

# COUNTRY REPORT ON THE INTERNATIONAL CONFERENCE on Population and Development +10



Republic of South Africa  
A Discussion Document

**INTERNATIONAL POSTER CONTEST 2003**  
**PROVINCIAL FIRST PRIZE WINNER**

Adolescent Reproductive health

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Age Category 2: 13-15 years

Northern Cape Province



# International Conference on Population and Development ICPD+ 10

Country Report  
Republic of South Africa



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# INTRODUCTION

The International Conference on Population and Development (ICPD) of 1994 was the first major international conference in which South Africa participated as a free, democratic country. The Programme of Action (PoA) that emanated from the conference was among the first of the major international programmes that the young democracy endorsed. In the same year, the Reconstruction and Development Programme (RDP) became national government policy. The ICPD-PoA and the RDP were the foundations on which South Africa's Population Policy (1998) was based.

The drafting of the country's ICPD+10 Country Report coincided with an extensive evaluation by the government of the extent to which it has achieved its reconstruction and development objectives over the past decade. The initial findings of this evaluation were recently published in a discussion document titled *Towards a Ten Year Review* (<http://www.10years.gov.za>). The ICPD+10 Country Report should be read with that, more comprehensive, document.

The purpose of this Country Report is to provide a descriptive overview of the country's progress in implementing the ICPD PoA. It serves another important purpose as well, though. By publishing this report, the government endeavours to stimulate discussion between itself and sectors of civil society on the state of the country's population. These discussions should inform the evaluation of national population and development priorities. Furthermore, it will guide the development of a (next) five-year strategy to pursue the objectives of the PoA, in the context of national population and development challenges.

The report was compiled by the Department of Social Development, with the assistance of other government departments, and provincial population units. The draft of the report was the subject of a national consultative meeting on its contents, held in November 2003. It was also presented to the Southern African Forum on Population and Development (SAFPAD), in December 2003.

# executive summary

## **South Africa and the International Conference on Population and Development Programme of Action**

The participation of South Africa in the International Conference on Population and Development (ICPD) (Cairo, 1994) coincided with its democratisation and re-entry into community of nations. South Africa was counted amongst the 179 countries that contributed to the development of the twenty-year ICPD Programme of Action (PoA), and the programme is fully supported by South Africans.

This report describes initiatives since 1994 in tackling the many population and development challenges faced by the country. Most of the activities reviewed were instituted before the promulgation of the national Population Policy, in April 1998. Nevertheless, the initiatives addressed population concerns and demonstrate the government's commitment to achieving the integration of population and sustainable development in the way that is expressed in the national Reconstruction and Development Programme and the ICPD-PoA.

### **1. South Africa's demographic characteristics**

South Africa's population grew from 40.6 million people in 1996 to 44.8 million people in 2001, which was a growth of about 10%. In 2001, more than three quarters (79%) of the population were African, about 10% were white, 9% were coloured, and Indians made up about 2.5%.

In the 1980s, it was estimated that the total population of South Africa would reach between 70 and 80 million by 2020. However, decreasing fertility rates and increasing mortality rates, mainly due to the impact of HIV/AIDS, have resulted in an estimation that the population will stop growing in the current decade, stabilising between 48 and 52 million people.

#### **1.1 Poverty and the socio-economic situation**

This section provides examples of how South Africa dealt with the challenges of poverty and inequality. The central programme of the government's social sector focuses on poverty alleviation through a range of programmes that address income, human capital and asset poverty. It is in the intersection between access to services, income and assets that overall poverty trends since 1994 are examined.

### **2. Gender equality, equity and development**

Gender equality is guaranteed under the South African Constitution. National policies for the advancement of gender equality comprise the creation of the Commission for Gender Equality (CGE) and the Office for the Status of Women (OSW), in 1997. The government instituted programmes that are aimed at implementing measures to enable women and girls to achieve their full potential,

through eliminating all forms of discrimination and disparities based on gender, and more effective participation in decision-making bodies.

### **3. The family, its role, rights, composition and structure**

The South African government acknowledges the social, religious and cultural diversity of families as well as the effects of social change on their nature and structure. Nowadays families are faced with new challenges and demands in their attempt to meet the needs of their members. Many families in South Africa, particularly those from black communities, have been adversely affected by the social, economic, and political policies of the past. Family dysfunction sets in when poverty is combined with environmental stress and feelings of powerlessness and frustration. Family disorganisation, family violence, mental health problems, crime, abuse of legal and illegal drugs, commercial sexual exploitation, and street children remain challenges.

### **4. Children and youth**

The Department of Social Development's theme "*Making South Africa Fit for Children*" resonates in all the work the department does, especially with regard to the Child Support Grant (CSG). The increase in the take-up rate of the CSG, the expansion of the Home/Community Based Care for people infected and affected by HIV/AIDS are encouraging, as are the other areas of work where the government has made substantial progress. The government recognises that the key to breaking the inter-generational continuation of the poverty cycle is to focus on youth as parents and as the human resources of the future. The *National Youth Commission* was formed to enable youth to shape their future, and to learn to take responsibility for their lives.

### **5. Reproductive rights and reproductive health**

The national population policy identifies a range of concerns in the field of sexual and reproductive rights and health, to be addressed as part of the overall national development strategy, to improve the quality of life of all South Africans. These concerns include high rates of maternal mortality, high-risk and teenage pregnancies, as well as the need to improve the quality and user friendliness of services. Addressing these issues requires both a change in the social value of women - a recognition and practice of human rights and gender equality - and improvements in diverse services. This section provides a brief overview of steps which have been taken in both areas since 1994, as well as current challenges.

### **6. Demographic, economic and social impact of HIV/AIDS**

The high geographical mobility of the South African population and extensive migrant labour are both important in understanding the spread of HIV/AIDS in the country. However, the causative factors have more to do with the power dynamics between partners, and their socio-economic situation. South Africa's response to the epidemic includes preventative programmes, as well as programmes to mitigate the impact of the epidemic, in most sectors of society.

## **7. Population distribution, urbanisation and migration**

Today's population distribution, migration and urbanisation patterns are the legacy of the apartheid era. The apartheid government forcefully moved over three million African, Indian and coloured people. It created urban concentrations of poor communities without viable commercial, industrial and other economic activities. It created many settlements in rural areas with similar, or worse, limitations in terms of opportunities.

## **8. Resource mobilisation for the implementation of population policies and programmes**

The Population Policy for South Africa focuses on coordination and capacity building for integrating population and development planning by aiming to enhance the technical capacity of planning staff in the various government departments, to integrate population variables in development planning and programming, and to expand training opportunities in demography and population studies. The main areas of support in this regard are summarised.

## **9. Conclusion and way forward**

Meeting the development backlogs facing many South Africans requires a careful balance between the current population trends and resources required to address those backlogs. A major challenge is that of a large youth population entering the economically active age cohorts.

# OVERVIEW OF THE POPULATION AND POVERTY SITUATION, AND PROSPECTS

## 1.1 Introduction

South Africa (SA) participated in the International Conference on Population and Development (ICPD) in Cairo in 1994 very soon after its first democratic elections. South Africa contributed to the formulation of the ICPD Programme of Action (PoA) and endorsed it. The task facing the country after the Conference was to implement the Programme in a way consistent with its new constitution and development priorities.

The Reconstruction and Development Programme (RDP) of 1994 formed the basis of the new government's overall policy approach, and aimed at achieving sustainable human development. The human development ideals contained in the ICPD PoA on the integration of population and development provided further direction to the government and the people of South Africa to develop a population policy that, for the first time in South Africa's history, put people first in all sectoral development initiatives.

The South African parliament adopted the national population policy in April 1998. The policy addresses population concerns, and demonstrates the government's commitment to achieving the integration of population and sustainable development in a way that is consistent with the RDP and the ICPD PoA. This section of the report will look at the dynamics that unfolded in South Africa since 1994, in terms of government programmes, strategies and policies that addressed the ICPD concerns. It will focus mainly on population, poverty, environment and sustainable development.

### 1.1.1 South Africa's demographic characteristics

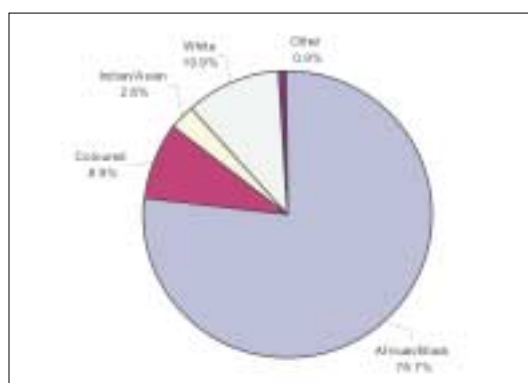
South Africa's population grew from 40.6 million people in 1996 to 44.8 million people in 2001, which was a growth of about 10%. In 2001, more than three quarters (79%) of the population were African, about 10% were white, 9% were coloured, and Indians made up about 2.5%. Africans have become a larger proportion of the population than in 1996.

In the 1980s, it was estimated that the total population of South Africa would reach between 70 and 80 million by 2020. However, decreasing fertility rates and increasing mortality rates, mainly due to the impact of HIV/AIDS, have resulted in revised estimations that the population will stop growing in the current decade, and that it will stabilize between 48 and 52 million people.

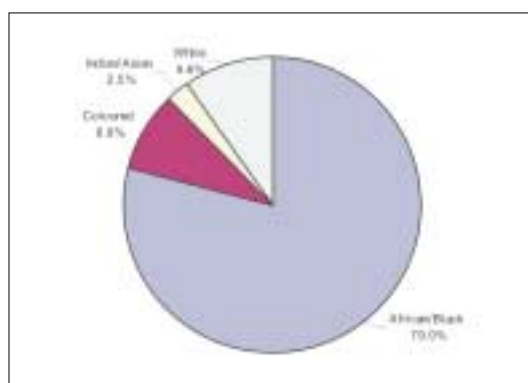
In 2001, just over half of the population (52.2%) were women. Almost a third (32.1%) of the population were younger than 15 years old, and 4.9% were 65 years

and older. Two-thirds of older persons were women. Sixty-three percent of the population fell into the economically active age group (15-64) in 2001.

**Figure 1: Population groups of South Africa, 1996**



**Figure 2: Population groups of South Africa, 2001**

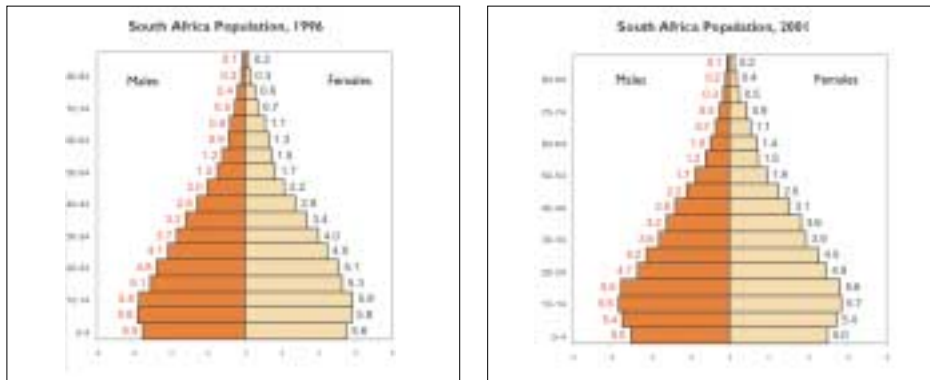


Characteristic	1996	2001
Women as % of total population	51.9	52.2
Population <15 as % of total	33.9	32.1
Population >64 as % of total	4.8	4.9
% 15 - 64	61.3	63.1
Median age	22.07	22.13
Household Size	4.5	3.8
Urbanisation rate	53.7	61.0

The proportion of women in the total population increased slightly between 1996 and 2001. By contrast, the proportion of people under the age of 15 years declined since 1996 due to declining fertility rates. Simultaneously the proportion of people older than 64 years in the population increased slightly from 4.8% in 1996 to 4.9% in 2001. The transition towards a maturing population is underscored by the observation that the economically active population (between 15 to 64 years) has

proportionally increased by almost 2% between the two censuses. The transition is further stressed by the increasing median ages (22.07 in 1996 to 22.13 in 2001). Household size decreased from 4.5 persons in 1996 to 3.8 persons in 2001. The proportion of urban residents has increased markedly, by 7.3%, between 1996 and 2001.

**Figure 3: Age distribution, % per age group and gender (1996 and 2001)**



There have been structural changes in the population between the 1996 and 2001. There is a definite proportional decline in the age group 0 to 9 years old. This is a result of a decline in the Total Fertility Rate (TFR) to below 3. A possible further explanation might be the impact of child mortality due to HIV/AIDS. Nonetheless, South Africa still has a youthful population, with the largest age cohorts being 10 to 19 years old.

There is a large difference in the age structures of urban and non-urban populations: 55.7% of the non-urban population is younger than 20 years old, while the corresponding figure for urban areas stands at 41.2% (Census 2001).

## 1.2 Poverty and socio-economic trends

Poverty is the single most profound socio-economic challenge facing South Africa today. It is coupled with high levels of inequality in the conditions of living and access to resources on the one hand, and intense vulnerability within households and communities on the other hand. The inequalities tend to be defined along the gender, age, race and space dimensions. Women and female-headed households, the young, older persons, African and rural people are the poorest. The post-apartheid government's recognition of poverty as its foremost concern is reflected in budgetary shifts to social spending, in poverty relief programmes and in development programmes that target women.

This section provides examples of how South Africa has attempted to deal with the challenges of poverty and inequality. The central programme of the South African government's social cluster focuses on poverty alleviation through a range of programmes that address income, human capital (access to services) and asset poverty.

### 1.2.1 Income poverty alleviation

According to Statistics South Africa (Stats SA), approximately 28% of households and 48% of the population were living below the estimated poverty line in 1995, calculated on the basis of expenditure, thus excluding access to services and assets. By 1999 there were 3.7 million households (out of 11.4 million) who were living below the poverty line. Of these, most were African. Part of this increase in poverty was due to large sized poor households unbundling into smaller households. Of female-headed households, 45% were below the poverty line, compared with 26% of male-headed households. On average the poor were living with incomes about 12% below the poverty line.

At least two major programmes of the government address income poverty, i.e. *income grants* and *public works programmes*. In 1994, social grants were still allocated on a racial basis. Since then, the government equalised the old age pensions, and introduced the child support grant for poor children. There are seven types income grants currently administered by the Department of Social Development. These are targeted at older persons, people with disabilities, poor children, war veterans, foster care, and grants in aid for families taking care of children and people in need. The expenditure on these social grants increased from R 10 billion\* to R 24.5 billion in the past decade. The total number of grant beneficiaries increased from 3,2 million in April 2000 to 7.3 million in November 2003 (mainly due to the increase of the qualifying age for children).

Research shows that the social grants are exceptionally well-targeted. The poorest 20% of households receive the largest amount from grants, not just as a proportion of income, but also in absolute terms. Fully two-thirds of the income of the poorest quintile is attributable to state transfers. Simulation studies also show that, in the absence of any grants, 55.9% of older persons would be in poverty and 38.2% would be in ultra-poverty. This falls to 22.9% and 2.5% respectively if all those eligible get grants. In the absence of the Child Support Grant (CSG), but after taking account of the Old Age Pension, 42.7% of children would be in poverty and 13.1% would be in ultra-poverty. Poverty among children (under seven) falls from 42.7% to 34.3% and ultra-poverty falls from 13.1% to 4.2% if all eligible children are to receive grants. Overall, social grants have the potential of reducing the portion of the population in poverty from 42% to 24%. Although great progress has been made in registering recipients, the full impact of these grants will only be realised when all eligible persons are registered.

Expenditure on the public works programme increased almost 10 fold since 1998. The public works programme employed a total of 124 808 people since 1998, however most of these jobs were temporary in nature. A total of 3407 permanent jobs were created in 1999/2000 and a total of 141 permanent jobs were created by the first half of the 2002/2003 financial year. Thus, public works programmes were not as efficient as income grants in alleviating income poverty. Nonetheless these programs have been successful in alleviating the asset poverty of communities. Over R 6.5 billion of expenditure on infrastructure provided 2182 community assets.

