# Critical Health

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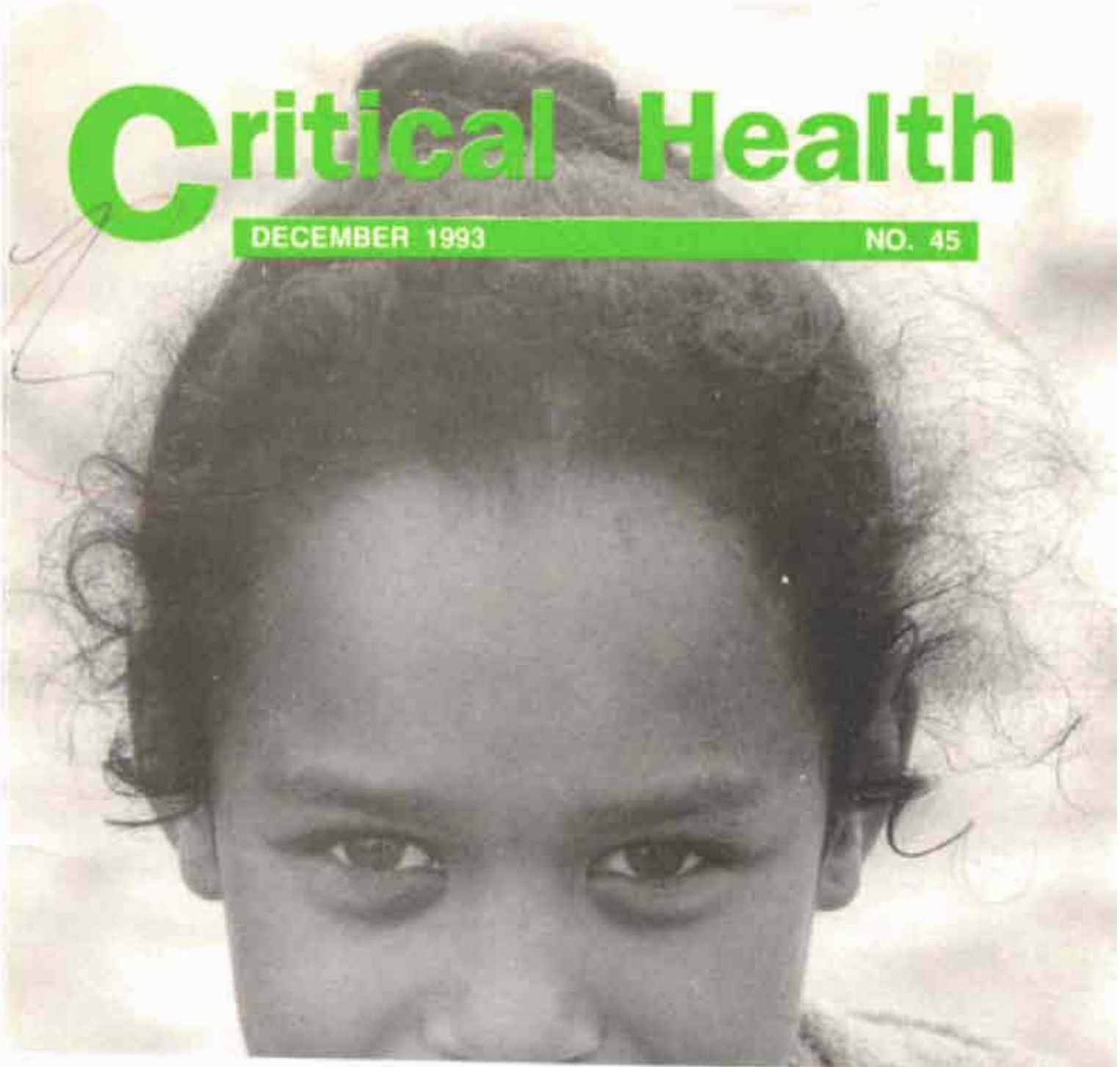



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**Typesetting by Critical Health**

**Critical Health is published by an editorial collective:**
PO Box 16250
Doornfontein
2028
South Africa
Tel: (011) 484 3078
Fax: (011) 484 3557

**The editorial collective:**
George Dor, Sharon Fonn, Joe Kelly, Laetitia Rispel, Shereen Usdin, Ahmed Valli, Ismail Vawda

**Marketing and distribution:**
Caron Kanareck

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# Editorial

Earlier this year, Critical Health was approached by concerned welfare workers to publish an edition on crimes against children.

On discussing this suggestion in the health and welfare sectors, it became evident that we should extend the scope of the edition beyond child abuse to cover the health and welfare of children in a broader sense.

Children have always been vulnerable to ill health and abuse under apartheid. However, within the current context of political change, the sad reality is that the situation is deteriorating.

The government is implementing an economic policy which is increasing the burden on poor households. It has also failed to provide adequate housing, education and health services. The recent drought has compounded the hardship faced by those in the fragile rural areas. It is frightening that, in a country as wealthy as South Africa, we are experiencing a large increase in child deaths from malnutrition.

Economic hardship is forcing more rural mothers to look for employment, such as domestic work, in distant urban areas. Almost 2 million South African children are permanently separated from their mothers. Our society has become increasingly violent and, more than ever before, children are exposed to political, gang, domestic, sexual and racial violence. According to the police, the incidence of child abuse has doubled in the last 4 years.

The growing number of "street children" in the urban areas, without families and homes, is a further indication of the level of social decay in our society.

## Children's Rights and the Harsh Reality

The abuse and neglect of children has come under increasing scrutiny internationally and world bodies have called on all countries to address these problems. The South African government has failed to take up the challenge, but NGOs have responded by adopting a Children's Rights Charter for South Africa, which is the opening item of this edition.

This is followed by an article which provides an insight into the level of hunger in rural areas. It shows, in contrast to government statistics, that child mortality has increased dramatically in the last few years. Operation Hunger argues that the government must provide pre-school nutrition programmes, school feeding schemes and free compulsory education to ensure that children have access to these feeding schemes.

Franz Reiger, from northern Zululand, confirms this picture. Bethesda Hospital experienced a two fold increase in child mortality during the drought. He points out that health managers lack commitment to primary health care and argues that this problem needs to be tackled urgently.

HIV positive mothers who lack access to clean water or do not have the resources to purchase formula feeds are forced to continue breast feeding and run the risk of infecting their children. Glenda Gray argues for the need to fight social inequality. She

also highlights the importance of preventing the spread of HIV to mothers in the first place and providing counselling on feeding options to those already infected.

Andre Venter indicates that it is difficult and expensive to find homes for abandoned children. He argues that the state has a responsibility to provide resources to place abandoned children and to support mothers in need, so that they can continue to provide for their own children.

## Crimes Against Children

Kruger and Richardson argue that, in communities beset by poverty and violence, preventing child abuse involves dealing with abuse as a family and community problem. With reference to the approach of the Liberty Life Foundation Child Care Centre, they suggest going beyond clinic based therapy to involving families in informal support systems and helping sexually abusive adults to change their behaviour.

Christine Mkhasibe and Lucy Wagstaff describe how Soweto residents have responded. They have set up a liaison group of health and welfare workers and community members as a means of educating each other and the wider community about sexual abuse and protecting children.

The economic exploitation of children, argues Jackie Loffell, is rooted in the poverty and illiteracy of parents and the willingness of employers, especially in white farming areas, to manipulate destitute families. Previously, farmers were not subjected to labour legislation and, with the extension of labour laws to agriculture, they are lobbying to entrench the exploitation of child labour in the Child Care Act.

Jeannette Schmid points out that the problem of child detention for criminal offences has been ignored. Street children are detained on supposedly humanitarian grounds, but experience harassment and trauma. For these children, proper places of safety are required. In the case of juvenile crimes, there should be alternative forms of sentencing and immediate rehabilitation of offenders.

## Disability, Rehabilitation and Early Education

Lidia Pretorious shows the relation between lack of primary health care and disability. Lack of health services in rural areas delays therapeutic interventions. She questions research oriented interventions of welfare workers, whose findings have no impact on transforming the conditions of rural child disability. Parents have responded by organising. The Rural Disability Action Group is investigating the concept of comprehensive community based rehabilitation within a framework of primary health care provision.

Vuyo Mahlati shows that the government fails to provide the necessary financial support to parents of disabled children. Where grants are available, parents face a maze of red-tape and experience delays of months before receiving them.

Babette Katz briefly describes START, a programme involved in early education

intervention for disabled children. She shows how START emphasises and ensures the involvement of parents over and above that of professionals.

Marion Stewart describes a home based programme, HIPPY, which focuses not only on school readiness of children, but on rebuilding families to nurture and support their children. She concludes with an appeal for more resources for educare.

An article on a Durban educare project shows how communities are forced to pursue low cost options, due to a lack of state resources. However, these low cost initiatives are not sustainable programmes and do not satisfy the demand for more stable educare services. The article stresses the need to link educare to community development.

Debbie Mbete reports on COSATU's workplace initiative in educare, intended as a model of the kind of service unions will demand of employers.

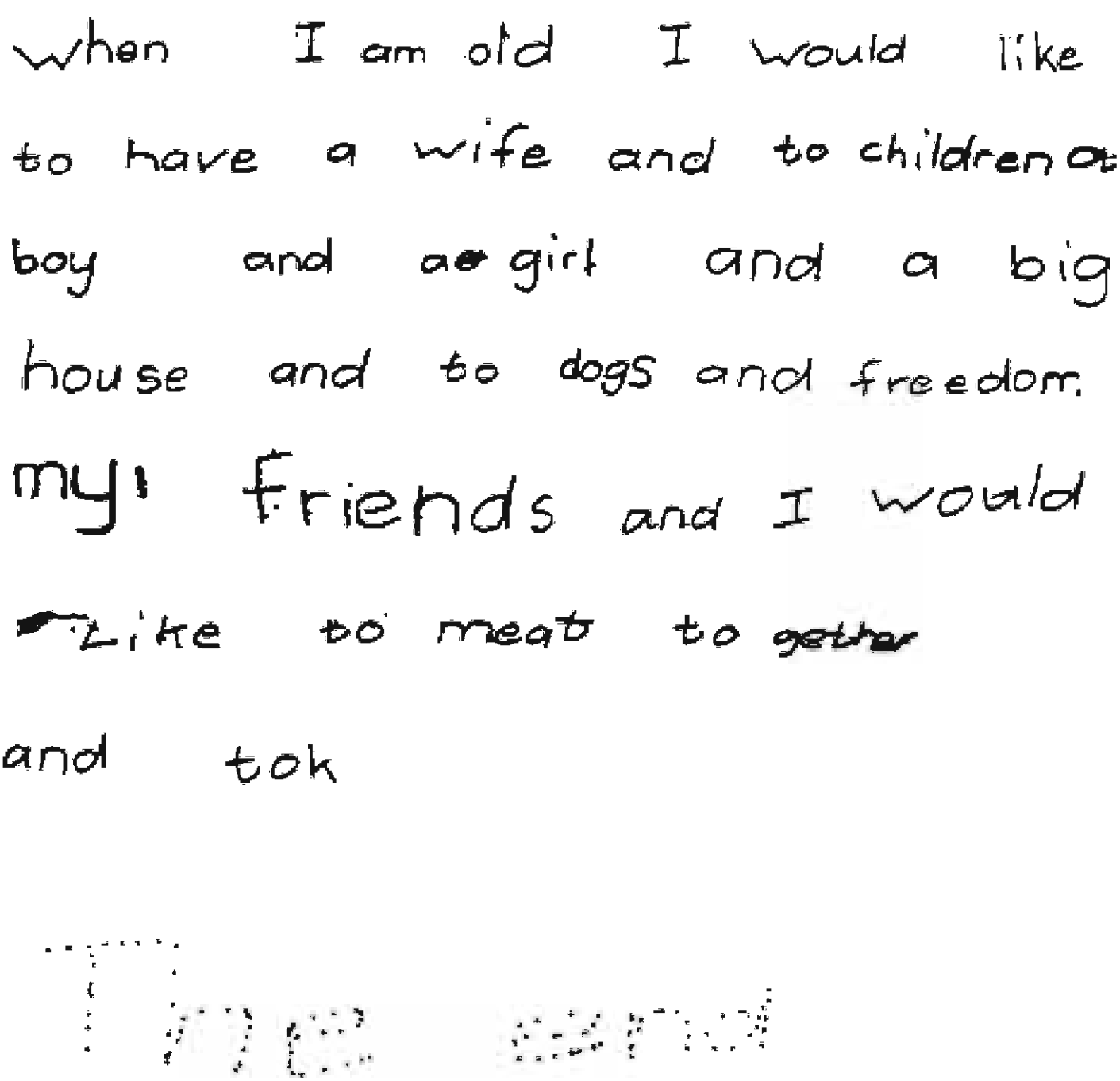
We include a resource list of national bodies involved in the welfare and education of children, as well as overviews of a short publication on children and drugs and the National Education Policy Investigation on educare and support services.

