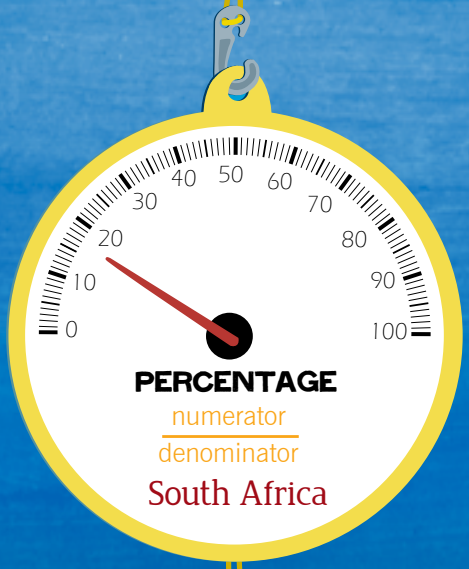
Scorecard 2009



WEIGHING UP

SOUTH AFRICA'S RESPONSE TO CHILDREN AND HIV AND AIDS

Scorecard 2009: Weighing up South Africa's Response to Children and HIV and AIDS

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What is the scorecard?

This scorecard provides information on how we are doing in implementing the HIV & AIDS and STI National Strategic Plan 2007–2011 (NSP) for children and families.

The NSP is South Africa's plan for working together as a country to address the problem of HIV and AIDS. The plan describes the actions we need to take so that we can:

- prevent further HIV infections
- make sure there is access to treatment, care and support for people living with HIV and their families.

The scorecard looks at progress on ten important indicators.

Five indicators tell us how well we are doing in the prevention of HIV and AIDS:

Two indicators tell us how well we are doing in the treatment of HIV and AIDS:

Two indicators tell us how well we are doing with care and support for affected individuals and families:

One indicator tells us how well we are working together as a country:

The scorecard also includes information on 'aspirational indicators'. These are indicators which are important to track but for which annual data are not currently available.

We hope the scorecard will be used:

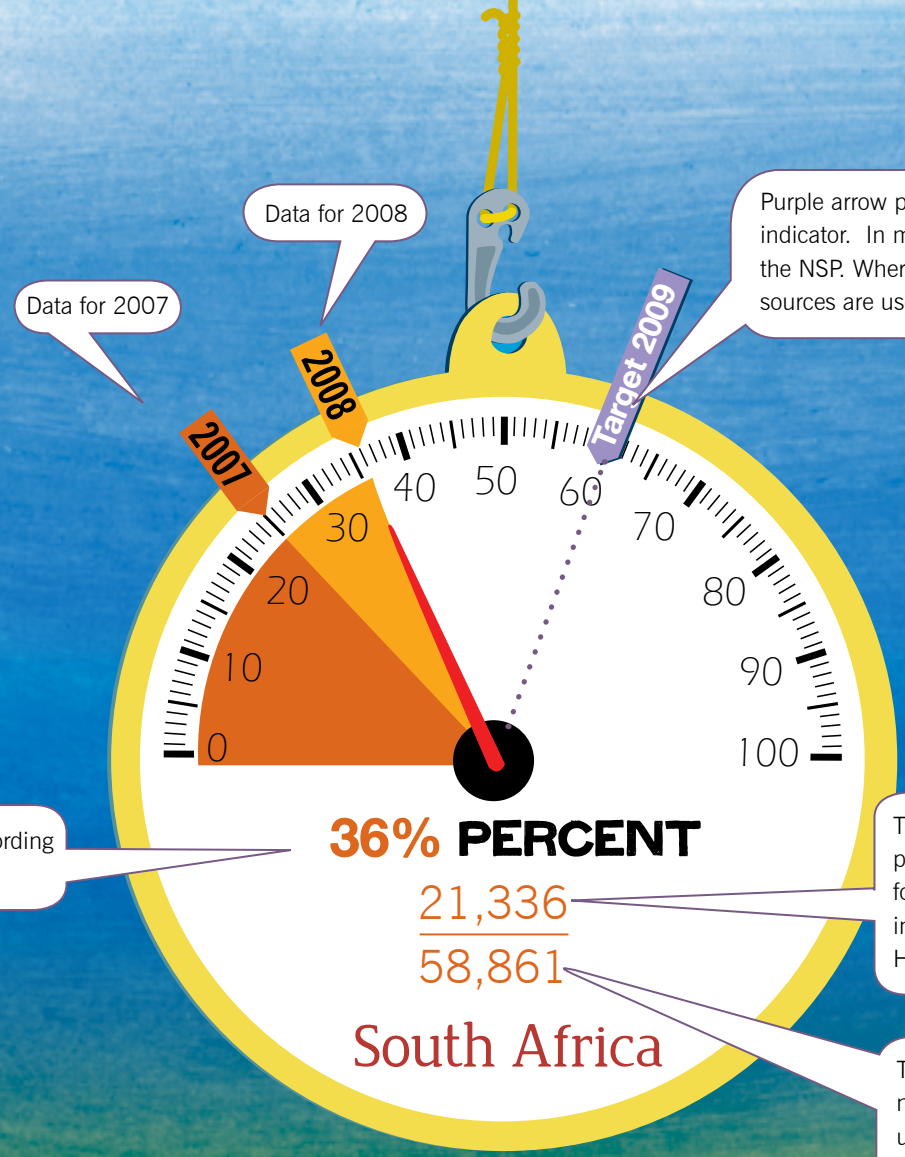
- to make people aware of the impact of HIV and AIDS on children
- to monitor the extent to which we are meeting the needs of children affected by HIV and AIDS
- to highlight gaps in the information we need to monitor our progress
- to provide an advocacy tool for addressing gaps in services and for collecting better information.

How to use the scorecard

The main part of the scorecard is divided into ten sections – one section for each indicator. For each indicator, the scorecard includes national and provincial information (where available) on service access, service quality or child outcomes.

- National data are presented in the form of a scale.
- For nine of the ten indicators, the higher the reading for each year, the closer we are to meeting our targets. In this way, the scorecard illustrates how well or how poorly we are doing in relation to the goals that we have set ourselves.
- The indicator number 4 (on infant mortality) is presented differently. This is because a higher reading shows worsening outcomes for children. In this case, the lower the reading, the closer we are to meeting our target.
- For each indicator, provincial data (where available) are presented in the form of a graph. This allows for comparison across provinces and over time.
- In addition to these figures, the scorecard includes information on critical data gaps i.e. information about services that we need but do not have access to at the moment.
- There is technical information on each indicator, including information on data sources and data strengths and limitations.

A summary of progress for all ten indicators is presented in the final section on page 24.



Purple arrow points to the national target for each indicator. In most instances, targets are drawn from the NSP. Where NSP targets are not available, other sources are used to determine appropriate targets.

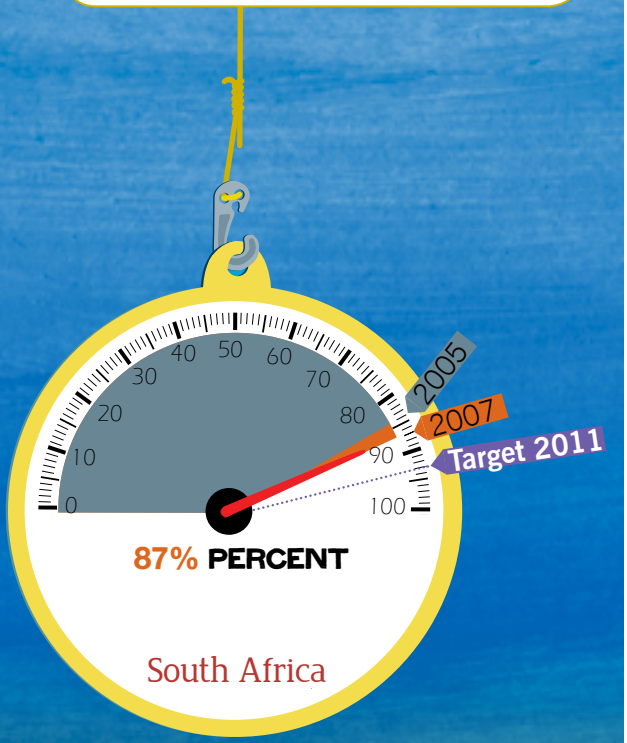
Percentage according to latest data.

