citizens who have been disadvantaged due to lack of delivery that was skewed along racial grounds in terms of apartheid policy in the past.

Children are also provided for in the Constitution, very specifically, in what is sometimes termed a ‘mini bill of rights for children’ in section 28, of which section 1(b – d) outlines the socio-economic rights of every child:

- a) to family or parental care, or to appropriate alternative care when removed from the family environment
- b) to basic nutrition, shelter, basic health care services and social services
- c) be protected from maltreatment, neglect, abuse or degradation

and in section 29 (1), the right to:

- (a) a basic education

In addition, section 28 (2) indicates the Constitutional validity of considering the best interests of children, in saying that “A child’s best interests are of paramount importance in every matter concerning the child”.

The history of inequality and prejudice that persisted from apartheid systems makes the right to equality and prevention of unfair discrimination even more crucial in the rights afforded to citizens by the Constitution. Section 9 of the Constitution guarantees equality and non-discrimination as follows: “everyone is equal before the law and has the right to equal protection and benefit of the law” and “the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth”.

Thus, children cannot be unfairly discriminated against simply because of their age.

Section 7 (2) of the Constitution obliges the state to “respect, protect, promote and fulfill” all rights enshrined in the Constitution. These Constitutional obligations set a high standard for the treatment of children. However, there has been little content analysis of the actual meaning of many of these socio-economic rights (Sloth-Nielsen, 2001).

Arguably, some have said that “the obligations on the state with regard to children’s rights are in a state of flux and the issues are contested. A key site of contestation is the interpretation of the true meaning and content of children’s socio-economic rights by South Africa’s courts, particularly the Constitutional Court” (Creamer, 2002). This contestation is compounded because children’s rights in section 28, although more “basic” than those in section 27, are not subject to the same ‘progressive realisation’ clause, as those rights in section 27. Thus, debate stirs around whether or not the rights given to children in section 28, do not perhaps place a higher level of obligation on the State, to deliver on children’s rights with more immediate effect (Streak & Kgamphe, 2004).

There have been two seminal Constitutional Court cases which have set the tone for interpretation of socio-economic rights, including those for children. These are commonly known as the Grootboom and Treatment Action Campaign cases, both of which have challenged government’s slow roll-out of delivery related to socio-economic

rights¹². Recent opinions have interpreted these cases as indicating that government is obliged to cater for *all children* in need and to “roll out services as a matter of urgency and as quickly as the building of administrative capacity permits (irrespective of financial considerations)” (Streak, 2004). There is however, debate about this interpretation of current jurisprudence, which has yet to be tested in the Constitutional Court. For more discussion about these court cases and their relevance to setting precedents in terms of socio-economic rights, see Liebenberg (2004); Streak (2004); Liebenberg (2001); Sloth Nielsen (2001); Cassiem & Streak (2004); Clark (2000); Creamer (2002).

While international treaties and the South African Constitution provide an admirable rights framework within which to view progress in our society, the “ultimate test of giving constitutional recognition to these rights is whether they result in real improvements in the quality of life of all. This can only occur if these rights precipitate concrete changes in social policies and laws so that they are responsive to the needs of the poor” (Liebenberg, 2001). The UN Committee which oversees compliance with the CRC has been critical about South Africa’s non-compliance with some provisions of the Convention (Taylor, 2002). Heywood and Altman (2000) also speak about the gap between policy and implementation in saying that “changes in law are meaningful only to the extent that they are actually implemented”.

There is great inequality and divergence in the state of South Africa’s children and it is difficult to determine an appropriate universal approach to adequately care for all South African children, since children’s circumstances differ substantially according to wealth or poverty; geographical location; and social contexts. However, government policy must concern itself with the protection of children’s rights, and particularly those who are most vulnerable, such as children living at the nexus of HIV/AIDS and poverty.

Researchers have proposed a strong link between children’s rights and poverty reduction, saying that “in many cases, child socio-economic rights realisation will also lead to child poverty reduction defined in the broad way” (Cassiem & Streak, 2001). However, the

¹² For more detail on the court cases, refer to www.concourt.gov.za

realisation of children's socio-economic rights is determined not only by laws and an enabling legislative framework, but crucially by a concerted effort on the part of the South African society as a whole, to ensure that law is implemented.

“The courts cannot ensure realisation of the right to health or to health care. In the end the fulfillment of core health obligations will depend primarily on the implementation of appropriate government policies in the health sector and beyond that to measures to eliminate poverty and promote greater economic and social equality” (Chapman, 2002).

There are several actors who are constitutionally obliged to work towards translating children's socio-economic rights into reality. These include state actors, namely. Parliament; the Executive; and the Courts. According to the 'separation of powers' as outlined in the Constitution, each of these actors has a particular role to play. Parliament introduces and approves laws at both national level (in the National Assembly); and at provincial level (in the National Council of Provinces). These laws give direction to services and programmes for example, those targeted at children. In addition, Parliament is responsible for passing the annual Government Budget which allocates funds to such programmes. The Executive at national level, in the form of the President and the Cabinet, is tasked with development and implementation of (national level) policy; as well as the initial preparation of legislation, both of which are guided by Constitutional norms and standards. The Executive at provincial level is responsible for implementing provincial level policy, such as some of the programmes related to socio-economic rights (Coetzee & Streak, 2004). The Judiciary (Courts) are the third and complementary arm of government, where enforcement of legislation and law is enacted. The Constitutional Court is the highest court in South Africa, and as such, determines the constitutional direction of policy and legislation. All three arms of government are instructed by the Constitution (in section 7) to work together to respect, protect, promote and fulfill the bill of rights.

Parents are also constitutionally obliged to care for children, in section 28 (1)(b) where every child has the right to family care or parental care, or to appropriate alternative care when removed from the family environment. Where parents are unable to care for children, the State is obliged to step in. However the extent of required state support in

these circumstances is still not clear in judicial terms (Coetzee & Streak, 2004), as was outlined earlier.

The Constitution, in chapter 9, also establishes supportive institutions such as the Human Rights Commission, whose role is to monitor and observe human rights in South Africa and make recommendations for redress where appropriate (Coetzee & Streak, 2004).

In addition, while not constitutionally obliged to do so, there are several actors who contribute towards the realisation of children's rights, notably, domestic and international civil society and the private sector. In South Africa community based organisations play a significant role in caring for children, and ultimately work towards the realisation of their socio-economic rights.

University of Cape Town

4. THE VALUE OF A HUMAN RIGHTS AND PUBLIC HEALTH FRAMEWORK

Human Rights and Public Health are often considered as two separate disciplines and have developed along their own trajectories, with different philosophical perspectives, vocabularies and methods. Yet they are both concerned with human well-being and advancement (Mann, Gruskin, Grodin & Annas, 1999). As discussed in chapter 2, modern concepts of health understand that the context in which people live, have a considerable impact on their health. Thus, the fulfillment or violation of socio-economic rights, which leads to a particular standard of socio-economic living, affects people's susceptibility to ill health. Also, people's good or poor health can determine their capacity to claim their socio-economic rights – for example, someone who is ill may not be able to attend school, or travel to a social development office to collect a social grant, which is their right. Health is about physical, mental, and social well being of people. Human rights is also concerned with optimizing this well being. (Marks, in Roache, 1999) Thus, recognising how public health goals and human rights can complement one another, can ultimately lead to more effective health policies and programmes (Mann et al, 1999).

This chapter proposes the value of a human rights and public health framework in considering children affected by HIV/AIDS in South Africa. The two individual disciplines, viz. 1) Human Rights; and 2) Public Health, are briefly discussed as separate disciplines. Then follows an exploration of the value of a multidisciplinary framework that links the two disciplines, both of which would be concerned with the advancement of children's well-being. Viewing the welfare of children through this dual lens allows a fresh perspective on the Child Support Grant, which follows in the next chapter.

Human Rights

The United Nations (UN) was formed in 1945 and was tasked with the promotion of human rights, in the wake of the atrocities of the Second World War . In 1948, the

Universal Declaration of Human Rights set out a “common standard of achievement for all peoples and all nations” (UN, 1948). Mann et al (1999) argue that the Universal Declaration of Human Rights addresses a range of public health issues because of its focus on societal well-being, and may well provide a more useful public health framework than those inherited from biomedical institutions. Further UN treaties were established in pursuit of a human rights framework, viz. the International Covenant on Civil and Political Rights; and the International Covenant on Economic, Social and Cultural Rights. These three documents together constitute the International Bill of Human Rights which has set the tone for international human rights thinking and practice (Mann et al, 1999). In the previous chapter, the cultural hegemony of international human rights documents was explored, noting that their applicability to developing country contexts needs to be interrogated. Regional documents such as the African Charter on Peoples’ and Human Rights, have sought to give space to African culture in the perception and enactment of human rights.

Since the election of the first democratic government in 1994, South Africa has endeavoured to instill a culture of human rights, to replace the oppressive apartheid system that violated many human rights. Given that apartheid that was created and endorsed through law, the value of a Bill of Rights (found in the second chapter of the Constitution) enshrined in a Constitution is a crucial tool in transforming South Africa into a democracy. The process of drawing up the South African Constitution was consultative and allowed for engagement from citizens, thus giving it social and legal legitimacy in the eyes of citizens. The Constitution is therefore an important part of providing a framework for children’s rights, as was described earlier. Such frameworks are broadly designed. Their aim is to provide the outline within which the content of children’s rights can be argued and established over time. The children’s rights framed by the Constitution are more intricately defined by ensuing legislation and implementation thereof, such as the Child Support Grant. The purpose of such legislation therefore, is to give content to Constitutional Rights and make them a reality.

In international treaties, the International Covenant on Economic, Social and Cultural Rights guarantees “the right to the highest attainable standard of physical and mental health”. This leaves it open to a subjective interpretation of what constitutes the highest standard of health in any given context. Specific health-related rights are guaranteed in the South Africa Constitution in two places that affect children. The first is in section 27 (1)(a) where “everyone has the right to have access to health care services, including reproductive health care”. The second is found in section 28 (1)(c) and states that “every child has the right to basic nutrition, shelter, basic health care services and social services”. Further specific children’s rights that are guaranteed by the South African Constitution have already been discussed in the previous chapter.

Public health

Public health emphasizes the health of populations (rather than the health of the individual). It has been defined as “ensuring the conditions in which people can be healthy” (Institute of Medicine, in Mann et al, 1999). The World Health Organisation (WHO) defines “health” as “a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity”. The Ottawa Charter of 1986 goes further, to say that “health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities”, and includes prerequisites for health of “peace, adequate economic resources, food and shelter and a stable ecosystem and sustainable resource use” (Nutbeam, 1998). Government policy needs to deal with the HIV/AIDS epidemic as one of the crucial public health challenges in South Africa’s context of inequality and poverty. “The discussion of HIV/AIDS on the African continent no longer revolves simply around issues of health. It has evolved rather, into a deliberation of economics, national development and poverty relief. The study of how this particular disease affects individuals, households and the national economy reveals a complex but important relationship between HIV and poverty” (Sogaula et al, 2002).

Public health is therefore concerned with the socio-economic context and conditions under which people live, which affect their health, access to medical services; physical environment; biological environment; and social environment (Mann et al, 1999); as well as disease. Calderon (1997) suggests that there are four different levels of causation when considering HIV/AIDS. These are 1) the individual level (e.g. people's perception of low risk, leading to unsafe sexual behaviour); 2) the environmental level (e.g. living conditions and socio-economic pressures that make access and use of condoms or protection difficult); 3) the structural level (e.g. domestic laws and policies that should protect vulnerable citizens and promote human rights and good public health); and 4) the super-structural level (e.g. macro-social and macro-political issues that determine the overarching conditions of life in a situation).

Because public health is primarily concerned with groups of people, rather than the individual, public health policy is determined by government and political priorities. A public health approach is also concerned with health promotion, which recognises the impact of socio-economic conditions on achieving good or poor health (Sanders, 1998). Naidoo and Wills (1998) argue that "effective health promotion must include in its aims, the reduction of inequalities in health which result from socio-economic inequality". In South Africa, health promotion practice is based on the principles and approach of the Ottawa charter, as mentioned above. It establishes five key action areas for health promotion : 1) to promote safe environments in which people can live and work; 2) to develop health public policy, including policies that address poverty; 3) to promote community action and support ; 4) to develop personal skills and knowledge for individuals to promote their own health; and 5) to re-orient the health service to act in the best interests of people's health (HST, 2000). Health promotion is unlikely to be successful without the buy-in of affected communities, as "the engine pulling community development is the people themselves" (Bracht, 1999). The World Health Organisation recognised in 1991 that "if conditions conducive to health are to be achieved in an equitable manner, all sectors of society must be involved and mobilized". Sanders (1998) adds to this by saying that "developing consensus by initiating a dialogue with the public

and enlisting their support can contribute to the continuity and sustainability of policies for health”.

Promoting health involves three levels of prevention. The first of these is *primary prevention* which prevents the disease from occurring at all, e.g. behaviour change so that people always practice safe sex; or an HIV/AIDS vaccine which would prevent people from acquiring HIV (note, an HIV vaccine is not currently available, but several vaccine initiatives are underway in South Africa and elsewhere¹³). *Secondary prevention* is necessary when a health condition occurs despite primary prevention, and requires detection and management of the condition, e.g. treatment for blood pressure, before it becomes a condition that causes a stroke or kidney dysfunction. If both of the above have failed or are not possible, then *tertiary prevention* is needed, which seeks to limit the damage, and prolong and increase quality of life (Mann et al, 1999). An example of tertiary prevention is the provision of anti-retrovirals for AIDS patients.

In the context of HIV/AIDS, public health must address prevention and treatment issues, both of which require social interventions. HIV/AIDS has been approached in different ways throughout the course of the epidemic. The management of HIV/AIDS started with a bio-medical approach, then swung strongly to a social model which considered human rights, risk-behaviour, anti-discrimination and other social issues related to the disease. Because of the introduction of anti-retrovirals, a medical model is becoming popular again. Public health attempts to position itself between these two poles.

Public health in South Africa and elsewhere is challenged mainly by problems created by human behaviour (Mann et al, 1999). Where a sexually transmitted disease such as HIV/AIDS requires public health intervention, much of the problem could be handled with different behaviour. Yet it is precisely human behaviour that is so complex and challenging, and difficult to change. Perhaps for this reason, traditional public health programmes for sexually transmitted diseases have focused on diagnosis and treatment rather than sexual behaviour itself (Mann et al, 1999). However, with the advent of

¹³ An example is the Medical Research Council work at www.mrc.ac.za

HIV/AIDS, prevention programmes have sought to modify behaviour through information dissemination and education.

An understanding of public health therefore should include reflection on underlying conditions, which are related to human rights. In particular, the HIV/AIDS epidemic has shown that individuals and groups who experience discrimination, marginalization and a lack of human rights are more vulnerable to HIV transmission and exposure (Mann et al, 1999). A public health settings approach which incorporates human rights perspective, is suggested in the following chapter, to deal with the challenges of children living at the nexus of HIV/AIDS and poverty.

The Dual Lens of Human Rights and Public Health

The societal context has been identified as a major determinant of vulnerability to disease by Werner & Sanders (1997) and others. Both fields of human rights and public health have a considerable impact on the societal context in South Africa, and elsewhere. It is this societal contexts that determines whose socio-economic rights are realised and whose are violated; as well as whose public health concerns are addressed, and whose are not. The societal context itself, plays an important role in the behaviour and environment that shapes risk of HIV infection and transmission. Therefore, a consideration of the dual lens of human rights and public health is useful in examining the way in which South Africa is dealing with the impact of HIV/AIDS. Mann et al (1999) have identified a three-part relationship between these two disciplines that is outlined here.

The first relationship between the two disciplines concerns the impact of health policies and practices on human rights. An example can be seen in policies that do not consider barriers to accessing public health care, and thus discriminate against people who cannot access public transport or child-daycare which would free them to attend a clinic (Mann et al, 1999). It is important to mention that there are times when the protection of public health (and the majority of the population) may require a restriction of rights, however this must be a last resort and is only permitted under certain conditions. These

restrictions are determined by Siracusa principles adopted by the UN Economic and Social Council (1985) (Gruskin & Loff, 2002).

With specific regard to HIV/AIDS, health policies have had an impact on human rights over the relatively short history of the disease. Annas (1999) highlights the international use of military metaphors, such as “war on AIDS”, which promotes a battlefield mentality, as opposed to a human rights discourse. He speaks about the destructive nature of an initial strategy by both US and Cuban governments to contain HIV/AIDS by quarantining infected individuals, thus limiting individual rights. Annas (1999) likens this to original strategies to contain tuberculosis in the US in the early 1900s. He reminds readers that the decline of tuberculosis in the US was largely because of improvement in living conditions, rather than the implementation of draconian law.