## Social Development, AIDS Education and Baby Deaths

In our last edition, Ann Ntebe argued for the need to develop a radical welfare system. In the first article in the general section, the Johannnesburg Child Welfare Society suggests that an appropriate welfare approach must encourage communities to take the lead in addressing social problems, such as unemployment, lack of housing and violence, in order to lessen their dependence on welfare workers and institutions. It highlights various conflicts and dilemmas that social workers may face in using this approach.

Rehad Desai, in response to the article in our last edition on AIDS and the trade unions, argues that the unions have focussed on providing information on AIDS and that this is not enough to encourage the behavioural change that is necessary to stop the spread of the disease. He stresses the need for peer educators and also suggests that COSATU has now developed a more comprehensive approach.

In the final article, Glenda Gray argues that the deaths which occurred at Ga Rankuwa Hospital during the 1990 NEHAWU strike were, in all likelihood, caused by infected SABAX solutions. The TPA charged NEHAWU shop stewards with murder, but finally dropped the charges in November this year. She notes that this is a victory for the union, against an employer that shows no interest in the welfare of either hospital workers or patients.

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## SECTION A:
## Children's Rights, Health & Vulnerability

# The Children's Charter

In the last few years, there has been a growing awareness across the world of the need to ensure a brighter future for all children. In 1989, the United Nations adopted the Convention on the Rights of the Child. This was followed by the 1990 World Summit, which agreed to the Declaration and Plan of Action for the Survival, Protection and Development of Children. The plan recognises that children have a right to "first call" on their nations' resources and outlines goals that should be achieved in all countries by the year 2000. The goals include significant reductions in infant mortality, under five mortality, maternal mortality and severe and moderate malnutrition, universal access to safe drinking water and sanitary means of excreta disposal, basic education, reduction of adult illiteracy and improved protection of children.

A South African summit was held in 1992, under the auspices of the United Nation's Children Fund (UNICEF) and the National Children's Rights Committee (NCRC). Non-government organisations (NGOs) and welfare bodies from all regions of South Africa participated and adopted the Children's Charter of South Africa. The participants stressed their concern with regard to the prevailing reality in this country. Children are abused, tortured, mistreated, neglected and abandoned. They are subjected to violence, poverty and racism. They do not receive proper education and health care. They are beaten and abused by police, gangs and other adults, and are arrested and held in prisons. The government and other political parties have put children last, not first.

After the summit, the NCRC and UNICEF conducted a detailed study, which underlines the inequalities in access to services for different people, and argues that the major threats to child survival in South Africa, namely diarrhoea, acute respiratory infections, malnutrition and child abuse, are preventable. In June this year, the organisations released a report on the study, titled Children and Women in South Africa: A Situation Analysis. According to the NCRC and UNICEF, the next step is the drawing up of a National Programme of Action, based on the goals outlined above, specific to the South African situation.

De Klerk and Mandela have finally signed the World Summit Declaration, but the NGOs, the NCRC and UNICEF will have to maintain sustained pressure on all sectors of South African society to ensure the future wellbeing of our children.

For the purposes of the charter, a child is anyone under 18.

**Preamble**

We, the delegates of the International Children's Summit held from 27 May to 1 June 1992, acting as representatives from the different regions, on behalf of all the children of South Africa,

- realising that all children are created equal and are entitled to basic human rights and freedoms and that all children deserve respect and protection, and
- recognising that within South Africa, children, as a direct result of apartheid have been subjected to discrimination, violence and racism that has destroyed families and communities and has disrupted education and social relationships, and
- acknowledging that children have not been placed on the agenda of any political party, or the existing government or the negotiations and are not given the attention they deserve and,
- recognising the urgent need for attention to improving the life of children and protecting their rights in every region, have agreed upon the following:

**Article 1**

* all children have the right to the protections and guarantees of all the rights of the Charter;
* all political parties, the government, communities, families and parents should ensure that children are not discriminated against;

**Article 2**

* all children have the right to a name and nationality as soon as they are born;

**Article 3**

* all children have the right to express their own opinions and the right to be heard in all matters affecting his/her rights;
* all children have the right to be heard in courtrooms and hearings affecting their future rights, and to be treated with the special care and consideration within those courtrooms and hearings;
* all children have the right to free legal representation if arrested;
* all children have the right to participate in the government of the country and special attention should be given to consultations with children on their rights;

**Article 4**

* all children have the right to freedom to practice their own religion, culture or beliefs without fear;

**Article: 5**

**Violence**

* all children have the right to protected from all types of violence, including: physical, emotional, verbal, psychological, sexual, state, political, gang, domestic, school, township and community, street, racial, self-destructive and all other forms of violence;
* all children have the right to freedom from corporal punishment at school, from the police, in prisons and at home;

* all children have the right to be protected from neglect and abandonment;
* all children have the right to be protected from township and political violence and to have community centres where they can go for help and safety from violence;
* all children have the right to be educated about child abuse and the right to form youth groups to protect them from abuse;
* all persons have the duty to report violence against, abuse of and neglect of any child to the appropriate authorities;
* children should not be used as shields or tools by perpetrators of violence;
* children have the right to say no to violence;
* the media has the duty to prevent the exploitation of children who are victims of violence and should be prohibited from the promotion of violence;
* all children have the right to be protected from violence by the police and in prisons;
* children should not be obligated or forced to follow adults in their political involvements;
* all children have the right to be free from torture and detention;
* all children have the right to protection from drug and alcohol abuse by their parents, families and others;
* children have the right to a special children's court and medical facilities to protect them from violence;
* special groups and organisations should be formed within the communities to protect and counsel victims of violence;
* no child should be held in prison or police cells at any time;

**Article 6** **Family Life**

* all children have the right to a safe, secure and nurturing family;
* all children have the right to love and affection from their parents and family;
* all children have the right to clothing, housing and a healthy diet;
* all children have the right to clean water, sanitation and a clean living environment;
* all children have the right to be protected from domestic violence;
* all children who do not have a family should be provided with a safe and secure place to live and with clothing and nutritious food;
* special protections should be given to children who are orphaned or abandoned, and every effort should be made to place them within a safe and secure family;

**Article 7** **Health and Welfare**

* all children have the right to adequate health care and medical attention both before and after birth;
* all children have the right to be protected from harmful substances such as cigarettes, drugs and alcohol and to be educated about the effects on their health and environment;
* all children have the right to free and comprehensive health services, especially in schools;
* all children have the right to demand health and medical care without the permission of their parent or guardian;
* all children have the right to be protected and educated about AIDS;
* disabled children have the right to special health care and protections;

**Article 8** **Education**

* all children have the right to free and equal, non-racial, non-sexist and compulsory education within one department;
* all children have a right to education which is in the interest of the child;
* all teachers should be qualified and should treat children with patience respect and dignity;
* parents have the duty to become involved in their children's education and development and to participate in their children's education at school and at home;
* all children have the right to play and to free and adequate sports and recreational facilities;
* all children have the right to participate in the evaluation and upgrading of curriculum which respects all traditions, cultures and values;
* all children have the right to education on issues such as sexuality, AIDS, human rights, history of South Africa and family life;
* all children have the right to adequate educational facilities and transportation to such facilities should be provided to children in difficult and violent situations;

**Article 9** **Child Labour**

* all children have the right to be protected from child labour and any other economic exploitation;
* all children, especially in rural areas, should be protected from hard labour including farm, domestic or manual labour;
* all children have the right to be protected from prostitution and sexual exploitation;
* there should be a minimum age of employment and no child should be forced to leave school prior to the completion of matric for the purposes of employment;
* there should be regulations and restrictions on the hours and types of work and penalties for those who violate these regulations;
* all children have the right to be protected from child slavery and from the inheritance of labour from their parent or family;

**Article 10** **Homeless Children**

* no child should be forced to live on the streets;
* homeless children have the right to protection from harassment and abuse from police, security guards and all other persons;
* homeless children have the right to a decent place to live, clothing and a healthy diet;
* street children have the right to special attention in education and health care;
* communities and families have a duty to protect their children from becoming homeless and abandoned;
* all persons should be made aware of the plight of homeless children and should participate in programmes which act to eradicate this problem;
* the government has a duty and responsibility for homeless children.

# Hunger and Death
## Time To Act

***Operation Hunger***

Earlier this year, we tried to underline the gravity of the life threatening situation in many parts of our country. The latest statistics indicate that the situation is even worse than anticipated. Hunger is the norm and child deaths are dramatically on the increase. In a report of the Co-ordinating Committee for Drought Relief, it is estimated that 17 million South Africans are living in a situation of extreme poverty. Twelve million of these are unable to acquire sufficient food to maintain themselves at an adequate nutrition level. Some 4 million are, we estimate, in a critical, and potentially life threatening situation.

We in South Africa can no longer use our favourite fob-off "but look at the rest of Africa". World Bank figures show that 53% of our children are physically stunted, the victims of chronic protein energy malnutrition. The all Africa average is 39%. South Africa has a worse child death and malnutrition track record than Botswana and Mauritius, countries which are far less wealthy than ours.

South African child death statistics are more than double that of the average for countries across the world with similar income levels. In this country, 73 out of every 1000 children die before reaching the age of five. The world average for countries of comparable wealth is 35.

## Economic Decline, the Drought and Violence

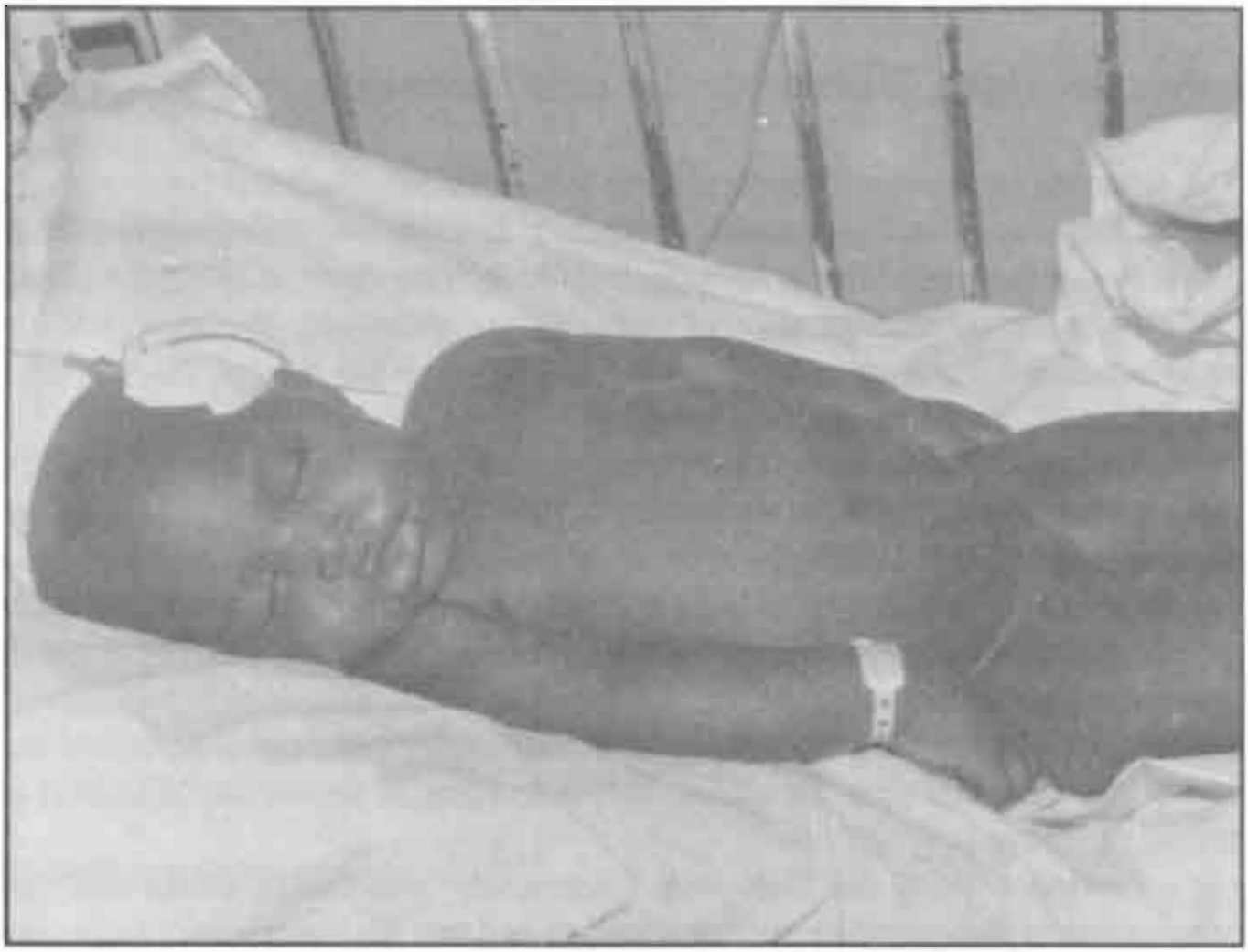
True, this represents a drop from the 91 deaths per 1000 live births in 1982, but it must be remembered that, by 1987, the 1982 figure had been halved. The last three years have shown a sharp increase. The continuing decline in the country's economy has affected all parts of the country. Unemployment has reached higher levels than ever before, and rural familes dependent on migrant bread-winners have been particularly hard hit.