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\* R: South African Rand (ZAR), currently fluctuating around R7/US Dollar

### 1.2.2 Human Capital Poverty alleviation

Human capital poverty alleviation includes education, health, water and sanitation services. Expenditure on education remains the largest budget item in South Africa. For early childhood development there has been a steady increase in enrolment between 1999 and 2002, from approximately 150 000 to 280 000, suggesting that full enrolment will be reached by 2015. Primary school enrolment remained steady at around 95.5% between 1995 and 2001. Secondary school enrolment is currently approximately 85% (a 15% increase from 1992). The learner to teacher ratio has declined 43:1 in 1996 to 38:1 in 2001. Progress in education is ahead of the Millennium Development Goals. The male to female enrolment ratio is greater than one, indicating that more girl children are enrolled than boys.

An important outcome indicator for education is the adult literacy rate, (the proportion of the population over 15 that can read and write in one language). This increased from 86% in 1996 to 89% in 2001 for the general population. The literacy rate for 15-24 year olds increased from 95% to 96%. A larger proportion of women are literate in South Africa than men. These improvements are also shown in a corresponding increase in the matriculation pass rate from 48.9% in 1999 to 73.3% in 2003, although there has been a decrease in the absolute number of matriculants as a result of tighter progression from lower levels, and limitations on repeaters.

Between 1996 and 2001, there was an increase of 55% in the number of people aged 20 years and older that completed grade 12 to 7.4 million, and a 66% increase in the population that completed tertiary education to 2.2 million, suggesting that the skills profile of the country is improving rapidly. However, approximately 71% of the total population over 20 years old have not completed secondary schooling. This is significant in terms of the impact of human capital on employment.

Indicators of health status show that infant mortality increased from about 40 per 1000 live births to 45 per 1000 live births between 1991 and 1998. Maternal health indicators such as antenatal care utilization have increased from 89% to 94%, between 1994 and 1998. Births received with no antenatal care have declined from 12% to 3%. Deliveries at health care facilities have increased from 78% to 83%.

However, maternal mortality ratios have averaged 150 per 100 000 live births between 1992 and 1998 despite improved service delivery and access. It is estimated to have increased to somewhere in the vicinity of 175 and 200 between 1999 and 2001. The HIV/AIDS epidemic, and unreliable pre-1994 statistics, combined with increased reporting may account for this negative trend. New data will only be available once the 2003 Demographic Health Survey is completed.

Public health care expenditure increased in the last eight years although real per capita expenditure remained at between R 967 and R 907. The main thrust of the Department of Health was to improve access to health care through the primary health care (PHC) approach. Major programmes include a Free Health Care policy for women and children under the age of six. The implementation of this programme has resulted in increased utilisation rates, which indicate increased

access. However the annual per capita PHC visits is between 1.3 and 2.7, which is still under the 3 to 3.5 recommended by the World Health Organization and the Department of Health. There are now over 4 350 primary health care access points available to the population. In terms of clinics alone this represents an increase of 454 additional clinics from the clinic upgrading and building programme.

The immunisation programme resulted in an increase in the rates of immunisation between 1994 and 2002 from 63% to 72% nationally, although provincial disparities remain. However, the greatest success of the immunisation programme was the elimination of deaths due to measles, and a reduction in the incidence of polio. The integrated nutrition programme increased its coverage of eligible and targeted learners from 89% in 1994/1995 to 94% in 2002, increasing its reach to about 4.58 million children.

### **1.2.2.1 Water and sanitation**

The provision of clean water is a major tool for protecting human capital and for reducing social asset poverty. The proportion of households that have access to clean water increased from 60% in 1995 to 86% in 2003. This translates into around 9 million more citizens or about 3.7 million additional households. The expenditure for the provision of water was approximately R 5 billion for the period under review. In terms of urban/rural distribution, in 1994, 4 million households had access to clean water in urban areas, with only 970 000 households having access in rural areas. By 2003, the number of urban households with access to water has increased by a further 1.7 million. The greatest gain however occurred in rural areas, where an additional 1.6 million households received water between 1994 and 2003.

The proportion of households with access to sanitation also increased, though at a slower pace. In 1994, 49% of households had access to sanitation. This figure increased to 63% in 2003. The reason for the higher backlog in sanitation provision can be attributed to the increase in the number of households and the increased focus on provision of water to households. Up until the recent floods, there was a declining trend in the incidence of cholera. Between 1991 and 1995, 119 cases were reported nationally which decreased to 70 cases in the period between 1996 and 2000.

### **1.2.2.2 Electrification**

During the time in review the proportion of electrified households increased from 32% to 80%. However, by 2001, most of the electricity in poor areas is still used for lighting and only 49.1% of households use electricity for heating purposes.

### **1.2.3 Asset Capital Poverty Reduction**

The housing and land reform programmes are the two lead programmes relating to the elimination of asset capital poverty. From these programmes, R 26 billion of assets have been transferred to poor households since 1994.

### 1.2.3.1 Housing

Between 1994 and 2003 approximately two million housing subsidies were approved, for an expenditure of over R24.22 billion. The efficiency with which houses are completed is 81%, indicating that there is a lag period between subsidy approval and completion of housing units. Moreover, transfer of deeds was made to approximately 577 163 households, of which 401 373 were transferred under the Discount Benefit Scheme. With respect to improving gender equality in housing ownership, 49% of all subsidies approved were granted to women. The outcomes of providing subsidised housing indicate that a total of over 6 million citizens received housing between 1994 and 2003.

A major challenge for the housing sector will be to meet the increasing demand for housing generated by the decrease in household size between 1996 and 2001. Household size decreased from 4.5 to 3.8 in that period, and this translates into an increase of two million additional households over and above that generated by population growth. It is expected that demand for housing will double as a result of this phenomenon.

### 1.2.3.2 Land

Land restitution, tenure reform and land redistribution are the other major policy instruments used for alleviating asset poverty since 1994. Since 1994, 1.8 million hectares of land was transferred under the redistribution programme, to about 137 478 households. Approximately 80% of these transfers occurred between 1997 and 2002.

By 2002 approximately 68 000 claims for land restitution had been lodged, of which 72% were urban and 28% rural. A total of 36 489 claims have been settled involving about 85 000 households. For urban claims there has mostly been financial compensation for victims of forced removals, and the total compensation paid by December 2002 was R 1.2 billion. For the rural claimants the restitution mainly takes the form of restoration of land ownership, and by December 2002 approximately 571 232 hectares have been restored at a cost of approximately R442 million.

## 1.3 Meeting the Millennium Develoement Goals (MDGs)

Access to productive natural resources cannot alone generate wealth and a good quality of life. Education and skills are necessary if people are to be able to exploit resources effectively. Apartheid denied the majority of the population access to a good quality education. In particular, it denied access to strategic scientific, vocational and business skills that would allow individuals to reach their full potential, and the country to benefit from the use of its full human and physical resource potential.

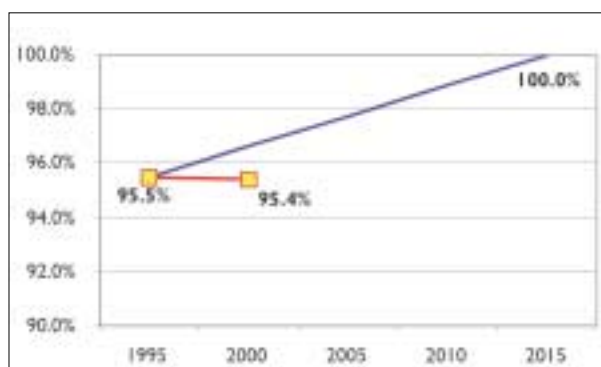
At the time when the population policy was drafted, concern was expressed about the high rates of premature mortality attributable to preventable causes. Also, high rates of infant and maternal mortality were identified as a major concern. The

following sections will illustrate the performance of South Africa in terms of education, child mortality, maternal mortality and environmental sustainability with reference to the Millennium Declaration Goals.

### 1.3.1 Education

Post-1994 government policies focused on the transformation of the education system - the SA Schools Act of 1996 provides for the development of national norms and standards. A National Qualifications Framework has been established. There is an expansion of the Adult Basic Education Programme; a Further Education and Training Act; a Higher Education Act; and a Skills Development Act. The White Paper on Inclusive Education (July 2001) provides for a national policy and norms for early childhood development and for learners with special needs. New policies on school assessment, and Outcomes Based Education (OBE Curriculum 2005); and a "New Academic Policy for Programmes and Qualifications in Higher Education" have been introduced. Transformation of the higher education system is in progress. The MDG target is to ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

**Figure 4: Net enrolment ratio in primary education**



**Definition:**

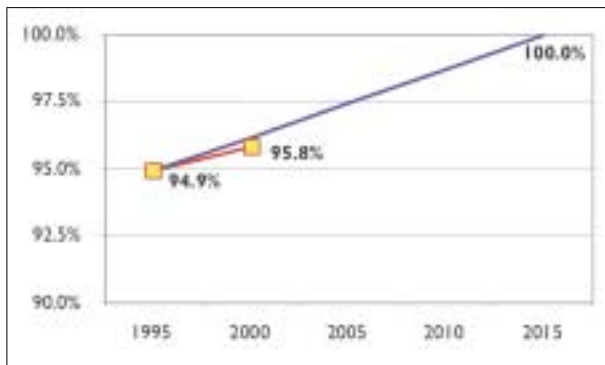
Total enrolment, regardless of age, divided by the population of the age group, which corresponds to a specific level of education. The net enrolment ratio is calculated by using only that part of the enrolment, which corresponds to the age group of the level considered.

Source: Statistics South Africa - October Household Surveys, 1995 and 1999

Net enrolment in primary education in South Africa is higher than 95%.

Almost 80% of adult South Africans have not matriculated; this figure is 87% for the African population group, 85% among the coloured, 65% for the Asian and 44% for the white population group. Approximately half of all South Africans who have studied beyond the level of grade 12 are from the white population group.

**Figure 5: Literacy rate of 15-24 year olds**



**Definition:**

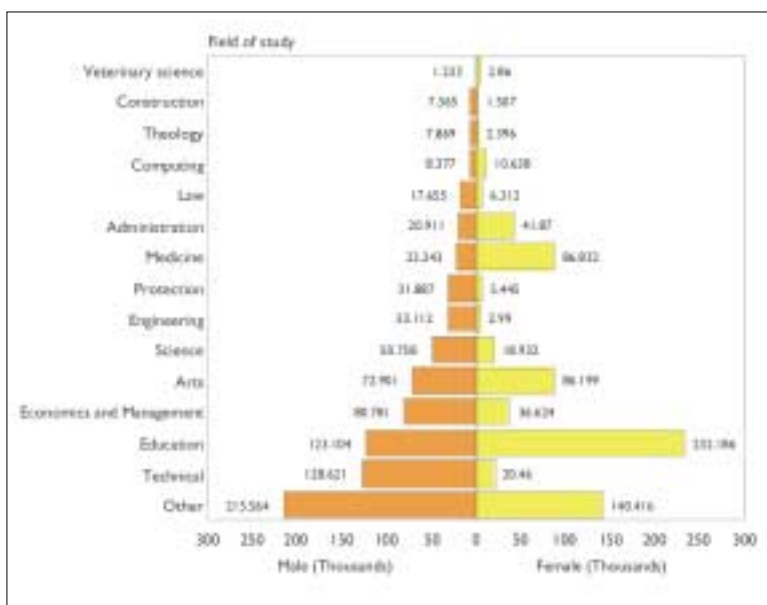
Proportion of the population aged 15-24 years who can read and write in at least one language.

Source: Statistics South Africa - Census 1996 and Labour Force Survey, 2000

The literacy-rate for 15-24 year olds increased by 1% from 1995 to 2000. South Africa's basic literacy rate for 15-24 year olds is considered high. The adult literacy rate in South Africa is 85,3%.

Curriculum 2005 introduced outcomes-based education in the country. The purpose of the School Effectiveness and Educator Professionalism Programme is to develop an efficient and effective school system aimed at realising the social, economic, demographic, environmental and educational goals of the country. It is also aimed at ensuring that schools have effective leadership and management with vision and sense of purpose to promote and enhance learning and teaching. It promotes the establishment of governing bodies for all schools and learner representative councils in secondary schools, in accordance with the South African Schools Act.

**Figure 6: Post-matric qualification by field of study and gender**



**Definition:**

Post-matric qualification by field of study and sex for population aged 26 or more.

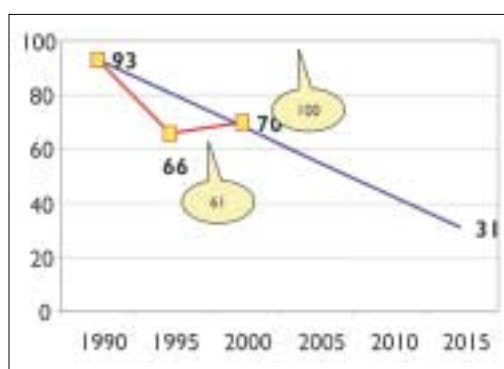
Stats SA 2001, Education in South Africa (1996 data)

The gross-enrolment rate at tertiary education in South Africa is 15.4%.

Technical, engineering, science and economics and management are male dominated, while education, administration, medicine and arts are female dominated. Of all students studying at tertiary education level, 18% are studying science, mathematics and engineering.

### 1.3.2 Child mortality

**Figure 7: Under-five mortality rate**



**Definition:**

The number of deaths among children aged below 5 years of age per 1,000 children in the age group 0-4 years in the same period.

**Comments:**

The under-five mortality rate from the Department of Health was 61/1 000 in 1998. The Health Systems Trust estimated the rate at 100 in 2002.

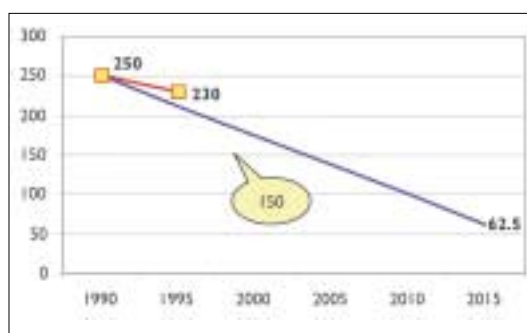
Source: SUNDP HDR 1993, 1998, 2002; Department of Health, 1998.

Under-five mortality decreased from 93 to 70 per 1 000 children between 1990 and 2000. This decrease was in line with the Millennium Development Goal target of reducing child mortality by two-thirds before 2015. The positive trend was however reversed during the 1990s, as a result of deaths of children who were born HIV+.

The under-five mortality rate is much higher in non-urban areas, compared to urban areas. There are also great disparities between the Provinces, with the highest rate of (80.5) occurring in the Eastern Cape Province, and the lowest (13.2) in the Western Cape Province. Also, the under-five mortality rate in the African population group (63.6) is more than double the rate for the coloured population group (28.2).

### 1.3.3 Maternal Health

**Figure 8: Maternal mortality rate**



**Definition:** Maternal mortality rate per 100,000 live births. The deaths of women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes.

**Comments:** The figure from the Department of Health was 150 deaths per 100 000 live births in 1998.

UNDP HDR 1993, 1998, Department of Health 1998

Maternal mortality rates decreased from 250 to 230 per 100,000 live births from 1990 to 1995. The most common reasons for maternal death were hypertension (24%), non-pregnancy related infections including HIV/AIDS (15%), obstetric haemorrhage (12%) and pregnancy related sepsis (7%). 61.5% of maternal mortality occurred in the period following delivery, 19.5% of cases occurred in the antenatal period, 8.7% of cases occurred during labour, and 8.5% of cases in early pregnancy.