The second relationship between the two disciplines concerns the impact of violations of human rights on health. Some of the most obvious of these are incidences of torture and imprisonment under inhumane conditions. There are more nuanced examples, such as a violation of right to information about the harmful effects of tobacco smoking (e.g. printed on packaging), which impacts on health (Mann et al, 1999).

The third relationship between the two disciplines concerns the inextricable link between human rights and health, which is of particular interest in this thesis. This relationship recognises that human rights and health complement one another, in advancing the well-being of humanity. In addition, this relationship recognises that more can be achieved through this dual lens, than through isolated health- or human rights-based approaches (Mann et al, 1999). “An epidemic as complex and as destructive as HIV/AIDS requires innovative and multisectoral responses beyond standard public health measures” (USAID, 2003). Such responses would include a public health approach informed by health promotion. Considering HIV/AIDS in South Africa through the dual lens of public health and human rights emphasizes the importance (and the complexity) of the relationship between poverty and HIV/AIDS. Socio-economic rights can be compromised in the context of poverty, leading to different stages of susceptibility,

including greater biological, sociological, environmental and behavioural risk of HIV transmission and infection. Thus it could be argued that the realisation of socio-economic rights for a greater number of South African citizens, would lead to better public health, and less risk of HIV transmission.

In considering a common strategy to promote human rights and public health, we turn to the work of Marks (1999), who mentions five categories of partners who would be instrumental in such a strategy. These are 1) health and medical professionals, who implement health and human rights policies; 2) state institutions, that determine policies and allocate resources according to political priorities; 3) non-governmental organisations, doing advocacy and service-delivery work related to health and human rights; 4) intergovernmental organisations, e.g. the UN, who have powerful influence and access to resources; and 5) ordinary people, citizens and taxpayers, who keep governments accountable and assist fellow citizens in need.

Marks (1999) also highlights the points of entry for promoting a common strategy around human rights and health activities. These points of entry include the policy making process; places where norms are set (e.g. Parliament, or intergovernmental organisations); service delivery areas (e.g. humanitarian relief, or vaccination programmes); research; and education¹⁴.

A common strategy for human rights and health could make substantial inroads into the poverty experienced by many children in South Africa. The next chapter will use a public health and human rights framework to analyse the Child Support Grant provided by government to South African children living in poverty, and affected by HIV/AIDS.

14 For further reading on political and power relations in the development of a common strategy for health and human rights, see Marks (1999). Further research needs to be conducted about useful strategies to encourage partnerships to promote public health and human rights.

5. REFLECTION ON THE CHILD SUPPORT GRANT IN THE CONTEXT OF PUBLIC HEALTH AND HUMAN RIGHTS IN SA

This chapter first examines the extent of child poverty in South Africa, before explaining the Child Support Grant policy and the impact that it has on poor children affected by HIV/AIDS. A theoretical framework is used to interrogate the policy for its value in terms of human rights and public health in South Africa. The Child Support Grant reaches many children living in poverty who would otherwise have no social assistance. However, several policy and implementation issues are raised, particularly in terms of barriers to accessing the grant. These are highlighted in the experiences of people who have struggled to access the grant and who appealed to the Children's Institute (an affiliate of the University of Cape Town) for help, in 2003 and 2004. Further discussion seeks to find ways to address these barriers, including the use of a public health settings approach to mobilize community and social capital.

Children and Poverty

“The perspective on child poverty, gained through the dual lenses of indicators and participatory research, makes it clear that after ten years of democracy, there is still an urgent need for government to enhance the effectiveness of its strategy to eradicate child poverty and realise socio-economic rights” (Streak, 2001).

Poverty is a multi-dimensional issue and can be measured in different ways. It is about exclusion and marginalization, as well as not having enough money. As was discussed earlier, it is usually the poorest of the poor who suffer more ill health (Naidoo & Wills, 1998). While specific figures may vary, there is widespread agreement across government and civil society that child poverty in South Africa is extensive and problematic. In July 2003, the Department of Social Development (DSD) released a baseline document stating that 59% of children aged 0 – 17 are poor and “poverty affects children by reducing their chances of living beyond their first five years, by stunting their growth, rendering them vulnerable to infectious diseases and disabling injury, reducing their confidence and hope in the future, and limiting their education capacity for

developing to their full potential” (DSD, 2003). Civil society research based on data from 2000 that considered child poverty along the lines of income and food insecurity/hunger, showed that nearly three quarters (74.8%) of South Africa’s children lived on less than R430 per month. When using a lower amount of R215 per month, more than half (54.2%) of children were considered poor. It was also found that more than half (52%) of children aged 1 – 9 experienced hunger in 1999 (Streak, 2004). Where HIV/AIDS prevalence is high, food security is negatively affected (including availability and access to food) (Munn et al, 2003). These high levels of child poverty have understandably been described as “alarming” (Sloth-Nielsen, 2001). South Africa is an extremely unequal society, and the relative poverty experienced by many children, linked to the unequal distribution of resources in society, is closely linked to health.

Child poverty is largely a function of greater poverty in their families and communities (Liebenberg, 2001). The Human Sciences Research Council uses a minimum living level to show poverty income according to household size, as shown in the following table (the larger the household the larger the income required to keep its members out of poverty). These figures are for 2001 rand values (HSRC, 2004).

Poverty income by household size (R per month)

Household Size	2001
1 person	R587
2 people	R773
3 people	R1028
4 people	R1290
5 people	R1541
6 people	R1806
7 people	R2054
8+ people	R2503

Source: (HSRC, 2004)

In 2001, it was estimated that more than half the South African population (22 million people) survived on R144 a month (SACC, 2001) – that is one quarter of the HSRC figures above. In the same year, children formed 44% of the population (Sloth-Nielsen, 2001).

Researchers argue that children living in households directly affected by HIV/AIDS are “among the most vulnerable to rapid socio-economic decline” (Giese et al, 2003). In 2002, The Taylor Report, which was the result of a Committee of Inquiry into a Comprehensive Social Security System, suggested the following definition for social security: “Comprehensive social protection for South Africa seeks to provide the basic means for all people living in the country to effectively participate and advance in social and economic life, and in turn to contribute to social and economic development” (Taylor, 2002). The report concurred that households and families affected by HIV/AIDS are placed under immense strain, as “the extended family as social support mechanism is eroded by factors such as poverty, HIV/AIDS, urbanization and over-stretched resources. These eroded family structures are resulting in a shifted burden of care for children orphaned by AIDS. The burden falls on the elderly or on other children, both who are ill equipped to carry this responsibility, financially and emotionally” (Taylor, 2002). Further potential long term effects of poverty include decreased development and later chances of unemployment. Cohen (1999) has made the argument that unless poverty is reduced, there will be little hope of reducing HIV transmission or of an enhanced capacity to cope with the socio-economic consequences of HIV/AIDS. Thus it can be argued that poverty alleviation is crucial to the fulfillment of children’s rights.

What is the Child Support Grant?

The Child Support Grant is the government’s primary poverty alleviation mechanism targeted at poor children. Prior to 1994, the main government grant for child and family care was the State Maintenance Grant, provided mostly to white people, in accordance with apartheid policies. In 1996, the Department of Welfare commissioned the Lund

Committee to review the existing system of state support for children and families. The Committee made several recommendations, including the introduction of a Child Support Grant, according to the following principles. The grant should be:

- paid to the primary care-giver according to a simple means test
- payable from birth for a limited number of years, with the number being used as a cost containment mechanism
- derived from the household subsistence level for food and clothing for children
- conditional on the child's proper registration at birth (Lund, 1996).

The previous State Maintenance Grant had catered for approximately 200 thousand children, while the Child Support Grant initially aimed to reach 3 million children over a five year period (Clark, 2000). The Child Support Grant was introduced in the Social Assistance Act 59 of 1992 by the Welfare Laws Amendment Act 105 of 1997, to replace the apartheid State Maintenance Grant (Sloth-Nielsen, 2001). After an initial proposal of R75 per child followed by civil society lobbying to increase this, the amount set for the Child Support Grant was set at R100 per child per month. Initially, the Child Support Grant was introduced in 1998 only for children up to the age of 6 years old. The ceiling imposed on the grant was primarily in recognition of the fiscal constraints facing the government in terms of a tight macro-economic policy that would not allow provision for all children up to the age of 18 years old.

In April 2003 the government approved the extension of the grant beyond the age of 6, to poor children up to 14 years old. Estimates showed that, in terms of the existing means test, which would also apply to the extension, another 3,2 million children would qualify for the grant (Department for Social Development, 2003). However, this was not intended to be immediately enacted, but rather a phased approach was taken so that

- From April 2003, children up to 9 years old became eligible for the grant;
- From April 2004, children up to 11 years old became eligible for the grant; and
- From April 2005; children up to 14 will become eligible for the grant.

The Department for Social Development (DSD) gave several reasons for its phased

approach to the roll-out of the Extended Child Support Grant, asserting that despite the vulnerability and poverty that many children face, an “orderly and phased” roll-out was necessary (DSD, 2003). The Department stated that the administrative system could not accommodate such a large expansion overnight; that administrative capacity was already limited and in need of improvement; and that Constitutional Court rulings implied the need for focusing on the most vulnerable, therefore a targeted and phased approach would ensure “equitable extension” (DSD, 2003).

In 1998, the grant amount was R100 and it has been increased four times in the six years since then, with the grant amounting to R170 per month in 2004. It is paid to a caregiver who meets the requirements, on a monthly basis. The caregiver must be a South African citizen (and residing here) with documentary proof (identity document); need not be biologically related to the child, but must produce an affidavit stating that s/he is the primary provider of care; and must provide a birth certificate for the child in question¹⁵. A means test is applied, based on proof of income and location. An applicant passes the means test if the personal income of the care-giver and his/her spouse is below R9600 (living in an urban area) or R13,200 (living in a rural area). These amounts were set in 1998 and have not been adjusted since then, despite rising costs of living (Coetzee & Streak, 2004).

The Extension of the Child Support Grant provided for the Department to set up an implementation team to support provinces in administrative, legislative and regulatory arrangements for extension of the grant. The Department also called on civil society and other partners who had been instrumental in widening the social security net in the past, to co-operate and assist with the extension of the Child Support Grant, viz. faith-based organisations, non-governmental organizations, business, labour, and the Department of Home Affairs. The Children's Institute, an affiliate of the University of Cape Town and concerned with the welfare of children, was an organisation that was active in monitoring the implementation of the extension.

¹⁵ For policy description of documentary evidence required, see appendix 2; for actual examples of documentation required and submitted for one case in this study, see appendix 4

Government's Budgetary Commitment to the Child Support Grant

Without requisite funding, government policies cannot be implemented and therefore some understanding of the specifics of poverty alleviation targeted at children is given through consideration of the Child Support Grant. Levels of inequality in South Africa are high, which are reflected in provincial capacities to administer government grants such as the Child Support Grant. South Africa has three 'spheres' of government, viz. National, Provincial and Local, each with their own operational roles. While policy is mostly set at the national level, provinces are responsible for the key spending areas in social security, education and health (Butler, 2004). With regard to the Child Support Grant, budgetary discretion is allowed at the provincial level of implementation of policy. This allows for greater flexibility and more targeted funding for areas of need. Here, the budget for the Child Support Grant is given attention because, despite suitable government policies to deliver on the socio-economic rights as enshrined in the Constitution, unfunded mandates which have no government budget for implementation of a policy, are futile as they cannot be implemented without appropriate resources. Also, with the historical context as described in chapter 1, where scarce resources are needed in many places for development, budgetary commitment to welfare and social services indicates political commitment to alleviating poverty.

Those who worked on the child's right to social services in 1999, noted that:

“in an ideal world, law reform would be shaped by a concern for matters of principle, the bedrock of precedent, a desire for internal jurisprudential consistency, adherence to constitutional and international standards, and academic engagement with the niceties of one or other legal solution. Then, having the necessary choices, the law reformers would be able to step aside, leaving matters of implementation and resourcing to the executive” (Sloth-Nielsen, 2001).

However, in recognition of the scarcity of government resources in the face of many levels of need, and the levels of poverty at which so many children live, it was concluded that “budgetary issues should assume a prominent role in shaping the legislative framework” (Sloth-Nielsen, 2001). Notwithstanding, a recent study showed that “at

present the budget process is such that there is no explicit system for linking budget planning and implementation to constitutional child socio-economic rights obligations” (Streak, 2004). This makes it difficult to monitor government accountability in terms of spending on socio-economic rights obligations to children.

South Africa’s Minister of Finance, Trevor Manuel, recently recognised the importance of budgeting for socio-economic rights, acknowledging that trade-offs and difficult choices must be made. He said “if the task of a developmental state is to fight poverty and expand economic opportunities for the poor, then the budget of a developmental state must reflect this in every respect.” In his budget speech early in 2004 Manuel said that “the budget must tell a story of the values a society eschews” and, quoted Joseph Schumpeter, saying:

“public finances are one of the best starting points of an investigation of society. The spirit of a people, its cultural level, its social structure, the deeds its policy may prepare – all this and more, is written in its fiscal history” (Manuel, 2004).

This is why when investigating our society’s commitment to realising socio-economic rights for children, an exploration of the budget for social assistance targeting children, such as the Child Support Grant, is so important.

Poverty alleviation is a starting point for all of the basic children’s rights that we are striving to respect, promote, protect and fulfill. The National Programme of Action for Children (NPA) was established in the 1990s by the government to:

“ensure that children and child rights are prioritized in policy, budgets and service delivery. However, there is as yet, in practice, no systematic process for prioritizing child-specific and other socio-economic rights in government’s policy formulation, budget allocation process or programme implementation. This is a crucial challenge for government budgeting, programme system design and monitoring in the future” (Streak, 2004).

The government’s Medium Term Expenditure Framework (MTEF) shows that current funding for the Child Support Grant come from two sources, viz. from total provincial revenue, and from the Child Support Grant extension conditional grant. The latter was introduced in 2003 at the same time as the extension of the grant, in order to help

provinces finance the age extension up to 14 years old (Streak & Kgamphe, 2004). These allocations account for the cash paid to recipients of social assistance (currently R170 per grant, per month), as well as the cost of administering the grant (approximately R29 per grant payment, per month) (Coetzee & Streak, 2004). The MTEF considers government's planned spending over a four year cycle, thus from 2003/04 to 2006/07. The following table shows provincial allocations to the Child Support Grant programme.

Child support grant programme, amount (R'000) and real growth (%)

Year	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007	2004/05-2006/07
Province	Audited	Revised estimate	MTEF			Average annual real growth ³
Eastern Cape	703345	1222636	2012656	2836043	3498399	
Real growth		66.03%	56.18%	33.56%	17.26%	35.67%
Free State	227200	416535	400396	486251	606864	
Real growth		75.10%	-8.80%	15.11%	18.64%	8.32%
Gauteng	456294	939116	1460927	1899907	2055696	
Real growth		96.57%	47.59%	23.27%	2.85%	24.57%
KwaZulu-Natal	1146327	1910225	2385870	3267314	4046454	
Real growth		59.16%	18.50%	29.81%	17.72%	22.01%
Limpopo	**	1339931	1815803	2450979	2601786	
Real growth			28.57%	27.94%	0.91%	19.14%
Mpumalanga	318441	595847	784540	1064429	1281286	
Real growth		78.71%	24.92%	28.60%	14.42%	22.65%
Northern Cape	74320	131692	151012	209958	217950	
Real growth		69.24%	8.80%	31.79%	-1.32%	13.09%
North West	**	646316	1060782	1477499	1796389	
Real growth			55.72%	32.02%	15.57%	34.44%
Western Cape	312161	500932	688162	880620	1098660	
Real growth		53.27%	30.34%	21.30%	18.59%	23.41%
All provinces	3238088	7703230	10760148	14573000	17203484	
Real growth		127.22%	32.53%	28.37%	12.22%	24.37%

** Reports for 02/03 not available

Source: Streak & Kgamphe, (2004)

As can be seen from the table, the extension of the Child Support Grant from April 2003 brought about substantial growth in budget allocations, particularly in the early years (Streak & Kgamphe, 2004). The Eastern Cape and Kwazulu Natal have the largest allocations, reflecting the estimates that these two provinces have the largest numbers of poor children (Streak & Kgamphe, 2004).

While this increase in spending on the Child Support Grant is important, a wider angle lens which shows the bigger picture, indicates that as a percentage of government's total spending, the Child Support Grant is still very small – just 2.32% in 2003/04 and 2.92% in 2004/05 (Streak & Kgamphe, 2004).