In addition, the drought has critically affected many people's ability to feed themselves. The lack of water has resulted in repeated crop failure, with a consequent increase in the number of mouths to feed. However, we must not lose sight of the fact that the drought simply exacerbated an already dangerous situation. The reality is that the vast majority of South Africa's rural population

are not in a position to sustain themselves off the land. The recent rains have not led to much of an improvement.

On top of all this, the levels of violence in many areas have contributed to escalating conditions of malnutrition and starvation. Over and above the physical destruction of homes, crops and facilities, the violence also drives people away from their traditional areas into regions where they are unable to support themselves.

The greatest hardship is still suffered by the rural population, but the problem of squatters in the urban areas is also a matter for serious concern. There is, for example, an influx of approximately 10 000 people from the Transkei and Ciskei to Cape Town every month. Squatting in this country has traditionally been identified with the migration of destitute black people to the towns. A rapidly evolving variation of this theme is the appearance of white squatters. These people are equally as desperate and provide their own set of unique social problems.



**Clinical signs of malnutrition, Transkei, circa 1988.** ***Photo: Medico***

## Appalling Levels of Malnutrition

Whenever Operation Hunger receives a new application for feeding, we survey children under 6 in that community, using median upper arm circumference and height for age or weight for age techniques. In Natal, only 25% of these children are adequately nourished. Of the remaining 75%, more than 30% are in the red, the life endangered zone. The rest are stunted, underweight, part of the world wide ineducable majority who die by inches from the moment they are born.

In the northern Transvaal, we are seeing a huge number of malnourished children in rural hospital wards. One hospital had a 500% increase in malnutrition related illnesses.

In the Orange Free State, the situation is far worse compared to that of 1992, with a 40% increase in clinically diagnosable malnutrition. It is deteriorating by the day. This dramatic decline makes it far and away the worst area in the country, with 80% of all new applicants stunted and underweight. Of these, 50% are in the danger zone.

## Inappropriate, Bureaucratic and Corrupt

The situation is deteriorating despite the government's National Nutrition and Social Development Programme (NNSDP). It launched this programme in 1991, in response to widespread opposition to the introduction of VAT on food and other necessities, as a way of partially compensating the poor for the additional hardship imposed on them by making them pay this tax (see *Critical Health* no.38, no.39, no.40).

The real need in our country today is for a massive famine prevention programme. The NNSDP, in attempting to provide more than the minimum for comparatively few, is falling far short of this need. Furthermore, the programme has failed to make aid available on a regular basis. The government has, for purely political motives, continued to channel most of its funding through bureaucratic structures that are, at best, inept, at worst, notorious for their graft and corruption. In many regions, government money runs out well before the end of the financial year. In others, only a fraction of the money allocated is actually received.

A visitor from the European Community was in no doubt that the programme is inappropriate for our situation and that the bureaucracy in charge of it is uncaring, power drunk and primarily concerned with protecting their own jobs.

There has been much euphoria recently about the imminent transitional

government and consequent foreign investment, but this alone will not bring urgent relief to the ultra-poor. Operation Hunger has stressed that the crises of drought and recession, when applied to the black rural population, were the last straw on the camel's hump, burdened with chronic poverty and chronic deprivation, a disgrace to a country of our wealth. Time and time again, we have talked about the two worlds that exist in South Africa and that it has been only too easy for us to ignore the misery out there.

## Ten Urgent Needs

The total eradication of the inequality of wealth is a huge problem, requiring vast financial resources. But there are things that can and must be done to bridge the horrendous poverty gap. We should demand of every political party at every opportunity that they include in their election platform a commitment to implement the urgent need for:

* free pre-natal care to all low income mothers, with food supplements if necessary;
* a pre-school nutrition programme for children from families below the poverty line;
* free compulsory education for all children from 5 to 16 years;
* a re-introduction of state school feeding schemes;
* literacy and numeracy programmes for adult men and women, to improve their prospects of finding work;
* land, land, land for those whose total lack of education gives them no alternative but to return to subsistence agriculture;
* housing projects geared towards South Africans with a family income of under R630 a month;
* a proper almoning system in our hospitals and clinics, so that the poor can get free medical attention;
* a hard look at our family planning structure; and
* less 'capacity building', less 'co-ordinating', and more listening, in order to nurture and expand on the survival wisdom and hands on expertise of the people out there.

## Feeding Schemes

We know that it takes at least 4 to 5 years for any community to turn itself around economically. This is why we believe that it is imperative that the need for school feeding schemes and a pre-school nutrition programme be addressed

immediately. Primary school feeding programmes, such as those that existed in this country in the 1940s, need to be introduced hand in hand with free compulsory education. This would take care of a large group of children of school going age who, at present, are too poor to go to school.

There has to be a programme to look after the needs of the under fives, the most vulnerable group of all. The ultimate solution will be the introduction of a programme similar to the Head-Start programmes in the USA, where all children whose parents are under the poverty datum line have a right to participate, at the state's expense, in a project that secures them nutritionally. Pre-schools in black rural areas in South Africa are virtually the prerogative of the middle class. Only 10% of black children attend these facilities. Massive funding must be found immediately for interim child care centres. At the very least, provision must be made for under fives to be part and parcel of feeding schemes at schools.

*This article was compiled by Critical Health from various recent Operation Hunger publications.*

## I Fear for the Future

**I hear talk of economic turnabout, of the miracle of foreign investment. But I see no benefit in this for the rural poor and I fear for the future of this land.**

**I see a government that has no money to feed the newly hungry, but gives one million rand to Malawi to create a reserve for two rhinos and I fear for the future of this land.**

**When I see how carefully the talk shop at Kempton Park has avoided the issue of urgent land redistribution, which is the only hope of the functionally illiterate migrant who has been thrown out of work by the demise of many mines and by mechanisation in agriculture, and I know that 310 million acres of trust land are available now, then I fear for the future of this land.**

**When I see that our three national imperatives, education, health and housing, have been referred to the new regions, and think of the past provincial and homeland track records, I fear for the future of this land.**

**When I hear the above basic human rights called "unreasonable expectations", I fear for the future of this land.**

**If the government of national unity, when it assumes power in 1994, does not have the giant courage to make immediate commitment to certain things, primarily to free and compulsory education and immediate and rapid land availability, then indeed I fear for the future of our land.**

**Ina Perlman, November 1993**

# Rural Child Health

## A Case Study in Negligence and Social Injustice

*Franz Reiger*

Northern Zululand, a holiday paradise for some, is hell for a large number of its inhabitants, particularly children. Unsafe water, insufficient food, widespread poverty, a low level of education and a poorly functioning health service form the background to a scenario where most child deaths at Bethesda hospital, a district hospital in northern Zululand, are due to diseases that can be prevented (see fig. 1).

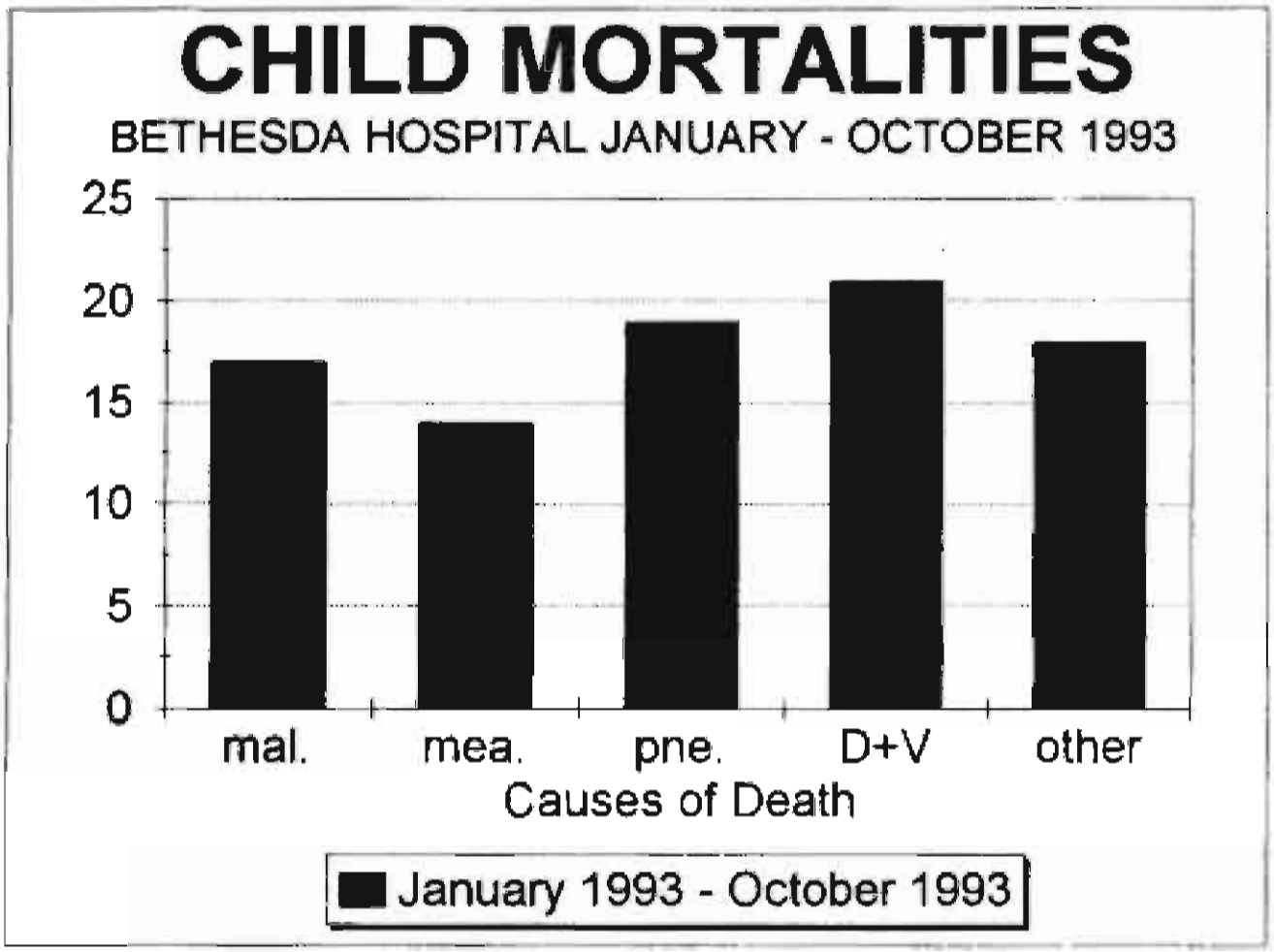



**Fig. 1: Infant Mortality Rate due to preventable diseases**
key: mal = malnutrition, mea = measles, pne = pneumonia, D & V = Diarrhoea & Vomiting

The extreme vulnerability of children in this area was highlighted during the recent drought, during which there was a more than two fold increase in child mortalities at Bethesda Hospital. From figure 2, it can be seen that we expect a 200% to 300% increase in deaths, from 44 deaths in 1991/92 to about 100 in 1993.