The numerator is the number of people within the relevant population for whom the characteristic described in the indicator is true (eg. number of HIV-positive children on treatment).

The denominator is the total number of people in the population under consideration (eg. number of HIV-positive children).

1. HIV prevention

The proportion of adolescent girls aged 15 to 19 years visiting antenatal clinics, who test HIV-negative.



What do these figures mean for children?

The prevalence of HIV in young people provides an indication of the success of our prevention programmes.

Between 2005 and 2007, there was a drop in HIV prevalence among adolescent girls attending public sector antenatal clinics.

In 2005, 84% of adolescent girls who were tested at their antenatal visit were HIV-negative – this means almost 16% tested HIV-positive. Between 2005 and 2007, this figure increased to 87% – this means 13% tested HIV-positive. This change shows a significant reduction in HIV-infection rates among this high-risk population group.

The proportion of adolescent girls who tested HIV-negative in 2007 ranged from almost 96% in the Western Cape to 83% in Kwazulu-Natal. This means that over 17% of 15 to 19 year olds attending antenatal clinics tested HIV-positive in Kwazulu-Natal, compared to less than 5% in the Western Cape.

One of the overarching goals of the NSP is to reduce the number of new infections by 50% between 2006 and 2011. This means that our prevention programmes should aim to bring HIV-infection rates in 15 to 19 year olds down to 7% by 2011 (i.e. 93% of adolescent girls should test HIV-negative).

What other information do we need to monitor HIV prevention?

A better way of understanding the success of HIV prevention programmes would be to measure behaviour such as condom use, the age at which young people start having sex, and multiple partnering. However, these data are not collected each year in South Africa.

Technical notes

Numerator: Number of HIV-negative adolescent girls aged less than 20 years who visited antenatal clinic.

Denominator: Number of adolescent girls aged less than 20 years who visited antenatal clinic.

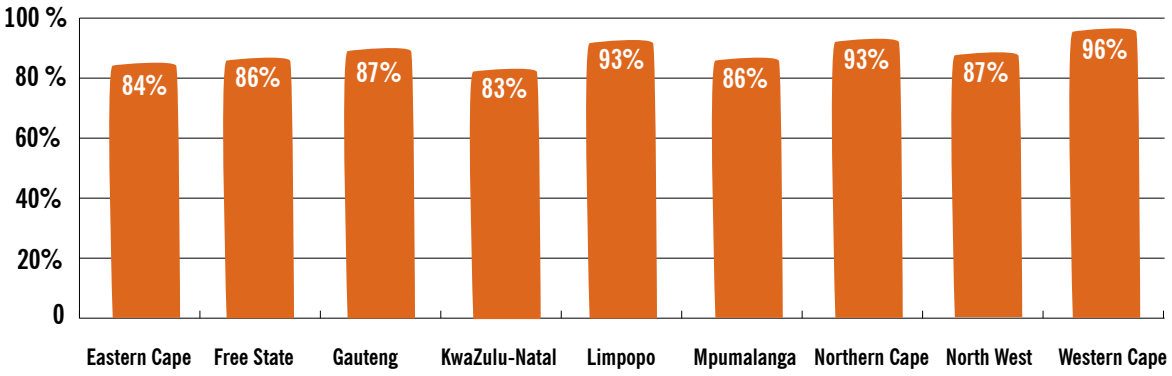
Data source: Department of Health. (2006, 2007, 2008) National HIV and Syphilis Sero – Prevalence Surveys of Women Attending Public Antenatal Clinics in South Africa

Strengths and limitations of data

These data are based on adolescent girls who visited public sector antenatal clinics. They do not show HIV prevalence among pregnant adolescents who visited antenatal facilities in the private sector and those who did not go for antenatal care at all.

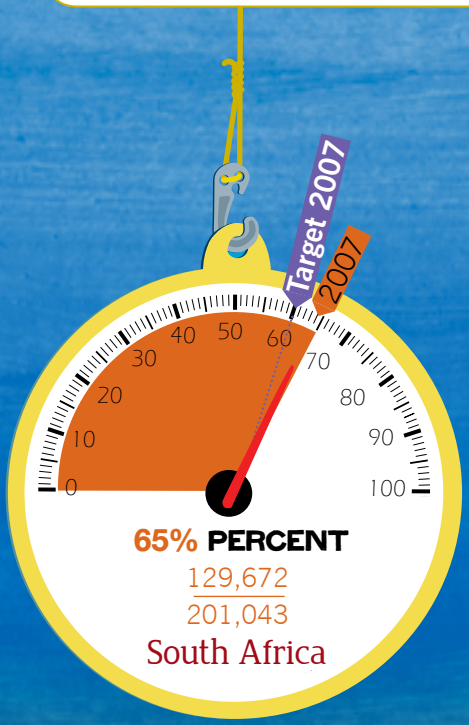
Numerator and denominator figures have not been included on the dial and graph because the data are weighted, and a simple arithmetic division would not produce the prevalence.

The proportion of adolescent girls aged 15 to 19 years visiting antenatal clinics, who test HIV-negative in 2007



2. Access to PMTCT

The proportion of HIV-positive pregnant women who receive PMTCT prophylaxis.



What do these figures mean for children?

The PMTCT (Prevention of Mother to Child Transmission) programme is a comprehensive health service package which aims to prevent HIV transmission from mother to child. If properly implemented, the programme is highly effective and relatively inexpensive, with massive benefits for mothers and their babies.

A comprehensive PMTCT programme offers:

- routine voluntary HIV counselling and testing to pregnant women
- labour practices that minimize the risk of HIV transmission
- dual- or triple antiretroviral drug combinations to the mother during pregnancy and labour and a daily dose of Zidovudine (AZT) to the baby for the first week after birth
- a single-dose of nevirapine (sd-NVP) to the mother if she is not taking triple therapy, and to the baby immediately after delivery
- safe infant feeding counselling and support to pregnant women and mothers
- infant formula to women who choose not to breast feed and who are able to formula feed safely in an acceptable, affordable and sustainable way.

The collection and availability of data on each of these components of the PMTCT programme has been variable across the provinces to date. The indicator in this scorecard therefore reflects access to ART for PMTCT in the form of either:

- dual (NVP plus AZT) or triple (HAART) therapy (Western Cape only), or
- a single dose of NVP for HIV-positive women during labour (all other provinces)

Nationally, the NVP uptake rate among HIV-positive pregnant women was 65% in 2007, meeting the NSP target of 60%.

Five of the the 9 provinces were able to meet the 60% target in 2007. However in the Eastern Cape, less than half of the women who tested HIV-positive during pregnancy received NVP prophylaxis during labour. Only slightly more than half received NVP in the Free State and in North West.

The Western Cape is the only province for which data are currently available on access to dual therapy or HAART for women on the PMTCT programme. In the WC, access increased from 69% in 2007 to 71% in 2008. The WC is therefore above target for access to PMTCT.

What other information do we need to monitor PMTCT access?