The *nominal* value of the Child Support Grant has increased from R100 in 1998, to R170 in 2004. However, the *real* value of the Child Support Grant (calculated in relation to the Consumer Price Index (CPIX), and shows purchasing power of the grant) shows that while the nominal value of the grant in 2003 was R160, it's real value was just under R110 (Cassiem & Kgamphe, in Coetzee & Streak, 2004). These calculations used 1998 as the base year, therefore indicating that the real value of the grant has only grown by just under R10 in 6 years. Creamer (2002) argues that this might run contrary to the requirement of 'progressive realisation' of rights, as stipulated in the Constitution and described earlier in chapter 3. He also suggests that

“since it can most probably be shown that recipients of such grants spent most of their income on foodstuffs, in a context where food inflation is running at about 12% (2002) ... a question arises as to whether the nominal increases in the level of the Child Support Grant should be linked to the level of food inflation rather than the CPIX (which is significantly lower than food inflation), in order to avoid a real cut and thereby trigger a challenge that the real cut runs contrary to the commitment to the progressive realisation of the right to social security, including social assistance” (Creamer, 2002).

This said, for many people, the Child Support Grant of R170 per month is the only support they receive to deal with the impact of HIV/AIDS.

It is apparent that the government has allocated increasing resources to poverty alleviation, and thus the fulfillment of children's right to social assistance, and indirectly their right to other socio-economic rights. However, many children still fall outside of the social security net and are vulnerable to the dual impact of HIV/AIDS and poverty.

The role of the Child Support Grant in poverty alleviation and mitigation of the impact of HIV/AIDS and Poverty

“The importance of mitigating the effects of the HIV/AIDS pandemic cannot be underestimated, because the human and socio-economic impacts of the pandemic will persist long into the future regardless of the success of any prevention messages, increased access to antiretroviral drugs, or even the development of an effective vaccine... even if by some miracle the spread of the disease were halted, people would still become ill and die (eventually) and we would still need to address the effects of the pandemic and associated mortality for generations to come” (Munn et al, 2003).

The UNAIDS *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* is structured around the goals set at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, for orphans and children made vulnerable by HIV/AIDS. The Framework recommends five key strategies, two of which relate directly to the potential of the Child Support Grant and its role in poverty alleviation and mitigation of the impact of HIV/AIDS, viz. a) strengthening the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support; and b) ensuring that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities. Both of these strategies are at the heart of the issue regarding household economic capacity and the impact it has on a family’s ability to cope with the consequences of HIV and AIDS.

While direct programmes to provide specifically for children’s needs are important, income support is a crucial backbone to a better standard of living, as was found in the Lund Committee’s original recommendations in 1996: “The Committee is firm in its belief that this cash benefit will be a more reliable form of support than the alternatives it considered. In a society of such extreme inequalities, social spending of this sort is an important contributor to household income. It should be seen as part of a bundle of private and state support for the development of vulnerable groups, and the alternatives should not be seen as mutually exclusive. It should be seen as a minimum basis from

which incremental growth can take place” (Lund, 1996). This is confirmed in the research of Sogaula et al in the Eastern Cape. “Even when good programmes are in place to realise particular children’s rights and basic needs – such as health care services and education – insufficient income and linked to this, transport, often prevents access to services” (Sogaula et al, 2002). It has been shown that “increased incomes for single mothers with children through social transfers have a significant impact on educational performance of children” (Taylor, 2002). More than protecting children, social assistance also facilitates greater empowerment of women as “greater economic independence is associated with a lower HIV prevalence rate” (Bonnel, in Sogaula, 2002). Thus, spending on social assistance programmes is considered “critical” in order to realise children’s rights to “basic nutrition, basic education and basic health services” (Streak, 2004).

There is recognition that “when HIV/AIDS begins to affect a household, family relationships provide the most immediate source of support. Recognising this reality, strengthening the capacity of families to care for and protect orphans and vulnerable children must be at the core of a response strategy” (UNAIDS, 2004). When considering the poverty in which many children live, as articulated earlier, and the way in which HIV/AIDS compounds the difficulties faced by communities, it is a policy imperative to find a way to provide adequately for children living at the nexus of HIV and poverty. “South African families need monetary and community-based assistance in order to cope with the levels of death, illness and poverty resulting from this current epidemic” (Sogaula et al, 2002)

As discussed in previous chapters, poverty feeds into the impact of HIV/AIDS on children and families. In a healthy household in South Africa, average household expenditure on healthcare is approximately 4%, but as the results of a survey of HIV/AIDS affected households show, some households spend between 26% (in urban areas) and 54% (in rural areas) of their monthly income on healthcare (Steinberg, in Giese et al, 2003). This places phenomenal burden on households that are already living in dire poverty, and need money for the basics - food, shelter, clothing, school fees.

Mutangadura (in Sogaula et al, 2002) estimates that one of the characteristics of HIV/AIDS related deaths is that the “financial cost to a household is considered to be as much as 30% higher than deaths from other causes”. Sogaula et al (2002) add that the capacity of the extended family or community network to cope with the high demands placed on poor people by HIV/AIDS, is becoming stretched and that “public sector intervention may be required to meet the basic needs of households.”

In this context, Liebenberg (2001) asserts that the realisation of socio-economic rights are “not only a moral and political imperative, but also a constitutional obligation”. In interpreting the socio-economic rights of South African citizens in the Grootboom case, the Constitutional Court stated that the government has a “positive obligation to ameliorate the plight of the hundreds of thousands of people living in deplorable conditions throughout the country, including providing access to housing, health care, sufficient food and water, and social security” (Constitutional Court, 2001).

Different kinds of coping strategies are seen to be employed in response to illness, in households coping with the impact of poverty and HIV/AIDS. Goudge and Govender (2000) found that “household coping is made considerably easier where infrastructure (such as water, transport and electricity) and social services (health and education) are provided and maintained”. In order to cope with financial constraints that increase because of illness, people have been found to resort to a variety of options e.g. using savings; reducing expenditure (e.g. on education); eating less in terms of quantity (reducing meals to one a day) and nutritional value; utilising child labour; borrowing; prostitution; begging; theft; among others (Goudge & Govender, 2000; and Sogaula et al, 2002). Many of these have a direct impact on children’s development, e.g. when school fees cannot be paid, thus stunting children’s educational and learning opportunities.

Poverty alleviation programmes “provide a safety net for the impoverished, and a foundation for the development of poor people’s capacity to participate in other social service areas, such as education, health and housing” (Sloth-Nielsen, 2001). The dual impact of poverty and HIV requires a comprehensive response, which includes social

security provisions, along with health provisions. Provision of medication will do little without adequate food with which to take the medication, or transport to return to the clinic for more medication and support, or clean water with which to take the medication, or psycho-social support to cope with stigmatization, or decent living conditions to stave off further illness. The kinds of difficulties that people encounter when trying to access health services related to HIV/AIDS include poverty-related and other barriers such as: inability to pay health user fees; long (and expensive) traveling distances to health facilities; inappropriate operating hours for children (e.g. during school); the requirement that an adult accompanies a child to a health facility; staff attitudes of overworked healthcare practitioners; stigma and discrimination related to HIV/AIDS; lack of drug supplies at the clinics; and long waiting times and queues (Giese et al, 2003).

The Child Support Grant is a mechanism which gives families the opportunity to provide their children with basic provisions that alleviate some of the destitute poverty that prevails in households. Extra cash from social security would help with issues such as travelling costs to health facilities, paying for nutritious food to keep healthy, paying for drugs or healthcare where necessary. Most importantly, providing this basic income in turn allows for a better standard of living that supports public health campaigns of prevention of HIV, and support and care for those living with HIV and AIDS. Thus, social security which feeds into the family's income support, is crucial to target poverty alleviation for children who are struggling with the impact of HIV/AIDS.

Among the potential poverty alleviation mechanisms considered to be instrumental in alleviating household and child poverty, is a proposed non-means-tested Basic Income Grant (BIG) , which would provide a suggested amount of R100 per month to every South African citizen. For those employed and not living in poverty, this could be reclaimed through taxes, but a universal grant such as BIG would create a social safety net for everyone, providing the basic means to achieve an adequate standard of living. While much has been done in the last ten years to extend social security to the poor in South Africa, in 2003, "half of those people in need of income support still [did] not have access to any income from the state, mostly because of exclusion from eligibility for

a grant, but also due to implementation failures” (Streak, 2004).

One of the concerns expressed by government about a potential Basic Income Grant, is the issue of sustainability, particularly in terms of affordability for the state in the future. Preferring rather to embark on an expanded public works programme, government has chosen not to go the route of a universal grant thus far. This choice of favouring an expanded public works programme as an *alternative* to a universal grant has attracted criticism from civil society, saying that economic growth is not enough to stem the tide of poverty: “South Africa's unemployment rate is so high that public works programmes would not be able to create enough jobs, however 'massive' they would be”. It has been suggested that the government should not consider an expanded public works programme and the proposed Basic Income grant as policy *alternatives* (Irin, 2004); rather that both strategies should be used in tandem, to fight poverty.

Archbishop Desmond Tutu raised the issue at a recent lecture, saying that "at the moment, many, too many, of our people live in gruelling, demeaning, dehumanising poverty. We are sitting on a powder keg. ... We should discuss as a nation whether a basic income grant is not really a viable way forward ... We cannot, glibly, on full stomachs, speak about handouts to those who often go to bed hungry." (Tutu, 2004)

While many non-governmental organisations and community based organisations consider that a universal grant is a worthy option, some have expressed concern that it will suffer the same difficulties as existing social grants – that those who are most in need will remain outside of the reach of administrative capacity of government to implement an entirely new grant. However, the Department for Social Development’s outreach to children and old age pensioners especially in recent years, has proven that it has the capacity to extend its reach successfully. Thus it would appear feasible for the government to extend the Child Support Grant to children up to the age of 18, as a precursor to a universal Basic Income Grant. For children struggling at the nexus of HIV/AIDS and poverty, their increased vulnerability calls for greater social security measures such as this.

Civil society researchers have highlighted the relationship between HIV/AIDS and poverty, saying that “mitigation efforts, whether designed to assist orphans, caretakers or households, should focus on the problem of poverty and not the specific problem of AIDS” (Sogaula et al, 2002). For many of those living at the nexus of HIV/AIDS and poverty, the Child Support Grant, currently at R170 per month, is the only form of governmental assistance they receive, and therefore the only relief provided in terms of mitigation of the impact of HIV/AIDS and poverty.

A Critique of the Child Support Grant through a Public Health and Human Rights Framework

The Child Support Grant attempts to provide for children in need of social assistance, and thus should be assessed in terms of how it applies to the fulfillment of children’s socio-economic rights in South Africa. While it is more common to find frameworks which assess the possible *violation* or *infringement* of rights, it is not as easy to find frameworks which assess the potential *fulfillment* or *non-fulfillment* of rights. This is somewhat understandable, given that both internationally and in the South African context, not many socio-economic rights have been substantively articulated in terms of clear and measurable guidelines for the actual content of such rights (Liebenberg, 2004; and Sloth-Nielsen, 2001). This lack of clarity has both advantages and disadvantages. The advantage of a lack of clear definition is flexibility which allows for changes and non-limitation as time passes; but the disadvantage is vagueness and difficulty in holding government or others accountable in terms of delivery of rights (van Bueren, 2002).

Following on from the earlier introduction to the relationship between human rights and public health, and reflecting on previous chapters in this thesis, the tool chosen to critique the Extension of the Child Support Grant is London’s (2002) “Framework for Analysing Policy: Integrating Public Health and Human Rights” (see Appendix 5) adapted from L. Gostin and J.M. Mann’s “Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies” (Mann, Gruskin, Grodin & Annas, 1999). The five questions asked by this framework are as

follows:

- 1) To what extent is the proposed public health response “good public health?”
- 2) To what extent does the proposed policy respect, protect, and fulfill human rights?
- 3) To what extent does the policy address common concerns to public health and human rights?
- 4) How do we achieve a balance between protecting public health and promoting human rights?
- 5) Given the above, does the proposed policy, as revised, still appear the optimal approach to the problem?

Each of these questions shall be considered in turn, below.

a. To what extent is the proposed public health response “good public health?”

The Child Support Grant is an important tool in the government’s response to poverty alleviation and the realisation of the right to social security and assistance.

“The right to social security and the values of human dignity, equality and freedom that are central to our new Constitution are inextricably related ... Access to social security protects people from the worst ravages of poverty and inequality, and enables them to maintain an adequate standard of living.” (Liebenberg, 2002).

In understanding the scope of the right to social assistance, and the conditions of public health, we need to consider the socio-economic conditions in which many South Africans live. The government is concerned about over-reliance on welfare, and therefore focuses rather on public works programmes, stating that creation of jobs is the answer to poverty. While job creation is crucial, there is little evidence, in the current climate of extreme poverty, to support the notion that South Africans are unhealthily dependent on welfare. Liebenberg (2002) highlights that because of structural unemployment and poverty in South Africa, the right to social assistance is particularly important, as it protects an adequate standard of living for everyone. “Poverty is closely associated with very high unemployment rates, regardless of how they are measured. Most of the poor do not have

formal jobs; many of the poor and not-so-poor are in the informal sector. Employed life is characterised by insecurity: under-employment, erratic employment, and jobs which are so insecure that they cannot promise certain futures” (Lund, 1996). As has been demonstrated in previous chapters, poverty has a negative effect on health, and therefore the need to access social assistance is even more urgent in the context of HIV/AIDS. The Child Support Grant, in alleviating poverty, has a positive impact on the health of children and therefore constitutes a good public health response. Since the South African economy doesn’t have the capacity to generate enough jobs, social assistance is crucial as a poverty alleviation tool (Liebenberg, 2002) This is congruous with Article 11 of the ICESCR which highlights “the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions” (ICESCR, 1976).

The government’s White Paper for Social Welfare in SA (February 1997) defines the scope of social security to cover

“a wide range of public and private measures that provide cash or in-kind benefits or both, first in the event of an individual’s earning power permanently ceasing, being interrupted, never developing, or being exercised only at unacceptable social cost and such person being unable to avoid poverty. And secondly, in order to maintain children”.

Children also “do not have a political voice that counts in a democratic process” and therefore, Viljoen (2002) proposes that children’s needs must be prioritized in the allocation of resources. Children’s vulnerability and contribution to family life has been considered in earlier chapters, and this is highlighted here because of children’s inability to obtain many government services or social assistance without the help of adults. As discussed earlier in this chapter, estimates range between 59% (Department of Social Development, 2003) or 6 out of 10 children in poverty (Sloth-Nielsen, 2001), and others who define poverty as “a situation in which a child does not have the income needed to meet his or her basic needs”, where 70% of South African children live in poverty (Haarman, in Cassiem & Streak, 2001). Whichever poverty line is used, all of these statistics point to an appalling situation of child poverty, which should be one of the primary concerns of a public health policy targeting children.

Social grants are the government's largest and most substantial poverty alleviation mechanism. The Child Support Grant aims to assist families to provide for the basic needs of children (Leatt, 2003). It is widely considered to be one of the government's most effective policies for assisting with poverty alleviation for children, and is instrumental in reducing general household poverty as well. Given the prior discussion of child poverty and living conditions, and the importance of social assistance in the context of HIV/AIDS, the Child Support Grant can therefore be considered a "good public health" response.

b. To what extent does the proposed policy or program respect, protect, and fulfill human rights?

The Child Support Grant provides for the right to social assistance which has a *positive impact* on children aged 0 – 11 years, and this will extend from April 2005 to children aged 14 years old. As the primary tool for poverty alleviation targeted at children, the Child Support Grant directly impacts on children's right to social assistance, and also contributes towards the realisation of children's rights to basic nutrition, shelter, basic health care services and social services, as determined in section 27 of the South African Constitution. Therefore it is a crucial tool in respecting, protecting, promoting and fulfilling the human rights of children. Given the history of socio-economic deprivation that was outlined earlier, the contribution of the Child Support Grant to achieving children's rights in just the last few years is a commendable achievement on the part of government.

The Child Support Grant recognises the interdependence of children and their caregivers, in that the grant makes a substantial and positive difference to the poverty level of a household. The Old Age Pension also recognises these realities, and is the second largest targeted poverty alleviating grant, in terms of numbers and take-up.

Despite the above comments, the Child Support Grant as it stands, has a *negative impact* on the right to equality. This is because the right to equality, a non-derogable right, is questionably threatened in discriminating against children on an administrative basis, based on age, availability of a care-giver, and provincial administration ability.