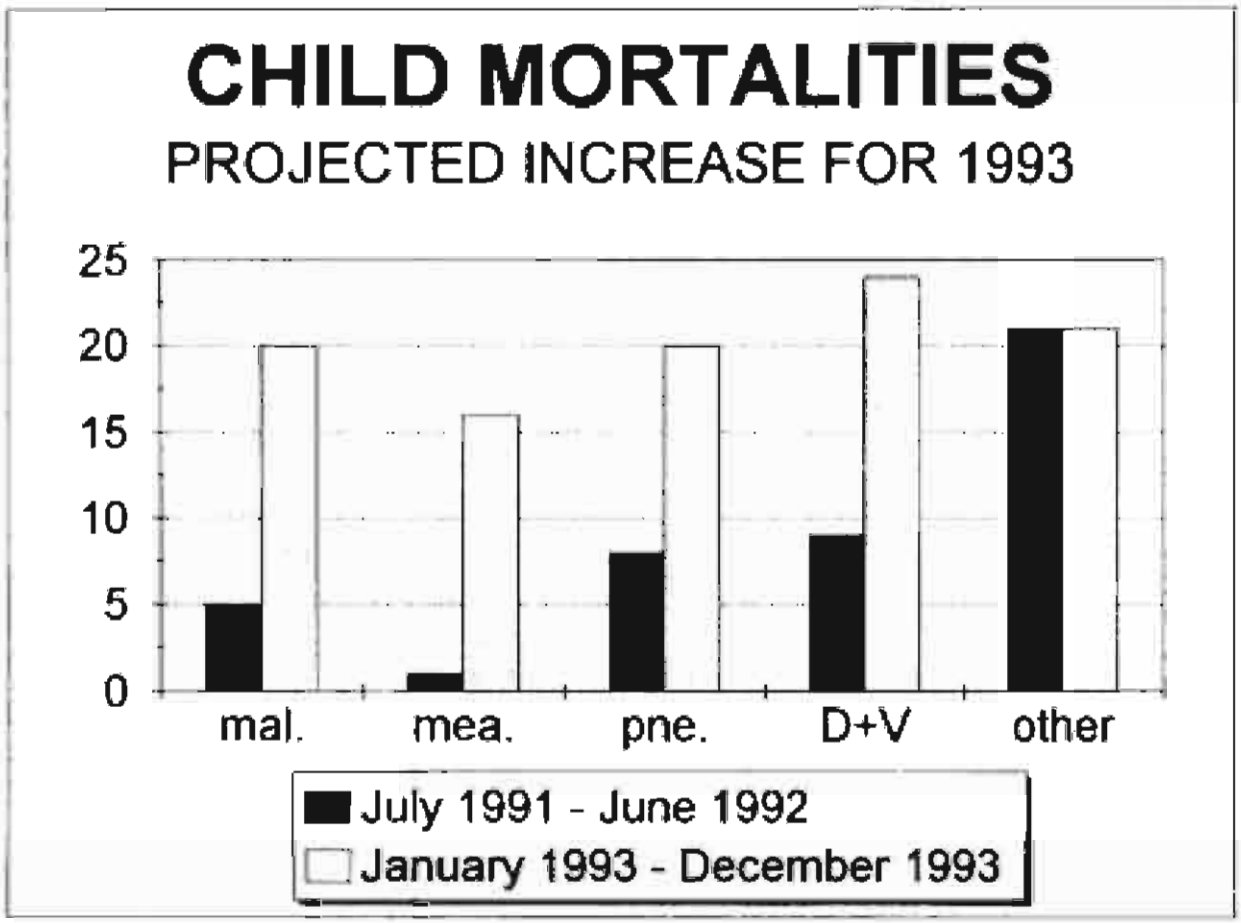



**Fig. 2: Expected Increases in Child Mortality for 1993**

At the same time, resources in the Bethesda health ward were not allocated according to priority health problems. Instead, they were apportioned to meet the personal interests of individual managers. In the face of rising child mortalities, new, expensive vehicles were allocated to the administrative section instead of outreach services. New air conditioners were put into offices at the district hospital, but the appalling working and living conditions in the community services were overlooked.

## Inappropriate Hospital Based Curative Work

The Bethesda health service is a prime example of a health service that has shown little commitment to primary health care as laid out in the Alma Ata declaration. Even selective primary health care measures, like GOBI-FFF, are

not effectively implemented. Monitoring of the cold chain is non existent and immunisation coverage is only about 60%. Growth faltering is often only detected when children present with symptomatic malnutrition to the health service.

Provision of sufficient numbers of scales to health workers was obstructed by local and head office management. Four million rand was allocated to erect new out-patient and office buildings at the district hospital, while peripheral clinics have no electricity and leaking roofs. Health services are centred around the hospital and strong emphasis is placed on relatively expensive curative procedures which have no lasting impact on the health of the community. Doctors and nurses, the most expensive component of the health ward budget (their salaries account for 74% of the total allocation), spend most of their time on curative work. Sporadic attempts by individuals to provoke a real change towards primary health care have met great resistance from local and national health service managers. Local management is not visibly accountable for the success or failure of its health programmes, either to the community, or the national managers.

## Bethesda No Exception

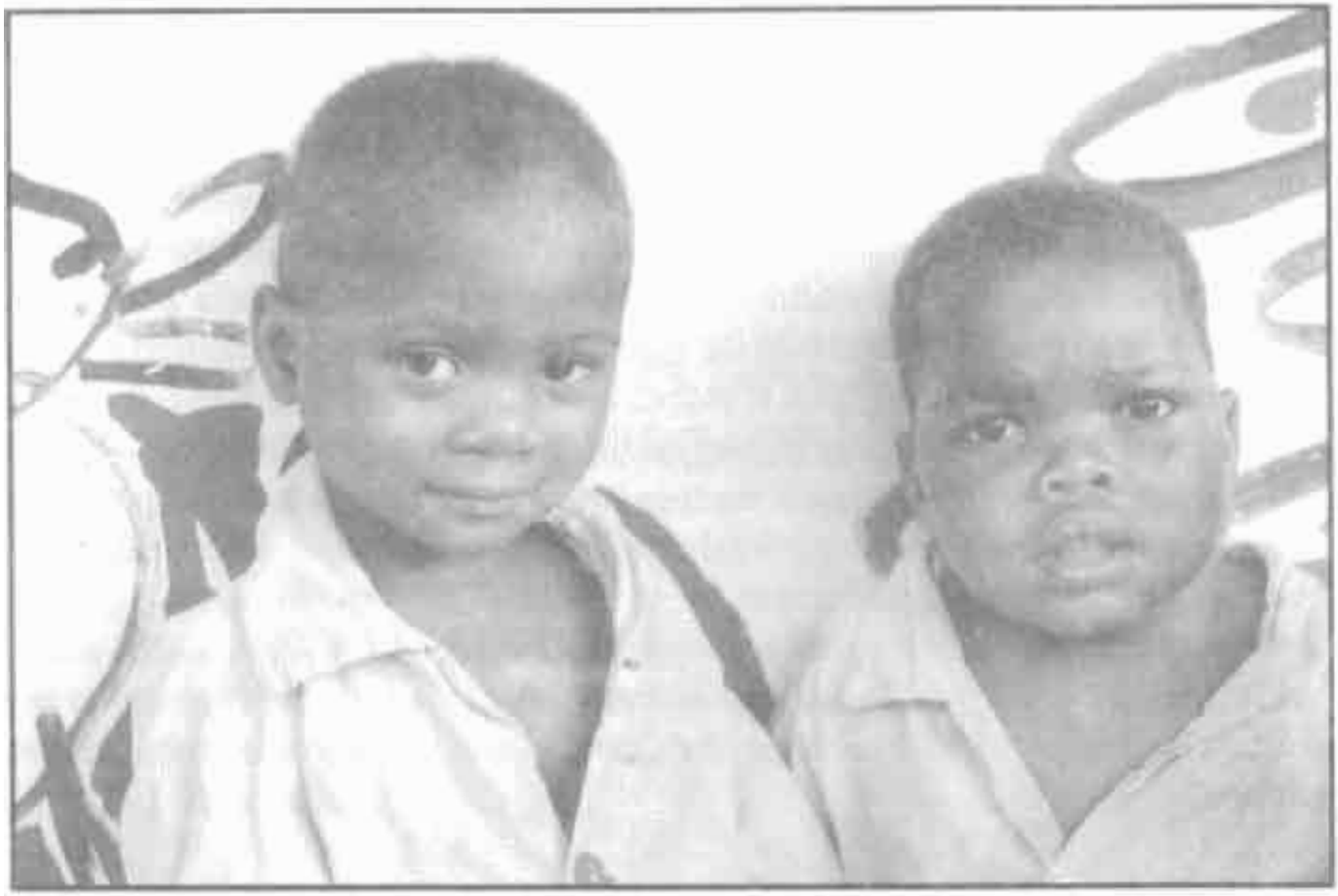
Is the Bethesda health ward just an unfortunate exception in a country that looks after its children's health? South Africa has an under five mortality rate similar to that of Burma, a country ten times as poor. Countries like Sri Lanka and Costa Rica are also poorer than South Africa, but have achieved far lower under five mortality rates.

Does this gloomy picture painted by national statistics and observations from the Bethesda health ward call for resignation? Is it just 'natural' that twice as many children die in years of drought? Is poverty and poor child health a reality that is here to stay?

There is reason for hope. The causes of poor child health in South Africa are not a mystery. The lack of basic necessities, such as food, clean drinking water, adequate education and accessible health services, are responsible for most illnesses. Comparison with other countries shows that it is possible for a country with less than half the wealth of South Africa to have a far higher level of child health.

## Health Management Support Programme

However, only a firm commitment to primary health care, in a climate of social and economic justice, will allow children the health they are entitled to. Will the



**Clinical signs of malnutrition, northern Natal, 1993.**

new government be able to translate a theoretical commitment to a more just society into real change?

National or regional managers from the apartheid days who created or sustained government services that proved grossly inefficient will inevitably have to be replaced by people genuinely committed to a more equitable society.

However, one of the most difficult challenges will be to take many of the other people working for the present government along on the path towards a more equitable society. Will it, for example, be possible to persuade mid level managers, like administrators of district health services, to change a system they identify with and have greatly benefited from in the past? Whatever the decision, both old and new managers will initially need a strong structure that is able to provide training, ongoing supervision and support. A health management support programme should be organised as soon as possible. Considerable amounts of funds and trainers from national and international resources will be required.

*Franz Reiger is a paediatrician at Besthesda Hospital in northern Zululand*

# According to the Medical Superintendent

**Dr Reid, in the six months that you have been the Superintendent of the Bethesda Health Ward, you have tried to change the curative hospital centred service into a more decentralised primary health care based service. What were the greatest obstacles?**
I would say lack of local control. Most strings are held by a central administration and decisions do not seem to take local needs into account. Let me give you an example. The Department of Works decides which building projects get given priority. Bethesda Hospital will soon have new offices and an outpatient building. The local need is to upgrade buildings in the community services.

**What are the priority child health problems in the Bethesda health ward?**
Malnutrition, diarrhoea, pneumonia and poor maternal education.

**Is there anything that gives you hope that child health will improve over the next few years?**
Meeting sincere and committed people in the health services. The community health worker structure is another source of hope for me. In our area specifically, it gives me hope to see community leaders who are prepared to actively participate in an attempt to improve the health of children.

**What, in your opinion, are the most important changes that have to be made to the present health service?**
A new health service must have an in built system of accountability to the community. It will be very important to decentralise power to district health services. Administration will have to be rationalised as much as possible.

# Breast or Bottle
## Infant Feeding and HIV

*Glenda Gray*

Worldwide, a rapidly growing number of women of childbearing age are being infected with the HIV virus. An increasing number of babies are being vertically infected, that is, infected by their mothers. Mother to child transmission rates have been reported to range from less than 15% to over 40%. A transmission rate of about 30% is considered average for pregnancies occurring in Africa.

Vertical transmission can occur in the uterus, during the delivery process or through breast feeding. Recent studies have shown that there is a higher risk of infection to infants born to HIV positive mothers if they are breast fed. Available data also indicate that a higher rate of transmission through breast feeding occurs if the mother has been infected after giving birth.

The detection of the HIV virus in breast milk and the publication of several reports implicating breast feeding as a transmission route raise the question of whether babies with HIV positive mothers should be breast fed or bottle fed.

## Debating the Advantages of Breast Milk

The arguments promoting breast feeding amongst HIV positive mothers are based mainly on the limited amount of research, on the relationship between different feeding modes and diarrhoeal mortality in infants, that took place before the 1960s. This research varies in quality, some findings are contradictory and substantial areas of ignorance remain. Many researchers have questioned its validity and its relevance to the nineties. Nevertheless, breast feeding appears to offer protection to children up to one year of age, the protection being greatest in the first three months.

Some recent research findings also highlight advantages of breast feeding. A study in Brazil found that the risk of death from common infections was higher in infants who had not been breast fed. These infants were 14 times more likely to die from diarrhoea and almost 4 times more likely to die from respiratory infections than those who were breast fed. In Malaysia, in homes without piped water or a toilet, infants who were not breast fed were 5 times more likely to die.

However, evidence is starting to emerge that, under certain conditions, bottle fed babies are not necessarily at a disadvantage. Presently, a substantial

number of well babies seen at the Baragwanath neonatal follow-up clinic get supplementary bottle feeds or are exclusively bottle fed. A recent review of the statistics from the birth to ten study showed a decline in the infant mortality rate in Soweto over the last three years, despite the higher rate of formula feeding in the community.

## HIV or Diarrhoea/Pneumonia

A small increase in the risk of transmission of HIV through breast feeding could affect large numbers of infants. A million HIV positive mothers breast feeding their children each year could result in tens of thousands of HIV infected children. If, on the other hand, HIV positive mothers were to bottle feed their infants, there would be a decrease in the vertical transmission rate and, therefore, fewer children suffering and dying from AIDS. The costs incurred by the health sector in treating paediatric AIDS would decline. If milk powder was cheap, and clean water and facilities for sterilising bottles universally available, artificial feeding would be the logical choice.

However, under conditions where access to water and heating is suboptimal and humanised milk feeds are unaffordable, advising mothers to formula feed will lead to increased infant morbidity and mortality, as indicated by examples from Brazil and Malaysia. Bottle feeding thus appears feasible in communities where alternatives to breast feeding are widely available and affordable. But, in developing countries, any HIV prevention programme which promotes formula feeding has to weigh the risk of acquiring HIV through breast feeding against the protective effects of breast milk from the common causes of early child morbidity and mortality.