New national PMTCT guidelines recommend the use of two treatments for women enrolled on the PMTCT programme:

- Dual regimen consisting of NVP plus zidovudine (AZT)
- Or, where necessary, triple therapy (HAART)

Single dose NVP is still recommended in emergencies, where neither of the two treatments above has been used. These guidelines follow the World Health Organisation's recommendations for PMTCT services in settings where there are limited resources.

It would be preferable to monitor an indicator for PMTCT access that reflects this current policy. The new guidelines were in operation in Cape Town from as early as 2004 but were rolled out nationally in 2008. All provinces are due to have data available on the rollout of the new guidelines. However, provinces other than the Western Cape have only recently started to collect these data and at time of going to print, they were not available.

It is strongly recommended that the NSP indicator for PMTCT coverage is changed to monitor access to all three treatment options i.e. dual therapy or HAART or sdNVP (in emergency situations).

Technical notes

Numerator (NVP): Number of women who were given a dose of NVP to take in labour.

Denominator: Number of women who tested HIV positive in pregnancy.

Data Source: District Health Barometer 2007/2008

Numerator (dual therapy or HAART): Number of women on the Western Cape PMTCT programme who received adequate dual therapy, or were on HAART.

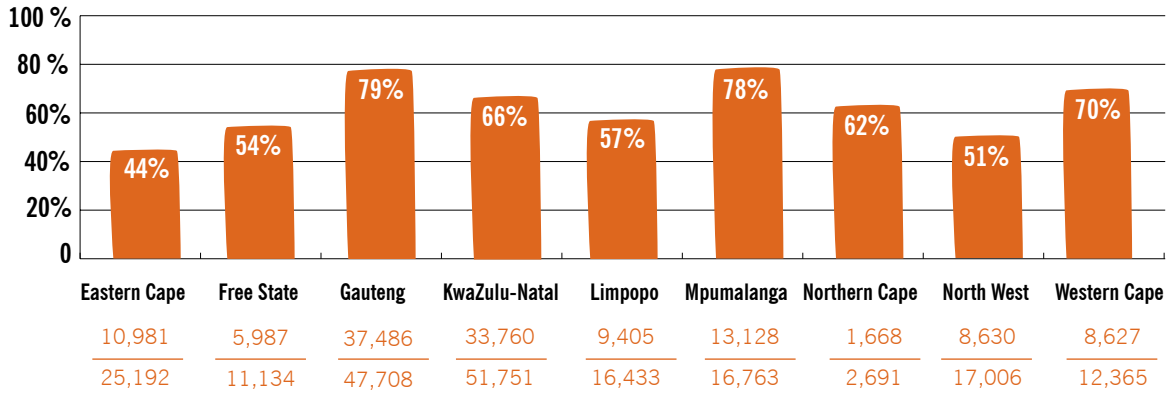
Denominator: Number of women on the PMTCT programme who were admitted to labour wards in the WC.

Data source: District Health Information System (WC)

Strengths and limitations of data

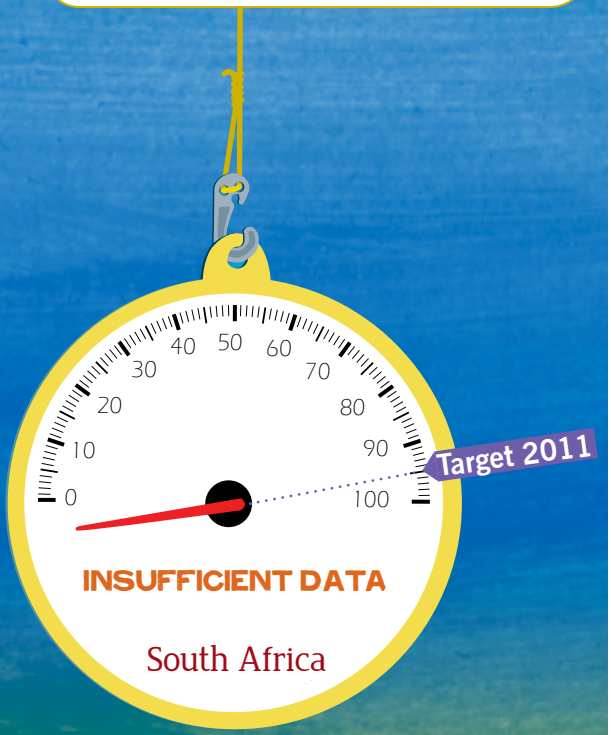
Dual therapy can be measured either as a composite indicator – comprising the proportion of women who received adequate antenatal AZT, as well as NVP in labour – or separately as AZT or NVP uptake indicators.

The proportion of HIV-positive pregnant women who receive PMTCT prophylaxis in 2007



3. PMTCT child outcomes

The proportion of infants born to HIV-infected mothers, who are HIV-negative at 3 months in 2007 and 2008.



What do these figures mean for children?

This indicator shows HIV-free survival in babies born to mothers who were known to be HIV positive in pregnancy, and who were enrolled on the PMTCT programme. It is a good indication of the success of the PMTCT programme.

Unfortunately these data are only available for the Western Cape (WC).The data show that the WC is on track to meet the NSP targets for 2011.

In 2007, 93% of babies on the PMTCT programme in the WC who were tested at three months, were HIV negative. This figure increased to 95% in 2008, bringing rates of transmission down to 5% in the province. The WC is therefore likely to meet the NSP target to reduce mother to child transmission of HIV to less than 5% by 2011.

The lack of available data on PMTCT child outcomes from other provinces is of great concern. Urgent steps need to be taken to collect these data nationally and make them available to the public so that we can monitor progress towards achieving this critical NSP target.

What other information do we need to monitor PMTCT outcomes?

No data on PMTCT child outcomes were available from eight of the nine provinces. All provinces were to have rolled out this information system in March 2009 but information from these provinces was not available at the time of going to print.

Technical notes

Numerator: The number of babies on the PMTCT programme who were tested for HIV for the first time and found to be negative.

Denominator: The number of babies on the PMTCT programme where the mother agreed to have the baby tested for HIV after receiving pre-test counselling.

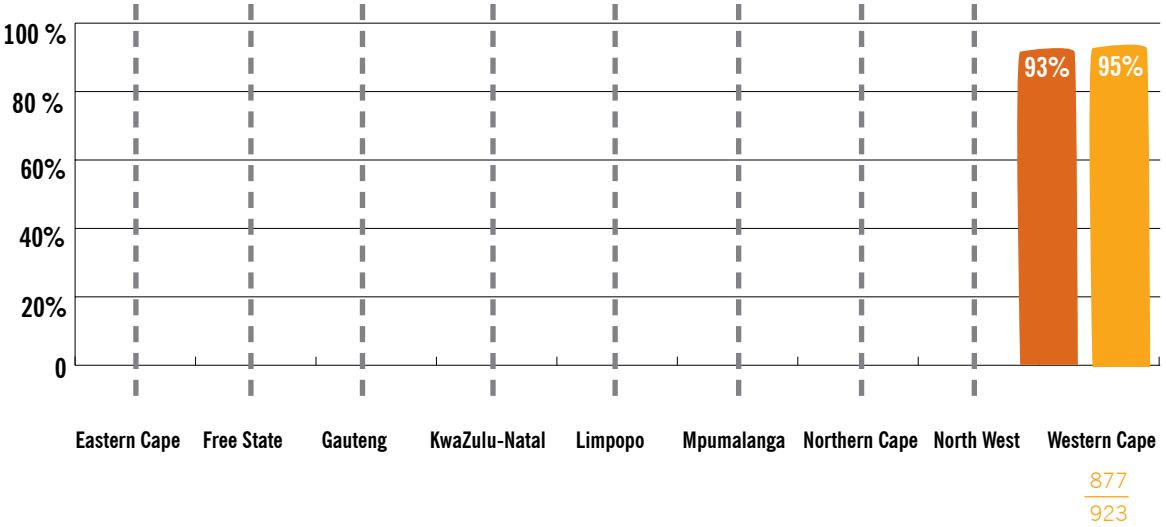
Data source: District Health Information System (Western Cape)

Strengths and limitations of data

The data presented here give an indication of HIV-free survival at three months. It is therefore a strong estimate of PMTCT programme effectiveness during pregnancy and labour. However, it is a less reliable measure of HIV infection associated with mixed feeding practices.