Discrimination based on age

The Child Support Grant does not yet protect the rights of children between 11 and 18, and even when it is fully implemented after April 2005, will not respect, protect and fulfill the rights of children between 14 and 18 years old. In addition, no measures to address the social security rights of this group have yet been forthcoming (Leatt, 2003). Thus, children between the ages of 14 and 18 will have their right to social security violated.

Effectively, the phased roll-out approach provides for “progressive realisation of the socio-economic rights of children” (Leatt, 2003). As was discussed earlier, some interpretations indicate that there is a higher obligation on the state to deliver children’s rights as in section 28 of the SA Constitution (i.e. independent of the progressive realisation clause), but this has not yet been fully tested in the Constitutional Court. In addition, given that there is intention and a stated plan for further roll-out, to 14 year olds at least, it would be difficult to challenge this position in judicial terms. Liebenberg (2004) states that “current jurisprudence has not resolved whether children have a *direct* entitlement to the socio-economic services in section 28 (1)(c) of the Constitution” (emphasis own). In addition, Sloth-Nielsen (2001) highlights that the Constitutional Court’s findings in the Grootboom case indicate a caution that “children’s claims cannot necessarily trump other forms of social deprivation” and need to be considered in the context of greater socio-economic conditions.

However, the socio-economic rights of children between the ages of 14 and 18 have yet to be tackled in Constitutional terms. Children affected by HIV/AIDS are not specifically catered for in terms of a grant, unless in the terminal stages of AIDS and qualifying for a Care Dependency Grant, or under the age of 14 and qualifying for the Child Support

Grant (Taylor, 2002). The Committee on the Rights of the Child, which oversees the UN Convention on the Rights of the Child, recommended, in its observations to South Africa's Initial Country Report, that either the Child Support Grant should be expanded, or that alternative programmes supporting children to the age of 18 years, should be developed (Sloth-Nielsen, 2001). The Grootboom judgement handed down by the Constitutional Court in 2001, stated that "a programme that excludes a significant segment of society cannot be said to be reasonable" (Creamer, 2002). The programme as it stands means that approximately 7 million poor children between 14 – 18 years old will be excluded from the Child Support Grant or alternative social security (Cassiem & Kgamphe, in Coetzee & Streak, 2004). It can be argued that this exclusion is unreasonable and therefore unconstitutional.

Discrimination based on availability of carer

Because the Child Support Grant cannot be obtained without the help of an adult, it overlooks children without care-givers, such as street-children and those living in child-headed households (Coetzee & Streak, 2004). Little direct provision has been made for child headed households in terms of social security, unless they have access to an adult who is responsible, reliable and will vouch for the children and collect the grant on their behalf. This possibly increases the vulnerability of children living in child headed households, unprotected from unscrupulous adults who could claim the money for themselves. It also does not recognise the difficult and valuable role that older siblings play in a household where no adults are present, as outlined earlier. This chapter later considers the barriers to accessing the Child Support Grant, one of which is the lack of availability of a carer for those living outside the care of adults. As mentioned in chapter 3, recent research has shown that child headed households get support from community support structures that care for children in need, thus, the children's need for *care* is not as acute as their need for *income* (Giese et al, 2003). Nevertheless, the barriers that are found to be prohibitive for adults in accessing the Child Support Grant are equally, if not more so, prohibitive for those living in child headed households.

Discrimination based on lack of provincial administrative capacity

Inequality in the provinces' capacity to roll-out the Child Support Grant has shown that some provinces are less able to care for poor children. Most often it is the poorest provinces that lack this capacity. In the Eastern Cape, where in 2003, 75% of children were poor and in need of social assistance, only 30% of children were registered to receive the Child Support Grant (Leatt, 2003). As mentioned earlier, the Treasury recognises the differences in provincial poverty levels, and in accounting for more poor children in certain provinces, has allocated more money for these provinces to provide the Child Support Grant to larger numbers of children. However, roll out of the Child Support Grant remains poor in these same poor provinces. Therefore children living in a poor, under-capacitated province would be better cared for if they lived in another area, and are discriminated against because of geographical location and a province's incapacity to administer grants effectively. The government intends to establish a national Social Security Agency in 2005, which will take over responsibility for administration of the grant, and potentially eradicate some of the provincial administrative inequalities that currently exist.

Further difficulties with the Child Support Grant, particularly regarding barriers to accessing the grant, are discussed later in this chapter. The Child Support Grant therefore does respect, protect, promote and fulfill the rights of many children in South Africa; however there are gaps in policy and implementation that need to be addressed before it can be considered a policy that fulfills these rights for *all* children.

c. To what extent does the policy address common concerns to public health and human rights?

The Child Support Grant addresses the human rights of children as enshrined in the Constitution, viz. the right to social assistance (section 27); and the impact this has on related rights to basic nutrition, shelter, basic health care services and social services (section 28). The Child Support Grant also addresses concerns of public health that relate

to child poverty and child health, as discussed earlier. Thus, it is a policy that targets both the rights and the health of children.

As discussed earlier however, the Child Support Grant does not recognise the need of children aged 14 – 18 years, and those without identifiable carers (such as those living on the streets or in child-headed households) are totally excluded, and therefore the Child Support Grant misses some of the most vulnerable in its target group, i.e. poor children. In addition, the barriers to access, mentioned above and below, even for those within the targeted age group, substantially undermine the value of the Child Support Grant since many children in need are not receiving any government support.

The policy can be considered unfair and under-inclusive in four ways, which have been mentioned. Firstly, it totally excludes street-children or those living in child-headed households because of lack of a care-giver who could apply for and collect the grant. Secondly in terms of the staged roll-out, it leaves targeted children (up to the age of 14) marginalized because of an administrative incapacity to roll-out more rapidly. Thirdly, the policy excludes older children by only including children up to the age of 14. This chapter has referred to children between the age of 14 and 18 who are not provided for in any form of social assistance. Arguably, this is a time when children are pressed into adult behaviour and employment because of poverty and dire socio-economic conditions in the home, and thus social assistance would go some way towards keeping children from such forms of exploitation. Fourthly, because the grant is provincially administered, children in different provinces have differing likelihood of accessing the grant, due to variances in provincial capacity to administer the grant.

The basis for age-based targeting is administrative, rather than based on epidemiological evidence, which seems a poor and at times arbitrary mechanism for discrimination. Extending the Child Support Grant to all children up to the age of 18 years old, and an abolition of the means test would remove problems of inequity and would substantially lessen the discrimination which ends up alleviating the poverty of only some children (Meintjies et al, 2003).

d. How do we achieve a balance between protecting public health and promoting human rights?

There is no inherent conflict between balancing public health and human rights, with regards to the Child Support Grant. The policy generally affords synergy between human rights and public health, although the limitations in terms of age proscription serves to undermine its full human rights and public health capacity. Perhaps given the constraints facing those dealing with public health and human rights, it could be argued that the progressive realisation of socio-economic rights is ultimately intended for children aged 14 – 18 years, although this is not yet indicated anywhere in policy. In considering this, we turn to Budlender (in Creamer, 2002), who assesses current jurisprudence on the interpretation of progressive realisation of socio-economic rights. This is based on what is considered judicially “reasonable”, as per section 27 (2) of the Constitution, which reads: “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights”. Budlender summarises as follows:

1. the programme must be reasonable both in conception and implementation
2. the programme must be balanced and flexible
3. the programme must make appropriate provision for crises, and short, medium and long-term needs
4. the programme may not exclude a significant segment of society
5. the programme must not leave out the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent must not be ignored.

On two specific counts of the above test of the Child Support Grant, there are issues which could be contested on behalf of children aged 14 – 18 years, namely (4) the programme may not exclude a significant segment of society; and (5) those whose needs are the most urgent must not be ignored. Were a reasonable programme of progressive

socio-economic rights realisation in place for children aged 14 – 18, this would not be an issue. However, government is taking no immediate action to provide social security to this grouping, and no plans are publicly available to incorporate children in this age group.

Were the Child Support Grant to be revised to address some of the policy and implementation barriers, there could be further synergy between protecting public health and promoting socio-economic rights for all children. These sorts of modifications include the extension of the grant to all children (as defined by the Constitution, as 18 years old), abolition or adjustment of the means test; reducing barriers to access the grants; ensuring that the grants follow the child, rather than the caregiver; and aggressive policies to increase take up by the very poor in under-serviced provinces.

The most glaring public health and human rights violation of the Child Support Grant is its failure to recognise children between the ages of 14 and 18.

e. Given the above, does the proposed policy or program, as revised, still appear the optimal approach to the problem?

Because of the high levels of child poverty in South Africa that were discussed earlier, there is still a strong argument for continued social grants, and particularly targeted poverty alleviation for children. In line with the South African Constitution, the needs of children should be prioritized by government and therefore the targeted social grant system for children is appropriate, and recognises children as living in conditions of greater household and community poverty, which in turn impacts on their vulnerability to HIV/AIDS. With some revisions to the policy, as mentioned above, an extended Child Support Grant remains an optimal approach to securing the right to social assistance and the right of access to healthcare for children, and thus in contributing to realisation of children's socio-economic rights.

Barriers to Accessing the Child Support Grant

In addition to some the policy difficulties mentioned above, there are difficulties with implementation that provide barriers for people trying to access the Child Support Grant and ultimately affect the public health and human rights value of this policy instrument. Ultimately, these constitute a violation of children's socio-economic rights. This section will draw on reflection from experiences of people who have tried to access the Child Support Grant. The stories used here were collected by the Children's Institute over a one year period, from April 2003 to March 2004 (from hereon called the Children's Institute research). The Children's Institute is housed in the Faculty of Health Sciences at the University of Cape Town, and its mission is to "contribute to policies which promote equity and well-being and fulfill the rights of all children in South Africa, by combining academic excellence and social responsibility"¹⁶. Prior analysis of these stories has been in the form of a submission to a Parliamentary Committee about the barriers encountered, and case alerts emailed to civil society and government stakeholders. The process of story collection began as a response to the government's policy announcement of an extension of the Child Support Grant, which was to be rolled out in a phased approach, as explained earlier in this chapter. A telephonic 'hotline' was established to monitor what was happening "on the ground" (Rosa et al, 2004), and to assist people to access the Child Support Grant through direct assistance and a referral system. The hotline was advertised through a variety of media, including radio interviews by Children's Institute and Access (Alliance for Children's Entitlement to Social Security) staff in different provinces. Callers were either referred to local paralegal offices or were assisted directly by the Children's Institute, through telephonic and written follow ups to departmental officials.

The Children's Institute recorded thirty-three cases (households) that were used in this research, involving more than sixty children. There was representation from every province, although the distribution across provinces was not even. Case representation was as follows: Western Cape (6); Eastern Cape (7); Gauteng (1) ; Mpumalanga (10);

¹⁶ For further details on the Children's Institute, see <http://web.uct.ac.za/depts/ci/>

Northern Cape (1) ; North West Province (1) ; Kwazulu-Natal (3) ; Orange Free State (1); Limpopo (3). Participants names have been changed, and pseudonyms used in their place, to protect the identity of those who had used the hotline. Their provinces or town names were not changed.

Interacting with Social Development

Interaction with the local offices of the Department of Social Development often proved to be difficult. The power of a departmental official is possibly underestimated. They are the first point of contact for people who live in abject poverty and are desperately in need of assistance from the government. They are powerful gatekeepers with access to phenomenal resources, dealing with people who are very poor and destitute. While social assistance is the right of those in need, and who qualify according to specific criteria, the “clients” in this situation cannot afford to alienate frontline social development officers, who effectively hold the ticket to their livelihood. Therefore, their confidence to assert their right to social assistance can be undermined. This is particularly complex in situations where eligibility and criteria for grant applications is unclear to both officials and the public, such as with the Child Support Grant.

While social development officers are powerful gatekeepers, they also work in less than ideal conditions, having to deal with many applications a day. In an area near to Nelspruit, where one participant was an applicant for the Child Support Grant, it was estimated that over 300 parents and caregivers queue every day to register for the child support grant at the only social development offices in the area of a population of over 2 million (Case Alert, 2003).

For several of the cases involved in the Children's Institute research, they were prompted to go back to social development offices only with the help of the Children's Institute or a local advice office. Without this persistence on the part of child rights activists, who can campaign for better service without the risk of their livelihoods being challenged, it is questionable whether many of these applicants would have returned and ultimately

received the Child Support Grant to which they were entitled. Intervention or assistance on behalf of applicants who are struggling to get their claims processed still appears to be a necessary measure in following up with the Department of Social Development. However, it is not possible to expect this kind of intervention in a routine application, and until the system caters more adequately for the needs of struggling clients, many people will not be able to access social assistance.

In all of the cases that were followed up by the Children's Institute, both national and provincial officials quoted the policy as written – that all children up to the age of 9 should be registered after April 2003; that was the national policy and anyone not implementing this, was going against national policy. Questions were asked about a communication strategy to inform departmental officials around the country about the new policy to extend the Child Support Grant to older children (ultimately up to the age of 14) in a phased roll-out over three years. The Children's Institute was told at the time, that the Department was working with the Government Communication and Information Service (GCIS) on a comprehensive communication plan, but no further details were given. From the stories collected in the Children's Institute research however, it appeared that confusion prevailed about age eligibility and criteria for the Child Support Grant, as well as other social grants.

Costs of Accessing Social Development Offices

District welfare offices are disparately scattered across provinces. See appendix three for an example of the small number and widely scattered location of district offices available to citizens in the Western Cape – just fifteen offices service the entire province, eight of which are within the suburbs of greater Cape Town (Athlone, Bellville, Cape Town Centre, Eerste Rivier, Guguletu, Khayelitsha, Mitchell's Plain, Wynberg). The financial and time costs of traveling to far-flung home affairs and social development offices for applications and documentation (such as ID documents, birth certificates) is often prohibitively high for applicants of the Child Support Grant (Leatt, 2003), thus discriminating against the poor – the very people that are supposed to be assisted by this

grant. Some respondents in the Children's Institute research indicated that it cost them R20 each way, to get to the local advice office. For some households in the Children's Institute research, whose household income was R160 or less per month, it is simply unaffordable to go to the Social Development offices once, let alone repeatedly. The opportunity cost of travelling to the social development offices time and time again, would be paying for food or other basic necessities. A greater number of more accessible offices, and a streamlined application process would make possible many more successful applications for the Child Support Grant and therefore far fewer children living in such dire poverty. Mobile offices which go to rural areas frequently and reliably would also be a useful form of outreach.

Documentation

Child Support Grant applicants must provide documentary proof that they are the primary caregiver of the child; that they are South African residents; and proof of income to show that they earn less than the minimum required i.e. less than R9600 (urban area) or R13,200 (rural area). Accessing these documents is time-consuming and not easy, due to administrative inefficiency on the part of the home affairs department, and because proof of income (such as bank statements) is difficult to obtain for many in informal employment (Leatt, 2003). Many people who participated in the Children's Institute research struggled with the documentation needed to apply for grants, including the Child Support Grant. Appendices 1 and 2 show the departmental *policy* documents setting out requirements, which appear reasonable. However, an assessment of the actual forms, documentation and process required indicate what a substantial barrier they can be, to many poor people in South Africa. Examples of participants who struggled with documentation issues follow.

Susanna* has twin sons who are eligible for the Child Support Grant. After spending money on travelling costs and being sent back and forth with requests for different documentation, she lost hope. Susanna's mother called the Children's Institute hotline

* Participant's names have been changed

and asked them to help. The Children’s Institute phoned the Departmental office to clarify their requests. They advised Susanna to get the required letter, viz. proof of where she worked before she was unemployed, and try again, but she was discouraged. After the Children’s Institute phoned again several days later to encourage her to try again, Susanna took in an affidavit of her casual work and previous employment, but was sent away and told to get the letter stamped at the police station. Susanna was also incorrectly told that she had to take the father of the children to court for child maintenance, before she could apply for the Child Support Grant. These visits to the social development office left her discouraged and she found few good reasons to return for the Child Support Grant, for which her two children were eligible and which would have improved her household’s income considerably. At the conclusion of the research, Susanna was not receiving the grant. Attached in Appendix 4 is an example of the forms and documentation that Susanna provided in order to be considered for a Child Support Grant. These include the following:

- 1) “Road to Health Chart” which she would have been given at the child’s birth;
- 2) Birth certificate from the Department of Home Affairs;
- 3) Affidavit of unemployment and lack of income, signed by the police station commander in Elsie’s River;
- 4) Form indicating proof of accommodation and support from the owner of the premises;
- 5) Letter from her previous employer to indicate that she is no longer employed;
- 6) School report for the child; and
- 7) Screening form for the Child Support Grant application.

A replica of the Screening form (no. 7) is produced here, to show that the main body of the form has multiple (and potentially confusing) requirements for the applicant.