## WHO, UNICEF and Discrimination

WHO and UNICEF issued a statement on HIV and breast feeding in March 1992, which commences by asserting that "in all populations, irrespective of HIV infection rates, breast feeding should continue to be protected, promoted and supported." However, health authorities in many developed countries are recommending that HIV positive women should not breast feed their infants. In their consensus statement, WHO and UNICEF state that the simplistic division between developed and developing countries is inappropriate and, instead, use the term 'settings' to describe the range of poverty and wealth around the world. They suggest that, if an alternative feeding method is possible, then a mother known to be HIV positive should use this feeding method, but, if this is likely to

cause illness and death from infectious diseases, then the mother should breast feed.

The consensus statement essentially provides different recommendations for rich and poor women. WHO and UNICEF are encouraging health workers to discriminate in the advice they give to mothers on the basis of the mothers' standard of living. This is an unusual, even unique, situation, since health directives and policies generally hold good for the global community, not just for certain 'settings'.

At present, the Johannesburg group of teaching hospitals affiliated to the University of Witwatersrand have only managed to avoid this discriminatory conclusion because they have failed to address the issue. There is no consensus regarding the best mode of feeding for the babies born to HIV positive mothers. Thus, different health workers at different hospitals offer different advice. An infant born to an HIV positive mother at Johannesburg Hospital will most likely be put onto artificial formula feeds whereas a similar infant born at Baragwanath Hospital will be breast fed.

## Social Change, Prevention and Counselling

The WHO/UNICEF recommendations leave much to be desired. The organisations take cognizance of the existence of different conditions in different 'settings'. However, the consensus statement, in keeping with the general thrust of the current work done by these organisations, implicitly accepts these differences. The statement fails to reject the underlying reason for the discriminatory recommendations, namely the current imbalance between the developing and developed world and between rich and poor 'settings'. The eradication of this imbalance and the attainment of basic human rights, such as the provision of a safe water supply, access to heating and a living wage, would pave the way to a single recommendation promoting artificial feeding to all infants of HIV positive mothers.

Meanwhile, in all countries, the first and overriding priority in preventing HIV transmission from mother to infant is to prevent women of child-bearing age from becoming HIV positive in the first place. WHO and UNICEF should be pressurising governments to set up appropriate educational programmes, to ensure easy and ready access to condoms and to provide prevention and appropriate care for sexually transmitted diseases.

HIV infected men and women have a number of important concerns, including looking after their own health, maintaining their jobs, and ensuring provision for their children in the future. They require counselling and guidance

**Is breast always best?** ***Photo: UNICEF***

on a wide range of issues, such as the risk of HIV transmission to sexual partners, the risk to infants, and infant feeding practices. All HIV infected persons who wish to avoid having children should have easy access to family planning information and services.

All pregnant women found to be HIV positive should have access to counselling and support. They should know the risks of perinatal transmission. If alternative feeding is an appropriate option, mothers should be encouraged to bottle feed and should get all the support they need. Finally, the decision makers or policy makers should be consulting with these very women and the communities from which they come, in order to ensure that policies are appropriate for the people they serve.

*Glenda Gray is a member of SAHSSO*

# Child Abandonment
## An Assessment

*Andre Venter*

From January to mid-June 1992, 25 abandoned children were admitted to the academic hospitals in Johannesburg/Soweto. Twenty one were admitted to Baragwanath, three to Coronation and one to Johannesburg Hospital. While this number may seem unimpressive, it represents a major dilemma for health as well as social services.

## Tertiary Care Inappropriate and Expensive

In 1990, 17 abandoned children were admitted to the Johannesburg Hospital and, in 1991, 12 were admitted. In many cases, there were no prospects of placement. It was felt that the admission of abandoned children to a tertiary care facility was both inappropriate and expensive. This unsatisfactory situation led to the drafting of a hospital policy which states that abandoned babies will not be admitted to the hospital. Only babies requiring medical attention will be admitted. As a result, only one abandoned child was admitted in 1992, because the case was complicated by a history of child abuse. The decline does not represent a decreasing incidence of the problem of child abandonment in the area serviced by the hospital. To the contrary, it is likely that the problem is growing.

The three babies admitted to Coronation Hospital include two newborns and one three month old child. By mid-1992, all three babies were still in hospital, having been there for 66, 44 and 19 days respectively, representing a total of 129 patient days.

## Abandonment and Poverty

Although 21 abandoned children were admitted to Baragwanath between January and mid-June 1992, there were a total of 40 abandoned children in the hospital. The higher figure includes those children admitted before 1992. Of the 40 children, 16 were male, and 24 female.

The age distribution was as follows:

| | |
|---|---|
| Less than one month | 16 |

| | |
|---|---|
| One month to six months | 4 |
| Six months to one year | 5 |
| One year to five years | 12 |
| More than five years | 2 |
| Unknown | 1 |

The vast majority of the abandoned children were less than 5 years old and most of the children fell into two distinct age groups. Almost half were less than one month old and a further third were between one and five years. The high number in the first group is linked to poor socio-economic circumstances. It is likely that most of the children in this group were abandoned shortly after birth because their mothers were in a desperate situation. The second group represents children that are mobile and therefore less dependent. There are probably a number of reasons why the children in this age group were abandoned. These include desertion of the mother by her partner and inadequate day care while parents are at work. In many cases, the reasons also reflect poor socio-economic circumstances.

Analyses of where these children came from or were found was not very useful. The majority were found in Soweto with no specific distribution. At least 10 of these children were classified as abandoned after admission to hospital.

## Long Stays before Placement

The length of stay in hospital was calculated for each child up to 10 June 1992. The shortest stay was one day and the longest 591 days. The mean hospital stay for all the children was 140 days. The true length of stay is higher than this figure as 16 children were still in hospital on 10 June. Ten children had been in hospital for more than 180 days. Most of these children had psychical problems and some had mental handicaps. The placement of these children poses a major problem and requires urgent attention.

The total number of hospital days for the 40 patients was 5349 days. The cost to the government is R234 a day (private rates, excluding any therapy whatsoever). This comes to a total of R1 251 666, which is a considerable expense. Although it is true that these children will have to be accommodated in some form of care anyway, there are options which are more cost effective.

The outcome for these children was as follows. Ten were placed with prospective adoptive parents by Child Welfare Services. Ten went to other members of their family. Three were sent to the Orlando Children's Home by TPA Community Services. One was placed with foster parents by TPA Community Services. Sixteen had not yet been placed by 10 June 1992.

These figures highlight the difficulties encountered in trying to place these children. Institutions that could provide safe accommodation are full, overcrowded and have long waiting lists. There are not enough facilities to cope with the demand. Moreover, very few children are placed with foster parents. In communities that are already experiencing financial hardship and poverty, the present inadequate and grossly inefficient provision of state grants to foster parents causes serious obstacles rather than encouraging potential foster parents.

## The State Must Act

Child abandonment is primarily a social problem and, as such, tertiary health care centres do not have a major role to play. Tertiary care is expensive and there is a limited number of staff in social work departments. Once children are

**This boy and his sexually abused sister were abandoned at a Soweto clinic. They had been living there ever since.** ***Photo: Ismail Vawda***

admitted to an academic hospital, it appears that the urgency to place them somewhere else diminishes, solutions are postponed and problems ignored.

It is obvious that the socio-economic situation for the majority of South Africans is deteriorating rapidly. The phenomenon of child abandonment will more than likely increase. Furthermore, the prevalence of abandonment as experienced in tertiary health centres only represents a small proportion of the real problem. If mechanisms are not developed to deal with these children now, the problems in the future will be even more daunting, and solutions ever more elusive. It is obvious that if the general standard of living improves, some of the reasons for abandonment will cease to exist. Unfortunately, this is not going to occur in the near future. The immediate future of abandoned children depends heavily on the involvement and intervention of the state.

The Child Care Act needs to be amended. In its present form, the act does not define 'abandoned children' as such, instead they are grouped together as children whose parents or guardians cannot be traced. For example, no mention is made as to how long a child may stay in hospital without parental contact before s/he may be classified as 'abandoned'.

Financial and human resources should be channelled as a matter of urgency into community care systems, which are far healthier and more cost-effective than hospitalisation and institutional care in any form. The first priority should be to provide financial and social support to the mother who may otherwise see abandonment as her only solution. Simultaneously, expansion and upgrading of the foster care and adoption systems is urgently required and can only be achieved through a major injection of state funds.

More facilities need to be created. It is encouraging to see that charity and volunteer groups have started addressing the problems in Soweto. Communities will also have to become involved through these groups, welfare organisations and municipalities.

The appointment of peripheral hospitals as referral centres for abandoned children in need of medical care should be considered. We will probably have to deal with abandoned children with AIDS soon. Where will they be placed? The placement of handicapped children also needs to be addressed urgently.

Child abandonment is a problem that can be dealt with, but it demands serious attention. It is a growing problem and there is an urgent need for financial resources and appropriate personnel. Planning for the future is imperative. A future generation is at stake and we have to avert a downward spiral into hopelessness and despair.

*Dr Andre Venter is a paediatrician at Baragwanath Hospital, Soweto.*

What is going on in the world arround
There are Pocple dying
There are sign of freedom everywhere
There are S.A.D.F everywhere you look
They are either playing soccer with their
the children or they are having war with them
They little kids don't understand why they
have been put (thrown) into jail
The people demand freedom for their
loving nation
Semany people have died because
they have fought for freedom
Maybe one day the freedom of
the people will be given to them

Bothale (12 years)

## SECTION B:
## Crimes Against Children

# Child Sexual Abuse
## The Search for Effective Interventions

*Kruger & Richardson*

Over the last decade, there has been a growing awareness of the problem of child sexual abuse. Child sexual abuse, according to one definition, is "the involvement of a child with or without the child's consent with an adult or age inappropriate adolescent within the family or outside the family in sexual behaviour designed for gratification of the adult or older adolescent". It has been estimated that, one in nine boys and one in four girls will have experienced sexual abuse by the time they become adults.

However, the validity of the estimate and the extent of the problem is very difficult to assess. Some of the reasons for this, include the secretive nature of sexual abuse, limited physical signs, the fragmentation of health and welfare services and questionable reporting proceedures. In spite of the Child Care Act, which requires the reportage of suspected abuse by health and social workers, such reportage frequently does not occur When it does, no standardised proceedure is followed.

## The Child Care Centre

Believing that the exposure of child sexual abuse is only the first point in an effective strategy for dealing with the problem, Johannesburg Child Welfare Society, sponsored by the Liberty Life Foundation, has established a Child Care Centre. This centre aims to render a therapeutic service to sexually abused children and their families. It also intends preventing sexual abuse through community education. The choice of approaches which are appropriate to our situation, has been influenced by numerous factors.

In our multi-cultural society, the concept of child sexual abuse is neither universally accepted nor defined by all. Levett suggests that because of a lack of knowledge about the sexual development of boys and girls in the varying social contexts operative in South Africa, we lack clarity as to the meaning of sexual abuse for local children. This means that preventive community education and treatment of sexually abused children needs to be offered with extreme sensitivity, whilst simultaneously overcoming community denial, avoidance or ignorance.

In Johannesburg, two factors having a significant impact on the community's response to sexual abuse, are poverty and violence. In communities beset by high levels of unemployment, overcrowding, violence and homelessness, and a dearth of resources for child care, sexual abuse does not take high priority. Poverty often severely limits the choices a family or child has when dealing with sexual abuse. An incestuous father may be the sole source of income for the family. The protection of the child, therefore, becomes a harder task for the non-perpetrating parent to preform.

Resources within impoverished communities are extremely limited, and at times, violence has prevented social workers serving particular areas. For example, car hijackings have left staff feeling afraid and vulnerable, and at times reluctant to go into the community. Fear of involving the South African Police and a lack of faith in the country's judicial system, impact on some community's use of these as a means of combating child sexual abuse. Possible intimidation by the accused, out on bail, deters many from reporting abuse, especially in communities where the police are seen as unwilling or unable to provide protection.

In this context, the Child Care Centre has based its services on several criteria including:

* the child's safety from continuing sexual abuse;
* respect for and sensitivity to the individual or community's experience and perceptions;
* dealing with child sexual abuse as a family and community problem;
* primary prevention of child sexual abuse, and secondary prevention of bad handling of sexually abused children within the legal, medical, education and welfare systems.

The Child Care Centre's practice is approached in terms of ensuring child protection, clinical treatment, community education and development, and advocacy.

## Child Protection

Child protection is the foremost consideration of the work undertaken by the centre. Following a child's disclosure of sexual abuse, it is essential that the abuse cease immediately. This does not imply moving the child from the family, although in terms of the Child Care Act, this is an option. Protection in this manner is often perceived by the child as punitive. It is only used as a last resort. In families with internal and external resources, the task of child protection is comparatively straight forward.

**One in four girls will be sexually abused before they reach adulthood.** ***Photo: Afrapix***

Focused work with the family, often linked to the use of the criminal court system, provides the answer. The prosecution of the perpetrator is usually necessary, as this provides an external source of control for him, while he develops an internal locus of control. A person who has perpetrated abuse may receive treatment at the Centre as a condition of a suspended sentence. Co-operation between the Centre, the Child Protection Unit (CPU) and court systems are sought.