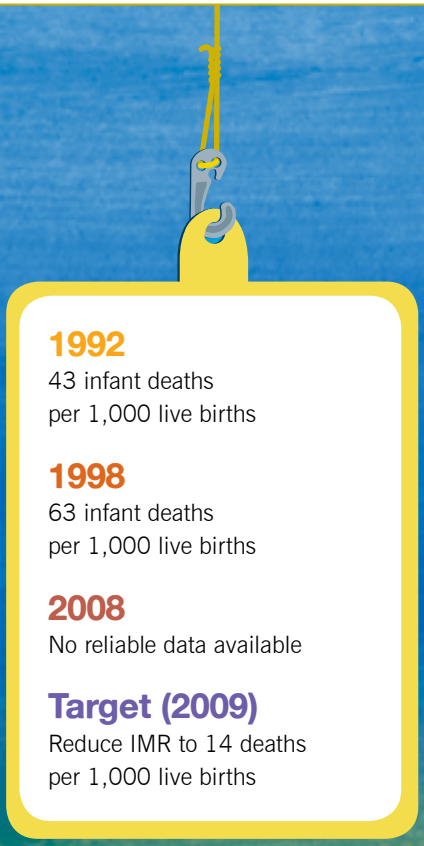
A further limitation of the data is the high loss to follow up: many mothers do not return to the health facility to have their babies tested. Due to high loss to follow up, this indicator should be used more for trends than as a direct measure of transmission.

The proportion of infants born to HIV-infected mothers, who are HIV-negative at 3 months in 2007 and 2008



4. Infant mortality

The number of children under one year of age who die in a year, per 1,000 live births in the same year.



1992
43 infant deaths
per 1,000 live births

1998
63 infant deaths
per 1,000 live births

2008
No reliable data available

Target (2009)
Reduce IMR to 14 deaths
per 1,000 live births

What do these figures mean for children?

South Africa experienced an increase in infant mortality between 1992 and 1998. In the 1990s, there was limited treatment available to HIV-positive women during pregnancy, so the rise in infant mortality is probably mostly AIDS-related. A decrease in infant mortality rate (IMR) would therefore be a good indication of effective mother to child prevention strategies.

In 1998, South Africa's infant mortality rate was 63 per 1,000 live births. This was up from approximately 43 per 1,000 live births in 1992. There is no reliable data on the IMR since 1998. However, indications are that in 1998 both infant and child mortality rates were still rising. These trends have been confirmed in populations under demographic surveillance, such as the sites in KwaZulu-Natal and Agincourt.

The data show big differences in infant mortality across provinces.

In 1998, the chances of a child dying before the age of one year in the Eastern Cape was double that of a child in the Western Cape. These differences are to some extent explained by provincial differences in maternal HIV prevalence.

In order for South Africa to meet the Millennium Development Goal for infant mortality (i.e. reduce infant mortality by two-thirds by 2015), the target infant mortality rate for 2009 was 14 per 1,000 live births.

What other information do we need to monitor infant deaths?

The reversal in the infant mortality trend makes it an extremely important indicator of child health to monitor. However, the absence of reliable data on IMR since 1998 makes it a difficult indicator to track. This gap will soon be filled with information from the 2009 Demographic and Health Survey.

The best way to monitor infant mortality rates is to have an efficient births and deaths registration system. The problem with the current system is that not all births and infant deaths are reported. A complete registration system with 100% coverage would allow the calculation of the infant mortality rate each year.

Technical notes

Numerator: The number of deaths that occurred to children under one year of age in the same year as the births.

Denominator: The number of live births in one year.

Data source: 1998 Demographic and Health Surveys

Strengths and limitations of data

Conclusions about the increase in infant mortality rates are based on data from the 1996 Census and the 1998 South Africa Demographic and Health Survey. The provincial rates in the table reflect ten year averages for period 1988–1997. The national rate is for 1998.

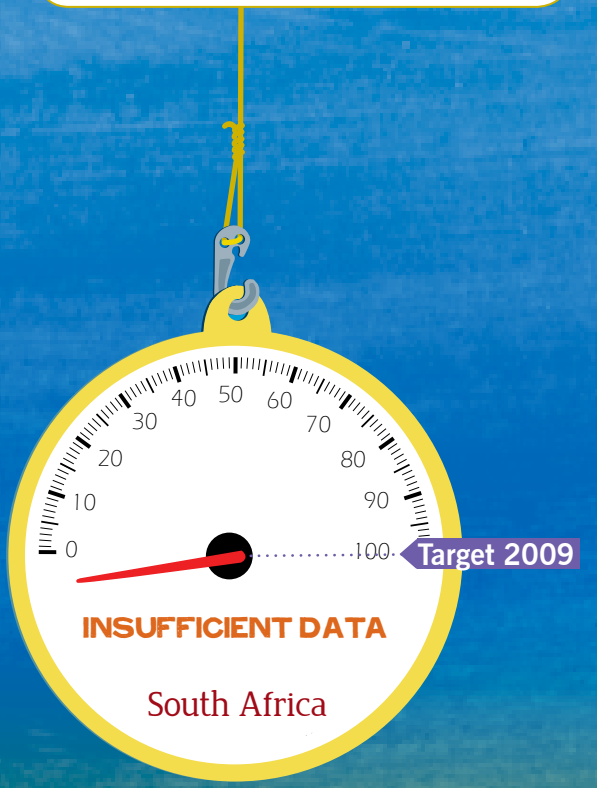
Infant mortality rates in FS, NW and WC have been adjusted on the basis of the relationship between the SADHS and the 1996 census data observed in the remaining provinces.

The number of children under one year of age who die in a year, per 1,000 live births in the same year for 1988-1997

Province	Infant deaths per 1,000 live births
Eastern Cape	61
Free State	53
Gauteng	36
Kwazulu Natal	52
Limpopo	37
Mpumalanga	47
Northern Cape	42
North West	42
Western Cape	30

5. Child protection

The proportion of eligible children who are given post-exposure prophylaxis after rape.



What do these figures mean for children?

Children who are raped are at risk of contracting HIV if the perpetrator is HIV-positive. This risk can be dramatically reduced if the child receives antiretroviral therapy within 72 hours of the rape, and takes the medication for 28 days. This course of medicine is called 'post-exposure prophylaxis' (PEP).

All children who present at a public health facility within 72 hours of a rape should be tested for HIV. If they are HIV-negative, they should immediately begin a course of PEP. If the child presents at the facility after 72 hours, or if the child tests HIV-positive he/she is not eligible for PEP.

Information on access to PEP is very poor.

Data on access to PEP were only available for Gauteng for 2008/2009. The data show that 39% of children who went to a health facility after being raped were not eligible for PEP because they arrived more than 72 hours after the rape had occurred. Another 6% were not eligible because they tested HIV-positive.

Of the children who were eligible for PEP, only 82% of children were provided with the medication. This means that almost 20% of HIV-negative children who were raped and who presented at a health facility within 72 hours of that rape were not provided with PEP.