Personal Details

13 digit bar coded ID document of yourself/spouse/children/foster children
 marriage or customary marriage certificate
 divorce and settlement order
 death certificate/last will and testament/original liquidation and distribution account
 letter from Master of High Court confirming that no estate has been registered

Income

Employment certificate of earnings by yourself/spouse. Employment discharge certificate/unemployment card
 Affidavit re self employment
 Lease agreement in terms of fixed property owned by you and rented out (inclusive of timeshare)
 Income derived from other pension fund/annuities
 Letter from Maintenance Court regarding maintenance (if maintenance is received)

Military discharge certificate

Medical certificate (DG)

Medical certificate (CD)

Court order/Transfer order/Extension order in respect of foster children

School attendance certificate

Implied/Express consent form if not the legal parent of child

Registration of birth

Written confirmation of persons supporting you financially or otherwise

Proof of occupancy/rent paper/confirmation as a boarder

Documentary proof of prison sentence from NICRO/SA

Prison Services

Documentary proof of interest derived from investments/shares

Income from trust fund/policies

Letter from employer if you only receive accommodation as remuneration

Other

Application for procurator/administration

Life certificate

ID document of the person appointed to collect your grant

Application form for bank payment

Application for Grant-in-Aid

Affidavit re circumstances of legal parents of child

Affidavit re:

Affidavit re: ...

Other:

Other:

Other:

Assets

Municipal rates paper

Market value of fixed property you own and reside at/other fixed property owned by you inclusive of timeshare

Documentary proof of outstanding bond on property/properties

Deed of sale and reconciliation statement w.r.t. fixed property/timeshare sold in the past 5 years. Proof of how the profit was utilized

Documentary proof of any assets donated in the past 5 years

Documentary proof of capital amount of investments/shares market value/bank accounts (Bank statements for the last 3 months l.r.o. each bank account)

While it is conceded that the Child Support Grant is currently a means tested grant and therefore requires some proof of eligibility, and protection from corruption or abuse, it also needs to be recognised that many people find the required documentation, as indicated above, an overwhelming barrier to accessing the social assistance they so desperately need. The documents cannot be considered user-friendly and are only useful to those who can read, write and have some understanding of technical (and English or Afrikaans) language. Also, given the conditions of poverty in which most of the applicants for the Child Support Grant live, several options available on the form are unlikely to be applicable. For instance, participants in the Children's Institute research used here, were all living below the poverty level as determined by the HSRC table discussed earlier in this chapter. Many live from hand to mouth and get by only with the assistance of family or neighbours who share food or money with them. They often go hungry and cold. Their need for money is acute. Mothers indicate that they struggle with feeding and clothing their children, paying school fees and paying the household bills. In a context where poverty is widespread and ubiquitous, as in many areas in South Africa,

it is unrealistic to expect people to own property (or timeshare), for their own use or to let out, or to benefit from trust funds, as is intimated in the above form. A revision of this document to reflect the reality of people living in poverty and trying to access the grant, could make the application process easier and more streamlined.

Another applicant struggling with documentation was Portia*, who was sent back and forth for 2 months, in her application for a Child Support Grant for her three year old child. Her ten year old child would not have been eligible for the grant. She was asked to submit documents which she did not have, particular a document showing how much the people in the house contribute towards rent (indicating income), but she didn't have this proof as she wasn't the owner of the house. Portia did not have access to the Child Support Grant at the conclusion of this research.

Margeret's* youngest daughter, Lerato is 8 years old, and qualifies for the Child Support Grant. However, she was turned away because she did not have a title deed, which she won't have because she does not own property. Margeret was told that she cannot apply for the Child Support Grant without the title deed. A follow up call was made by the Children's Institute, to inquire what documents were needed. The social development official in Pretoria said that she needs water and electricity bills to prove where she lives, however she won't be able provide these documents because she lives with her sister, after being thrown out by her husband (to whom she is married in community of property). A local advice office suggested that Margeret ask her sister to sign an affidavit saying that they lived with her. At the conclusion of this research, Margaret's sister had yet to sign such an affidavit, and Lerato was not receiving the Child Support Grant.

Miriam* is unemployed and lives with her own three children and her five grandchildren. Under normal circumstances, Miriam should qualify for an old age pension, but documentation is a problem for her. The date of birth written on her dompas (old identity book) is not the same as that on her new identity document. The dompas says she was born in 1943, but the new identity document says 1949. She has for the past 3 years been trying to explain this discrepancy to the social worker, and also been trying to apply for

the Child Support Grant. She says the social worker told her to find the children's father to pay maintenance, and she says she cannot process her application for a foster care grant until there is proof that both parents have died. Miriam has never met the children's father and therefore proving his death or pursuing him to pay maintenance has been a problem. Miriam and the eight children she cares for have no assistance from government, largely because the required documentation is absent or incorrect.

Administrative Inefficiency

The current approach to phasing in children of different ages leaves departmental officials confused as to who does and does not qualify for the grant in terms of age, adding to administrative inefficiency. In addition, officials are accused of being disrespectful of citizens, and of abusing their power. In general, "the administrative infrastructure for the existing grant system is cumbersome, under-resourced both in financial and human capital terms, and not geared towards dealing with developmental realities or needs in rural areas ... The Departments of Social Development and Home Affairs have installed some promising outreach programmes. However, these are not meeting the enormous demand" (De Swardt, in Leatt, 2003).

In four cases involved in the Children's Institute research, where parents/carers tried to apply for a Child Support Grant for their children, departmental officials told them that they should first procure child maintenance from the children's fathers before being allowed to apply for the grant. When looking at the Screening form for the Child Support Grant it could be understood how officials construe maintenance as a requirement, since it is one of the possible options on the form. However, it is obviously not clear to officials that this is not a *mandatory* requirement. This may also be an outdated legacy from the State Maintenance Grant, where mothers did first have to apply for paternal maintenance, before applying for the grant (Lund, 1996). The Children's Institute followed up one such case in the Western Cape, phoning the manager of the Social Development office concerned, who confirmed that it was "regulatory requirement for single mothers to take the father to court for child maintenance before she could apply for

the Child Support Grant.” The Children’s Institute then followed this up with a letter to the Minister of Social Development to highlight the confusion that creates a barrier to accessing the grant.

Some participants in the Children's Institute research discovered, after waiting for the required three months for a response from the Department, that their documentation had been lost and they had to re-apply. Others found themselves sent from pillar to post to verify their records or find payments. Pumla* was told by the Bisho Post Office that her money was issued by the Indwe Post Office; however the Indwe Post Office said that they had no records of her money.

In another instance, Desree* is a mother of four children, aged 2, 5, 7 and 9. She only receives a grant only for 5 year old Chantelle. She applied for grants for her 2 and 7 year olds . After a three month waiting period she went to the welfare offices only to find that the application forms were still in the office and nothing had been done to process her application. Her 9 year old daughter is mentally impaired. When she tried to apply for a care dependency grant for her, she was told, incorrectly, that her daughter does not qualify because she is too old.

Other individual cases showed confusion or ignorance amongst departmental officials about the criteria for qualification for grants. Selinah* is a mentally impaired mother, whose only source of income is the disability grant. When she went to the social development offices in March 2003, to inquire if her 3 year old son would qualify for the Child Support Grant, she was told, incorrectly, that he did not qualify for the Child Support Grant because she was already receiving the Disability grant.

These instances show misinformation and lack of knowledge on the part of departmental officials regarding what are the criteria for people’s eligibility for a variety of grants, including the Child Support Grant. It is the responsibility of the Department to ensure that all their officials are well informed about criteria and eligibility, to remove this unnecessary barrier to people’s access to social assistance.

Age criteria of Child Support Grant

Age itself, and the confusion surrounding age criteria were formidable barriers for almost all of the cases in this research, all of whom were desperate for social assistance. While the Department of Social Development has been campaigning to increase the take-up rate of children who receive the Child Support Grant, it is apparent from the Children's Institute research that there was confusion about the age criteria for the grant, both among departmental officials and the public alike. Some people were incorrectly turned away from social development offices because their children were “too old” to qualify for the grant. Some were told to come back the following year. People found these mixed messages from government very confusing.

In almost a third of the cases, children were indeed too old to qualify for the grant in terms of its reach at the time – to children aged 9 years old. In one of these, the child was just 20 days too old to qualify for the grant. “I don't understand why I have to wait until next year just because of twenty days”, says Violet*. “The government said all children must register for this grant. Now they are saying I must come next year ... at school they want textbooks, calculators and I have to make sure that they eat every day with what I can get. It's difficult. I don't understand this,” added Violet.

Patricia* from KaDantjie, queued for a week before she was finally told that her 9 year old son Joseph would only qualify for the child support grant the following year.” These people gave me a number and let me queue for a week,” she says. “Then they tell me that I must come next year. I've been waking up at 4am for the whole week. Most of these people are turned away because we don't know what's the right age ... all the papers that they give us are written in English and we can't read. We don't know if they [the social workers] are telling the truth or not because some people are saying it's all children under 14,” says Patricia.

Nomsa* has been to the social services offices more times than she can count. She uses what ever she gets from doing domestic chores in the area to pay for transport to the city, only to be told that her daughter does not qualify for the child support grant. Every time

she is told that her 8-year-eight-month old daughter, Sara will only qualify for the child support grant next year. “I have explained to the officials that on the radio they said she (Sara) qualifies for the grant, but they insist that she will only qualify next year” she says. According to Nomsa many parents and caregivers of children in the area, who qualified for the grant, were turned away everyday.

Nthando's* son, Jabulane, was turning 8 years old when he applied. But Nthando has been told by officials that her son will only qualify for the child support grant next year because “it is only children who are under 8 years who qualify for the grant this year.” Nthando says “I don't know what to do ... on the radio they say we must go and register our children but the social workers are saying we must come next year.” According to Nthando there's a big sign in the offices which says “Only children under 8”. “When you go there they just say didn't you see the sign on the door? We just have to leave. The social workers don't have time to explain why you should come next year. If you keep on asking the people will shout at you and say you are wasting their time.”

Siviwe tells of his mother's dilemma: “My mother tried to register Siphoh for the children's grant early this year. But she was told he (Siphoh) does not qualify,” said Siviwe. Siphoh, 8 years old, did qualify for the child support grant but his mother was turned away several times by officials saying he will only qualify the following year.

Nontobeko* tried to apply for the Child Support Grant, but officials at Indwe Social Services said that “the R500 she earns a month is enough” and that she would only qualify for the grant the following year. Even though Asanda did qualify at the time when the application was made, she was turned away by departmental officials.

Some carers were ill-advised that their children did not qualify in terms of age, and therefore missed out on valuable income that could have made a substantial difference to their lives. Ashraf* was another one of these carers. He wanted to apply for the Child Support Grant for his child in November, but was told by departmental officials that she did not qualify because she was three months away from her ninth birthday. However,

this meant that she was eligible for three months of the Child Support Grant. By the time Ashraf reported this case, his daughter was already nine years old, making it difficult to negotiate back pay, as an application was never allowed to be made.

Children who have fallen off the grant and struggle to re-register

With children becoming ineligible because of age, and then a year later having to re-register, as the grant is slowly rolled out to older children, many children miss out on social assistance that is their right. It was estimated that over a period of 6 months, nearly R4.7million of government funds were wasted in the process of removing children who only have to be re-registered later (Leatt, 2003). It is not only government's time and money that is wasted in these re-registration processes, but also the applicants and their carers (see *Costs of Accessing Social Development Offices* above). This is also in direct contradiction to the purpose of a phased roll-out, which the department cited would "ensure equitable extension" (DSD, 2003). Children who turned 7 years old prior to the extension of the Child Support Grant in April 2003, had to be re-registered on the Department's system, in order to again receive the grant. Several people who participated in the Children's Institute research had fallen off the grant in this manner, and been unable to re-apply.

Thembeka* is unemployed and relies friends and family members to provide for Simphiwe, her eight year old son, who used to get the CSG . When he reached seven years old, two years prior to this research, he was no longer eligible for the grant. Thembeka went to register him at the social development offices, after hearing on radio that all children under nine years should register for the grant. She was told that Simphiwe did not qualify because he turned nine years old on the payday for the first monthly installment of the child support grant. However, the regulations specify that the grant lapses on the *last* day of the month when a child turns nine. Therefore, Simphiwe was eligible for one month of the Child Support Grant.

Joe* is a mentally impaired father of three. His youngest child fell off the grant when the child's mother died and he'd been unable to re-register the child, as he was turned away at the social development office.

Lindiwe* was receiving the Child Support Grant for Sibusiso until he turned 7 years old. In April 2003, she heard about the extension of the Child Support Grant and realised that Sibusiso, then 8 years old, would qualify. She called the hotline to confirm this. When Lindiwe went to the social development office, she was incorrectly told that a child born in 1994 does not qualify for the Child Support Grant, that they were busy registering children born in 1995, and would only register children born in 1994, in 2004. On her second visit, she was told that children born between January and August 1994 qualified, but those born from September 1994 did not qualify. She then appealed to the Children's Institute, who inquired about the application and were referred to the operations centre in Mmabatho, where the manager confirmed that the reason why Lindiwe's application was unsuccessful was that only children below 8 years old qualified for the Child Support Grant in 2003. The Children's Institute reminded him that Lindiwe's child had been 8 years old when he had first applied and he agreed to pay the monies owing to her.

Children once registered, should not be removed from the Department's records until they reach adulthood. This would alleviate the problems encountered by people trying to access the grant, and would save time and money for the Department, as well as for people trying to access their right to social assistance.

The Adequacy of the Means Test

Many poor children who do qualify on an age-basis, are disqualified from receiving the grant because they are "not poor enough". De Swardt (in Leatt, 2003) comments that "social grant allocations indeed often appear quite ineffective and even arbitrary in terms of various poverty criteria". The income levels qualifying people for the grant, which have not been adjusted for inflation since 1998, are too low to include many poor people who fall outside of the social security net and are desperate for assistance. In addition,

where more children live in a household (and thereby adding to the income through access to a grant), subsequent children may not be provided for because the household is considered “not poor enough”.

Lapsed grants because of death of caregivers

Children also become vulnerable because of the death or loss of caregivers who are responsible for collecting the grant. “After losing parents and caregivers, children have an even greater need for stability, care and protection” (UNAIDS, 2004). Despite the Lund Committee’s original recommendations, the Child Support Grant currently does not ‘follow the child’ and therefore when the caregiver dies, a re-application process must take place for a different person to care for the child. In the interim, the child is without social assistance. This is currently the most prevalent cause of grants lapsing, other than children who become too old to qualify for the grant any longer. In a study in 2003, nearly 16,000 caregivers died in six months, who were responsible for collecting a Child Support Grant (Leatt, 2003), leaving all of these children vulnerable until another caregiver was able to make application for a Child Support Grant again.

The vast numbers of children who should, but are not able to, access the Child Support Grant speak for themselves. Coetzee & Streak (2004) state that “it would appear that the Child Support Grant is still exclusionary in its implementation and has not yet reached all of the most vulnerable.” In 2003, between 28-39% of poor children under the age of nine (i.e. nearly a third of those who were eligible) were not accessing the Child Support Grant (Leatt, 2003). A study in the Eastern Cape showed that the take up rate for social security grants targeting children was very low. In that study, a potentially eligible 50 out of 54 children were not receiving the grant (Sogaula et al, 2003). Clearly this shows that the issues with implementation of the Child Support Grant lead to discrimination against children who cannot overcome the obstacles to access.

Addressing Barriers that Hinder Access to the Child Support Grant

A creative approach needs to be found in addressing the barriers mentioned above. The social capital inherent in communities and available to children needs to be mobilized to ensure fulfillment of their rights. Some basic concepts of public health were explored in the previous chapter, particularly in terms of the links between public health and human rights. Here, in the context of the kinds of barriers described above, a health promotion ‘settings approach’ will be briefly explored, that could be of benefit to communities struggling with HIV/AIDS and poverty in South Africa.

Antonovsky (in Kickbush, 1997) argues that it is important to ask “what creates health?” in order to create an environment that supports health. The Child Support Grant, in alleviating poverty for many children, is an important part of service delivery to children, and also contributes substantially to the health of children and communities. However, in its current form the grant lacks the capacity to reach all children in need. This is why a settings approach might be appropriate for revisiting the policy and implementation thereof. A ‘settings approach’¹⁷ refers to the context in which health promotion takes place, such as a school, city, clinic or village, but also refer to the process of socialization in which people learn (or re-learn) to make healthy choices (Tones & Tilford, 2001). A settings approach assumes that health is well-being and therefore includes a range of social challenges. It seeks to identify the obstacles to achieving health within a particular setting. By thinking in this way, small changes can be made that have large impacts. In a community dealing with HIV/AIDS, different partners need to be drawn in. Faith-based organisations can be useful at counselling and providing care for the ill. Government authorities can be lobbied to improve and co-ordinate service delivery in terms of electricity, water, transport, infrastructure and food subsidies.