However, the protection of a child from further abuse presents a problem in communities beset by violence and poverty, and in which the relationship between the police and community is poor.

Attempts have been made to engage grassroots community structures in addressing this difficulty. It was hoped that an informal support system might develop to assist children and families dealing with abuse. Several joint meetings were well attended, but the voluntary committee emanating from this process failed to function. Protection of children in such communities remains in need of an urgent solution.

## Clinical Treatment

Research has substantiated the view that sexual abuse is damaging to children. Clinical treatment is, therefore, offered by the Centre to assist the child come to terms with abusive experiences, to empower non-abusive parents to protect their children and to help sexually abusive adults to change their behaviour. At present, fixated paedophiles are not admitted to the programme. The perpetrators treated are incestuous fathers who acknowledge the abuse. Clinical treatment is offered to communities of all race groups and socio-economic strata.

A concern has been raised that intensive treatment is a luxury that we cannot afford in South Africa. However, we believe the value of therapy lies not only in its usefulness to the recipient. It assists in developing understanding of the causes and effects of child sexual abuse.

This understanding is effected in preventative community education programmes which have a far broader reach. It is also used in the education of professionals and in lobbying. The insights gained from work with communities is incorporated into the treatment itself. Therapy also contributes to breaking the cycle of abuse.

**Streetkids at shelter in Hillbrow. There are no simple methods for the prevention and treatment of child sexual abuse.** ***Photo: Ismail Vawda***

It is ideal for treatment to occur soon after a disclosure of abuse, to prevent the child from establishing maladaptive coping mechanisms which lead to psychological, emotional and relationship dysfunction. Depending on the particular child and family's treatment needs and ability to respond to treatment, as well as the therapist's style of working, the treatment approaches vary from being structured and directive, to unstructured and reflective.

To determine the family's treatment needs, an assessment is undertaken which may include: structured interviews with children, play observation, recording the history of abuse, clinical assessment interviews with adults as well as psychological assessments. The team, often with the aid of a consultant, then assists the scheduled therapist to plan appropriate treatment to be offered to the family. This plan is presented to the family and their agreement sought. Should the family stay in treatment, which may be for any period from three months to two years, the methods employed include: play therapy, individual therapy, marital counselling, family therapy, group work, case management and supportive counselling.

This approach has been useful for families whose basic needs are met. However, the Centre grapples with the problem of serving children from deprived communities whose families cannot afford to treat the ending of abuse as a priority. As part of our answer to this, we have begun to provide training and ongoing support for those in the community who have contact with these children, such as teachers and nurses. Earlier this year, in collaboration with the Wits Department of Community Paediatrics, a weekly course over three months was provided for nurses at Baragwanath Hospital's satellite clinic in Soweto. Ongoing meetings are planned as a forum for feedback, support and additional input.

The course was intended to equip primary health care workers with knowledge and skills in handling the plight of sexually abused children. Not only will a child benefit from receiving an appropriate response to disclosure, but primary care recipients and the community as a whole will learn from the behaviour modelled by those trained. We hope that by making treatment insights accessible to communities, we will contribute to the development of an expanding network able to offer support and information to children and families dealing with sexual abuse.

## Community Education and Development

An important aspect of the Centre's work is the primary prevention of sexual abuse. When we started, we focused on pre-primary and primary school

children, teaching them their rights and the rules of safety. However, research shows that children, because of their dependence, are relatively powerless in society and are not always able to prevent abuse. We have thus altered our target group and broadened our message. We address adults, reinforcing the responsibility parents have to their children and teach them safety skills.

We also focus on youth, placing education about sexual abuse within the context of self development. We inform and encourage community members to spread the message of prevention. The Ikageng youth group of Soweto in collaboration with the Wits Department of Community Paediatrics, has provided a model for the possibilities of this method. They have developed a play which they perform upon request in the community.

Collaboration with existing community structures, such as the Baragwanath Child Abuse Committee, hospitals, clinics, CPU and other welfare organisations is regarded as essential in all aspects of the Centre's work.

## Advocating Change

The medical, legal and welfare systems often do not function optimally to protect children and relate to them sensitively. Attempts are being made to bring the flaws of these systems to the attention of the authorities and the public, and change is lobbied for. Our record in this area varies. For example, we liaise regularly with the CPU and public prosecutors. We have worked with them on a number of cases to the benefit of the family. A workshop has also been held, alerting those involved to the child's experience of the court system. However, we have been unable to persuade the CPU based in Jabulani to alter their requirement that, in the case of stranger abuse, the complainant accompany the police to identify the accused. This, and ongoing work with the public prosecutors remain priorities for the Centre.

There are no simple methods for the prevention and treatment of child sexual abuse. The Centre will continue to wrestle with the challenge of developing a relevant service. It is our experience that the sexual exploitation of children has an enormous impact on their emotional and physical well-being, which extends into adulthood. It is our belief that the sexual abuse of children is a major mental health issue for South Africa.

It is planned that the principles of empowerment and development receive greater visibility in our work, and that practice be developed to serve the needs of sexually abused children and their families in impoverished communities.

*Zelda Kruger and Jane Richardson work for the Johannesburg Child Welfare Society.*

# Child Abuse
## Sowetans Respond

*Mkhasibe & Wagstaff*

Child abuse appears to be an increasing problem in Soweto. This increase is thought to be a reflection of growing awareness, understanding and detection. It is also attributed to a rising incidence, resulting from adverse family and societal circumstances.

Many people, in one way or another, are victims of violence. The plight of young children suffering sexual abuse has had particular impact. There is concern that insufficient attention is being paid to the affected child and other involved family members. There is also neglect of the need for rehabilitation, where possible, of the perpetrator.

The inadequacy of formal resources and facilities could evoke responses of distress, outrage and despair in people. However, the constructive and commendable response of concerned members of the Soweto community has resulted in the formation of the Bara/Soweto Child Abuse Liaison Group. This group has grown and flourished over the past seven years. The Baragwanath based Division of Community Paediatrics of the University of the Witwatersrand performs a co-ordinating role and provides a venue and back-up support.

## Soweto's Liaison Group

The liaison group comprises nurses, social workers, doctors, teachers, ministers of religion, psychologists, Child Protection Unit police, a speech therapy assistant, youth groups and others from the community. Representatives from the Medico-legal Clinic, Correctional Services and the legal profession have also participated. The world flyweight boxing champion - Sowetan Jake Matlala - is an active supporter. Almost 200 names have been entered in the Group's mailing list. Members hold monthly meetings. The local authority community health sisters play an important role in long term field work, following up affected families.

The objectives of the group include increasing members' knowledge and understanding of child abuse, and thereby promoting proper detection and handling of cases; providing mutual support for people stressed by ongoing

encounters with child abuse; creating community awareness of child abuse with emphasis on prevention through education and the provision of supportive intervention when necessary; and encouraging community involvement and participation. In addition, the group aims to facilitate identification and follow up by maintaining an unofficial confidential register of actual or suspected cases of child abuse. These records are located in the office of the Division of Community Paediatrics at Baragwanath Hospital. Forms for completion are available in the Soweto Clinics, the Baragwanath Paediatric Department and the Medico-Legal Clinic.

Abused children reported in this way represent only the tip of the iceberg. Most of the notified cases have been sexually abused, and in the circumstances, are limited to those who present with medical needs. The majority are females ranging in age from two to twelve years.

This extreme end of the spectrum presenting with overt and often gross signs and symptoms, plus other inevitable under-reporting precludes the availability of unbiased and reliable incidence figures. Nevertheless there are records of several thousand cases over less than a decade.

## Educational programmes

These have been developed to meet particular identified needs. Each course consists of 6 to 10 half or full day weekly meetings. Those group members encountering child abuse in their working environment requested that courses be arranged to better equip them to cope in their situations and to provide them with counselling skills. The course was titled 'Family Friends' to avoid any stigmatising label. To date fifty three people have attended, forty five are nurses and eight teachers.

Many requests for group members to address meetings of various kinds created awareness that speakers should be assisted with both the content and process of such presentations. This ensures that such opportunities are well used. To date forty-nine people have completed the educators' course.

Youth members expressed interest in joining the adult group who were about to participate in a course on prevention and awareness of child abuse. It was decided that a separate youth course would better meet their peer group needs. The youth course was designed to facilitate greater self awareness and a clearer understanding of their own sexuality. The course included sexual responsibility and communication skills. In addition, they were given information about child abuse and its consequences. To achieve their aim of reaching their peers, the Ikageng Youth Group Against Child Abuse has presented role

plays. They have eighteen members, of which twelve are committed and dedicated. They have been joined by another group.

All these courses, in which staff of Johannesburg Child Welfare Society's Liberty Life Child Abuse Centre have provided input, now have waiting lists. Community symposia and workshops have also been organised. These educational forums included subjects such as, discipline in a changing society, children's right to say no to abuse, teaching children to say no and to report abuse. Other activities include youth role plays for peer group education and participation in the Child Protection Week. This involved presentations at clinics, at hospitals and street processions drawing attention to child abuse.

## Limitations

Course participants have been positive and enthusiastic in their evaluations, but no other measure of the outcome is available. Although medico-legal matters have received attention, and the Child protection Unit plays a role, the wider police force is still insufficiently prepared to deal sensitively and effectively with child abuse victims and perpetrators.

The establishment of a medico-legal unit at Baragwanath is valuable. The incumbent district surgeon is a committed, caring Soweto doctor. Unfortunately, his appointment is only a part time one resulting in unavoidable delays for complainants. The service is designed for Soweto residents only. Those from further afield still face shunting around and fragmented care.

Doctors, in general, are reluctant to become involved and be subjected to time consuming court appearances. This adds to the delays in resolving victims' cases. Courts are becoming more child-friendly and prosecutors are co-operating, yet the legal route to counter child abuse may prove frustrating, ineffective and indeed traumatic. Punitive action against perpetrators often fails to occur and in any event may not help victims overcome their trauma. However, few alternative interventions are available. Abused children have immediate and long term needs which are not being met. The scene remains set for a perpetuating cycle of child abuse from one generation to the next. We are aware that we are only scratching the surface.

*Christine Mkhasibe is a registered nurse, and Professor Lucy Wagstaff is head of Community Paediatrics, University of the Witwatersrand*

# Child Labour

## Economic Exploitation a Form of Abuse

*Jackie Loffell*

Throughout the developing world, millions of children are exploited for their labour. The International Labour Organisation (ILO) believes that more than 90% of these children are in Africa and Asia. There is an appalling lack of data on the extent of the problem in South Africa. The ILO estimated that, in 1987, more than 60 000 black children between 8 and 14 years were employed as labourers on South African farms. According to the National Children's Rights Committee (NCRC) and the United Nations Children's Fund (UNICEF), there were possibly as many as 781 268 children in unprotected labour in this country in 1991 (Children and Women in South Africa, 1993). Whatever the actual figures, it is clear from the accounts of many organisations and individuals that we have a widespread and serious child labour problem in this country, involving abuse in multiple forms. Despite this, we have lagged behind many other developing countries in opposing the economic exploitation of children.

### Poverty and Child Labour: A Vicious Cycle

Child labour is rooted in poverty, illiteracy and the willingness of employers to exploit the survival needs of impoverished children and families. A vicious cycle occurs in which children prematurely enter the work force, their education is limited or non-existent and their physical, emotional and social development is impeded or in some cases severely damaged. They emerge as adults able to command only the lowest wages and, where labour in childhood has taken a heavy physical toll, have a shortened working life. They are then more likely to be dependent on an income from their own children. Furthermore, because children can be more easily underpaid and exploited, it often happens that they are employed in preference to adults. Hence, unemployment and the resultant poverty increase, setting the scene for an increase in child labour.

Patterns of coerced or semi-coerced labour have been a feature of life in South Africa for centuries, and children have been part of this reality. From the times of early European settlement in the Cape, child slaves were at work in homes and on farms. There are records of the capture, sale or barter of indigenous children for labour up to and long after the legal emancipation of

slaves in the Cape Colony in the 1830s. Coercion continued via the web of laws designed to dispossess black people of their land, restrict their movement and channel them into specific types of work. These measures reached their extreme under apartheid.

## Exploitation on the Farms

Employers in the agricultural sector have, until recently, been free from the constraints of industrial legislation and its associated minimum age provisions. An increasing number of children on the farms have become part of a captive workforce along with their parents. An investigation by the London based Anti-Slavery Society in 1979-80 into fruit, wine, maize and vegetable farms in various parts of the country (*Child Labour in South Africa*, 1983) revealed numerous instances of children doing hard labour while being provided with poor food and squalid accommodation. Many migrant children working on a contract basis existed in conditions approximating captivity and slave labour. Children's wages were far lower than those for adults. Wages were often paid irregularly or in small quantities of produce rather than in cash.