There is no NSP target that deals specifically with the provision of PEP to children who have been raped. For the purposes of this scorecard, we argue that 100% of eligible children who present at a public health facility should be provided with PEP after rape.

What other information do we need to monitor post exposure prophylaxis

Routine data on post-exposure prophylaxis (PEP) is collected through the health information system (HIS) by provinces. However, these data are not collected and reported in the same way by each province. Information collection on PEP for child rape survivors needs to be improved and standardised. This information should include:

- The age of the rape survivor
- The number of child rape survivors presenting at public health facilities who are eligible for PEP, and those who are not (including reasons)
- The number of children who are given the 28-day course of PEP

- The number of children who complete the full 28-day course
- The number of children who return for repeat testing as required
- The number of children who test HIV-negative after treatment.

Technical notes

Numerator: The number of eligible children who have received a 28 day supply of PEP.

Denominator: The number children in South Africa who present to a public health care facility within 72 hours and have a negative HIV test after rape (i.e. number of eligible children).

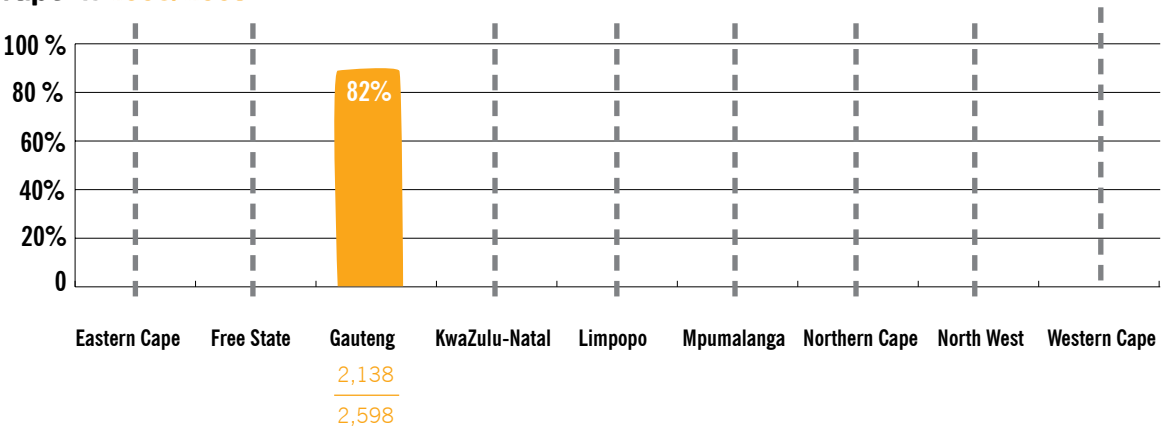
Data source: Gauteng Department of Health (public sector data)

Strengths and limitations of data

Data were only available from Gauteng province. Gauteng provincial data were only complete for all health districts for two months in the 2008/2009 period. This means that there are gaps in the available data. The effect of the missing data on the proportions presented here is unknown.

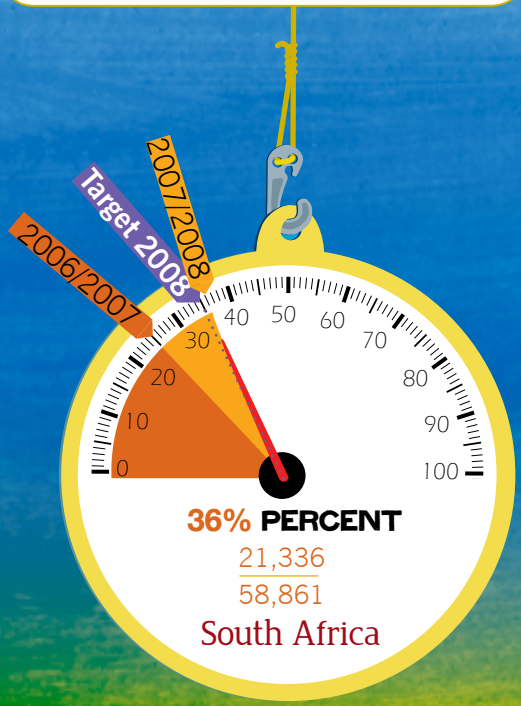
Furthermore, this information is an indicator of the health sector response to child protection after rape with a focus on HIV prevention. It is not an indicator of the other sectors involved in child protection such as the criminal justice sector.

The proportion of eligible children who are given post-exposure prophylaxis after rape in 2008/2009



6. Antiretroviral treatment for children

The number of children under 15 years old starting antiretroviral treatment as a proportion of the number of new HIV infections in children.



What do these figures mean for children

It is very important for HIV-positive children to receive antiretroviral treatment (ART) early. Without treatment, more than 40% of children who were infected as babies will die before their first birthday. Access to treatment for children in South Africa improved from mid-2006 to mid-2008. However, there is a lot that still needs to be done to make sure that all children who need treatment receive it.

ART coverage in children in South Africa increased from 26% between mid-2006 and mid-2007, to 36% between mid-2007 and mid-2008. This means that more than 21,000 children started treatment from mid-2007 to mid-2008, compared with less than 17,000 in the previous year. The NSP target for paediatric treatment is 24,000 children starting on treatment during 2008. Given that South Africa enrolled 21,000 children on treatment between mid-2007 and mid-2008, it is likely that we will have reached our NSP target by the end of 2008, although data are not available at the moment to confirm this.

Between mid-2007 and mid-2008, the rate of antiretroviral coverage varied greatly between provinces, from 22% in the Free State to 97% in the Western Cape.

The success of the Western Cape programme can partly be explained by the relatively low numbers of new paediatric HIV infections in the province. This was the result of the province's successful PMTCT programme.

The Western Cape, Northern Cape, North West and Gauteng are the only provinces in which ART reached half or more children born with HIV.

What other information do we need to monitor antiretroviral treatment for children?

The Department of Health data collection system defines children as 0 to 14-year-olds. All people aged 15 and over are classified as adults. This makes it difficult to report on service delivery to children as defined in the SA Constitution (all people under the age of 18 years).

Within the category of 'children', it is important that data are further broken down to reflect service access and coverage for different age groups.

We also need to monitor the extent to which children are surviving on treatment and continuing to take their medication.

Technical notes

Numerator: Number of children under 15 years starting antiretroviral treatment, over a given year.

Data source: Department of Health (public sector data), Adam and Johnson (2009) (disease management programmes and NGO services)

Denominator: Number of new HIV infections in children, over the same period.