¹⁷ The development of a ‘settings approach’ project will not be explored in depth here, as further description and detail can be found in Sanders (1998)

The school is an avenue for government delivery for children's education, providing ample opportunity for accessing the target population of children. Therefore the school could also serve as a site of delivery for other targeted child-interventions, such as delivery of the Child Support Grant. Targeting of this kind is popular among health promoters as it is seen to channel resources to the needy, in an equitable manner (Naidoo & Wills, 1998). It also allows for a multidimensional approach to addressing the impact of HIV/AIDS and poverty in communities where children are affected¹⁸.

Tones & Tilford (2001) suggest five questions that would help to interrogate the value of a particular settings approach, which we could apply to the use of schools for promoting health in communities.

Access: What kind of target group is accessible through this setting? How many people will be reached? How easy will it be to reach them?

The school is an ideal setting in which to reach children, and to extend a child-targeted poverty alleviation programme such as the Child Support Grant. Schools usually only provide for children aged 6 – 18 years old, and thus pre-schools would have to be targeted for children younger than this age. Many children will be accessed through schooling, and since their attendance is required daily, they are a captive audience. For children who do not attend school and may be considered the most vulnerable, the availability and distribution of the Child Support Grant through the school, may be a motivating factor for increased school attendance. Rural schools will be more difficult to reach than urban schools. Nevertheless, they are sites of delivery for a government service (i.e. education) and therefore a level of infrastructure and support already exists. In addition, communities already expect to receive a government service (i.e. education) at a school, and therefore can be persuaded to expect other government services (e.g. grant payments) here as well. This one-stop-shop approach could include other government services as well (e.g. payments of other grants such as the Old Age Pension; healthcare services such as a mobile clinic; among others).

¹⁸ Further discussion on addressing HIV/AIDS on a comprehensive, societal level can be found in Calderon (1997).

Philosophy and purpose: Has the institution with which the strategy is associated a particular philosophy or goal?

The philosophy and purpose behind an educational institution can be considered compatible with other forms of social service delivery, such as grant payment. There is no inherent conflict between the delivery of these two services, in philosophy or purpose.

Commitment: How committed are the institution and its members to the preventive philosophy underpinning the aims (of health education)?

Levels of commitment to poverty alleviation is something that will vary between educational institutions. However, it could be assumed that communities in which children are struggling with poverty and HIV/AIDS would be willing to work with initiatives that would uplift the community, including the use of their facilities to distribute social grants targeting poverty alleviation for children.

Credibility: How credible are the institution and the people in it who will act as health educators? How will the public respond to them?

Schools and teachers play a valuable and respected role in a community. Credibility may vary between different communities. However, it is likely that where school facilities are utilized for social grant payment, that a communities' perception of the school will be improved. Social development officers do not necessarily have to double up as teachers, as the skills required are different; therefore may elicit a different response from the community.

Competence: Do the potential health educators have the necessary knowledge, communication/training skills to promote efficient learning?

Teachers do not necessarily have to double up as social development officers. Partnerships are crucial to a settings approach (Kickbush, 1997), and would be necessary to ensure that appropriate skills are brought into the process of grant delivery. Faith-based organisations, non-governmental organisations, community based organisations, and other government agencies would be crucial to success of implementation.

According to the questions posed above, by Tones and Tilford (1997), a settings approach using schools as a site of delivery for the Child Support Grant could be an effective way to overcome some of the barriers in terms of reaching out to children in need. Several of the concerns mentioned in the previous section could be more easily dealt with, when using schools as a mechanism of delivery for the Child Support Grant. Schools are local institutions and therefore reduce the *cost of travel associated with reaching social development offices*, which have been shown to create a substantial barrier to accessing social assistance. This devolvement of responsibility to a local level may assist with *administrative inefficiency*, as grant administrators will be held to account by other community members. In addition, schools should be intimately acquainted with children's situations, thereby facilitating a quicker response when *children fall off the grant*, either because of the death of a caregiver or because children struggle to re-register because of a prior age restriction on the grant, as was seen in the previous section.

Children living at the poverty levels found in South Africa have an acute need for social assistance. It has been shown that where HIV/AIDS has deepened child and household poverty, the Child Support Grant has the potential to improve living conditions substantially. As a policy, it has been tested against a human rights and public health framework. It meets several requirements to be considered a 'good public health and human rights' policy, however concerns have been raised about barriers to accessing the grant, and recommendations will be made in the following chapter.

CONCLUSION AND RECOMMENDATIONS

South Africa is ten years into a new democracy, with an aspirational Constitutional framework that seeks to protect, promote, respect and fulfill human rights, including the rights of children. Substantial gains have been made in terms of recognising and realising the rights of children. However, many years of pre-1994 apartheid policies have left a social (dis)order that poses a major challenge for a young democratic government. The backlog of service delivery that remains post-1994 continues to plague the government's ability to reach the most vulnerable.

The South African Constitution, like the African Charter, has defined a "child" as someone under the age of 18 years old. The Constitution provides for a variety of socio-economic rights for children, such as the right to basic nutrition, shelter, basic health care services and social services, as well as social assistance, the right to education; as well as protection from exploitative or hazardous work. The development of such a progressive framework for children's rights in just ten years of democracy is impressive; however it has been acknowledged that much work still needs to be done to give content and meaning to these rights. While the Constitutional Court has proven its sympathy for the rights of poor, it has also recognised the difficulty faced by government in rolling out services to large numbers of those in need, over a short space of time.

HIV/AIDS and poverty are two of the main challenges faced in many South African communities. There is widespread agreement that child poverty in South Africa is alarmingly high - as many as 70% of children in South Africa are poor - and that children in families and communities that are affected by HIV/AIDS are experiencing deepened poverty as a result of the epidemic. The South African government's primary poverty alleviation mechanism targeted at children is the Child Support Grant. This thesis has set out to explore the use of the Child Support Grant in contributing to the realisation of children's socio-economic rights, according to a human rights and public health framework. Both public health and human rights disciplines are concerned with human well-being and are focused on changing the socio-economic context in which people live,

for the better. The realisation of socio-economic rights for a greater number of South African citizens, would lead to better public health, and less risk of HIV transmission.

The Child Support Grant has a substantial role to play in mitigating the impact of HIV/AIDS and poverty on children. Even in areas where other programmes or services are available, lack of income can be a significant hindrance to accessing other support or services from government, and therefore to the realisation of children's socio-economic rights. Heywood et al (2000) assert that "the most important connection between human rights and vulnerability to HIV is through poverty". Arguably, children living in extreme poverty are more susceptible to the impact of HIV/AIDS; and children affected by HIV/AIDS are more likely to be impoverished. Social assistance programmes are therefore considered vital in the realisation of children's rights to nutrition, education and health services. HIV/AIDS impacts differently on children at various ages and stages of development. It was concluded that HIV/AIDS posed a potential threat to children's rights to education, nutrition, protection, and access to healthcare at different stages of their lives.

In seeking to meet the needs of children living in poverty, the government has increased the budget of the Child Support Grant substantially in the last few years, to accommodate increased numbers of poor children, and this is welcomed. However, considering the bigger picture, and despite this being the government's largest poverty alleviation programme targeting children, the budget for the Child Support Grant is relatively small - just 2.92% of the government's total spending.

The Child Support Grant is at its core, a good public health policy; and has made significant inroads into alleviating poverty for many children in South Africa. The basic philosophy behind the Child Support Grant respects, promotes, protects and fulfills human rights, but there are several levels of discrimination within the policy that still need to be addressed. Notably, these include discrimination based on age, as the grant currently leaves approximately 7 million poor children between 14 – 18 years excluded from social assistance, which could be considered unconstitutional. Also, children

without carers, such as street-children or those living in child headed households, do not have access to the grant without an adult caregiver.

Particular barriers that have been found to hinder access to the Child Support Grant include: relationships with departmental officials; costs of accessing social development offices; the extensive documentation required to access the grant; misinformed or unhelpful social development staff; administrative inefficiency; children falling off the grant and requiring to be re-registered at extra cost; lapsed grants due to death of caregivers; the adequacy of the means test; and age criteria and eligibility for grants.

In conclusion, this research has shown that the Child Support Grant makes a significant contribution to the realisation of socio-economic rights of children who are affected by HIV/AIDS in South Africa. In particular, an extended Child Support Grant remains an optimal approach to securing the right to social security and the right of access to healthcare for children. There are policy and implementation challenges that, if adequately addressed, could improve delivery of the grant considerably, and therefore extend the reach of the grant to more children in need. The following are concise recommendations flowing from the conclusions of this thesis.

Recommendations

The Child Support Grant should be extended to all children, as defined by the SA Constitution, with the upper age limit of 18, thereby respecting, promoting, protecting and fulfilling the rights of *all* children in South Africa.

Given the pervasive poverty of children in South Africa, the means test that restricts children's access to the Child Support Grant should be removed (as argued by Meintjies et al (2003) and Sogaula et al (2002)). Thus, the grant should be a universal child grant, encouraging an equitable approach to alleviating child poverty.

A greater number of offices, and more accessible offices, and a simpler, streamlined application process should be pursued. Mobile offices visiting rural areas frequently would enhance delivery. Schools could be harnessed as application points.

The documentation required for a Child Support Grant application needs to be simplified and made more accessible for the illiterate. Application forms and processes that are more reflective of the reality of people living in poverty and trying to access the grant, would make the application process easier and more accessible. It would be useful for this process to be available in all South African languages.

Once children are registered, they should not be removed from the Department's records until they reach adulthood. This would alleviate the problems encountered by people trying to access the grant, and would save time and money for the Department, as well as for people trying to access their right to social assistance. It would also redeem the policy's oversight in terms of children who fall short of the current year's extension, but would become eligible again the following year.

Government officials should be well briefed about the criteria and age eligibility for grants, and about the implications for children who are close to the age limit. This requires a comprehensive communication plan to eradicate confusion among both departmental officials and the public.

A creative alternative needs to be found to ensure that the Child Support Grant "follows the child" rather than the caregiver, so that the grant does not lapse on death of the primary caregiver, and support of the child is able to be continued through a vulnerable time.

An increase in the Child Support Grant uptake should be actively encouraged to ensure that all children who are eligible for the Child Support Grant are indeed receiving it, especially in the poorest provinces.

More recognition needs to be given to children who are carers of children (living in child headed households). There is an urgent need to undertake further research to understand and support the coping strategies of children living in child headed households.

A one-stop shop approach should be developed for children in need, so that their basic rights to food, water, education, social security, health care services and social services can be seen to at one place, rather than several different points of delivery, which all require travel, queuing and dealing with different officials. Existing facilities should be used, such as schools, since they are already the site of education for children. Such a system could increase efficiency in the bureaucracy, and streamline delivery to children. Each child could have one file, that held all of their details, and was kept at a local office, to which the child and their carer could easily travel.

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List of Appendices

Appendix 1 - Fact Sheet: Social Grant Guidelines: Child Support Grant Extension
Source www.welfare.gov.za

Appendix 2 – Procedural Guidelines for the Child Support Grant, from the Social Assistance Guidelines 2003. Source www.welfare.gov.za

Appendix 3 – List of District Offices in the Western Cape. Source Cape Gateway, Provincial Government of the Western Cape

Appendix 4 – Forms for Child Support Grant application, and documentation required

Appendix 5 - London's (2002) "Framework for Analysing Policy: Integrating Public Health and Human Rights"

University of Cape Town



Department of Social Development

Press Briefing by Minister Zola Skweyiya

FACT SHEET : EXTENSION OF THE CHILD SUPPORT GRANT

Government has approved the extension of the means-tested child support grant beyond the age of six, to poor children up to their 14th birthday. It is estimated that in terms of the current means test, which would also apply to the extension, another 3,2 million children will over time qualify for this grant.

Currently (children 0-6) about 3,6 million children qualify for the child support grant, with nearly 2,5 million children having been registered for the benefit. This means that somewhat more than one million children aged 0 to 6 must still be registered.

While Government is most aware of the severe poverty and vulnerability afflicting large numbers of children, and therefore the urgency to roll out the extension of the grant as rapidly as possible, an orderly and phased roll-out is necessary:

- No administrative system can overnight accommodate an expansion by such large numbers. While it is Government's intention to roll out as fast as possible, the expansion will have to be progressive, in line with the Constitutional commitment to progressive realisation of socio-economic rights.
- Administrative capacity in the welfare system is limited and has been pushed to the extreme by the enrolment of 2,5 children over the past 5 years. In addition, weaknesses in the system of grant administration and payment have received widespread publicity in recent times. Government will therefore at the same time be implementing a grant delivery improvement programme as well as extending the child support grant. Expansion of grant access has to take cognisance of these administrative realities and challenges. If not, the promise of extension will remain for many an idle dream.
- Constitutional Court rulings have made it clear that Government needs to take into account the urgent needs of the most vulnerable. This implies a targeted, and in this instance, phased approach to the extension of access to Government services (grants) to ensure equitable extension.

For the reasons above, and because it is the only practical, sustainable and fair way of extending the grant, Government has decided to phase the extension of the child support grant over the next three years:

- From 1 April 2003, children aged 7 and 8 years will become eligible for the grant
- From 1 April 2004, children aged 9 and 10 years will be become eligible
- From 1 April 2005; children aged 11, 12 and 13 will become eligible. .

In the medium term expenditure framework Government makes provision for R1,1 billion in 2003/04, R3,4 billion in 2004/05 and R6,4 billion in 2005/06 to fund extension. In addition to the actual cost of the grant, funding is also made available for administrative expenditure related to registration and payment.

1. This funding will flow to provinces, which will implement the extension, in the form of a conditional grant. This will ensure transparent funding of this new national mandate on provinces.
2. An implementation team has been established to finalise legislative changes, administrative arrangements and support to provinces in the extension of the grant. Amended regulations will be published by 1 April 2003.
3. The growth in the numbers of grant beneficiaries to approximately 5,5 million by February 2003, including the addition of 2,5 million child support grant beneficiaries since 1998, bears testimony to the significant expansion of the social safety net over the last five years. It shows the significant success of Social Development Departments and their partners - faith-based organisations, non-governmental organizations, business, labour, and the Department of Home Affairs – in implementing an important Government policy. To successfully extend the child support grant will again require cooperation from all stakeholders. We call on all stakeholders and civil society to join us in making a reality of this promise of enhanced support to our children in order to build a prosperous future, free from poverty.

Should you require any more information from the Department feel free to call us at TOLL FREE NO 0800 601 011
End.

Visit the Department's web site at www.welfare.gov.za

For media enquiries: Mbulelo Musi 083-602-5795

Chapter 11

Child Support Grant

Overview

Introduction

Now that you know the Grant Administration Process, it can be applied to the child support grant.

The child support grant is one of the three child grants supported by the Department of Social Development. The grant is extended to children under the age of nine, who are under the care of a primary care-giver. This grant will be extended progressively over three years to cover children under the age of 14 ie.

2003/2004 below 9 years

2004/2005 below 11 years

2005/2006 below 14 years

Definition

A child support grant is a grant payable to a primary care-giver in respect of a child under the age of nine. A primary care-giver is any person who takes primary responsibility for the daily needs of the child and who may or may not be related to the child/ren.

In this chapter

This chapter contains the following topics:

Section A Qualifying Requirements Page 11 – 2	Section B Supporting Documents Page 11 - 5
Section C Waiting period Page 11 – 7	Section D End of grant Page 11 - 8

Section A

Qualifying Requirements

Overview

Introduction

When the applicant applies for a child support grant he or she has to qualify for the grant. There are certain requirements, which have to be met in order to qualify for the child support grant. These requirements are discussed in this section.

In this section

This section contains the following topics:

Who Qualifies?