In response to this situation, the government developed and implemented the following measures:

- Provision of free primary health care to all pregnant women and children under the age of six years;
- Revision of the Sterilisation Act (1999) to make sterilization more accessible;
- Promulgation and implementation of the Choice of Termination of Pregnancy (TOP) Act (1996), whose accessibility has been increased by allowing nurses to provide TOP in the first trimester of pregnancy;
- Establishment and review of the implementation of the National Committee for Confidential Enquiry in Maternal Death's (NCCEMD), recommendations concerning supplies and equipment, e.g. partographs, improved blood transfusion facilities and access to transport for referral;
- Introduction of national cervical cancer screening guidelines;
- Development of a national primary health care package
- Development of national contraceptive policy guidelines.

#### 1.3.4 Environmental sustainability

The issue of environmental sustainability was highlighted during the Dakar-Ngor and ICPD deliberations. South Africa enacted the National Environmental Management Act (107 of 1998) (NEMA) as its environmental statute that guides decision-making and administrative actions concerned with the environment. It creates institutional obligations to ensure co-operative environmental governance, both vertically between and horizontally within the three spheres of government. The pursuit of environmental justice and equitable access to environmental resources, benefits and services to meet basic human needs is one of the main founding principles of NEMA. The principle of Private Public Partnerships is firmly entrenched into environmental management in the country, as illustrated in the following two case studies.

##### Case study 1

An initiative that was recently implemented in South Africa to reduce the littering of plastic bags added to the management of pollution in the environment. The disposal of non-reusable plastic bags was seen as a growing waste problem in South Africa. The use of plastic made of plastic film has increased significantly in recent years. These bags were indiscriminately dumped, and not collected for recycling or disposal because the thin plastic film they were made of had little commercial value. The problem was severe in low-income areas where waste collection services were inadequate. The Minister of Environmental Affairs and Tourism, under section 24 (d) of the Environmental Conservation Act, 1989 (Act

No. 73 of 1989), made regulations for plastic bags that came into effect on 9th May 2003. The regulations were formulated in partnership with plastic bag manufacturers, organised business and labour, and were aimed at protecting the environment. The new rules stipulated that plastic bags should be thicker, about 30 microns, to make them recyclable, and should be sold to customers.

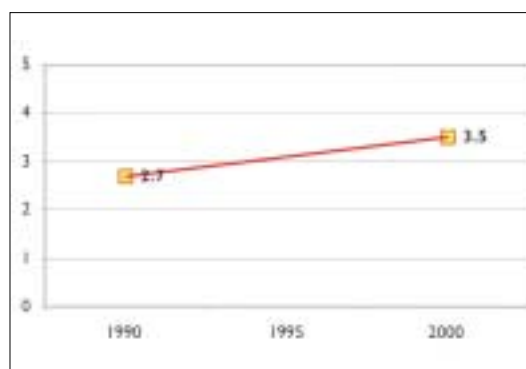
This initiative is a good example of a Public Private Partnership to protect the environment against the threat of plastic waste, while ensuring that jobs in the plastic industry are retained. New jobs are created through a boosted recycling industry.

### Case study 2

Another sterling initiative is the "Collect a Can" programme. It was founded by the Iron and Steel Corporation (Iskor), Nampak (Metal Box) and Crown Cork in 1993, with an express purpose of addressing its corporate responsibility towards environment, the people, the government of South Africa and the needs of the steel beverage can industry. As the name indicates, the programme encourages people to collect metal cans for recycling, by re-selling used cans to the metal industry. "Collect a Can" has a long-and short term strategy for environmental education. Short-term collectors are paid cash for cans, and the environment is effectively cleaned with some awareness created. Long-term, can collecting competitions and educational programmes at schools are creating awareness among the youth of the advantages of recycling.

South Africa also promotes the maintenance of biological diversity. Currently 5.4% of South Africa's land area is protected with an aim to increase this to 8% by 2010. The following figure shows GDP per unit of energy use:

**Figure 9: GDP per unit of energy use (as proxy for energy efficiency)**



**Definition:**

Energy use per units of PPP GDP is commercial energy use measured in units of kilograms of oil equivalent per \$1,000 of GDP converted from national currencies using purchasing power parity (PPP) conversion factors.

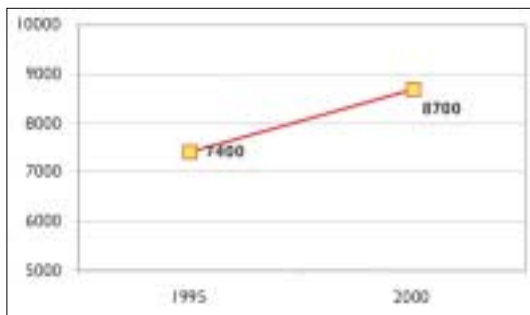
**Comments:**

The GDP per unit of energy use in South Africa is 3.5 in 2000. The average for developed countries is 4.8 and for Sub-Saharan Africa 2.6.

UNDP HDR 2002

In 2000, 74.4% of total energy consumption in South Africa was from coal consumption. This reliance on coal, a highly carbon-intensive fossil fuel, has negative environmental impacts. For example, electricity generation from coal combustion in the industrial sector is the prime contributor to air pollution. Mining also adversely effects the environment through the disruption of ecosystems and the pollution of groundwater.

**Figure 10: Carbon dioxide emissions (per capita)**



**Definition:**

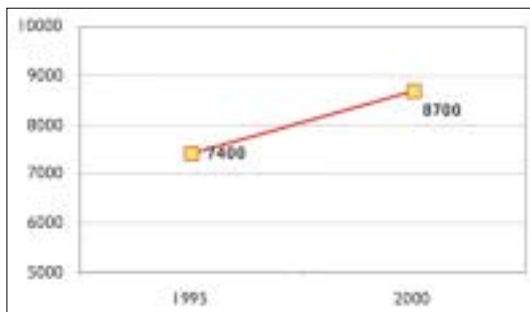
Carbon dioxide emissions (CO<sub>2</sub>), kg of CO<sub>2</sub> per capita.

UNDP HDR 1998, 2002

South Africa is a comparatively energy and carbon intensive country compared to other African countries. Carbon Dioxide emissions per capita are relatively high (1.4% of world total).

The Departments of Environmental Affairs and Tourism and Trade and Industry have announced a multi-point plan to address pollution problems and the health hazards arising from the different types of pollution found in most industrial areas in South Africa.

**Figure 11: Proportion of population /households using solid fuels**



**Definition:**

Proportion of households using solid fuels (including wood, coal, paraffin, animal dung, or candles) for cooking.

Stats SA - OHS 1995 and LFS 2000

The most widely used solid fuel source in South Africa is fuelwood, which meets the daily energy needs of more than one-third of the country's population. The proportion of households using solid fuels for cooking has increased slightly between 1995 and 2000. In the urban areas 28.5% of households use solid fuel for cooking and in non-urban areas 76.3%. Among the provinces, the highest proportion of households using solid fuel for cooking are in Eastern Cape (75.2%), followed by Limpopo. The lowest proportions are in Western Cape (22.0%) and in Gauteng (24.4%). Deforestation attributed to increased fuelwood consumption by a growing population has prompted interest in developing other (renewable) energy sources, particularly solar, which could play an important role in supplying power to isolated rural areas not currently connected to the electric power grid.

Government departments have launched a number of programmes in partnership with private and public sector stakeholders to promote sustainable consumption

and production patterns. These include Local Agenda 21 implementation programmes, which take into account the outcomes of international conferences and multi-national forums. Specific activities include the following:

- Development of a land type database for South Africa (90% completed) for the assessment of macro agricultural potential;
- Investigating the feasibility of using remote sensing and GIS modeling to refine the land type data to ecotype level for the demarcation of homogeneous production and conservation units;
- Identification of the extent of different forms of land cover and monitoring of changes;
- Combating of alien invader plant species;
- Development of a National Policy for Sustainable Use of Agricultural Resources. The process feeds into the food security policy process and involves a large number of stakeholders.
- The launch of the Land Care South Africa Programme, involving provincial Departments of Agriculture, the Department of Water Affairs and Forestry, the private sector and local communities; and
- Implementation of the White Paper on the Protection of the Country's Biological Diversity (commenced in 1998).

#### 1.4 Challenges and constraints

Among aspects that need further strengthening are the following:

- Stronger mechanisms that link economic growth to sustainable human development, and in particular to poverty alleviation;
- Alignment of population trends and dynamics with objectives for economic growth and sustainable human development;
- Ongoing monitoring and evaluation of activities - this requires reliable and up-to-date population and development data, development of skills in implementing agencies, sound monitoring and evaluation systems, as well as the development of indicators that contextualise the themes around poverty;
- More focused targeting of poverty nodes (both spatially and socially);
- Cultivating the culture of male responsibility and opening up opportunities for women; and
- Targeting and involvement of youth in poverty alleviation programmes.

# GENDER EQUALITY, EQUITY AND DEVELOPMENT

## 2.1 Introduction

Gender equality is entrenched in the South African constitution. National policies for the advancement of gender equality comprise the creation of the Commission for Gender Equality (CGE) and the Office for the Status of Women (OSW), established in the Presidency in 1997. The Department of Public Service and Administration instituted an affirmative action programme which is aimed at implementing measures to enable women and girls to achieve their full potential through eliminating all forms of discrimination and disparities based on gender, and at equal representation in decision-making bodies. In recruitment and selection practices, cognisance is taken of candidates whose transfer, promotion and appointment would promote gender representivity. According to the Department of Public Service and Administration the most recent updated information on the ratio between males and females in senior management positions in government is 76,8: 23,2. Twenty-eight percent of Local Government Councillors were women in 2001. This is a remarkable improvement, considering the situation before 1994, when female representation was below 5%.

## 2.2 Women empowerment

Currently, women hold almost one third of seats in parliament. The trend in South Africa shows that a much higher number of women hold seats in parliament now compared to earlier years.

One of the most significant achievements of the last decade of the millennium was the recognition given by the United Nations and a growing number of governments, including that of South Africa, that violence against women and children is a human rights issue. Violence against women and children is recognised as a major public concern and a serious violation of basic human rights.

Programmes to address these issues have been put in place. These include the National Crime Prevention Strategy, the Sexual Offences Guidelines, the Justice Department's Gender Policy and a National Plan of Action for children, to name a few. The need for a programme addressing the needs of victims was identified, and the Victim Empowerment Programme (VEP) was implemented in 1999.

## 2.3 Victim Empowerment Programme (VEP)

The VEP is strongly based on building and maintaining partnerships between the government and civil society, e.g. volunteers, business, Non-Governmental Organizations, Faith Based Organizations, Institutions of Higher Learning, and research institutions. The belief is that the partnership will lead the way to the co-ordination of activities on advocating and lobbying for victim-related issues.

Two pilot One-Stop Centres were established in the Mpumalanga and Eastern Cape Provinces. These were established to reduce the re-victimization of victims of crime and violence by ensuring that their health, psychological, welfare and judiciary needs are met. The services are rendered in collaboration with the United Nations Office for Drug Control and Crime. On average each centre serves 55 clients per month. There are also forums in Gauteng, Free State, Western Cape, North West and Limpopo (with representation from the government and NGOs) to ensure that VEP issues are addressed and co-ordinated properly.

The major challenge now is raising awareness among rural, illiterate and marginalised women on their new rights. The Department of Justice and civil society are planning a major information campaign about new legislation. The CGE already embarked on a public campaign on issues with a direct impact on rural women, including legislation on customary marriages. The CGE, together with the Human Rights Commission and South African Non-Governmental Organisations Coalition staged a joint public awareness campaign on violence against women.

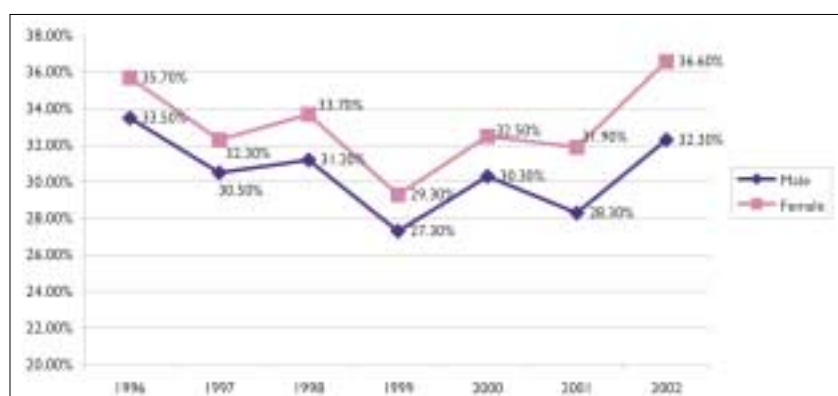
In addition to the policies, programmes and projects outlined above, there are a number of activities that are overtly gender-focused. For example, the government is planning to establish a *Women's Bank* in order to give women access to capital.

## 2.4 The girl-child

The achievement of girls in schools is a good example of progress towards gender equity. In spite of the tremendous barriers that female learners face in participating in education, it is clear that the various initiatives to improve their performance and achievement levels are beginning to pay off. Girls are doing better at key performance tests. For example, the Grade 3 systemic assessment exercise carried out by the Department of Education in 2001, average scores for female learners were higher than those for male learners.

This pattern is also observed in the Grade 12 Senior Certificate Examination. The percentage of female learners who passed with merit and with distinction (average of over 80%) was larger than the male learners in almost all the provinces. The following figure shows the pass ratios by gender in Grade 12 from 1996 to 2002:

**Figure 12: Pass ratio for Male and Female Matric results 1996-2002**



The figure on the previous page shows that the pass efficiency in the cohort of female learners is higher than that of male learners.

Three new acts to entrench woman's rights were passed by Parliament during 1998. The *Domestic Violence Act*, the *Maintenance Act*, and the *Recognition of Customary Marriages Act* provide powerful legal tools to protect the human and socio-economic rights of women.

- The Domestic Violence Act protects women from all forms of abuse, including emotional, verbal, psychological, sexual, physical and economic. The act also extends the definition of domestic relations beyond married partners, and includes homosexual relationships.
- The Maintenance Act provides courts with better ways to enforce the payment of maintenance money, including the attachment of the property of parents who fail to maintain their children. The Act is a temporary measure while the South African Law Commission investigates more far-reaching changes to the current maintenance system.
- The Recognition of Customary Marriages Act ensures equal rights within customary marriages in matters such as property ownership, signing of contracts, etc.

## 2.5 Challenges and constraints

Gender disparities still exist in many indicators of human development that reflect the generally lower status of women compared to men. For example:

- Women are disproportionately represented among the poor: some 60% of the poor are women.
- The income share of females is only about 30.5% of total income, because they are largely employed in lower-wage jobs.
- Women are under-represented in the decision-making structures of both the government and private sector.
- The high maternal mortality rate reflects challenges in the reproductive health and socio-economic status of women.
- The incidence of violence against women remains unacceptable.

Although the South African constitution guarantees equality between the sexes in all aspects of life, including the workplace, changes will have to be fast tracked, and many administrative and cultural practices that still discriminate against women have to be abolished.

# THE FAMILY, ITS ROLE, RIGHTS, COMPOSITION AND STRUCTURE

## 3.1 Introduction

The South African government acknowledges the social, religious and cultural diversity of families as well as the effects of social change on their nature and structure. Nowadays families are faced with new challenges and demands in their attempt to meet the needs of their members. Many families in South Africa, particularly those from black communities, have been adversely affected by the social, economic, and political policies of the past. Family dysfunction sets in when poverty is combined with environmental stress and feelings of powerlessness and frustration. The incidence of family disorganization, family violence, mental health problems, crime, abuse of legal and illegal drugs, commercial sexual exploitation, and street children remain a challenge.

The financial, social and emotional resources of families are especially taxed when they have to care for members who have special needs, such as older persons, people with disabilities and those infected or affected by HIV/AIDS. A major contributor to family problems, dysfunction and breakdown is the increasing economic stress facing households today. Those living below the poverty line are worst affected.