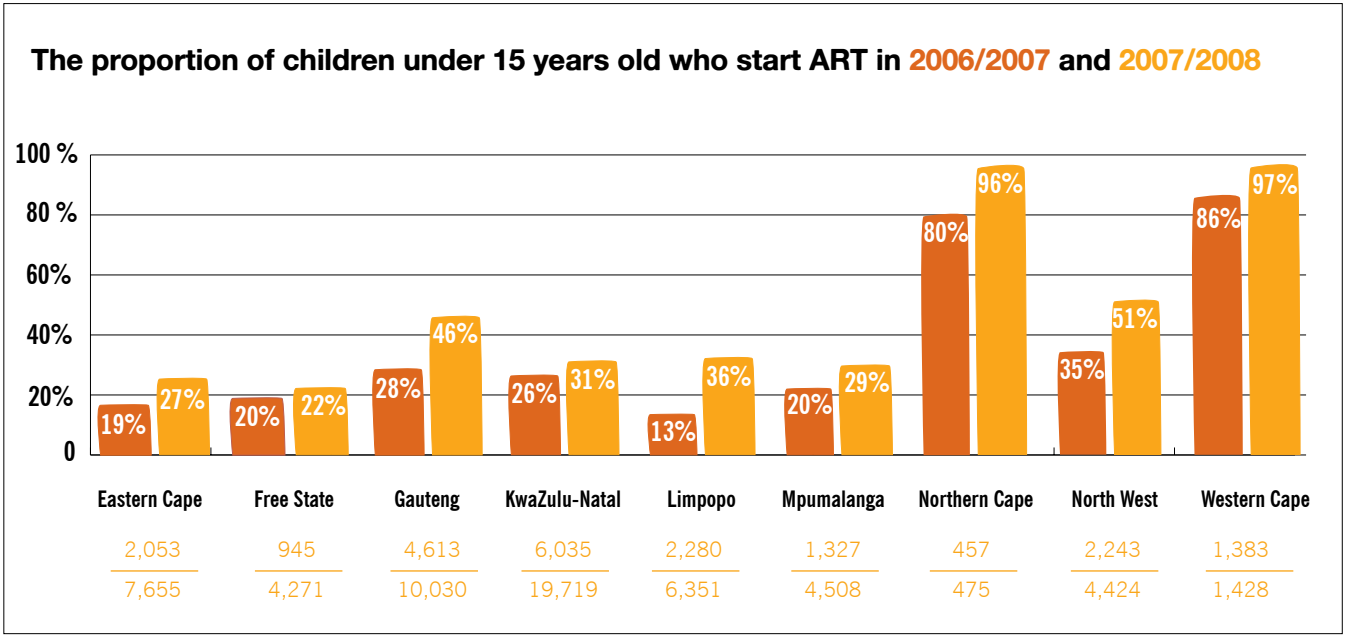
Data source: The ASSA2003 AIDS and Demographic model (Dorrington et al, 2006), together with the District Health Barometer (on extent of PMTCT coverage) (Barron et al, 2008)

Strengths and limitations of data

The strength of this analysis is that it combines antiretroviral treatment data from the public, private and NGO sectors.

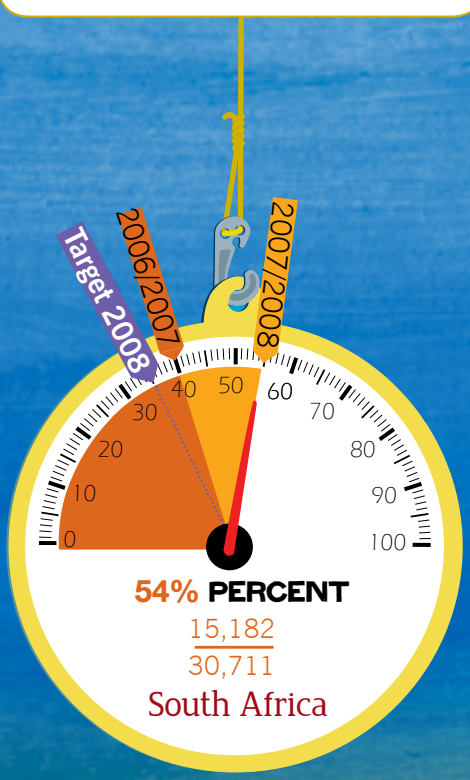
However, some of the smaller disease management programmes have never provided data. We also do not know how many people are paying for their own treatment, outside of any recognised ART programme. This means that there could be some under-estimation of the number of children on treatment.

There are also peculiar trends for province-specific data for children that suggest reporting errors or changes in indicator definitions.



7. Maternal health

The proportion of women progressing to AIDS who start antiretroviral treatment.



What do these figures mean for children?

AIDS is the leading cause of death in women below the age of 49 years. Many of these deaths can be prevented if women have access to antiretroviral treatment (ART). ART keeps mothers and other caregivers alive and healthy for longer, which means that they are better able to care for their children. Over the last year, many more women in South Africa have been able to get antiretroviral treatment. However, there are also many more that still need treatment.

The proportion of women progressing to AIDS who access ART in South Africa has increased from 40% over the period from mid-2006 to mid-2007, to 54% over the period from mid-2007 to mid-2008.

In both 2007 and 2008, the proportion of women starting ART was higher than the National Strategic Plan's target for adult treatment uptake. This was set at 24% in 2007, and 35% in 2008.

Despite the good progress, much more needs to be done to ensure that all women who need treatment are able to get it. Between mid-2007 and mid-2008, 120,000 women who developed AIDS did not start treatment.

Women's access to treatment varies greatly between provinces, although all provinces have exceeded the treatment target of 35% for 2008. Rates of access range from over 75% in the Northern Cape and Western Cape to as low as 41% in the Free State.

What other information do we need to monitor anti-retroviral treatment for women?

It is not good enough to only be monitoring how many women start treatment. We also need to monitor:

- the age at which women start treatment
- the extent to which they are surviving
- how many are continuing to take their medication.

Unfortunately, the Department of Health is not currently collecting this information at a national level, although the information is being collected in certain sentinel sites.

Technical notes

Numerator: Number of women starting antiretroviral treatment, over a given year.

Data source: Department of Health (public sector data), Adam and Johnson (2009) (disease management programmes and NGO services).

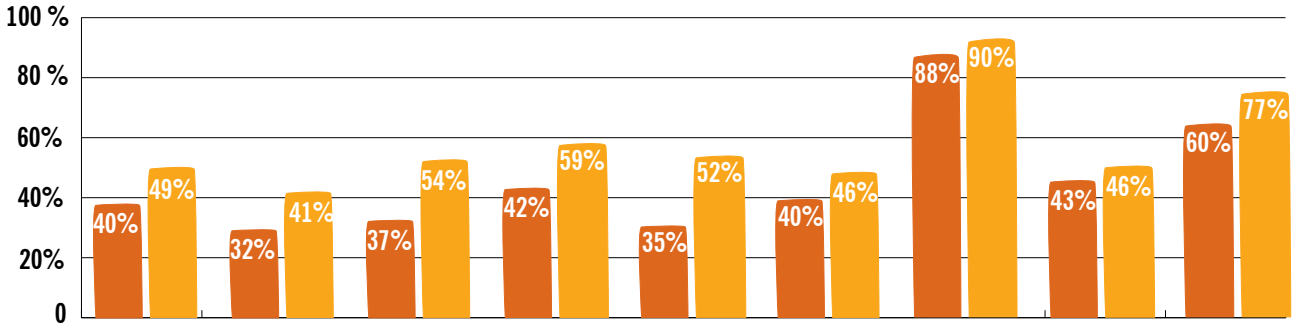
Denominator: Number of new AIDS cases in women, over the same period.

Data source: The ASSA2003 AIDS and Demographic model (Dorrington et al, 2006)

Strengths and limitations of data

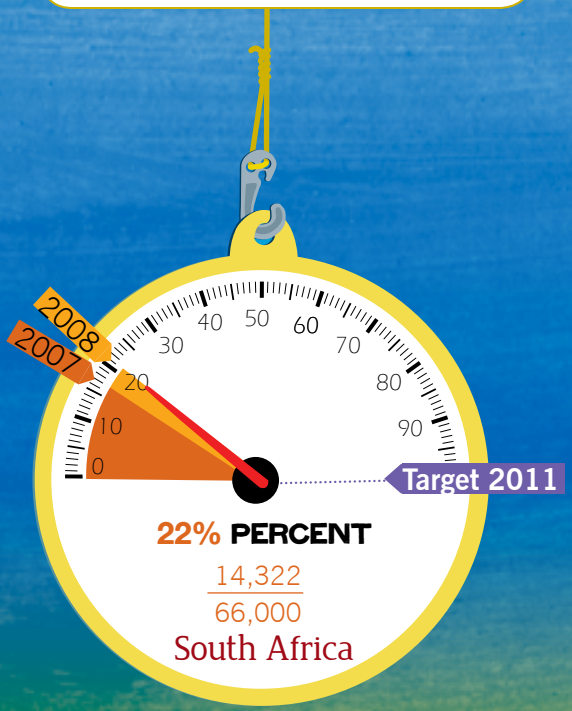
A key strength of this analysis is that it combines antiretroviral treatment data from the public, private and NGO sectors. However, there are some odd trends for province-specific public sector data which suggest reporting errors or changes in indicator definitions. Private sector data gaps mean that the number of women on treatment could be under-estimated.