There is ample evidence that serious abuses are still occurring. Since 1991, the Network Against Child Labour has been gathering reports of abuses. According to the Food and Allied Worker's Union, the piecework system involves hard work for low pay, for example, 20 cents for a basket of oranges. Employers often use unregistered labour contractors to recruit workers. They pay contractors for the labour, but, in many instances, the contractors fail to pay the workers and vanish without trace.

According to another report, "Refugee children from Mozambique work for wealthy black and white farmers. Some farmers go to a refugee settlement and recruit every available child for labour. The children work until pay day arrives and are then reported to the police as illegal aliens, following which they are repatriated to Mozambique. Unions are powerless to help such children and their families."

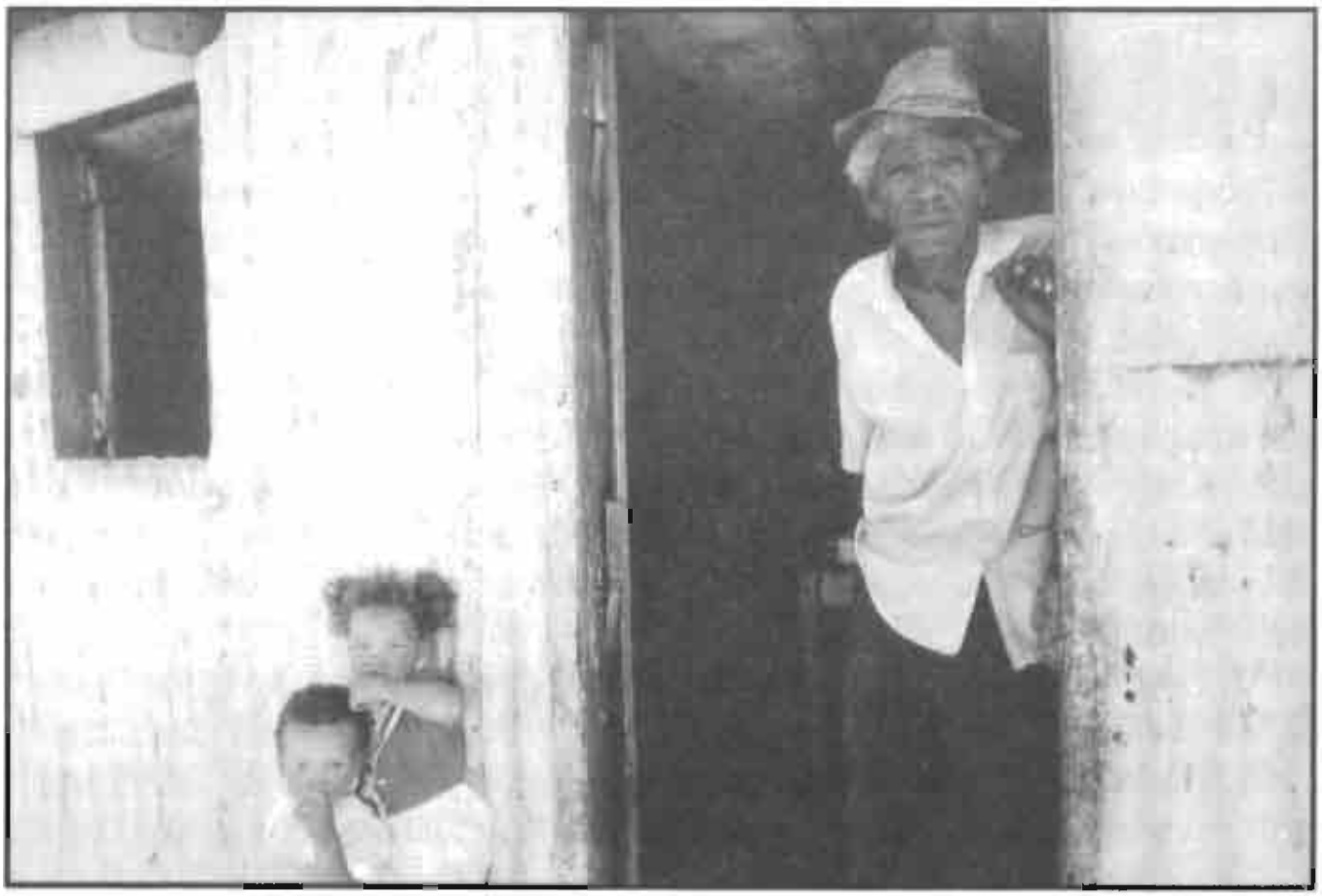
Farm workers are dependent on their employers for their accommodation. In another input, it is pointed out that this "makes it extremely difficult to counteract the exploitation of workers' children, regardless of the law. Parents will not want to divulge the fact that their children's labour is being used by the farmer when they run the risk of being thrown off the farm."

The exchange of child labour between farms appears to be a common practice. Children are transported to other farms on weekends, from as early as five in the morning. There are accounts from the northern Transvaal of children

working on another farm being selected by lot for rape by adult workers on that farm. Child farm workers are also exposed to a number of other hazards.

For example, children on an eastern Transvaal tobacco farm were photographed spreading pesticides with their bare hands (*New Nation*, 4/2/1993). In *A Brutal Harvest* (Black Sash, 1991), Segal quotes, "A girl of twelve had her leg mauled by a dog belonging to the farmer. Her leg was amputated. Not only were her parents not told of the incident until some time after it had happened, but they were threatened with eviction from the farm. The little girl had been the only working member of the family and they were no longer of any use."

Where education is provided for farm children, this is dependent on the goodwill of the farmer. Not only does he provide for the establishment of the school, but he can also influence the hiring and firing of staff. Furthermore, farmers take children out of school when they require their labour. Many children have to walk long distances to school. In a recent survey by the Rural Education Forum, teachers on farm schools in the southern Transvaal estimated that the school children were working between 10 and 50 hours per week, for wages ranging from R2 to R10 a day.



**Farmworkers are dependent on their employers for their accommodation.** ***Photo: Afrapix***

Mphahlele describes the reality on the farms as follows, "There are atrocities and these are never reported, farm labour children get beaten up, they get sexually abused, accidents and deaths take place on the way to the farm fields ... and the farmer is always protected by the law" (Child Labour and Farm Schools, paper for SACC seminar on children's rights, 1991).

## Behind Closed Doors, On the Streets and In the Coalyards

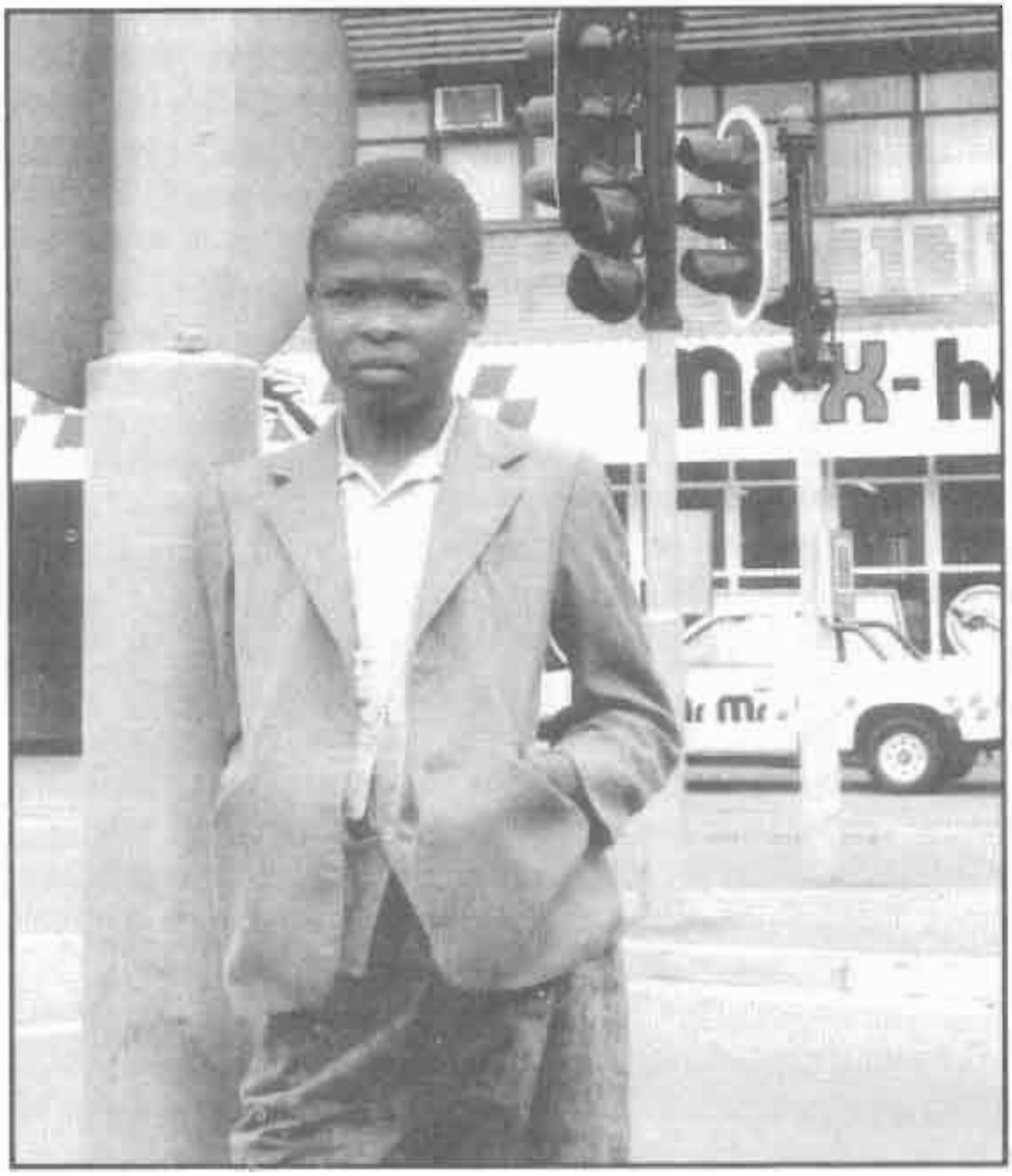
Child labour is also exploited in a number of other sectors, including domestic service. Internationally, child domestic workers have been found to be subject to every kind of child abuse. Apart from long hours, poor pay, and age-inappropriate responsibilities, they are frequently victims of physical, emotional and sexual abuse. In South Africa, this form of child labour is particularly well hidden, literally behind closed doors. Employers of these children have, like farmers, been free of the restrictions of industrial legislation.

Child hawkers can be seen at work on pavements and roadsides in all parts of the country. They include newspaper vendors. Young boys, dodging traffic to sell papers, often until late at night, come rain or bitter cold, have been a feature of our streets. Trade union efforts have led to many of them being replaced by adults, but children still sell papers in many areas.

The harsh and unhealthy working conditions of child coalyard workers in Soweto are vividly captured by Peter Magubane's photographs. The children carry weights which are excessive for young bodies. Addiction to glue is rife and reported to be a means by which employers hold children in their service. Magubane's personal follow-up work shows such children typically graduating to a life of crime. He points out that the situation is perpetuated not only by exploitative township employers but also by residents who are prepared to buy coal from children.

## No Child Labour Under 15

Internationally, various steps have been taken to counter child labour. For a number of decades, the International Labour Organisation has been advocating that all countries include minimum age requirements in their labour legislation, thus barring children from the work force. It is striving for a situation in which, within the shortest possible time, no child under 15 years will be employed, with the limit rising to 18 for hazardous work. The ILO accepts that light work for children over 13 should be provided for, subject to strict safeguards. It has, at the



**Young boy begging at an intersection.** ***Photo: Ismail Vawda***

same time, recognised the large numbers of child workers in many poor countries who are without alternative provision for their support, and has allowed for a certain amount of flexibility while this reality persists.

Articles 31 and 32 of the United Nations Convention on the Rights of the Child recognise the child's right to rest, leisure, play and recreation, and to protection from economic exploitation and hazardous work or work harmful to his/her education or development. The Organisation of African Unity Charter on the Rights and Welfare of the Child, and the recently adopted Children's Charter of South Africa, have similar clauses.

In South Africa, enormous loopholes in labour and child protection legislation have permitted many employers to hire children without restriction. The Basic Conditions of Employment Act (BCEA), which sets the minimum age

for employment at 15, specifically excluded a number of sectors from its ambit, including agriculture and domestic service. However, by 1990, the trade union movement ensured that the wheels were set in motion for these sectors to be covered by the BCEA.

In 1991, a new section, 52A, was added to the Child Care Act. This prohibits the employment of persons under fifteen years, but empowers the minister of health to allow employment sectors or specific employers to benefit from child labour. The agricultural employers' lobby is pushing to be allowed to employ children over 12, subject to a series of conditions and safeguards, which are regarded in children's rights advocacy circles as unenforceable. The government initially developed draft regulations for the implementation of Section 52A, which allow children over 12 years to work for 'pocket money'.