The quality of family life is also affected by the disadvantaged position of women resulting from gender roles. This manifests itself in women's limited access to power, education and training, and economic resources. Research shows that women-headed households are generally much poorer than other households. This is in large part a reflection of the absence of an income-earning man. Female-headed households in rural areas are at a particular disadvantage.

The well-being of children depends mainly on the ability of families to function effectively. As a result of the increasing pressure on families, adults are often unable to perform their parenting and other roles effectively without the active support and, where necessary, the intervention of government, the community and the private sector.

The South African government focuses on empowering people at risk, such as juveniles and youth in conflict with the law, people (especially children) affected by HIV/AIDS, the disabled, the elderly, refugees and the unemployed. The government sees the promotion of the well-being of families and communities as a means of promoting the overall well being of the society. The government's commitment is reflected in the paradigm shift towards a developmental social welfare approach, as reflected in the White Paper on Developmental Social Welfare Services of 1997.

The discussion below will also cover areas of development that provide the context for family life in South Africa, eg. legislation, and social and economic development programmes.

### 3.2 Marriage customs, and family size

The South African constitution recognizes the validity of customary law, culture and religion alongside common law and legislation. Nevertheless, customary law remains subject to the constitution and the Bill of Rights, whereby cultural and religious rights are subordinated to the right to equality.

The Recognition of Customary Marriages Act has given legal recognition to customary unions, finally removing a longstanding source of discrimination against women married in terms of customary law. The act also recognises polygamy.

The South African Law Commission (SALC), in conjunction with the Department of Justice, is currently undertaking Project 59 entitled Islamic Marriages and Related Matters, that will result in a Discussion Paper addressing the inequities suffered by women in non-civil unions. A draft bill is anticipated in the near future. Civil unions and marriages in general under the Marriage Act of 1961 are also under review by the SALC. It is hoped that major recommendations for change will result, especially in view of the fact that South Africa is now bound by *inter alia* the Convention on the Nationality of Married Women, the Convention on Consent to Marriage, Minimum Age for Marriage and Registration for Marriages, and the constitution.

As indicated above, Parliament passed three new acts during 1998 (the *Domestic Violence Act*, the *Maintenance Act*, and the *Recognition of Customary Marriages Act*) to regulate family life.

A basic human right is the right of all persons to decide whether or when to have children. The South African constitution entrenches this right. The status of women and their level of empowerment influences both contraceptive use and the control that they have over sexual and reproductive matters. Women were oppressed and disadvantaged under apartheid. The human development potential of women was often compromised by unplanned, unwanted and teenage pregnancies. The population policy sets as objective to reduce unwanted pregnancies by improving the quality, accessibility, availability and affordability of primary health care services, including reproductive health and health promotion services. The policy places special focus on disadvantaged groups, previously underserved areas, and adolescents, and the elimination of disparities in service provision.

Data confirm that South Africa underwent a very sharp fertility transition during the past decade, to a current Total Fertility Rate (TFR) of less than 3. According to the findings of the Demographic and Health Survey of 1998, non-urban areas had a TFR of 3.9, compared to 2.3 in urban areas. Also, women with no formal education had fertility rates of 4.5, while women who have achieved post grade 12 education had fertility rates of 1.9. Fertility rates also differed according to population group: Africans had the highest at 3.1 (4.0 in non-urban areas), followed by coloureds at 2.5 and whites and Asians at 1.9.

One factor that impacts on fertility rates is the overall contraceptive prevalence rate among women of reproductive age (15-49 year olds). The overall contraceptive prevalence rate in South Africa was 61.2% in 1998. The rate was the highest in the

Western Cape Province, with 73.7%, and the lowest in Mpumalanga, with 53.3%. Among the population groups, contraceptive use by women was most common among the Asian group, with 80.1%, and least common among the African population group, with 57.6%.

### **3.3 The impact of migration on the changing trends in family life**

Families throughout the world are affected by, and have adapted to a variety of broad social trends, migration, colonisation, urbanisation and globalisation. As a result of these social forces, family members move away to seek work and opportunities. These social changes have led to increases in non-traditional families such as single-parented and constituted or blended families of multiple marriages. Non-family households were formed as people adopt living arrangements and strategies to support emerging lifestyles, and as an adaptation to increased stresses. In South Africa, the system of migrant labour, which has been one of the drivers of urbanisation, was responsible for fragmenting the extended family system and delaying, and even forestalling, formal marriage. Migration separates migrant workers from families for long periods of time and the erosion of family relationships under such conditions may be substantial.

Rapid rural-urban migration is also associated with changes in family composition; unstable family relationships and sexual partnerships; and patterns of household dissolution and re-formation, including the formation of women-headed households especially among low income groups.

Counterbalancing these negative effects, patterns of behaviour evolved that enabled individual and household strategies to adapt, survive and improve well-being. Principal among these are diversification of income earning activities; the formation of households whose composition differs from conventional nuclear or extended families; the establishment and maintenance of social networks consisting of kin and friends to serve a variety of purposes, including securing employment and housing; and the maintenance of urban-rural links among dispersed family networks.

### **3.4 Strategies for families to safeguard the health of their children**

The post-apartheid government has an impressive record in delivery on health care. Free health care services are now available to all pregnant and lactating women and children up to the age of six years. Primary health care services are available for all poor people through the district health service. Health care has become a reality for people living in previously underserved areas through strategies, which include clinic building and upgrading, and the implementation of community service for graduated medical students. Mass immunisation, nutrition, improved housing, developmental welfare and human resource development programmes have also had an impact on the health profile and quality of life of many South Africans. A recent important breakthrough is the commitment of a wide range of government departments to strengthening partnerships around HIV/AIDS campaigns and care-giving, and the establishment of the National AIDS Council, chaired by the Deputy President.

The RDP provides the framework for the health care and related development

policies of post-apartheid South Africa. Three of the Presidential Lead Projects initiated to kick-start the RDP were related to health services. These projects were the *primary school feeding scheme*, the *free health care programme* and the *building of new clinics* in under-served areas. The examples below illustrate further how the subsequent policy logic and programme design for the health sector has been squarely rooted in the RDP.

The *Transformation of the Health System Act* of 1997 aimed at unifying the racially fragmented health services of the apartheid era; promoting equity, accessibility and utilization of health services; developing health promotion strategies; human resource development in the health sector; fostering community participation; and strengthening planning and monitoring of health status and services.

The *National Health Act* serves as the cornerstone of the ongoing transformation process. The development of a district health system promotes decentralisation of delivery and community participation as also recommended by the ICPD-PoA. The move towards fewer and more viable local authority structures is expected to impact positively on the operation of the district health structures.

The *Basic Conditions of Employment Act (BCEA)* of 1997 protects among others, pregnant and breastfeeding women in matters of employment. It does not, however, provide for the continued payment of salary when a woman takes leave to have a family.

The *Health Information System* encompasses routine data collection at primary health care level within provinces; the new birth and death registration system devised in collaboration with the Department of Home Affairs; the system for notification of maternal deaths; a surveillance system for notification of pregnancy terminations; and the recent Demographic Health Survey commissioned by the Department of Health. The health information system is to be underpinned by provincial information technology policy, and planning and will be progressively consolidated under the National Health Care/Management Information System.

The *Population Policy* directly and indirectly acknowledges primary health care and related issues as areas of concern and stipulates strategies to address them. Among its major concerns are the growth and structure of the population relative to the growth and capacity of the economy to cope with backlogs in, among others, health; inequities in access to social services especially in rural areas; insecure family and community life; and the limited knowledge base and demographic analysis and use of population data in respect of planning and implementation of delivery of basic health care.

Increasingly, labour legislation is paying heed to family responsibility, not only as a criterion on the basis of which discrimination is prohibited but also as a factor to be taken into consideration by employers when regulating the working time of each employee. The BCEA provides for three days paid family responsibility leave per annum, where the employee has worked for longer than four months and works at least four days per week. Family responsibility leave can be taken to care for a sick child and in the case of death of a spouse or life partner, parent, grandparent, child, grandchild or sibling.

### 3.5 Economic measures and actions to alleviate poverty

The South African government is approaching poverty alleviation holistically and not focusing on individual families as such. Various measures and actions have been taken to improve the quality of life of the population by introducing programmes such as the following:

The *Working for Water Programme* links environmental, developmental and population concerns within a unified operational framework at the same time as enhancing the quality of life of the most marginalised groups. Strategic targeting within the programme has attempted to maximise its poverty alleviation effects. During 1997/98, more than 40 000 people were employed, of whom more than 53% were women and 25% youth aged 16-25. The programme has generated a range of small-scale secondary industries. The annual budget allocation has increased from R25 million in 1995/6 to R300 million in 1998/99.

*Community forestry* is aimed at meeting social, household and economic needs, and at developing local economies. It includes farm forestry, agri-forestry, community planting, woodlots and woodland management by rural people. More than 3 500 community forestry projects have been undertaken during the last five years in South Africa.

The *Community Based Public Works Programme (CBPWP)* is part of the National Public Works Programme of the Department of Public Works. With an annual budget of R250 million, the CBPWP focuses on rural areas, targeting the most vulnerable in the communities, that is, youth, women and poor households. It aims to create much needed assets that impact on local communities, including rural access roads, potable water and sanitation, clinics, crèches, community halls and environmental protection. It provides both temporary jobs and training during the creation of these assets, as well as opportunities for sustained economic participation by local communities.

*Small, medium and micro enterprises (SMMEs)* can play an important role in economic development and hold significant prospects for job creation. The *White Paper on the National Strategy for the Development and Promotion of Small Business in South Africa* identifies the need for targeted support for specific groups, including women, the disabled, rural enterprises and youth. The institutional support framework for this purpose includes provincial SMME Desks that focus on SMME development at a provincial and regional level.

The Department of Environmental Affairs and Tourism supports community eco-tourism, which has the potential to contribute to economic development and job creation. These initiatives (in the form of arts and crafts work) promote tourism development in the townships; improve poor people's lives in communities; contributes to a steady growth in the country's economy; and has the outstanding advantage of affording local people the opportunity to contribute to the mainstream economy of the country.

### 3.6 Social sector service provision

The South African government focuses on empowering people at risk, such as juveniles and youth in conflict with the law, people (especially children) affected by HIV/AIDS, the disabled, the elderly, refugees and the unemployed. The government sees the promotion of the well-being of families and communities as a means of promoting the overall well being of the society. The government's commitment is reflected in the paradigm shift towards a developmental social welfare approach.

The government has made deliberate attempts to put in place programmes and policies to enhance self-reliance, as follows:

The *White Paper on Developmental Social Welfare Services* [of 1997] seeks to transform expensive and unsustainable institutional models of service delivery to community-based developmental models.

The *National Plan of Action for Children (NPA)*, was formulated in 1996 by a Cabinet-appointed Intersectoral Steering Committee. The NPA represents the country's plan to meet its commitments in terms of the United Nations Convention on the Rights of the Child. It covers activities developed by government departments, NGOs and other child-related structures countrywide. It includes policy priorities related to nutrition, child health, water supply and sanitation, early childhood development and basic education, social welfare, leisure and cultural activities, and child protection measures.

*The transformation of the child and youth care system* has been a major focus of work since 1994. This systematic process, involving six government Departments and a range of NGOs, aimed at implementing effective developmental, inter-sectoral and integrated services to children, youth and families. Initiatives include the interim policy guidelines of 1996; the Child Care Amendment Act of 1996; the establishment of a task team to investigate a national register for convicted sexual offenders against children; a National Strategy on Child Abuse and Neglect; and the Prevention and Combating of Commercial Sexual Exploitation of Children of 1998. There are also draft policy documents on child pornography and the Internet; street children and early childhood development services; a draft discussion document on foster care guidelines; and a draft issue paper on adoption.

*The Relief Funds Act* includes the Disaster Relief Fund, the Social Relief Fund, the State President's Relief Fund and the Refugee Relief Fund.

The *Not-for-Profit Organisations (NPO) Act* of 1997 lays the foundation for a strong NPO sector and a constructive relationship between the government and the non-profit sector. It promotes voluntary registration - a fundamental shift from past government control and intervention.

The *National Crime Prevention Strategy (NCPS)* is an inter-sectoral, inter-departmental government strategy to reduce the level of crime in South Africa. It adopts a restorative justice approach, which protects the rights of young persons so as to be less restrictive and more empowering. The Department of Social Development

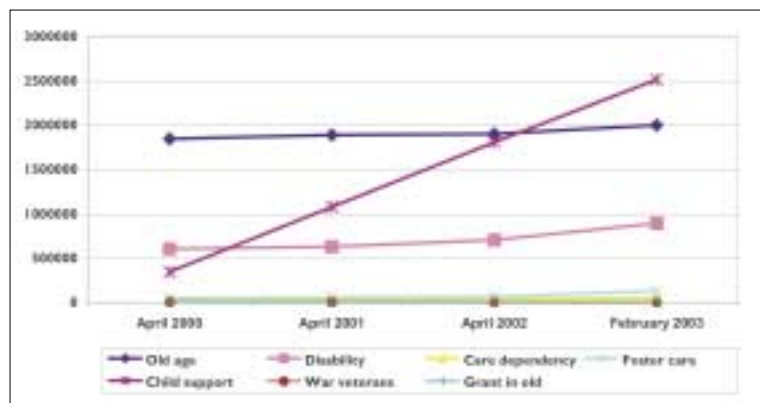
bears primary responsibility for managing the Victim Empowerment Programme. Implementation occurs in collaboration with the nine provinces and the NGO sector.

The development of the *National Welfare Information System* began in 1994. When completed, it will provide the means to monitor welfare trends and inform policy making and planning processes.

Increasing economic stress is a major contributor to family problems and breakdown in family functioning. Clearly, then, there is a wide area of overlap between this section of the report and the discussion on poverty. The achievements in this section are additional to those discussed previously.

Social security plays a vital role in the alleviation of poverty for children, women, the elderly and people with disabilities and their families. The Department of Social Development provides social grants to more than seven million beneficiaries monthly at a cost of more than 2,2 billion per month, representing income support to a large number of poor households. The government has committed itself to ensuring that this vital source of income for the most vulnerable sector of the community continues to contribute to development and the eradication of inequality. Benefit transfers include *old age grants, child support grants, war veterans grants, disability grants, care dependency grants, foster care grants and the grant-in-aid*.

**Figure 13: Trends in the number of grant beneficiaries**



The figure above shows the number of beneficiaries per grant type from April 2000 to February 2003. The total number of grant beneficiaries increased from 3,2 million in April 2000 to 5,5 million in February 2003. This represents an increase of 74% over the last four years.

The Child Support Grant accounts for the most of the increase in the number of beneficiaries. The number of children in payment has increased from 348 532 about three years ago to over 2.5 million in February 2003. Because of a rollout extension of the grant to children up to the age 14 years over a three-year period, the number will continue to increase sharply. The Old Age Grant is the second most popular grant. The number of recipients increased from 1 848 726 in April 2000 to 2 002 320 in February 2003, representing an increase of 7.7% in three years.

The economic and social empowerment of *women* is a government priority. A range of initiatives in the areas of economic empowerment, health and nutrition, education, employment creation and infrastructure development incorporate a special focus on women. The developmental social welfare approach seeks to lift women out of dependency into self-reliance. The greatest challenge for the government remains the inculcation of male responsibility in providing for their families and participating in all aspects of family life.

One of the initiatives of the Department of Social Development is the Flagship Programme for unemployed women with children under the age of five. The programme entails the development of projects that foster economic independence and self-reliance. Fifteen pilot projects have been established with at least one project in each of the nine provinces. The intention is to replicate the programme once a model has been well developed.

One of the agreements at the Presidential Jobs Summit of October 1998 was that women should be primary beneficiaries of special employment programmes. This will apply not only in respect of the number of women employed, but also to the percentage of wages and salaries paid

### **3.7 Challenges and constraints**

The social development approach is new and the service delivery system is not yet adequately re-orientated in line with the new approach. Family concerns have not yet been integrated into all development, environment and population interventions. Partnerships with civil society organizations and the private sector have to be developed further. Population, environment and family interrelationships are still often not considered in decision making and planning. In particular, population data is under-utilised in developmental social welfare planning.