The proportion of women progressing to AIDS who start ART, in 2006/2007 and 2007/2008



8. Social services

The proportion of registered social workers compared to the number of social workers needed to deliver services to children in terms of the Children's Act.



What do these figures mean for children?

One of the overarching goals of the NSP is to provide care and support to 80% of all people diagnosed with HIV, as well as their families, by 2011.

In order to achieve this goal, we need to ensure that we have enough social workers in place. The number of registered social workers in SA has increased over the past 5 years, but there are still too few to deliver the necessary services to children and families.

All social workers have to register with the SA Council for Social Service Professions (SACSSP). These include social workers in private practice, state social workers and those working for NGOs.

In February 2009, there was a total of 14,322 social workers registered with the Council. This figure is up from 11,372 registered social workers in April 2005. These social workers are responsible for the full range of social work services in South Africa. It is not known how many of these social workers are actually working with children and families.

It is also not clear how many social workers we need in order to reach the NSP goal for care and support. What we do know is that by 2011 we need an estimated 66,000 social workers just to fully implement the Children's Act (No.28 of 2005 as amended). This is only one of the Acts requiring social workers for implementation. In other words, just to help children, we need almost 5 times more social workers than those providing services to the entire population of South Africa at the moment.

Action is needed to address this shortfall. This should include recognition and remuneration for a broad range of social service providers (such as social auxiliary workers and child- and youth-care workers) to undertake some of the tasks traditionally assigned to social workers.

What other information do we need to monitor social services for children?

Improved data collection on registered social workers and social auxiliary workers is essential, including information on:

- whether the individuals are actively practising social work
- where these individuals are practising (provincial breakdown and whether they are rural or urban)
- whether they are in private practice, in state employment or in the employment of an NPO.

This information is critical in order to plan effectively for improved service delivery. In addition, information is needed on the range of other categories of workers and volunteers providing social services to children and families.

Technical notes

Numerator: The number of social workers registered with the SACSSP.

Data source: The SA Council for Social Service Professions register

Denominator: The estimated number of social workers required to fully implement the Children's Act.

Data source: Barberton C (2006) report on the costing of the Children's Bill

Strengths and limitations of data

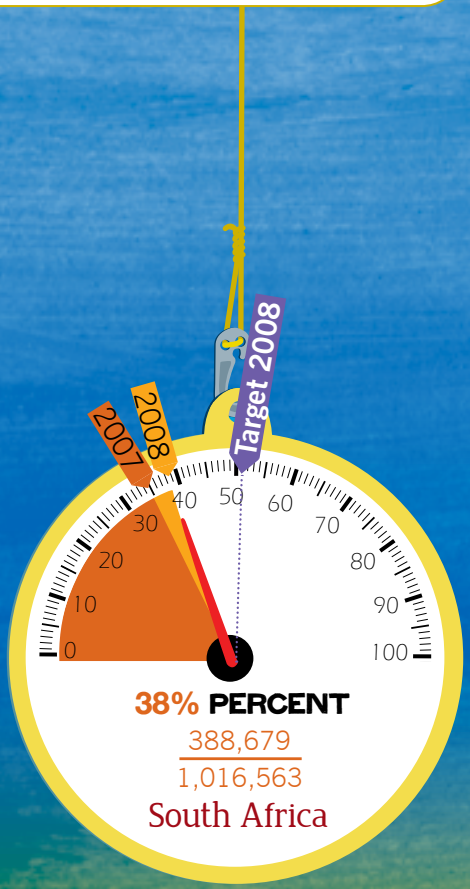
This figure presents the total number of social workers in the country compared to the number of social workers needed to implement the Children's Act alone. As such, it is a proxy indicator because:

- not all of the social workers in the country work with children
- not all social workers who are registered actually practise
- those in private practice would not be working with the vulnerable populations in terms of the Act.

Data on registered social workers are not disaggregated by province

9. Income support

The proportion of children under one year who receive the Child Support Grant.



What do these figures mean for children

Poverty relief is an important part of the national response to HIV and AIDS. The Child Support Grant (CSG) is an unconditional cash transfer for poor children under the age of 15 years. In 2009 the grant amount is set at R240 per month, and increases every year. This helps many families, but there are a large number of children under the age of one year who still do not receive the grant.

This indicator measures grant uptake in children under the age of one year. Early access to grants helps caregivers to provide young children with better health care and nutrition, which is vital for healthy growth and development. These children will, in most cases, continue to access the grant, at least through early childhood.

In mid-2006, 30% of children under the age of one year were accessing the CSG. This figure increased to 35% in mid-2007 and to 38% in 2008. This increase was in spite of no changes to targeting criteria over this period. Improvements in grant uptake therefore reflect improvements in service access and/or delivery.

However, there is a lot more that needs to be done to improve early access to grants for young children. In 2008, 38% of children under one year were accessing the grant, but about 60% of children would probably have qualified for it. According to the NSP target for CSG uptake, approximately 51% of all children under the age of one year should have been accessing the grant by 2008.

Grant uptake varies across provinces, with the highest rates of uptake in the poorest provinces. This is an indication of good targeting.

Technical notes

Numerator: Number of Child Support Grants disbursed to caregivers of children under one year.

Data source: South African Social Security Agency (SASSA): SOCPEN, July 2007 & July 2006

Denominator: Number of children under the age of one year.

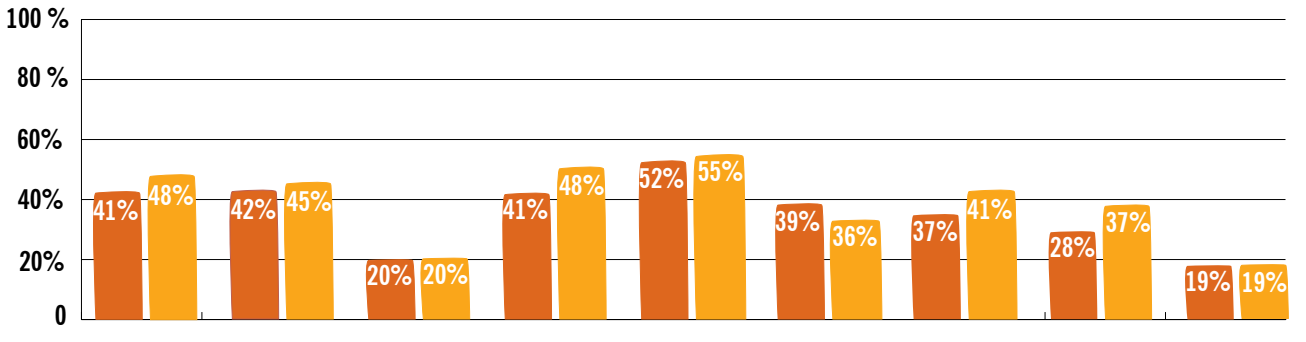
Data source: Statistics South Africa: General Household Surveys 2007 & 2006; Statistics South Africa: 2008 Mid-term estimates in single years; Centre for Actuarial Research: ASSA2003 (national population only)

Strengths and limitations of data

A limitation of the General Household Survey is that young children, especially babies, are regularly under-counted (although a comparison of StatsSA and ASSA model estimates indicate that this is less of a problem in recent years).