Page 11 - 3

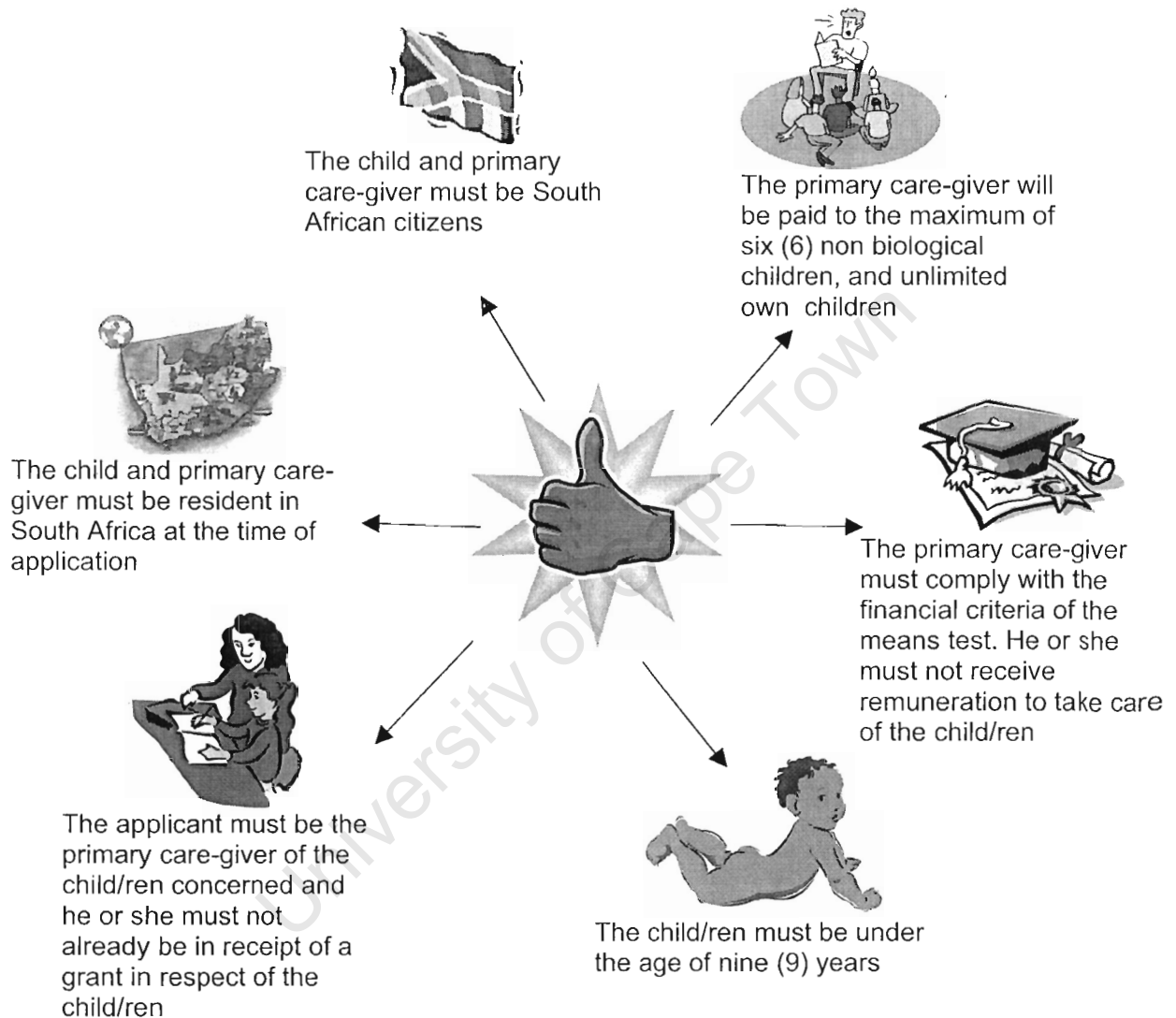
**Who does not
Qualify?**

Page 11 - 4

Who Qualifies?

Qualifying Requirements

When applying for a Child Support Grant the applicant must meet the following requirements:



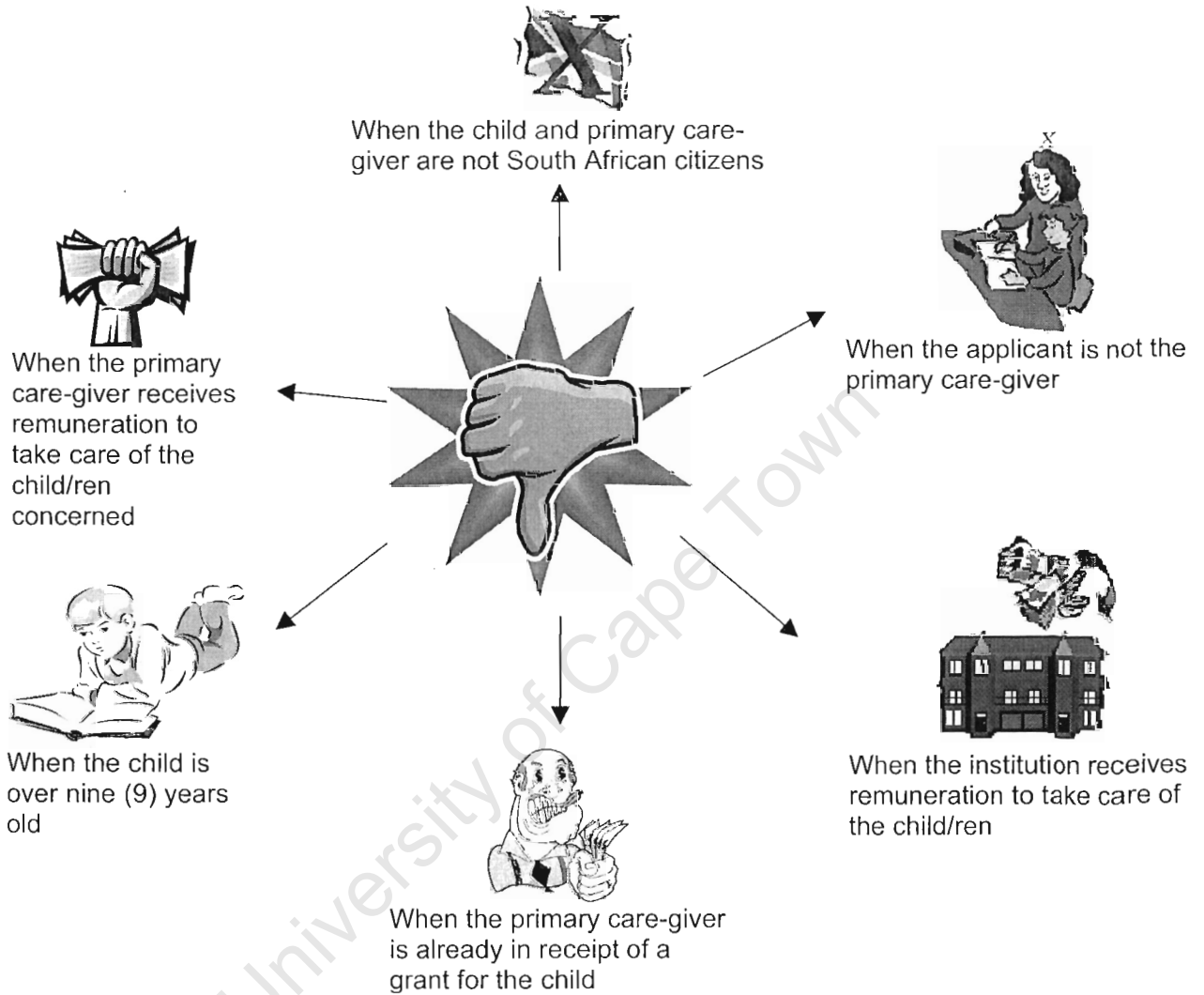
Means Test

The means test is a formula that is used to help ensure that the poorest people benefit from the money that is available to assist South African citizens

See Chapter 3, Section B ~ Verification for more information about the means test for the Child Support Grant.

Who does not Qualify?

The applicant will not qualify for the child support grant if the following applies:

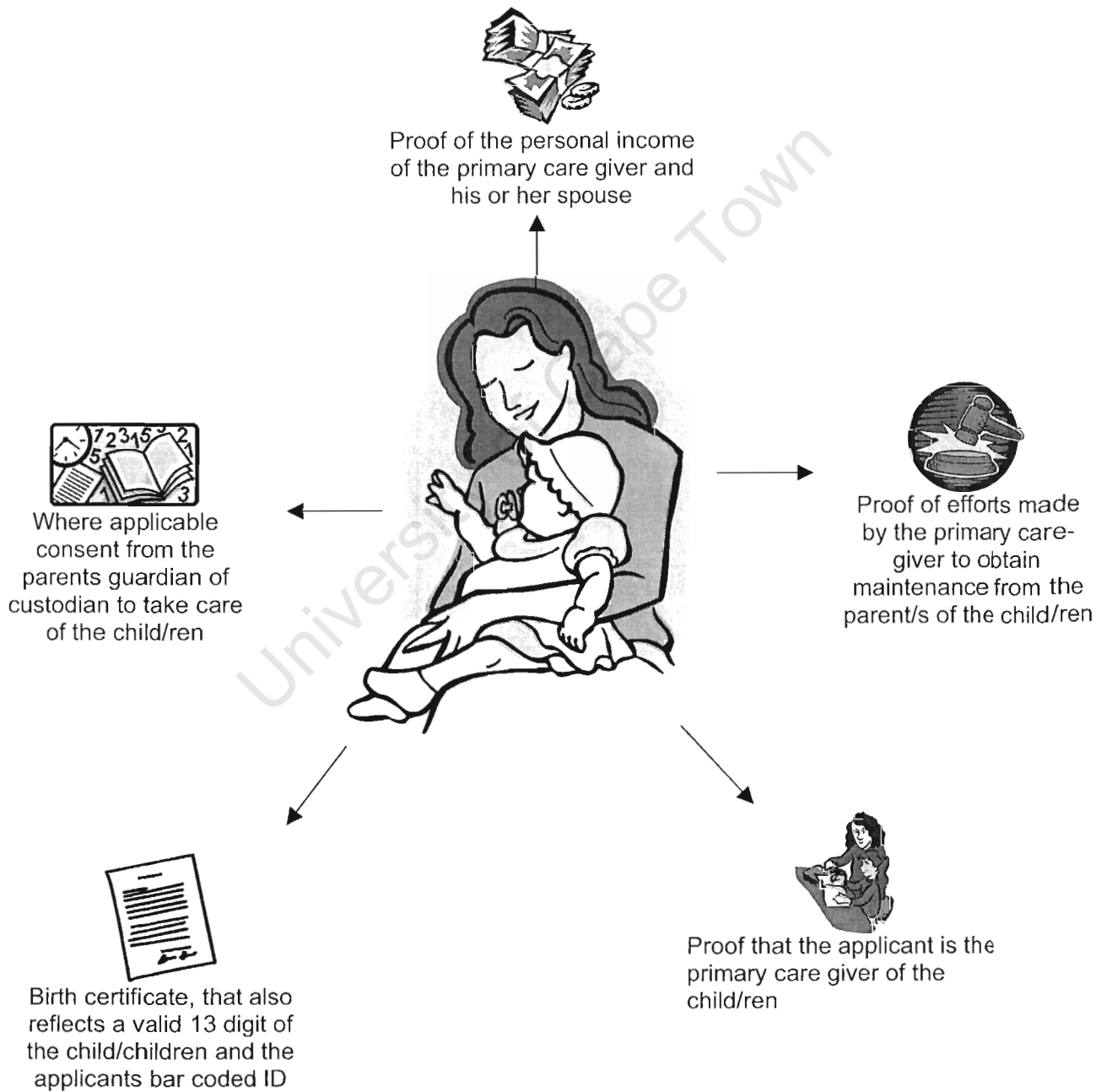


Section B

Supporting Documents

Introduction

In order for the primary care-giver or applicant to qualify for the child support grant, certified copies of the following documents must first be provided:

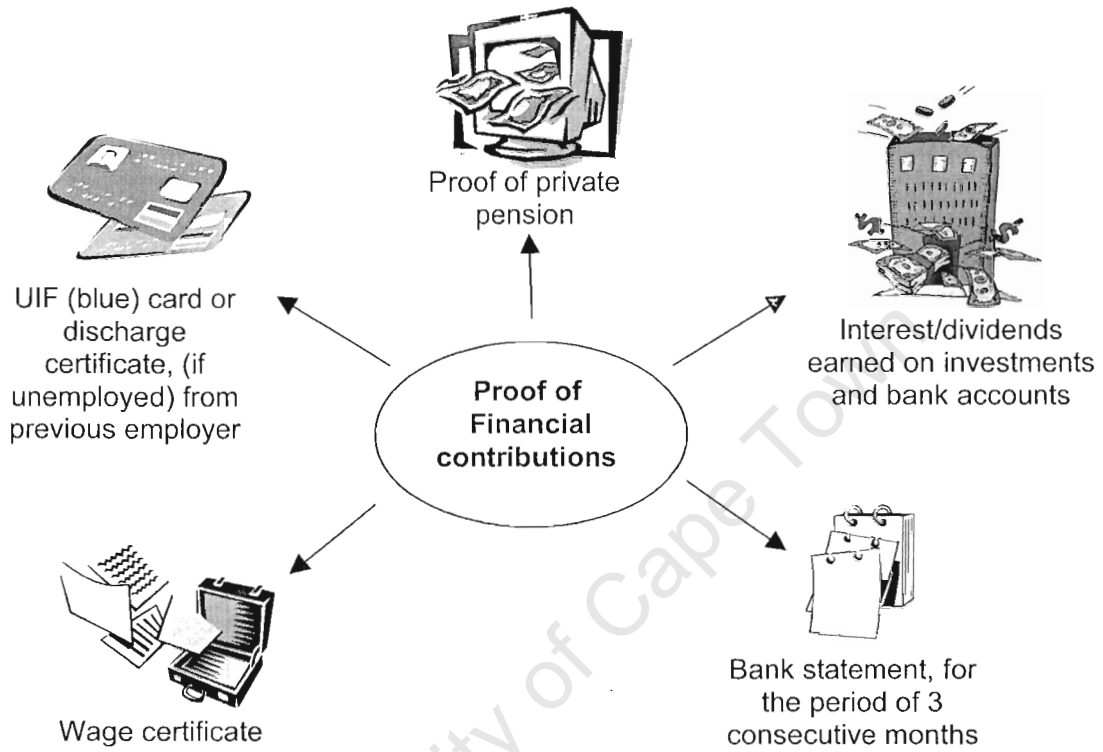


Continued on next page...

Supporting Documents, *Continued*

Proof of Financial Contributions

The applicant's and spouse's personal income



Section C

Waiting Period

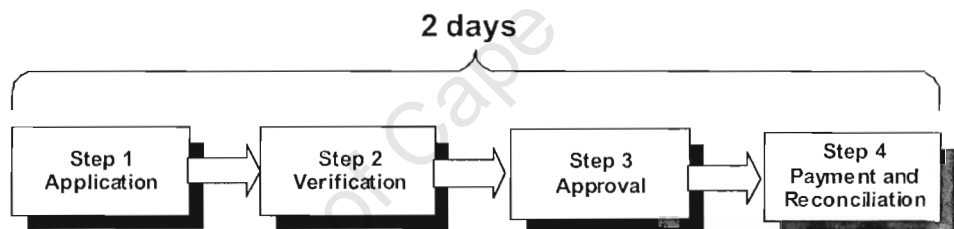
Introduction

Once the applicant has completed the child support grant application form, the grant is sent to the relevant authority for finalisation. The applicant will receive a letter informing him or her whether the grant has been approved or not. If the grant is approved the applicant will receive a monthly payment.

If the grant is refused the applicant must be informed of the reason in writing and his or her right to appeal.

Waiting Period

Due to best practices, the new norms and standards require that this process should not take longer than two days.



Section D

End of Grant

Introduction

The grant can be cancelled if one of the following occurs:



On the last day of the month in which the primary care-giver dies



On the last day of the month in which the child/ren is no longer in the custody of the primary caregiver



On the last day of the month in which the child attains nine (9)



On the last day of the month in which the child/ren dies

APPENDIX 3 - List of Welfare Offices in the Western Cape

FACILITY	LOCATION
Athlone District Welfare Office	Athlone, Cape Town
Atlantis District Welfare Office	Atlantis, Cape Town
Beaufort West District Welfare Office	Beaufort West, Central Karoo
Bellville District Welfare Office	Bellville, Cape Town
Caledon District Welfare Office	Caledon, Theewaterskloof
Cape Town District Office	Cape Town, Western Cape
Eersterivier District Welfare Office	Eerste River, Cape Town
George District Welfare Office	George, Eden
Gugulethu District Welfare Office	Gugulethu, Cape Town
Khayelitsha District Welfare Office	Khayelitsha, Cape Town
Mitchell's Plain District Welfare Office	Mitchell's Plain, Cape Town
Oudtshoorn District Welfare Office	Oudtshoorn, Eden
Paarl District Welfare Office	Paarl, Drakenstein
Vredendal District Welfare Office	Vredendal, Matzikama
Wynberg District Welfare Office	Wynberg, Cape Town

University of Cape Town

Road to Health Chart

Department of Health



IMPORTANT: always take this card with when you visit any health clinic, doctor or hospital, and present the card on school entry.