# CHILDREN AND YOUTH

## 4.1 Introduction

The Department of Social Development's theme "*Making South Africa Fit for Children*" resonates in all the work the department does, especially with regard to Child Support Grant (CSG). The increase in the take-up rate for the CSG, the expansion of the Home and Community Based Care programme for children and families infected and affected by HIV/AIDS are encouraging, as are the other areas of work where the department has made substantial progress.

The overall goal is to ensure that children who are infected and affected by HIV/AIDS have access to integrated services that will address their basic needs for food, shelter, education, healthcare, family or alternative care, and protection from abuse and maltreatment.

In order to improve child survival, the provinces have been provided with health guidelines for *improving the quality of prenatal and antepartum care*. Initiatives include a Perinatal Education Programme and the Decentralised Education Programme for advanced Midwifery and Neonatal Science. Information is provided in terms of the breastfeeding policy to allow women to make informed decisions on infant feeding. The Department of Health also identified the primary causes of child mortality, and these are being addressed as priority areas for health delivery.

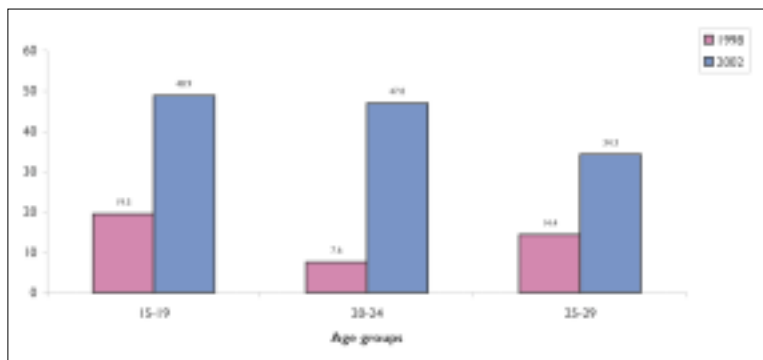
## 4.2 Children and Youth Skills Programmes

The government and other role players have introduced a wide range of *life skills programmes* for youth and adolescents in the areas of sexuality, teenage pregnancies, HIV/AIDS and health promotion. These include campaigns, led by the NGO sector, which encourage young people to postpone sexual activity until they have completed their education.

The Youth and Adolescent Health Programme of the Department of Health is aimed at improving the health status of young people, and to develop and implement policy guidelines for promoting the health of people, by disseminating appropriate IEC material, and by establishing youth-friendly health services as an integral part of existing primary health care services.

The Life Skills Programme of the Department of Education forms an integral part of the school curriculum, aiming at raising awareness on sexuality and the level of knowledge of HIV/AIDS and other health issues among educators, learners and students at all levels in the education and training system. It is also aimed at promoting values that inculcate respect for girls and women, and recognise the right of girls and women to free choice in sexual relations. Gender equity programmes focus on the needs and interests of women, youth and children. The use of condoms among youth aged 15 to 29 is a good example of progress made by the Youth and Adolescent Health Programme. The following figure depicts the trend in 1998 and 2002:

Figure 14: Condom use 1998 and 2002



The figure above shows a significant improvement in the use of condoms by youth. The age group 20-24 has improved markedly from 7.6% in 1998 to 47.8% in 2002.

The key to breaking the inter-generational continuation of the poverty cycle is to focus on youth as parents and the human resource of the future. The *National Youth Commission* was formed to enable youth to shape their future and to learn to take responsibility for their lives.

The National Youth Commission, the National Youth Service Programme (NYSP), the Young Positive Ambassadors and the National Youth Information Service (NYIS) are aimed at involving young people in the reconstruction and development of the country. One of the projects of the NYSP is to refurbish public buildings and to make them environmentally friendly, particularly for the elderly, disabled and for women. Previously disadvantaged communities are involved in the project, and young people acquire skills. The Young Positive Ambassadors is an HIV/AIDS programme aimed at employing young people to educate other young people about the danger of unprotected sex. The NYIS is an information programme that provides young people with information on careers, education, their rights and HIV/AIDS.

### 4.3 Youth health promotion

The Department of Health (in partnership with the Departments of Education and Social Development) developed policy guidelines on 'Health Promotion in Schools'. This will direct schools, communities and service providers to create schools as sectors for youth development. The crucial areas of focus of these guidelines are:

- Community involvement
- Personal skill development
- Effective support services
- A healthy supportive environment
- A healthy school policy

The National Crime Prevention Strategy identified violence prevention in schools as a major focus area.

During 1998/99 a primary school life skills and HIV/AIDS education programme was developed and piloted in 20 schools in South Africa. In the process 20 master trainers and 140 teachers were also trained. A learning programme that will form an integral part of Curriculum 2005 was developed. Teaching and learning support material were also developed, as well as guide for parents.

#### **4.4 Secondary schools life skills programme**

Besides the primary schools' programme, 1999 saw the nation-wide implementation of the life skills and HIV/AIDS education programme at secondary schools. Preliminary monitoring and feedback from Provincial Coordinating Committees revealed several problems that have affected the implementation of the programme, such as the impact of the redeployment of teachers in the programme, lack of basic equipment at schools, etc. Corrective measures were taken resulting in widespread life skills and HIV/AIDS programmes countrywide.

#### **4.5 South African AIDS Youth Programme**

Following the release of the 1998 antenatal statistics (which indicated that the age group between 20-30 was the most vulnerable to HIV infection), the Inter Ministerial Committee (IMC) on HIV/AIDS recommended that a youth programme be developed and implemented as part of a holistic strategy to curb the rapidly spreading epidemic.

Whilst the HIV/AIDS and Life Skills Education Programme primarily targets the youth through the educational system, the South African AIDS Youth Programme (SAYP) attempts to reach youth through social mechanisms outside educational settings.

In 1999 a multi-disciplinary group consisting of government and civil society developed a framework for the implementation of the South African AIDS Youth Programme. Consensus was reached amongst a wide range of stakeholders within the AIDS sector regarding the need for a single, integrated South African plan of action to address the HIV/AIDS epidemic amongst the youth. Business plans have been developed to address the identified problems, and implementation started during 2000/2001.

#### **4.6 Challenges and constraints**

- Insufficient targeting of vulnerable groups within the health delivery system: Particular attention needs to be given to youth and the girl child;
- The rate of teenage pregnancies is still too high despite the work being done by NGOs such as the National Progressive Primary Health Care Network, the Planned Parenthood Association of South Africa, the Women's Health Project and a range of other NGOs, CBOs and religious organizations. Male responsibility needs to be encouraged, particularly, within youth programmes;
- Coordinated multi-sectoral targeting of those affected and infected by HIV/AIDS and the role of people living with AIDS in nation-wide campaigns needs to be strengthened within youth programmes;

- Further targeting and involvement of youth in poverty alleviation programmes;
- Security programmes at schools should also be reinforced to prevent incidents of violence in schools.

# REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

## 5.1 Introduction

The population policy highlights a range of concerns in the field of sexual and reproductive rights and health. These have been addressed since the adoption of the policy in 1998 as part of programmes and projects implemented by a range of government departments and their counterparts in different sectors of society. One of the major strategies of the population policy focuses on "improving the quality, accessibility, availability and affordability of primary health care services, including reproductive health and health promotion services (such as family planning), to the entire population in order to reduce mortality and unwanted pregnancies, with a special focus on disadvantaged groups, currently under-served areas, and adolescents; and eliminating disparities in the provision of such services."

Major concerns in the reproductive health and rights field include high rates of maternal mortality, consequences of violence against women, high-risk and unplanned teenage pregnancies, and the need to improve the quality, user-friendliness and accessibility of reproductive health care services and facilities for different target groups, including the youth.

Addressing these issues requires both a change in the social value of women - a recognition and practice of human rights and gender equality - and improvements in diverse services. This section provides a brief overview of steps that have been taken in both areas since 1994, as well as current challenges.

The Bill of Rights contained in Chapter 2 of the constitution of South Africa (1996) establishes gender equality and the right to "freedom and security of the person". It stipulates that "everyone has the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction; to security in and control over their body; and not to be subjected to medical or scientific experiments without their informed consent". Moreover, the constitution provides that everyone has the right to have access to health care services, including reproductive health care.

This stipulation in the constitution entrenches the international consensus on reproductive rights reached at the International Conference on Population and Development in 1994. The constitutional provision also gives expression to the consensus achieved in the Platform of Action of the Fourth World Conference on Women in Beijing in 1995 regarding sexual rights.

Sexual health services are understood to include the full range of services that allow the enjoyment of sexuality without danger, such as prevention and treatment of sexually transmitted diseases and prevention and treatment of the consequences of sexual violence against women and children.

Reproductive health is understood to include the full range of services that allow people to achieve their reproductive goals, such as maternal health, contraception, abortion and infertility services, as well as prevention and treatment of diseases of the reproductive system, such as cancers. In the perspective of both the international agreements the South African government believes that these services should be delivered within primary health care services.

## 5.2 Fertility trends

The Total Fertility Rate (TFR) in South Africa was high and stable between the fifties and the seventies, estimated at an average of 6 to 7 children per woman. During the period 1980 to 1995, the number of children per woman dropped to between 4 and 5 children on average. The fertility rate in South Africa has now declined to under three children per woman.

However, considerable variations occur between the different racial groups, as well as between different geographical areas and urban and non-urban areas in the country, depending on a range of socio-economic and cultural factors. Non-urban areas had a fertility rate of 3.9, compared to 2.3 for urban areas. Women with no formal education had a TFR of 4.5, while women who had achieved post standard 10 education had fertility rates of 1.9. Also, different population groups had different fertility rates: Africans have the highest at 3.1 (4.0 in non-urban areas), followed by coloureds at 2.5 and whites at 1.9 (All data from the South African Demographic and Health Survey, 1998).

In normal social contexts, fertility rates are an indicator of development. In South Africa, however, fertility patterns for the majority of the population are not directly associated with level of development, mainly due to the fact that previously family planning services were delivered without the necessary attention to socio-economic upliftment and human development.

## 5.3 The state of sexual and reproductive rights in South Africa

Since 1994, there have been significant legal and policy reforms in the area of sexual and reproductive health and rights in South Africa. The passing of the Choice on Termination of Pregnancy Act, (Act no 2 of 1996) was one of the first major developments in this field. It replaced the restrictions imposed by the Abortion and Sterilisation Act of 1975. The Act stipulates that all women in South Africa, irrespective of age, location and socio-economic status can choose to terminate a pregnancy within the first 12 weeks, and thereafter under particular circumstances. The main objective is to reduce infections and the number of deaths due to illegal abortions, by giving every woman the right to choose whether to have an early, safe and legal termination of pregnancy. In 2000, out of 292 designated facilities rendering pregnancy termination services, 88 (32%) were functioning, of which 62 (70%) and 26 (30%) were public and private sector facilities, respectively.

The increasing demand for the service since the implementation of the act in 1997 clearly illustrates the need for this kind of service. For example, from the beginning of 1997 to the end of 2000, more than 161 867 terminations were performed,

which represented a figure of 428 per 100 000 of the female population. Almost a third (51 132) of these terminations were performed in 2000 only. Approximately 55% of the terminations were requested by women older than 18 years, and 8% by women younger than 18 years. The total number of terminations from February 1997 to December 2003 was 328 123, with details as follows: women younger than 18 years: 27 571; women older than 18 years: 195 698; unknown age: 104 854.

Since the implementation of the act there has been a major reduction in morbidity due to unsafe abortion. Morbidity almost halved from 16.5% in 1994 to 9.7% in 2000. By 2000, most of the cases (90.1%) had no signs of infection on admission, significantly more than in 1994. The modest side effects reflect the inadequacy of services in some areas and need for greater public education on reproductive health and rights.

While there have been significant strides since the implementation of the act, inequities and barriers in access to services for the termination of pregnancies still remain. There are stark regional disparities in the provision of abortion services, with more resourced provinces performing most of the abortions while some regions do not provide any services. Health workers are not obliged to refer women seeking abortions; referral mechanisms are ad hoc and are not being monitored. Many health workers view abortion as a "privileged" service rather than a woman's right, and thus do not feel obligated to assist them. This indicates the need to reorient and train health workers regarding woman's reproductive health needs. Most terminations are done in the first trimester, and few hospitals provide appropriate second trimester procedures. This results in long waiting lists, with many women and teenagers who present late being turned away.

Overall contraceptive prevalence rate (CPR) among sexually active women (15-49 year olds) was 61.2% in 1998. The rate was the highest in the Western Cape Province (73.7%), and the lowest in Mpumalanga (53.3%). The national rate for Contraceptive Injections was 30.1%, for the Pill 13.2%, and Condom Use was 2.3%, in 1998. Contraceptive use among women was most common among the Asian group (80.1%), and least common among the African population group (57.6%).

The Second Draft Guidelines for Contraceptive Services, released in 1999, were aimed at improving the range of contraceptive choices and the efficiency of provision. An important development has been the introduction of femidoms and emergency contraception. The promotion of condom use to ensure "dual protection" is an issue that needs attention within the context of contraceptive use, especially given the priority accorded to preventing HIV infection.

Notwithstanding the decline in fertility rates, there remains a disjuncture between actual and preferred family sizes. This may be partly attributable to lack of access to contraception or contraceptive failure. But more importantly, it identifies the underlying problem, namely the current context of inequality in sexual and reproductive relations. Many couples still do not communicate and share decision-making regarding family planning and childbearing, and women's rights to make informed reproductive decisions is disregarded in many cases. The extensive use of contraceptive injections, (which is a legacy of the past, when it used to be general

family planning practice to exclusively provide injections to women in their fertile years), also reflects women's attempts to take control over their reproductive capacity without having to discuss other options to prevent pregnancy with their partners.

#### **5.4 Sexually Transmitted Infections (STIs) treatment and condom distribution**

Focused prevention and treatment campaigns contributed to a significant decrease in the incidence of STIs. For example, the STI partner notification rate increased from 39% in 2000 to 71% in 2002, and has reached 77% by the first quarter of 2003. Condoms of high quality (approved by the SA Bureau of Standards) are available free of charge from clinics and other outlets throughout the country. Public sector male condom distribution has increased dramatically from 150 million in 1997 to 270 million in 2003. Distribution of male condoms through non-traditional outlets was strengthened and monitored. Condoms are currently being distributed to more than 3000 different outlets in the public sector, with an average of more than 1 million condoms distributed in the public sector per month. The Department of Health increased the number of designated sites for the access of female condoms from the initial 28 pilot sites in 2000 to more than 200 sites in 2003. In 2003, 1,4 million female condoms were distributed countrywide.

#### **5.5 Maternal Health**

The maternal mortality rate is an important health status indicator and a critical measure of human development. In fact, one of the Millennium Development Goals focuses on improving maternal health, with a target to reduce the maternal mortality rate by three-quarters between 2000 and 2015. As indicated above, maternal mortality rates decreased from 250 to 230 per 100 000 live births during the period 1990 to 1995. The SADHS 1998 revealed a figure of 150/100 000.

In 1997, the Minister of Health appointed the National Committee for Confidential Enquiry into Maternal Deaths (NCCEMD) to investigate problems related to the paucity of data, and more importantly, to delve into the causes of deaths and to institute mechanisms for reducing the numbers of women who die during pregnancy and childbirth. The investigation revealed the causes of maternal deaths in order to take purposeful action to decrease maternal mortality in South Africa. In October 1999, the Minister released the "Saving Mothers Report", containing findings and recommendations based on the investigation of more than 600 maternal deaths reported in 1998. Some of the major findings included the following:

The most important causes of death were hypertension, non-pregnancy-related infections (including AIDS), obstetric haemorrhage, pregnancy-related sepsis and pre-existing maternal conditions. Other causes of deaths included abortion, anaesthetic accidents, acute collapse and embolism. 3,2% of deaths were not classifiable and a small number of deaths could not be related to pregnancy. Women older than 30 years, those with more than 5 previous pregnancies and those experiencing their first pregnancies were found to be at higher risk. African women

were found to be generally at higher risk than other race groups in the country, confirming that racial disparities in risk is indicative of socio-economic status differences and different levels of access to health care.