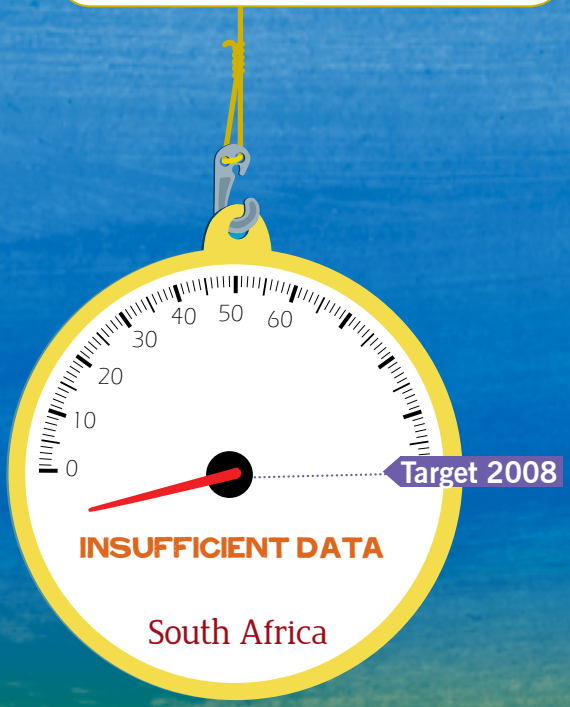
This indicator does not directly show the proportion of eligible infants who receive the CSG. This is because estimates of income eligibility would be unreliable for such a small sub-population (i.e. for children under the age of one year).

The proportion of all children under 1 year in receipt of CSG in 2007 and 2008



10. Co-operative governance

The proportion of civil society sectors represented at SANAC Programme Implementation Committee meetings.



What do these figures mean for children?

The South African National AIDS Council (SANAC) is responsible for co-ordinating a joint response to HIV and AIDS in South Africa. This includes implementation of the NSP. Poor record keeping by SANAC makes it difficult to know if the council is functioning effectively.

SANAC has three levels, with various committees and sub-committees. One of the most important of these is the Programme Implementation Committee (PIC).

- PIC is a technical committee and functions as the engine of SANAC.
- It consists of representatives from Government and from each of 17 civil society sectors, including the Children's Sector.
- It meets at least four times each year and is chaired by the relevant Director-General of the Social Cluster, with a civil society co-chair.
- The SANAC secretariat is responsible for arranging meetings and for covering all costs.
- The number of people who come to the PIC meetings gives an idea of the extent to which SANAC is achieving the goal of co-operative governance.

Out of a total of eight PIC meetings between August 2007 and July 2008, attendance data were only available for two meetings. The rates of attendance dropped from 94% at the first meeting on 27 August 2007 to 71% on the 1 November 2007. No attendance data are available for meetings held between November 2007 and July 2008.

What other information do we need to monitor co-operative governance?

There are no attendance records for most PIC meetings. This is cause for concern about the capacity and functioning of the SANAC Secretariat.

Ideally, future editions of the scorecard will include a composite indicator of governance and leadership.

Technical notes

Numerator: Number of civil society sectors represented at PIC meetings.

Denominator: Total number of civil society sectors represented on SANAC.

Data source: South African National AIDS Council Secretariat

Aspirational Indicators

These are indicators that would help in monitoring the implementation of the NSP for children and families, but for which there is currently inadequate data.

Food security

For HIV-positive children, and for children living in AIDS-affected households, the risk of malnutrition is increased. It is essential for HIV-infected children to receive a diet that provides enough energy and vitamins and minerals (micronutrients) to support the immune system and promote better health.

- The NSP recognises the importance of nutritional support for HIV-affected households. However, information on access to food in these households is not routinely collected.
- A good indicator of food security is the proportion of children (6 months to 4 years) in HIV-affected families, or caregivers of the same children, who have skipped meals in the past week or month.

This information could be routinely collected at all clinic or hospital visits. Until that happens, data could be collected each year through health facilities, using a suitable sampling approach.

Psycho-social support

There are particular stressors associated with the experience of illness and death for children. These include:

- The reversal of parent-child roles when a parent becomes ill.
- The psychological impact of illness and death (including possible fear, insecurity and hopelessness).
- For many children there is also the risk of other losses because if they have lost one parent to AIDS, they may lose the other parent and siblings.

The NSP recognises the importance of psychosocial support, but there are no regularly collected data on access to psychosocial support for children affected by HIV and AIDS.

In measuring psychosocial support, we need to focus on the kinds of support that are likely to have the greatest value for the largest number of affected vulnerable children.

- For children to have a feeling of well being, they need to know they are supported and connected to people who mean something to them.
- A good measure of psychosocial support is therefore the proportion of children who report having someone they can depend on (for advice, comfort, material needs etc).

It would be sensible to have this as an aspirational indicator – one that is collected in child and adolescent surveys from time to time.

Disability

Children with HIV are at high risk of mental and physical disabilities, especially if they do not receive antiretroviral treatment early (for infants this would be from the point of HIV diagnosis). It is critical that disabilities in children are:

- prevented where possible
- detected early and monitored regularly
- appropriately referred to the necessary supportive services.

The NSP recognises the importance of monitoring children for developmental delays. It has set targets for developmental screening twice a year for all children under the age of 5 years.

The new clinic card (Road to Health card) provides a possible tool for improved monitoring of disabilities in children.

2009 Summary scorecard

Indicator	How are we doing?		
	Below target	On target	We don't know
1. The proportion of adolescent girls aged 15 to 19 years visiting antenatal clinics, who test HIV-negative			
2. The proportion of HIV-positive pregnant women who receive PMTCT prophylaxis.			
3. The proportion of babies born to HIV-infected mothers, who are HIV-negative at three months.			
4. The number of children under one year of age who die in a year, per 1 000 live births in the same year.			
5. The proportion of eligible children who are given post-exposure prophylaxis after rape.			
6. The proportion of children under 15 years old starting antiretroviral treatment as a proportion of the number of new HIV infections in children			
7. The proportion of women progressing to AIDS who start antiretroviral treatment			
8. The proportion of registered social workers compared to the number of social workers needed to deliver services to children in terms of the Children's Act.			
9. The proportion of children under one year who receive the Child Support Grant.			
10. The proportion of civil society sectors represented at SANAC Programme Implementation Committee meetings.			

In summary

- There is an urgent need for more and better information on service delivery and child outcomes related to HIV and AIDS in South Africa.
- More needs to be done to ensure access to dual therapy and HAART for HIV-positive pregnant women.
- We have done well in reaching our treatment targets. However, these targets need to be brought in line with actual need.
- We need to substantially increase the capacity of our care and support systems so as to ensure that we meet the NSP targets by 2011.
- South Africa is far from meeting our target for reduced infant mortality. The absence of reliable annual data on infant mortality is a critical gap.
- Special attention needs to be paid to provincial inequalities in service access and child outcomes.

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CATCH: Network for Coordinating Civil Society Action on Children, HIV and AIDS

CATCH is a children's sector civil society network of networks representing thousands of organisations and individuals around the country working to address the impact of HIV and AIDS on children and families.

The CATCH Network was established in 2003 to co-ordinate Children's Sector representation on SANAC and to champion children's sector activities in support of the NSP. This scorecard is one of several outputs produced by the network and its members to support implementation, monitoring and evaluation of South Africa's responses to children, HIV and AIDS.

For more information, contact the CATCH Secretariat housed at the Children's Rights Centre:

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