Child's name _____ boy girl

Date of birth 24 08 96 year of birth 170488509

Birth weight 1830 Birth length 43cm Birth head circumference 31cm

Problems during pregnancy / birth / neonatally
1/9/96 intaking mass GREEN

APGAR 1 min. 9 Gestational age (wks) 34 Weekly Weeks Serology -
5 min. 10

Mother's file Antenatal N.S.G.
numbers - Delivery Sh. Lacer No 83062588

IMMUNISATIONS	PRIMARY SCHEDULE		BOOSTERS	
	Age	Date given	Age	Date given
B.C.G.	1	<u>18.4.96</u>	2	
Polio	0	<u>18.4.96</u>	1	<u>18.2.2004</u>
	1	<u>10/52 3.10.96</u>	5	
	2	<u>10/52 31.10.96</u>	6	<u>25.11.96 A. Garding</u>
	3	<u>28.11.96</u>		
D.P.T. (Diphtheria, Whooping cough, Tetanus)	1	<u>10/52 3.10.96</u>	1	<u>18.2.2004</u>
	2	<u>10/52 31.10.96</u>	OT	
	3	<u>28.11.96</u>		
Hepatitis B	1	<u>10/52 31.10.96</u>		<u>A. Garding</u>
	2	<u>10/52 31.10.96</u>		<u>(R) A. Garding</u>
	3	<u>28.11.96</u>		
Measles	1	<u>17.12.2007</u>	2	<u>18.2.2004</u>
Other		<u>2000</u>		

Clinic 1 ADRIANSE Clinic 2 ERCU GV12/17
Address _____ Address 96 89 88
933.36.80

Mother's name _____
Father's name _____
Caretaker if not the _____
Where does the child live? 9

How many children has the mother had?
Number alive _____ Number dead _____

SPECIAL NEEDS (circle the correct answer)

Was the baby less than 2.5kg at birth	no	yes
Is this baby a twin	no	yes
Is this baby bottle fed	no	yes
Does the mother need more family support	no	yes
Are any brothers or sisters underweight	no	yes
Are there any other reasons for taking extra care for example - tuberculosis, single parent etc.	no	yes

Vision screening (4 1/2 - 6 yrs) date _____ Hearing screen (7 to 9 months) date _____
Manchester Rattle used

CARD GIVEN AND MOTHER TAUGHT BY _____

ORAL REHYDRATION DATES

Taught		
Used		

TUBERCULOSIS SCREENING

Heaf / Mantoux / Tine	Date	Grade

TB contact _____
TB notified _____



DEPARTMENT OF HOME AFFAIRS
 DEPARTEMENT VAN BINNELANDSE SAKE

BI-5

PARTICULARS FROM THE POPULATION REGISTER I.R.O.:
 BESONDERHEDE UIT DIE BEVOLKINGSREGISTER T.O.V.:

BIRTH/GEBOORTE

IDNO.:
 IDNR.:

SURNAME:
 VAN :

FIRST NAMES:
 VOORNAME :

DATE OF BIRTH:
 GEBOORTEDATUM: 1996-08-24

SEX :
 GESLAG: MANLIK

COUNTRY OF BIRTH:
 GEBOORTELAND : SUID-AFRIKA

DATE ISSUED :
 DATUM UITGEREIK: 1998-10-26

-2003 09:56

From-WIZARDZ-INC

0214620279

T-018 P.009/013 F-553

WERKLOOSHEID VERKLARING

DATUM: 03-04-13

NAME

ADDRESS

Elsiesrivier

nee verklaar ek, die bogenoemde persoon dat ek werkloos is en geen inkomste het nie.
werkloos. Ek het geen inkomste nie.
besit geen eiendom of beleggings nie.
besit geen erf porsie nie.
het geen bankrekening nie.

is vertrouwd met die inhoud van hierdie verklaring en begryp dit.
het geen beswaar teen die aflegging van die voorgeskrewe eed nie.
beskou die voorgeskrewe eed as bindend vir ny gewete.

VERKLAARDER

Ek sertifiseer dat bostaande verklaring deur my afgeneem is en dat die verklaarder erken dat hy/sy
vertrouwd is met die inhoud van hierdie verklaring en dit begryp. Hierdie verklaring is voor my
eëdig/bevestig en verklaarder se handtekening/merk/duimafdruk is in my teenwoordigheid daarop
aangebring.

te Elsiesrivier op 2003-04-13 om 15:40

KOMMISSARIS VAN EDE 201782135 Sers M L Swart

VOLLE NAAM EN VAN Marinus Lits Swart

SA P D Kiltlingweg, Elsiesrivier

RANG Sers



WERKLOOSHEID VERKLARING

NAAM & VAN ..

ID NR ..

ADRES ..

RIVER 7490

Ek verklaar onder eed in Afrikaans:

Ek is werkloos en verdien geen inkomste nie.

Ek besit geen eiendom of beleggings nie.

Ek het geen bankrekening nie.

Ek besit ook geen erfpoisie nie.

Ek is vertrouwd met die inhoud van hierdie verklaring en begryp dit.

Ek het geen beswaar teen die aflegging van die voorgeskrewe eed nie.

Ek beskou die voorgeskrewe eed as bindend op my gewete. x

701217-7

(HANDTEKENING)

(VOORLETTERS EN VAN)

2003-06-09 12.11.35
(DATUM EN TYD)

Elster River S.A.P.S
(PLEK)



-09-2003 09:55

From-WIZARDZ-INC

0214620279

T-018 P.007/013 F-553

BEVESTIGING VAN VERBLYF PROOF OF ACCOMODATION

Naam en Van:
Name and Surname:

ID no:
ID no: _____

Adres:
Adress: _____

Tel/Sel: _____

ST. _____

Hiermee bevestig ek dat ek verblyf/versorging aan Mr/Ms

EM. SWINDERS bied.

ZEE

I hereby declare that Mr/Ms _____
is staying by me and that I support him/her.

Handtekening
Signature

17/6/2003
Datum
Date

AAN WIE DIT VAN BELANG IS

Ek 1

ID

Verklaar hiermee dat ek vir
en kinders onderhou

En dat ek maar net char werk
doen. Ek is verplig om vir haar
te se ek kan nie meer vir haar
onderhou nie. Want my rekeninge
raak nou agter

Buie Dankie

DEPARTMENT OF SOCIAL SERVICES AND POVERTY ALLEVIATION
DIRECTORATE: SOCIAL SECURITY



SCREENING FORM - COMPLETE IN DUPLICATE

Identity No : Name :
Address :
: APPLICATION / RE-APPLICATION / REVIEW FOR CSG

Before an application / re-application / review for Social Assistance in terms of Act 59 of 1992 as amended can be made the following documents / information are required :

Personal details

- 13 Digit bar coded Identity Document of yourself / spouse / children / foster children
- Marriage certificate / Customary marriage cert.
- Divorce and settlement order
- Death certificate / Last Will and Testament / Original liquidation and distribution account
- Letter from Master of High Court confirming that no estate has been registered
- Military discharge certificate
- Medical certificate (DG)
- Medical certificate (CD)
- Court order / Transfer order / Extension order in respect of foster children
- School Attendance Certificate (Additional form 10)
- Implied / Express consent form If not the legal parent of child (CSG)
- Registration of birth (CSG)
- Written confirmation of persons supporting you financially or otherwise
- Proof of occupancy / rent paper / confirmation as a boarder.
- Documentary proof of prison sentence from NICRO/SA Prison Services (CSG)

Assets

- Municipal rates paper
- Market value of fixed property you own and reside at / Other fixed property owned by you inclusive of timeshare.
- Documentary proof of outstanding bond on property / properties
- Deed of sale and reconciliation statement w.r.t. fixed property / timeshare sold in the past 5 years. Proof of how the profit was utilized.
- Documentary proof of any assets donated in the past 5 years
- Documentary proof of capital amount of Investments / shares market value / bank accounts (Bank statements for the last 3 months I.r.o each bank account)

Income

- Employment certificate w.r.t earnings by yourself / spouse. Employment discharge certificate / unemployment card.
- Affidavit re : Self Employment
- Lease agreement in terms of fixed property owned by you and rented out (Inclusive of timeshare)
- Income derived from other pension fund / annuities
- Letter from Maintenance Court regarding maintenance (if maintenance is received)
- Documentary proof of interest derived from investments / shares
- Income from Trust Fund / Policies
- Letter from employer if you only receive accommodation as remuneration.

Other

- Application for procurator/administration (Annexure D)
- Life certificate
- Identity Document of the person appointed to collect your grant.
- Application form for bank payment (Annexure E)
- Application for Grant - In-aid (Annexure G)
- Affidavit re : Circumstances of legal parents of child
- Affidavit re : wr.k. record

Affidavit re : Verklaring p.a. v. kind

- Other :
- Other :
- Other :

N.B. This is not an Application form. ONLY when you return the original form and also the required documents / information, will an Application form be completed

Intake / Screening officer :

Date :

PROVINCIALE ADMINISTRASIE
MANTENING VAN WERK
PRIVAATBAK/PRIJWIS

Applicant : [Signature]
Date : 2003-08-01

BELLEVILLE 2105
PROVINCIAL ADMINISTRATION WESTERN CAPE
SOCIAL SERVICES

SWORN AFFIDAVIT/ BEEDIGE VERKLARING

NAAM/NÁME:

ADRES/ADDRESS:

TEL/HUIS/HOME:

TEL/WERK/WORK.....

VERKLAAR ONDER EED IN AFRIKAANS/ STATES UNDER OATH IN ENGLISH:

Dat ek nog nooit in formele werke gehaal het nie. Ek doen los werkies soos 'chon' werke vir mense in Table View. Ek werk so twee dae in in maand ken K120/dag. Hulle name is Katy en Simon. Ek werk maar net die twee dae in in maand by hulle want hulle reis baie en is tans in Engeland. Ek het geen ander inkomste nie. Ek besit geen eiendom nie. Ek het ook geen bankrekenings, geen beleggings, aandele of erfporsies nie. Dit is al wat ek het om te verklaar.

Ek is vertrou met die inhoud van hierdie verklaring en begryp dit. Ek het geen beswaar teen die aflegging van die voorgeskrewe eed as bindend vir my gewete.

.....
VERKLAARDER

Ek sertifiseer dat bostaande verklaring deur my afgeneem is en dat die verklaarder erken dat hy/sy vertrou is met die inhoud van hierdie verklaring en dit begryp. Hierdie verklaring is voor my beëdig en die verklaarder se handtekening is in my teenwoordigheid daarop aangebring te

.....
KOMMISSARIS VAN EDE

VOLLE NAAM EN VAN:

AMPTELIKE POSISIE:

STRAAT ADRES:

09-2003 09:54 From-WIZARDZ-INC
G.P.S.

0214620279

T-018 P.001 F-553

VR-T 147



REPUBLIC OF SOUTH AFRICA
REPUBLIEK VAN SUID-AFRIKA

Ref. No.
Verw. No.

The Regional Representative
Die Streekverteenwoordiger

Administration: House of Representatives
Administrasie: Raad van Verteenwoordigers

Department of Health Services and Welfare
Departement van Gesondheidsdienste en Welsyn

Private Bag
Privaatsak

THE PRINCIPAL
DIE PRINSIPAAL

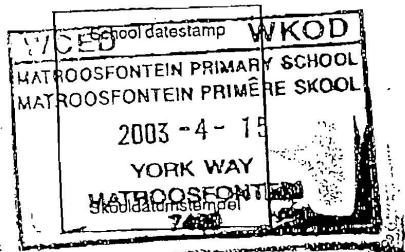
SCHOOL ATTENDANCE
SKOOLBYWONING **D**

CHILDREN
KINDERS

Kindly supply the information requested hereunder and return the completed form to this office.
Geliewe die inligting hieronder aangevra te verstrek en die vorm daarna aan die bostaande adres terug te stuur.

District Pensions Officer
Distrikspensioenbeampte

Name Naam	Std St.	Progress Vordering			School attendance Skoolbywoning	
		Good Goed	Satisfactory Bevredigend	Weak Swak	Good Goed	Weak Swak
	Gr 1		✓		✓	
	Gr 1		✓		✓	



Signature of Principal
Handtekening van Prinsipaal

TABLE 2. APPLYING A FRAMEWORK FOR ANALYZING POLICY TO AN ANTIRETROVIRAL-LINKED MOTHER-TO-CHILD TRANSMISSION PREVENTION PROGRAM.

STEP	KEY TASK	ELABORATION
<p>1. To what extent is the proposed public health response "good public health"?</p>	<p>What exactly is the health problem, and the public health goal, objectives, and strategy? Consider <i>only</i> health benefits or harms at this stage.</p>	<p>The objective of preventing 50 percent of the cases of mother-to-child transmission in South Africa is highly compelling, although sustainability of this benefit at two years with breastfeeding is still controversial. Coupled with potential benefits of reinforcing prevention activities, helping to create a climate for relief of stigma, and potentially fueling infrastructure development, the strategy may have very high public health value.</p> <p>Cost data do not indicate a major obstacle. In all likelihood, the program will prove cost-beneficial. At the very least, its cost-effectiveness will be comparable to existing health programs. The cost estimates are robust.</p> <p>It will place stress on public health infrastructure but may lead to injections of capital and human resources that could benefit health care generally.</p> <p>Health worker morale may be boosted by the ability to intervene; alternatively, demand without capacity to deliver may further demoralize.</p> <p>The sustainability relates to implementation of national and international agreements and strategies to reduce drug costs, but is within national reach. Indeed, national legislation to allow parallel importation is in place to support implementation.</p> <p>Greater numbers of HIV orphans will occur as a result of preventing mother-to-child transmission. The numbers are likely to be small relative to the overall impact on HIV orphans.</p> <p>Development of drug resistance in the mother may theoretically reduce effectiveness of future treatment.</p> <p>Prevention efforts may be reinforced.</p>
<p>2. To what extent does the proposed policy or program respect, protect, and fulfill human rights?</p>	<p>Does the policy or program directly or indirectly affect rights? Consider <i>only</i> rights implications at this stage.</p>	<p>Negative Rights Impacts:</p> <ul style="list-style-type: none"> • The program may discriminate on the basis of sex by providing treatment intended to benefit only the fetus; theoretical risk of resistance may impair women's capacity to benefit from future treatment. • If faulty implementation, may result in testing without proper informed consent. • Testing may result in stigmatization and victimization. • The program would impose additional obligations on the state to ensure the protection of the rights above.

Continued on next page

TABLE 2, CONTINUED.

STEP	KEY TASK	ELABORATION
		<ul style="list-style-type: none"> • The frequency and scope of the violations would depend on how well the state protected rights. • Testing without consent and victimization from stigmatization may be long-lasting, if not irreversible violations. • Discrimination in denying treatment to nonpregnant women may be time-bound given shifts in drug policies and costs over time. • None of these rights are nonderogable in the sense that they would be balanced against other rights. <p>Positive Rights Impacts:</p> <ul style="list-style-type: none"> • increases access to health-care services, including reproductive health care; • gives women rights to make choices regarding reproductive health care; • affords recognition of dignity and equality to women and children; • reduces discrimination; and • protects children's right to life. <p>The policy will have widespread impact in both frequency and scope. Duration of impacts will be cross-generational and multiplicative.</p> <p>The policy enables the state to meet obligations to respect, protect, and fulfill rights to dignity, nondiscrimination, equality, enjoyment of the benefits of scientific progress, access to information, and access to health care (including reproductive health care) as well as the right to life.</p>
<p>3. To what extent does the policy address common concerns to public health and human rights?</p>	<p>The policy targets those in need and will redress the current exclusion of public health sector patients from treatment access.</p> <p>The epidemiological evidence is strong.</p>	
<p>4. How do we achieve a balance between protecting public health and promoting human rights?</p>	<p>The policy affords clear synergy between human rights and public health.</p> <p>Safeguards directed at ensuring equity should be included.</p> <p>Process objectives should aim at development and consolidation of infrastructure.</p> <p>Periodic review can be built in as is done for other lead projects.</p>	
<p>5. Given the above, does the proposed policy or program, as revised, still appear the optimal approach to the problem?</p>	<p>Compared to Table 3:</p> <ul style="list-style-type: none"> • This program optimally meets public health and human rights objectives. • There is a high degree of mutual consonance. • The threats to the public health system, while not insubstantial, are not insurmountable. • Analogous public health programs (e.g., free care for children) have been introduced with less strong public health rationales. 	