The enquiry paved the way for instituting and implementing mechanisms for reducing the number of deaths among pregnant women, especially to curb avoidable factors and missed opportunities as contributing factors to maternal deaths. The following strategies flowed from the enquiry:

- Implementation of guidelines to manage conditions that commonly result in maternal deaths.
- Implementation of referral routes and criteria for referral.
- Establishment of staffing and equipment norms by level of care in institutions caring for pregnant women.
- Expansion of termination of pregnancy services and ensuring that the public is informed of their availability.
- Applying the partogram routinely for monitoring labour.
- Making available blood transfusion at all institutions where cesarian sections are performed.
- Establishment of Medical Obstetric Clinics to manage pregnant women with pre-existing conditions.
- Intensification of Family Planning education for women over 35 years and those with parity >5 on the risks of pregnancy.

Following this enquiry and report, follow-up actions since 1999/2000 included the development and implementation of practical guidelines for use at facilities for the management of major causes of maternal deaths, as well as norms and standards for better maternal care.

There was an increase in the proportion of births attended by skilled health personnel. In South Africa, it is more likely to have skilled health personnel attending the birth if the birth is of earlier birth order, in the urban areas and the higher the education level of the mother. Also, people from the white, coloured and Asian population groups are more likely to have their birth attended to than do people from the African population group.

## 5.6 Adolescent health care

Childbearing levels for South African adolescents do not appear to be changing and is still significantly high, with one third of women having experienced at least one pregnancy before the age of 20. Teenage pregnancies are also more prevalent among coloured and rural African girls, and those with little or no education.

The onset of sexual activity has become progressively earlier. Many young South Africans become sexually active at 13 or 14 years of age. However, adolescents' knowledge on reproductive functions and sexuality is generally poor. A substantial number of young people have indicated that they need information on matters such as pregnancy, sexually transmitted infections, sexual intercourse and relationships. Recent research also highlights the issues of coerced or forced sex and its relationship to teenage pregnancies. The research showed that many teenagers did

not want to become pregnant at an early age, but were significantly more likely to have experienced forced sexual initiation and physical abuse at the hands of their partners. These factors have dire consequences, i.e. the high levels of teenage pregnancy reflect a pattern of sexual activity that puts teenagers at risk of HIV and other sexually transmitted diseases.

The 1999, 2000, and 2001 antenatal surveys show that the HIV status among young South Africans appears to have stabilized at about 16%. The prevalence in the 15-19 age group declined in recent years. HIV infection is spreading at a rate of 1 700 new infections per day, one of the fastest growing rates of HIV in the world. Over half of these new infections occur in young people. This creates an imperative to understand teenage pregnancy and the pattern of high-risk sexual activity amongst adolescents.

There are studies however that indicate that many young people do have a high level of awareness of HIV/AIDS. For example, 95% of teenage women interviewed during the South African Demographic and Health Survey (1998) knew about AIDS. Most of them got their information from the television, radio, friends and health workers.

One reason for the rate of adolescent fertility and the resultant risk of contracting sexually transmitted diseases including HIV may be because the youth do not have easy access to contraceptive services. Although a large number of family planning clinics and services exist throughout the country, adolescents are often not welcome at these services. This is despite the fact that health providers are legally obliged to provide contraceptives on request to young people from the age of fourteen.

To combat the high fertility rate among adolescents and the resultant risk of STDs, including HIV/AIDS, it is imperative to make reproductive and sexual health services, including contraceptive services more accessible to the youth. To address this concern, one of the major strategies of the Population Policy (1998) has been 'Promoting responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the incidence of high-risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/AIDS through the provision of life skills, sexually and gender-sensitive education, user-friendly health services and opportunities for engaging in social and community life'. This strategy is in line with the ICDP goal of 'Reducing the HIV rate amongst 15 to 24 year olds by 2003 in the most affected countries and by 25% by 2010 globally'.

In order to ensure easier accessibility to health services, more than 60 health facilities countrywide were actively involved in the provision of Youth Friendly Services (YFS). Furthermore, the National Adolescent Friendly Clinic Initiative (NAFCI) was established to make reproductive and sexual health services more accessible and appropriate to young people. This is a five-year project, which started in September 1999. It is led by the Reproductive Health Research Unit (RHRU) (University of the Witwatersrand), which is based at the Chris Hani Baragwanath Hospital in Gauteng. Other partners include the Planned Parenthood Association of South Africa (PPASA), Health Systems Development Unit, and the Health Systems Trust's Initiative for Sub-district support. The NAFCI project provides a comprehensive service performance and quality improvement accreditation

programme. Its main objective is to contribute to making healthcare facilities more accessible and acceptable to adolescents. The initiatives of the project include:

- Expanding access to youth-friendly services including the prevention of HIV and sexually transmitted disease (STD), and providing reproductive health information to young people;
- HIV/AIDS testing and counseling; and
- Providing care and support services.

As an integral component of the loveLife programme, NAFCI contributes to loveLife's goal to effect positive behaviour changes among young South Africans to reduce teenage pregnancy, STDs and HIV/AIDS. The project also aims to:

- Promote a holistic approach to the management of adolescent health needs by healthcare providers;
- Set national norms and standards for adolescent healthcare in clinics throughout the country; and
- Promote an appropriate clinic environment for the provision of adolescent health services.

The project was initially piloted at 10 clinics in 4 of the 9 provinces, namely in Mpumalanga, Limpopo, Kwazulu/Natal and the Western Cape, with the idea of expanding it to 50 sites in 2001. The NAFCI concept was also introduced nationally and workshops on NAFCI were successfully conducted in eight provinces. Appropriate IEC materials on different topics, aimed at promoting responsible sexual behaviour, were also developed and disseminated in all 9 provinces.

The NAFCI has been innovative enough to collaborate with schools and surrounding communities. It was linked with the HIV/AIDS and Life Skills programme at schools. Life skills education is one of the most critical interventions, since it serves to build self-esteem, confidence and the ability to act with mutual respect and responsibility in sexual relationships. The need to promote a culture which asserts equality between women and men, including the assertion of sexual and reproductive rights, is necessary in order to challenge these current norms and the consequences they have for the sexual health of the current generation of youth. This is an integral step to promote gender equality in relationships, including sexual relationships.

The implementation of the NAFCI by NGOs can be seen as enhancing the ability of government health facilities to respond to the reproductive health needs of young people.

A similar programme was implemented by the Department of Health, namely the Youth and Adolescent Health Programme (refer section 4.1 above), aimed at improving the health status of young people. Programme implementation is supported by IEC material that promote youth-friendly health services as an integral part of existing primary health care services.

The South African AIDS Youth Programme (SAYP) caters for out-of-school youth through social mechanisms and opportunities that exist outside formal educational settings.

Some of the major challenges regarding adolescent reproductive health include the continued high levels of teenage pregnancies despite various efforts to reduce teenage fertility; active involvement of boys and men in programmes aimed at promoting gender equality and male responsibility; effective multi-sectoral coordination of campaigns and programmes that focus on young people infected and affected by HIV/AIDS; targeting out-of-school youth who are not usually exposed to formal life skills programmes conducted in schools, with a specific focus on gender relations.

### 5.7 Challenges and constraints

Although South Africa demonstrates relatively high contraceptive prevalence rates in comparison with other sub-Saharan countries, the mix of contraceptive methods used by different groups needs to be considered in the interest of effective use of contraception. Another issue of concern is that women have expressed concern regarding the side-effects of injections, that are not addressed by service providers - a situation that leads to the discontinuation of contraceptive use. Some clients expressed dissatisfaction with approaches of health workers to contraception, a problem that is also experienced by young people. One issue not yet addressed through the guidelines for contraceptive use is the promotion of condom use within the context of contraceptive services. The need for "dual protection" is important, given that the prevention of HIV infection is a national priority.

Substantial attention has to be devoted to the continued development and strengthening of health systems. In addition, issues of gender equality need to be included in health worker curricula and in-service training, with a specific focus on building health workers' understanding of their clients' experience and their ability to help clients achieve sexual and reproductive rights and health. Finally, data available at the national level are inadequate to provide the necessary insights into the causes and consequences of the absence of sexual and reproductive rights. This impacts on policy-making and planning to ensure cost-effectiveness of interventions aimed at addressing these issues.

With regard to adolescent health, the following challenges should be focused on:

- continued high levels of teenage fertility and the social and economic consequences thereof
- involvement of men in programmes aimed at promoting gender equality and male responsibility
- coordination and integration of campaigns and programmes that focus on young people, including those infected and affected by HIV/AIDS
- life skills programmes that target out-of-school youth, which include a focus on gender relations.

# DEMOGRAPHIC, ECONOMIC AND SOCIAL IMPACT OF HIV/AIDS

## 6.1 Prevalence trends

The antenatal survey conducted in October 2002 found 26.5% of pregnant women to be HIV positive. Although this estimate is higher than the 24.8% prevalence recorded in 2001, the increase is not statistically significant. These findings confirm the observation that the rapid growth of the South African epidemic may be slowing down.

## 6.2. Factors in the spread of HIV/AIDS

The high geographical mobility of the South African population and the extensive migrant labour system are both important in understanding the spread of HIV/AIDS in the country. South Africa's well-developed system of transportation routes also influences the geographical mobility of its population. South Africa's superior air, rail and road transportation network provides excellent corridors for the more rapid spread of the disease across the country.

However, the causative factors have more to do with power dynamics between partners and their socio-economic situation.

The reciprocal effects of the simultaneous epidemics of tuberculosis (TB) and sexually transmitted infections (STIs) also have to be considered as an important factor in the rapid spread of HIV/AIDS. HIV-positive people are particularly prone to the opportunistic invasion of TB. This means that there is a broader base from which the disease can be spread. The Medical Research Council estimates that approximately 55% of all TB cases were HIV-positive. In 2002, the incidence of TB was estimated at from 172,4 cases per 100 000 in Limpopo to a particularly high incidence in the Western Cape of 917,4 per 100 000. The STI prevalence is also unacceptably high, and highly correlated with HIV in the poorer provinces.

## 6.3. Demographic implications of HIV/AIDS

HIV/AIDS mainly kills young adults, which has a direct and indirect effect on population size. Directly people, who would otherwise have been alive, die. Indirectly people who otherwise would have been alive as well as people who live with HIV/AIDS have fewer children, which leads to an accelerated decline in fertility. Hence South Africa now has a population of between 45 and 46 million, whilst it would have had a population of almost 50 million without the effects of the decline in fertility brought about by the epidemic.

If South Africa does not intervene to treat those who have contracted HIV/AIDS then the country's population will stabilize during the current decade at around 48 million. If the South African government achieves a 100% roll-out of Anti-Retroviral

Treatment (ART) within the next year, then the population could continue to grow to about 52 million by 2010.

Untreated HIV/AIDS leads to a concentration of deaths amongst young adults (especially women) between the ages of 30 and 40. The introduction of ART will increase the life expectancy of HIV+ adults by up to 10-15 years, thereby shifting the concentration of deaths to the 40-50 age group. The effect will also be that the number of deaths due to AIDS (currently about 400 000 per year) may not increase to almost 1 million per year by 2010 (as previously expected), but will probably decline in the next few years, and then increase gradually to almost 500 000 by 2010. The average life expectancy of South Africans has declined from over 60 to 50 due to HIV/AIDS. In the absence of ART, it would have declined further to 40 by 2008. A 100% roll-out of ART will however keep life expectancy at around 50 until 2010.

At the moment South Africa has about 600 000 orphaned children. Earlier projections (excluding Anti-Retroviral Treatment) expected a rise to 2 million by 2014, mainly as a result of HIV/AIDS. The introduction of Anti-Retroviral Treatment could halve the anticipated number of orphans. This should however not divert attention from the fact that the number of orphans will still increase by two-thirds in the next decade, with the sharpest part of that increase occurring in the next few years until 100% coverage by Anti-Retroviral Treatment is achieved.

#### **6.4. Strategic interventions to curb HIV/AIDS**

The government is adopting best practices from selected countries where strategic interventions have been successfully implemented to curb the HIV/AIDS pandemic. Moreover, a number of strategic interventions that are of key importance locally have been identified in order to combat the prevalence and impact of HIV/AIDS in South Africa. These include:

- Poverty eradication and accelerated socio-economic development.
- Improved prevention programmes, including information, education and communication (IEC) aimed at reducing the stigma attached to HIV/AIDS, and assisting people to diagnose the infection in its early stages and to deal with the impact of HIV/AIDS.
- Intersectoral coordination and capacity building to ensure the cost-effective use of scarce resources and to meet the needs of affected people, without compromising other national priorities
- Monitoring and evaluation of the impact of intervention programmes to ensure cost-effective allocation of available resources to HIV/AIDS programmes in the context of sustainable development
- Active involvement of employers and employees in the workplace and mobilizing support from organized labour for HIV/AIDS
- Integration of HIV/AIDS interventions into all public and private health care planning
- and enhancing the skills and knowledge of health workers to ensure cost-effective service delivery in this field
- Financial and social support to infected and affected people, especially orphans
- Improving the social and economic status of women in order to increase the

ability of households to cope with the impact of HIV/AIDS and reduce women's vulnerability to HIV/AIDS

- Focused research studies and the development of monitoring systems to improve the quality of information on the impact of HIV/AIDS - to serve as a basis for sound policy making and planning about HIV/AIDS, and to ensure that the effect of HIV/AIDS on society is adequately managed.

### **6.5. South Africa's response to HIV/AIDS**

South Africa is fortunate to have a very strong and vocal civil society response to HIV/AIDS. NGOs and CBOs have gone a long way in the last few years to ensure that people living with HIV/AIDS have access to services, thereby complementing the work of government. The national Department of Health also supports this by funding NGOs and CBOs annually to render HIV/AIDS services, including care and support services.

NGOs and CBOs also play an important role in creating awareness and building knowledge and skills in HIV/AIDS programmes. However, much more work is needed in this sector to ensure that NGOs and CBOs provide the most appropriate services where they are needed. Skills required in NGOs and CBOs extend beyond just HIV/AIDS, but include skills in project management and financial management.

The government's response to the HIV/AIDS epidemic prior to 1994 was restricted to limited condom distribution, with some training and awareness campaigns. Since 1994 commitment was increased. One of the most significant indicators of the increased commitment is the growth in the budget for HIV/AIDS since the early 1990s.

In 1998 the Inter-Ministerial Committee (IMC) on HIV/AIDS was established to craft a more comprehensive government response to HIV/AIDS. The IMC was chaired by the Deputy President, and attended (monthly) by all Ministers and Deputy Ministers. This body was instrumental in "broadening" the response of the government to HIV/AIDS. An Interdepartmental Committee on HIV/AIDS mimicked this body that functions on a departmental level, attended by officials.

In this time the HIV/AIDS programme at the Department of Health also broadened its own focus to include aspects such as Partnership Support, a Youth Programme, and integrating HIV and TB.

The IMC created an ideal platform for interaction on a government level on HIV/AIDS, and this structure was replicated in the provinces, where the Premier would chair the provincial IMC. However, in 1999 there was also the realization that the structure needed to reform itself to include civil society, which had been responding to HIV/AIDS with only minimal interaction with and support from government. Government and civil society needed to be brought together in a single structure that would enhance coordination and integration of HIV/AIDS activities and programmes.

To this end the South African National AIDS Council (SANAC) was launched in early 2000 to replace the IMC. This body is chaired by the Deputy President, and has 16 government representatives (14 Ministers, and 2 Members of Parliament) and 19 civil society members, representing 16 civil society sectors. The sectors represented include traditional healers, faith-based organizations, and trade unions. SANAC is also supported in its work by 5 Technical Task Teams in the areas of (1) Prevention, (2) Treatment, Care and Support, (3) Legal and Human Rights, (4) Monitoring, Research & Evaluation, and (5) Social Mobilization, Information, Education & Communication.

In the next section there will be an attempt to document some of the responses by the government to HIV/AIDS. It would be virtually impossible to provide a full list of interventions and programmes, so this section will focus on **some** of the responses by government departments that have a crucial role in responding effectively to HIV/AIDS.

## 6.6 Prevention, treatment and care

One of the messages from the 13th International AIDS Conference held in Durban, South Africa in July 2000 clearly reiterated that the key to success in fighting the spread of HIV/AIDS is prevention. Prevention strategies such as effective STI management, HIV/AIDS education and life skills, and the provision of barrier methods have since the inception of the epidemic shown to be effective.

Clearly the prevention of HIV infection is about developing a range of strategies and interventions that support behaviour change. To achieve behaviour change, earliest efforts in HIV prevention provided information about the dangers of HIV infection as well as recommendations for safe behaviour. This was the era of eager confidence - that when people learned about HIV/AIDS, they would generally "take steps" and "do the right thing". This approach helped to alert people but was insufficient to promote or sustain behaviour change.

Interventions that have been shown to be effective include:

- Treatment by health care staff who are well trained and experienced in HIV care;
- Early treatment of any infections in HIV-infected people, particularly tuberculosis;
- Prevention therapy against certain common infections; and
- Treatment with anti-AIDS drugs.

Other interventions such as maintaining healthier life styles, good nutrition, and avoiding re-infection with different viral strains through unprotected sex are also of value.

The welfare and development of all countries are dependent on the status and well-being of their women citizenry. In a previous section the burden on women has already been highlighted. Challenges in promoting the rights of women are societal values regarding women's rights to control their own sexual and reproductive health, including negotiating condom use. The complex, multi-layered connection between women's status and women's health, between women's health and the health of their families, communities, and even countries, cannot be

overemphasized. Thus, while there is an immediate imperative to develop programmes for counseling HIV positive women, if it is to succeed, women should be generally empowered through involvement in local, national and international HIV care and prevention initiatives.

Responding to HIV/AIDS is not just about prevention, it is about creating and applying a series of interventions that are coordinated and that bring together prevention, care and support activities. The prevalence of HIV infection varies both geographically and across "risk groups", and this raises some considerations that must be addressed in AIDS prevention efforts. Effective planning and action are required to manage prevention and the impact of infections that already exist.

Leaders at all levels in politics, the labour movement, business, religion, traditional structures and community organizations can no longer ignore their obligation to combat the epidemic. They need to use every opportunity to speak out and mobilize action on HIV/AIDS, because the benefits of many activities that currently preoccupy them will be enormously reduced. They must ensure that HIV/AIDS is explicitly considered in all policies, plans and activities. They must also strive to participate as partners in broader campaigns and programmes.

Community resources can be used to implement and support HIV/AIDS prevention initiatives. One of our greatest challenges in preventing the transmission of the virus is that if HIV information and counselling are only available in clinical settings or if we promote physicians as the most important source of information, prevention will also be dangerously over-medicalised.

Even though changing people's sexual behaviour is not easy, people need to have knowledge of HIV/AIDS and how to prevent it, they have to realize personal, social and economic circumstances which make it difficult for them to protect themselves.

Caring for HIV/AIDS patients is the biggest problem that South Africa is faced with. Challenges in doing this include the fight against discrimination in order to build a network of supporting patients. This support should include family members, community leaders, religious leaders, government, NGOs and the broader civil society.

The South African government approved the Operational Plan for Comprehensive Treatment and Care of HIV/AIDS in August 2003. It is envisaged in the Plan that, within a year, there will be at least one service point in every health district across the country and, within five years, one service point in every local municipality, to provide Anti-Retroviral Treatment.

## **6.7 Department of Correctional Services**

Health education programmes and awareness are promoted on a continuous basis through interdisciplinary efforts and participation from community structures and NGOs. National and International Commemorations such as Human Rights Day, World AIDS Day etc. are used as opportunities to focus on HIV/AIDS.

The involvement of organizations such as Hope Worldwide, National Association of People with AIDS (NAPWA), ATIC (AIDS Training and Information Centre), Churches, SACMA (South African Civil Military Alliance) and others contributes meaningfully where the health services are over-stretched. Correctional Services recognize that the involvement of NGOs, CBOs, other government departments, professional organizations, unions, educational institutions, media, business sector, families and volunteers is a pre-requisite for a credible HIV/AIDS strategy in prisons.

The decision to make condoms available to offenders came in 1996 after a report by a Work Group that was appointed by the Commissioner to investigate health services in South African Prisons. After serious consideration of all relevant issues including the promotion of sexual practices, it was decided that condoms and information about their correct use be made available to offenders on the same basis as condoms are provided in the general public. While condoms are made available to prisons, it is important that partners are empowered to be able to negotiate for safer sex while in prison, and for life after release.

Peer education is replacing instructor-led education in HIV/AIDS as offenders are seen as important vehicles for behavioural changes, acting as educators and agents for change. Within South African prisons, offenders participate actively in these programmes. Increasingly more offenders are being trained to assume this responsibility, with the assistance of NGOs.

The workplace should be seen as an excellent place to raise awareness among employees. Employee Assistant Practitioners have been appointed in South African Prison Services in all the nine provinces to focus on the needs of employees.

In line with the guidelines of the WHO and United Nations no mandatory testing is conducted on offenders. In an effort to establish scientifically the extent of HIV/AIDS in prisons, an anonymous sero prevalence survey is planned.

The practice in South African prisons is to isolate those who are in the active stage of TB, incontinent or have skin infections. This is done to prevent the spread of infection and to optimize therapeutic interventions. Symptomatic treatment is provided for complications arising from the compromised immune system, no antiretrovirals are yet administered to offenders with HIV/AIDS.

## **6.8 Department of Education**

The Minister of Education has declared HIV/AIDS a strategic priority for the Department. HIV/AIDS is part of integral work of the various branches of the education sector, namely planning & monitoring, general education (for grades 0-9), further education & training (for grades 10-12, as well as technical colleges), and higher education (all tertiary institutions). Activities include:

- **Planning and monitoring:** The department has conducted an HIV/AIDS impact assessment study on the Education Sector. The process of developing a strategic plan that takes into account the findings and recommendations of this

study is underway. The overall objective is to ensure that the education system is ready and equipped to deal with the impact of HIV/AIDS and that the planning and the programmes of the core branches reflect this.

- **Learners:** It is National Curriculum Policy to have Life Skills and HIV/AIDS Education as part of the Life-Orientation Learning Area curriculum. In addition, HIV/AIDS is infused into all learning areas in the schools e.g. history, mathematics, languages, etc. The initial focus has been in the most affected ages of 9-16. The branch has also started activities targeting primary schools as well as peer education for students. The ultimate objective is to have all learners, primary through to high school, exposed to this curriculum.
- **Educators:** HIV/AIDS Emergency Guidelines have been developed in all official languages and distributed to all schools. The key features of the guidelines are to outline the role of the educator in the epidemic, to provide information that will enable educators to respond to HIV/AIDS as an emergency and to reiterate the position that it is against the law for educators to have sexual relations with learners.

The department is in the process of developing a workplace programme targeted at prevention, support and creation of an enabling environment for educators. This will include management of HIV/AIDS for school principals.

- **Further Education and Training:** This branch focuses on High School Education (Grades 10, 11 & 12) and the national technical certificates 1,2 & 3 in technical colleges. The Life Skills and Education curriculum policy covers high schools and high school learners are catered for by this as well as the peer education programmes. A plan for the National Technical Colleges is underway.
- **Higher Education:** The branch is working with the South African Universities Vice Chancellors Association, SAUVCA, to develop a response to HIV/AIDS for this sector. The Impact assessment study led by the planning branch covered this sector. At this point, a strategic plan to institutionalize the response to HIV/AIDS in the University and Technikon sectors has been developed and the SAUVCA Board has approved an implementation plan. Activities reflected in this plan should be visible by the end of the year and individual universities should have programmes in place by then.

## 6.9 South African National Defence Force (SANDF)

The Defence Force from early on recognized the important link between the effective management of STIs and HIV infection. The strategy for HIV/AIDS prevention thus focuses strongly on this element. Subsequently, as knowledge in HIV/AIDS has developed, the prevention strategy in the Defence Force has expanded to include HIV/AIDS and STI education. In addition, HIV/AIDS is managed as a chronic debilitating disease in all aspects to reduce stigmatization and normalize the disease.

The emphasis for the Defence Force in managing HIV/AIDS is indeed in the area of

prevention, treatment and care. Key components of this programme include:

- Condom promotion and distribution
- Mass awareness and mobilization
- HIV/AIDS workplace programme
- Peer education as well as other broader education initiatives
- Counselling services (both lay and professional counseling)
- STI management
- HIV specialist referral services
- Training of personnel involved in HIV/AIDS management

The management of HIV/AIDS focuses strongly on peer education, and the SANDF currently has one peer educator per 100 members. Peer educators also complement mass awareness programmes, that provide crucial information. Professional counseling is provided to members as part of pre- and post-test HIV counseling.

Care of those infected is based on a multi-disciplinary and multi-professional approach and address the complete continuum of care. This care and support includes:

- General healthcare, nutritional support and prevention of opportunistic diseases.
- Post-exposure prophylaxis for the prevention of HIV transmission in the occupational setting.
- Home-based care with referral to external support structures after medical discharge.

In addition the Defence Force also offers programmes for the prevention of mother-to-child transmission of HIV and prophylaxis for documented cases of sexual assault. Specialist referral centers have also been established to manage HIV/AIDS related complications and to implement and coordinate HIV/AIDS research.

## **6.10 Social Development**

The Department of Social Development is a very active partner in the fight against HIV/AIDS in South Africa. It has very strong role in addressing the social development and welfare needs of the population of the country. This commitment is encapsulated in the Social Development Plan on HIV/AIDS.

The main aim of this plan is to:

- Achieve a decline in the prevalence of HIV/AIDS through targeted preventative interventions;
- Manage the impact of AIDS on social security;
- Develop affordable community-based care and support models;
- Formalise strategic alliances; and
- Develop appropriate policy

Following this document the Department developed a Plan of Action, identifying seven critical outputs:

- Develop a model to understand the social impact of HIV/AIDS;

- Identify a national pilot project;
- Facilitate paradigm changes in social welfare;
- Develop an appropriate social welfare infrastructure to deal effectively with HIV/AIDS;
- Promote community cohesiveness by enhancing family preservation;
- Develop a model for caregivers and training; and
- Create partnerships within state structures and civil society.

Subsequently the Department of Social Development collaborated with the Department of Health to develop appropriate models of home/community-based care (see following). Other important contributions have been:

- Development of a population and development information service specifically focused on HIV/AIDS as a national population concern.
- Development of the government-wide human resource development strategy on planning for the impact of HIV/AIDS.
- Reviewing the Child Support Grant to include children between the ages of 7 and 14.
- Reviewing the regulations of foster care grants to increase its coverage of kinship foster care.

### **6.11 Social Development, Education and Health**

In the year 2000 the Cabinet provided a special allocation to the Departments of Social Development, Education and Health to develop an integrated plans focused on children infected and affected by HIV/AIDS. This based on the demographic impact of HIV/AIDS on children, especially the increasing number of AIDS orphans.

The National Integrated Plan for Children Infected and Affected by HIV/AIDS intends to:

- Provide access to integrated services that address their basic needs for food, shelter, education, healthcare, family or alternative care, and protection from abuse and maltreatment.
- Develop and implement approaches that effectively capacitate and mobilize children, families and communities to combat many of the effects of the HIV/AIDS epidemic.
- Develop a longer-term strategy that will prepare South Africa adequately for future challenges.

The four elements of the National Integrated Plan are:

- a) Home/community-based care and support
- b) Voluntary HIV counseling and testing
- c) Life skills and HIV/AIDS education
- d) Community mobilization

### **6.12 Challenges in HIV/AIDS for South Africa**

South Africa faces several challenges in dealing with the HIV/AIDS epidemic. The most important ones are:

- Improving social conditions in South Africa (e.g. poverty, housing, water, sanitation)
- Establishing a district-based response to HIV/AIDS
- Building a strong civil society response to HIV/AIDS
- Increasing leadership, will and commitment in all spheres of society
- Building the capacity of the healthcare system at local level to implement effective prevention, treatment and care interventions
- Establishing strong and effective care and support programmes at ground level, focusing strongly on community-based home care
- Maintaining a strong and motivated public healthcare system in the face of increased burdens on that sector.

# POPULATION DISTRIBUTION, URBANISATION AND MIGRATION

## 7.1 Introduction

Today's population distribution, migration and urbanisation patterns are the legacy of the apartheid era. The apartheid system forcefully 'removed' over three million African, Indian and coloured people. It created urban concentrations of poor communities without viable commercial, industrial and other economic activities. It created many settlements in rural areas with similar, or worse, restrictions in terms of opportunities.

The government has developed Urban and Rural Development Frameworks, and a National Spatial Development Perspective, which reflect its thinking on internal spatial issues. The population policy promotes an increase in alternative choices to migration from rural to urban areas; to reduce backlogs in urban infrastructure and social services; and to review the nature and impact of all forms of international migration on sustainable development.

## 7.2 Internal Migration

2001 Census data show that in the major metropolitan areas, and in some of the regional centres and small towns, more than 20% of the population are new migrants. This has impacted on the major urban centres of Gauteng and Western Cape, and inversely on rural provinces such as the Northern Cape, the Eastern Cape and Limpopo. Along with these changes is the continued existence of mainly informal settlements around major cities and towns. This has implications not only for fiscal allocations but also on the approach to spatial development, including identification of areas of potential concentrations of absolute poverty and interventions required in migration feeder communities.

The nature and magnitude of migration and urbanisation have a major impact on planning for sustainable development. Housing provision to the poor in urban and rural areas is an important programme, especially for poverty reduction and employment creation, skills development and training, to make a difference to their socio-economic conditions. Planning for and provision of community services and facilities have to be aligned with migration and urbanisation trends to cope with the needs and demands of growing numbers of people in urban areas. In the same way rural areas have to be developed and serviced in an effort to improve living conditions and enhance sustainable human development. The Population Policy proposes strategies for optimising the benefits and limiting the negative consequences of international migration. Partnerships with the NGO sector and international agencies such as the United Nations High Commission on Refugees and International Organization for Migration (IOM) are assisting in managing the demands arising from refugee movements and surveillance of documented and undocumented immigration.

### 7.3 International Migration

There are many different reasons for international migration. The common assumption is that people move in order to improve the quality of their lives by acquiring better employment opportunities elsewhere. People have been influenced to migrate to South Africa by economic, political and climatic factors, and they believe that they will be better off by moving. Reliable and available data on the extent of migration in general is not readily available. The number of non-South African citizens resident in the country has slightly increased since 1996. In 1996, 2.1% were non-South African citizens. In 2001 the percentage count of non-South African citizens was 2.3. These migrants mainly came from SADC countries, Europe, and Asia.

In order to create an enabling environment for population distribution, migration and urbanization in South Africa, a number of policies and legislation to facilitate the process are mentioned below:

- The International Migration Policy seeks to change the nature of and/or attitude to cross-border flows so as to stimulate socio-economic development both inside South Africa and in the wider region.
- The *Population Policy* proposes three major strategies regarding urbanization and migration:
  - to increase the available choices in respect of migration through the provision of social services, infrastructure and better employment opportunities in the rural areas;
  - to reduce backlogs in urban infrastructure and social services, and make adequate provision for future increases in the urban population; and
  - to review the impact of international migration on sustainable development in order to formulate and implement an appropriate policy.
- The *Land Policy* seeks to facilitate greater access to and productive use of land towards balanced regional development with a strong rural bias. The premise of the *Rural Development Framework* is that the rural communities themselves should determine the rural development agenda, with the government playing a support role.
- The *Urban Development Framework* seeks to integrate previously inefficient, disjointed localities into units, which provide socio-economic benefits to all inhabitants. Service backlogs are addressed through the *Municipal Infrastructure Investment Framework*.
- The *Minerals and Mining Policy* proposes reform of the migrant labour system in consultation with other stakeholders in the region. Legislative and regulatory changes have already been effected in response to Convention 97 and Recommendation 86 of the International Labour Organization concerning migration for employment.

#### 7.4 Achievements in respect of spatially balanced development

There have been several achievements in respect of decentralization, thus creating an enabling environment for local development:

- The Land Administration Act of 1995 provides for delegation to the provinces of powers and administration regarding land;
- The transformation of many government departments includes delegation of some powers and administrative functions down to district level, with a strong emphasis on partnerships with local civil society organizations and, in rural settings, a role for traditional leaders;
- The Rural Development Framework promotes decentralized planning and decision-making through the establishment of district level planning units.

A number of initiatives that focus on rural development promote alternatives to rural out-migration:

- The Extension of Security of Tenure Act has brought greater security to farm tenants and others who live on land owned by others than themselves;
- The land reform programme provided land to those previously denied it;
- Farm equity schemes have been established in which business, investors and land reform beneficiaries form partnerships;
- A special Rural Anti-Poverty allocation of R274 million to the Department of Public Works has augmented public works programme activity in the poorest, and most rural, provinces.

There have also been a number of achievements in the area of international migration:

- The government is encouraging foreign investment and immigration by skilled people;
- South Africa has a long-standing agreement with Botswana, Lesotho, Mozambique and Swaziland by which short-term work opportunities are available to their citizens;
- Documented migrants, unless restricted on their permits as to their location, have the same rights as a citizen except citizenship, suffrage and political rights;
- A bill is presently being proposed to regulate procedures for refugees;
- An Inter-Ministerial Disaster Management Committee has been formed to cater for refugee needs, and to add to the critical efforts of NGOs in this domain;
- An Action Plan on Xenophobia has been launched;

In acknowledgement of the long-standing denial of rights under the migrant labour system, temporary, but long-term, contract workers were given a window of opportunity to apply for permanent resident status and, in this way, qualify for social protection on the same basis as South African citizens. By 31 March 1997, 51 504 permanent resident permits had been granted, predominantly to mineworkers. Cabinet also established an amnesty period during which long-term illegal migrants could identify themselves and obtain permanent resident status. Approximately 200 000 applications were received, half of which had been granted by 30 November 1996.

A number of aspects in the approach to international migration emphasize non-discrimination:

- There is no discrimination in respect of nationality, gender, etc. in granting residence rights;
- Family re-unification is integral to the Migration Policy;
- The migration of children and elderly persons is facilitated in various sections of the Aliens Control Act, 1991;
- Women and men have equal rights concerning the acquisition, change or retention of nationality;
- Marriage to a non-citizen or change of nationality does not affect a woman's nationality;
- Birth or parentage determines citizenship, not marriage;
- Spouses enjoy equal rights in obtaining residence where one spouse is a non-national;
- Birth and parentage on an equal basis determine the nationality of a child; and
- A woman does not need the consent of her husband or male guardian to obtain a passport to travel.

There has been some development in the area of data relating to this previously under-researched and difficult-to-document area.

In 1996 the Human Sciences Research Council (HSRC), in conjunction with the University of Pretoria, launched a large research project into the causes and impact of cross-border migration and its implications for regional development.

The Department of Home Affairs developed a national computer network, which will make information on entry and exit available throughout the country. The data on movement of people to and from South Africa as captured on the Movement Control System of the Department is available to all persons who wish to involve themselves in this field of research.

## **7.5 Challenges and constraints**

Most of the constraints on rural development emanate from the country's long history of discrimination, forced removals and apartheid. Most of the restrictions to development in rural areas impact particularly severely on woman, as they face additional constraints such as those relating to customary marriage and inheritance laws, restricted access to land, finance, information, training and markets and lower literacy rates. They nevertheless constitute the backbone of the rural economy.

The extent to which cross-border migration from the Southern African region contributes to the rate of South Africa's population growth is unknown. Although a more balanced debate about cross-border migration in South Africa is developing, xenophobic stereotypes about migrants of African origin are still common. They are exacerbated by perceptions that the migrants constitute economic competitors.

Of major concern is the lack of reliable and timely data regarding the spatial mobility and migration of the population and its empirical inter-linkages with national concerns such as poverty, HIV/AIDS, crime and unemployment.

# RESOURCE MOBILIZATION FOR THE IMPLEMENTATION OF POPULATION POLICIES AND PROGRAMMES

## 8.1 Introduction

Programme management and human resource development intrinsically go together. This relationship was confirmed at the International Conference on Population and Development (ICPD) in Cairo, 1994. According to the population policy (April 1998), the country's capacity to implement the policy's strategies was very weak at the time. Population and development data and information were not sufficiently available and accessible for use in the design, monitoring and evaluation of strategies and programmes. As result of this, and insufficient appropriate information, education and communication on population and development, South Africa had a poor knowledge base of population and development relationships. For example, immigration policy development was constrained by an inadequate analysis of the nature and impact of immigration.

In response to this assessment, the policy set an objective to make "available reliable and up-to-date information on the population and human development situation in the country, in order to inform policy making and programme design, implementation, monitoring and evaluation at all levels and in all sectors." This objective was instrumental in realizing the first policy objective, the "systematic integration of population factors into policy, plans, programmes and strategies."

To realize these objectives, three strategies were formulated, namely:

- Coordination and capacity building, which included:
  - Technical capacity building, training and information sharing.
  - Intersectoral collaboration and civil society participation.
  - Development, promotion and use of indicators.
- Advocacy and population information, education and communication, targeting leaders, schools and other relevant programmes.
- Data collection and research, including capacity for data collection and use to inform policies and planning; and a National Statistical System.

South Africa was assisted in this initiative by international donors, who mobilized financial and technical resources to build capacity in government and non-governmental organizations in the country.

Before the democratic elections in 1994, total foreign funding (Development cooperation) was relatively small, but increased from USD 169 000 in 1993, to 872 000 USD in 1994. After 1994 donor funding increased rapidly, USD 9 693 000 in 1995 to USD 15 588 000 in 1996, and USD 20 654 000 in 1997. The largest

portion of financial support for population activities came from the European Union, United Kingdom, USAID, UNAIDS and UNFPA.

## **8.2 European Union (EU)**

Under the bilateral agreement between the European Union and South Africa, EU funds for South Africa's development are channeled through the European Programme for Reconstruction and Development (EPRD). In the health and population field, the EU has supported South African programmes and projects in Primary Health Care, Health infrastructure development, HIV/AIDS education, and NGOs cooperation and strengthening.

## **8.3 United Kingdom Department for International Development (DFID)**

DFID's population and development assistance in South Africa is aimed at health sector reform, women's reproductive health and support to the Department of Health, and the promotion of STI/HIV/AIDS awareness campaigns. DFID's funding for projects in South Africa increased from USD 543 150 in 1991 to USD 42 million in 1998. Since 1994, the percentage of DFID's funds spent on health, fluctuated between 18-20 %. At present, there is a trend from small projects towards larger projects and a sectoral approach. At present, DFID has 22 active projects that were started around 1995.

A GBP 19.8 million Water and Forestry Support Programme was agreed in July 2002. This is part of a coordinated programme with other donors in support of Department of Water Affairs and Forestry's strategic plan, including the implementation of major changes in the way water and forestry are managed in South Africa.

## **8.4 United States Agency for International Development (USAID)**

USAID has been in South Africa since 1985. Since then, over USD 1 billion has been allocated, mainly to the NGO sector. After 1994, USAID channeled funds bilaterally, and funded projects aimed at institutional development and capacity building of government ministries, and for development activities, including the NGO and private sector.

## **8.5 UNAIDS**

UNAIDS started activities in South Africa in 1996 as part of the activities of the Inter-country Technical Team responsible for backstopping East and Southern Africa. UNAIDS funded conferences on HIV/AIDS, multimedia campaigns for the promotion of safe sex and condoms, and support for research on HIV and STI prevention.

## **8.6 United Nations Population Fund (UNFPA)**

UNFPA has played a significant role to help South Africa implement the goals of the ICPD PoA. UNFPA provided support to the South African government for the population census in 1996.

The first international cooperation in support of national population policy in South Africa was the Interim Programme of the United Nations Population Fund. The programme operated from November 1994 to December 1997, with a budget of USD 4.2 million.

The interim programme was designed to address three major concerns, namely,

- The absence of reliable population data upon which development plans could be based. This included support to conduct the 1996 census.
- The transformation of health services to include reproductive and women's health.
- Advocacy both to address the negative image of population from the past, and to work with government in the formulation of a new national policy which was adopted in April 1998.

The first Country Programme of Assistance, 1998-2001, reflected the priorities of Government as set out in the new population policy. Priority was given to strengthening the capacity of both national and provincial government departments as well as NGOs.

The current Programme, (2002-2006) budgeted at USD 7.5m, is implemented in the KwaZulu-Natal, Eastern Cape and Limpopo provinces. The overall objective of the Programme is to strengthen institutional and technical capacity for integration of population and development programmes into government planning at local level, where implementation occurs. At the end of the Programme cycle, local-based organizations and civil communities should be able to conduct programmes that address population and development challenges in their areas. Established NGOs will be considered if they indicate that they will subcontract local based community organizations and co-implementing agencies/partners.

## 8.7 Population and Development training

In 1994, the University of Pretoria was the only institution offering demographic training and research programmes. By 1998, two demographic training and research programmes were offered in South Africa, at the Universities of Pretoria and North West. In 2004 five Universities are offering training in population studies, namely the University of North West, University of Cape Town, Rhodes University, and the Universities of the Witwatersrand and Kwazulu-Natal. The National Research Foundation provided financial support the Universities of Pretoria and North West to strengthen their programmes, as well as to the Universities of KwaZulu-Natal and Rhodes to support the establishment of new programmes. The United Nations Population Fund (UNFPA) also provided financial and human resource support to the latter two.

A very important new training initiative was the Applied Population Studies and Research (APSTAR) programme, based at the University of KwaZulu-Natal since 2000. Its training courses were interdisciplinary, practice-oriented, with the focus on understanding population and development problems and issues as they manifested themselves in South Africa. The programme is designed to strengthen strategies to deal with such issues in various sectors, and is aimed at:

- Empowering officials in all spheres of government and stakeholders in the private sector, as well as NGO executives and field staff involved in the design, implementation, monitoring and evaluation of people-centred sustainable development strategies, programmes and projects.
- Strengthening the multi-disciplinary capability of academics and/or researchers through the integration of population science in their disciplines.

Training was conducted in 2000-2002. It is now being reviewed, to be resumed in 2004.

### **8.8 Involvement of Parliamentarians**

Since 1998, three presentations were made to the Parliamentary Portfolio Committee on Social Development, and one to the National Council of Provinces (NCOP) Select Committee on Health and Welfare, on the country's population and development trends and challenges, and the government's response thereto. Furthermore, two seminars were conducted in parliament, to commemorate the Day of Six Billion and to release the United Nations' State of the World's Population Report 2001.

Members of Parliament were also included in the country delegations to the United Nations Commission on Population and Development in 1998 and 2000. Parliamentarians, premiers, traditional leaders, members of provincial executive councils, local government councilors and provincial legislators participated in the Third African Population Conference (1999). Some of the above leaders participated in the Joint Population Conferences (2000, 2001, 2003), and in most of the advocacy and information, education and communication activities of the national and provincial population units.

It is fair to conclude that the country's political leadership is actively committed to achieving the objectives of the population policy.

### **8.9 Partnership with the academic community**

After the population policy was adopted, the Department of Social Development embarked on a partnership programme with the national and international research community to ensure that research findings in the social sciences are shared with all three spheres of government. This collaboration also provided a mechanism through which the government was able to communicate its priorities for research to social scientists. Whilst informal interactions are difficult to monitor, the partnership approach was cemented through annual joint population conferences, since 1999.

South Africa hosted the *Third African Population Conference* of the Union for African Population Studies (UAPS) in Durban in 1999.

Subsequently, national Joint Population Conferences were held in partnership with the Demographic Society of South Africa (DEMSA), in 2000, 2001 and 2003. In 2002, the Department of Social Development and the Human Sciences Research Council

partnered to host a national seminar on *Fertility trends and the current South African issues of poverty, HIV/AIDS and youth*. The national population unit also implemented a seminar series since 2000 to promote information sharing and knowledge exchange between national government departments, other spheres of government, researchers and civil society organizations.

These conferences and seminars facilitated massive information exchange between participants, from all spheres of government, researchers, and civil society sectors. During each conference and seminar, further research and information exchange needs are identified, and various follow-ups agreed on by participants, and implemented. Information sharing is supported by the National Population and Development Information Service, which includes an e-mail and website based information exchange facility.

### **8.10 Strengthening donor support and co-ordination**

Inadequate donor co-ordination is one of the core issues that South Africa and its partners will have to address in ensuring effective and efficient donor support management.

In addition to its established foreign donor support co-ordination mechanisms and its efforts in improving their efficacy, the National Treasury embarked on improving donor support information management by means of an interactive management information system for donor funding - the Development Co-operation Information System (DCIS), which will be accessible via the National Treasury website; and strengthening donor support management capacity at sector/implementing agency level through the provision of training and technical support.

### **8.11 Conclusion**

In the whole, integration of population factors into development planning has progressed in certain areas. The current challenge is to support local level capacity development for Population and Development integration.

# CONCLUSION AND THE WAY FORWARD

As a result of the ICPD as well as its own new post-apartheid priorities, during the period 1995-98 South Africa was engaged in the development of a new Population Policy. The Policy seeks to facilitate the integration of identified population concerns into sectoral development plans, strategies and programmes. It seeks to facilitate the redressing of past inequities and alleviation of poverty while ensuring that a solid basis for sustainable development is laid.

The development of inequities and poverty in the past was aided by a deliberate neglect of the collection of comprehensive and accurate data on the majority of the population. The new population and other development policies cannot be implemented without accurate population statistics. A major achievement during the last ten years was the conducting of two truly national censuses. This provided South Africa with comprehensive national data that will support development planning right down to the level of small communities.

Meeting the development backlogs facing the country requires a careful balance between the current population trends, and resources required to address those backlogs.

This report highlights a range of policies and legislative instruments that are necessary for effective implementation of the strategies designed to tackle the population and development concerns outlined in the South African Population Policy. These policies are complementary to one another in addressing the population and development issues raised in this review. They contain the key to sectoral synergy for effective multi-sectoral engagement in implementing the Population Policy and therefore the global mandate as agreed to in Cairo in 1994. At this stage South Africa faces the challenge of carrying forward the ideal of a coordinated, multi-sectoral approach into the implementation stage.

Any initiatives aimed at addressing population and development concerns as expressed in the South African population policy require practical developmental initiatives at the grass-roots or community levels. The role of NGOs is critical in this regard. Strong partnerships with NGOs and other civil society organizations will facilitate faster and more effective delivery on development programmes and projects.

Ten years after ICPD, the South African government continues to strengthen and redirect institutional mechanisms towards the implementation of the Population Policy by all sectors.



Republic of South Africa: population per province, 1996 and 2001			
Province	1996	2001	% growth
Eastern Cape	6 302 525	6 436 763	2.1
Free State	2 633 504	2 706 775	2.8
Gauteng	7 348 423	8 837 178	20.3
Kwazulu-Natal	8 417 021	9 426 017	12.0
Limpopo	4 929 368	5 273 642	7.0
Mpumalanga	2 800 711	3 122 990	11.5
Northern Cape	840 321	822 727	-2.1
North West	3 354 825	3 669 349	9.4
Western Cape	3 956 875	4 542 335	14.3
<b>South Africa</b>	<b>40 583 573</b>	<b>44 819 778</b>	<b>10.4</b>

Source: Statistics South Africa - Census 2001

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