## The Emerging Lobby Against Child Labour

In the past three years, the number of organisations and individuals committed to ending the economic exploitation of children has been growing. Developments in legislation were the main catalyst for the emergence of a multi-sectoral lobby, namely the Network Against Child Labour. It currently includes some thirty seven organisations and several individuals. The education, trade union, welfare, health, law, human rights, development and church sectors are represented. The network's secretariat is provided by the NCRC.

It held a media campaign to heighten public awareness of both the prevalence of child labour and the related legal issues. It made strong representations to Rina Venter against the draft regulations allowing children over 12 to work and these are now being reconsidered.

The BCEA was extended to farmworkers this year and will cover domestic workers in the near future. The employment of children on farms is now illegal in terms of both the Child Care Act and the BCEA, unless the minister decides otherwise. However, there is a lack of effective machinery to prevent the illegal use of child labour. The Manpower inspectorate is overloaded and child farm workers and their families face numerous risks in laying charges at the nearest police station, which is their option in terms of the child care act. The relevant laws are being ignored and children are still being exploited on a large scale.

## Strategies for Change

The network recognises that child labour is a multi-dimensional problem. Its roots lie in poverty and underdevelopment, it contributes to adult unemploy-

ment, and it must be combatted by a range of strategies. Appropriate laws and machinery for enforcement are vital, but universal compulsory education, proper social security provision and development are also indispensable.

To date, the network has largely been concerned with raising consciousness and with lobbying for the necessary legislative reforms. Increasingly, it is facing the need to deal with reports of specific abuses. The network is encouraging its member organisations, and others who wish to take up the issue, to form local linkages to join in the lobby for broader changes and to tackle reported cases of exploitation of children in their areas.

Hence, for example, court action could be initiated by local branches of legal groups, while welfare organisations could assist families who depend on the labour of their children to apply for grants or pensions. Local churches and civics could also play a vital role in helping children and their families, in conscientising their communities regarding the effects of child labour, and in negotiating with amenable employers. Trade unions, which now have the right to organise farm workers, have a key role to play.

The Community Law Centre of the University of the Western Cape has recently commenced major research into the South African child labour problem. This is a vital step forward for the local lobby. It is envisaged that the research will both draw on and inform the work being done by the network.

*Jackie Loffell works for the Johannesburg Child Welfare Society*

# Detention and Imprisonment
## No Panacea for Child Offences

*Jeanette Schmid*

During the state of emergency (1986-1990) the public was horrified to learn that a significant number of people detained were children. The 'Free the Children' campaign captured the imagination and sympathy of the international community. Johannesburg Child Welfare appointed two social workers specifically to deal with the needs of these youngsters.

At this time, the National Association of Child Care Workers (NACCW), then regarded as a rather moderate body, attempted in its own publications to remind progressive welfare workers that the detention of children was an everyday phenomenon, preceding the emergency era. Progressive professionals did not show much awareness of this fact. Perhaps they felt that NACCW was insincere, as the issue had not been raised previously. Perhaps children arrested on criminal charges were not seen to be relevant, or perhaps we believed that the issue was raised to distract us from political detentions.

Young children are most vulnerable to becoming either victims or perpetrators of crime. Most children lack encouragement in terms of problem solving and coping skills. They are unable to resolve conflict in a constructive manner. Many have a poor sense of self. As a result they are easily influenced by their peers. Support structures for children in trouble are often absent, leaving the child to be self reliant.

## The Extent of Child Detention

Every year hundreds of children suffer the trauma of imprisonment. Official statistics place this at an average of 600 awaiting trial and 800 sentenced a day. These figures are considered to be gross underestimates by welfare agencies. Accurate statistics have been extremely difficult to access. By mid-September 1993, there were 300 unsentenced children at Johannesburg Prison, with a further 700 detained in prisons of the southern Transvaal region. This does not include children who are held in police or prison custody because they are in need of care and are waiting to be referred to social workers. It does not include children who, following a children's court case, are waiting for a vacancy in a place of safety.

## Facilities for Care

The continued detention of children is a symptom of the inadequate facilities and policies for South African children. Children in need of care should temporarily be accommodated in places of safety. At present, places of safety are limited. This is partly as a result of race based admission criteria. A non-racial approach has increased the number of available vacancies in the Cape. However, in the Transvaal, all places of safety remain filled to capacity.

It is felt that children currently cared for in institutions should increasingly be placed in foster care, where they can participate in family life. Children's homes should be made available for emergency placements, and for children who required specialist interventions. Child welfare societies are actively advocating increased foster care grants which would encourage potential families to apply, and with a greater number of applications, would allow societies to better screen the applicant families. It is often alleged that poorer families take on a foster child purely for the additional income, and in these cases the child is not properly cared for. Jackie Loffell, of the Johannesburg Child Welfare Society, motivates the increased grants by pointing out that personnel providing institutional care should not be seen only as means of providing for the foster child's needs, but should also be seen as payment for this service.

## The Trauma of Arrest

Street children sometimes are arrested by police on the basis that they are "abandoned children" or children "in need of care". The police view is that they are caught between the needs of the public and child care workers. They also feel they are providing the child with a "roof over his head for one or two nights and a plate of food." There is little understanding that the removal of a destitute child to a police cell is experienced as an arrest and as harassment. It is experienced as a traumatic, rather than a charitable act.

## Contacting Parents/Guardians

Police officers have always been obliged to contact parents of arrested children. However, it is evident from work carried out in Cape Town that officers often lapsed in terms of this duty, Theoretically, improved mechanisms now exist for parents to be contacted. Faxes are sent to the welfare departments of provincial authorities, who then link the child with a social worker. However, at the time of writing, problems in this regard still existed. Many children were not being

**Children need protection from violence and detention.** ***Photo: UNICEF***

referred to the authorities. Social workers, already overloaded, struggle to execute this task responsibly. In some cases, there is reluctance to do the job reliably.

It must be noted that some parents, once contacted are reluctant to take responsibility for their children. They feel overwhelmed, frustrated and fed-up by their child's behaviour. There is often the belief that a period in custody will "teach the child a lesson."

## Court Proceedures

Although it is not practice that bail should be set for children, where the charges are seen as severe, bail is imposed. Lawyers for Human Rights succeeded over the 1992 Christmas period in reducing bail for a number of children, making it more affordable for parents and thus securing the release of children.

Most children are not legally represented in court. Often the case is heard in the juvenile court where the same conditions as those in an adult case apply. There is infrequent conversion of cases into children's court enquiries, in which it is assumed that the child is in need of care.

## The Diversionary Approach

Magistrates and prosecutors themselves are often frustrated by the lack of alternatives to prison sentences. NICRO has set as a priority the development of community based sentences, which, at present, vary from region to region. These are applicable on two levels. Firstly, as diversionary mechanisms whereby children are charged for their offences, but where charges are dropped or withdrawn once the child completes a prerequisite course, and secondly, as a condition of a suspended sentence.

Diversionary mechanisms are increasingly being recognised as an effective means of keeping children out of detention. At a conference on drafting legislation hosted by the Community Law Centre in October the following suggestions were made:

*** Children must, where possible, be diverted from detention at the point of arrest ***

They should be immediately placed in their parents'/guardian's care or suitable specialised care. It was proposed that assessment centres be established. On arrest children would be taken to the assessment centre, where a social worker and possibly a prosecutor would be available on a 24 hour basis. An assessment regarding the child's crime and circumstances would be made. Dr Paul Cooper, a lecturer in juvenile justice at the University of Liverpool, suggested recently that the task of assessment should not be left to police officers as they tend to decide in favour of detention.

In New York, an escort system has been established, where children are fetched from their homes for the trial. It has been demonstrated that children who have not been held in custody are also less likely to receive a prison sentence. Social workers often demonstrate that the young person has been motivated to continue schooling, and in so doing they have avoided trouble in this period.

*** Children must where possible be diverted from prosecution ***

Court appearances are traumatic and alienating experiences for children. If found guilty, the young person receives a criminal record which has a lifelong impact. Youths admitting to first offences should be diverted into rehabilitation programmes. On completion of these programmes, charges should be withdrawn. The young person has to suffer the consequences of their actions, but in a manner in which the person gains life skills which will prevent them from coming into conflict with the law a second time. NICRO is cautious about simple warnings or cautionary discharges, because the offender is not punished or made to make reparation in any way.

*** Children must where possible be diverted from the criminal court ***

Any child under the age of 15 must be seen in a Children's Court Enquiry and considered a child in need of care. Only if this court feels it is necessary, should the case be transferred to the criminal court. In all cases with juveniles, an inquiring rather than antagonistic approach should be adopted.

*** Children must be diverted from imprisonment ***

Community based sentences must be made available for youthful offenders, as imprisonment is a sure recipe for the youth falling back into crime. Where a juvenile has committed a violent crime and needs to be kept in safe custody, this should be in an environment with trained staff and in which the young person's needs are met.

## NICRO's Offering

Current programmes offered by NICRO nationally include juvenile schools or 'youth on probation programmes', which range from 5 to 16 sessions over ten to sixteen hours. Life skills are taught, and the causes and consequences of crimes are discussed. Parents are invited to one session, at least.

Another programme deals with shoplifters. This is an eight hour session. It is done either as group or individually, through a course of cassettes. The programme is being initiated in Johannesburg. It is intended for first time offenders and not for compulsive shoplifters. It is envisaged that this programme will be included as a component of the Juvenile School's programme.

A five session programme, lasting 15 hours, for the education of drug related offences, focusses on the legal and medical consequences of drug abuse. It also targets first time offenders. A victim/offender mediation programme, being researched in Cape Town, allows victims to express their feelings about an offence directly to the guilty party. Where appropriate the offender must make reparation.

Offenders whose crimes do not make them a danger to the community are assessed by a panel of professionals as to their suitability. If given a community service order, offenders are expected to complete a stipulated number of hours serving a non-profit agency. In all these programmes, non-compliance results in the matter being referred back to the court. Where charges were suspended, pending completion of the course, non-compliance results in prosecution. In the case of a conditionally suspended sentence, non-compliance results in the sentence coming into effect.

Alternative sentencing has been used widely in other countries. Local authorities in the Netherlands, for example, involve young people caught for vandalism, in education and reparation programmes. Diversionary mechanisms have been used successfully in places like New Zealand.

## Prison Conditions

In the short term, conditions in both police and prison cells need to improve. Recent visits have shown that at John Vorster, cells are filthy and poorly lit, children sleep on mats and the outside exercise area is too small for reasonable activity. At Johannesburg Prison, children awaiting trial have to share steel bunk beds with blankets, doubled up, in place of mattresses. Although sentenced juveniles at Leeukop Prison have clean cells, plus a large outside exercise area, they have no enclosed recreational area. The dining room facility, although covered by a roof, has no walls to protect the youngsters from adverse weather conditions.

Although prisons make social and psychological services available to the juveniles, with many involved in life-skills programmes, both warders (at police stations and in prisons) and other professional staff lack specialised training in dealing with troubled children. The focus remains on punishment rather than rehabilitation.

A number of organisations have come together in the various regions to form lobby groups which aim at reducing the arrests of children, at facilitating the release of children into alternative care and of promoting community based sentences for youth. It is hoped that through our combined efforts our goal of no children in detention will soon be reached.

*Jeanette Schmid is the Johannesburg branch director of the South African Institute for Crime Prevention and Rehabilitation of Offenders (NICRO)*

This is the life for freedom the blacks are fight for freedom because they are surfering the must of whites ar not surfering this life is need a education Because if you not want aducation you will surfer, if you got Education you are going to have nice work for more money. If we want freedom wemust respect our self wemust not divided our self wemust stay together we must not hate another person we must lover together like lord made us The black must gots a shops in the towns

Mongezi (13 years)

## SECTION C:
## Disability, Rehabilitation & Childhood Education

# South Africa's Forgotten Children

*Lidia Pretorius*

Much has been written on the health status of women and children in South Africa's rural areas. Yet very few have highlighted the plight of children with disabilities living in the rural areas of South Africa.

## Prevention, Identification and Early Intervention

The majority of disabilities in rural areas are preventable. Ineffective immunisation programmes, poor health of pregnant mothers, lack of accessible delivery care (clinics do not operate on a 24 hour basis in rural areas), poor nutrition status of infants and lack of services, have led to a situation in which South Africa renders one of the poorest health services to children in developing countries. Impairments such as eye diseases or chronic ear infections often lead to permanent blindness or deafness. Measles, tetanus, polio and other preventable illnesses are common causes of disability in a country where organ transplants or triple by-pass surgery is an every day occurrence. Genetic research and counselling services are still a myth in the majority of rural areas, although slow in-roads are being made by a few initiatives. It is important that any counselling and research be done in consultation with local organisations of disabled people, and be coupled with direct service-delivery.

Early identification of and intervention among children at risk is vital to prevent disabilities from becoming handicaps. The disabled child has to learn to cope in a disabling world while experiencing the normal development phases of a child. Parents need to support the child in this process. The family needs to cope with the attitudes and barriers that society erect as defence mechanisms.

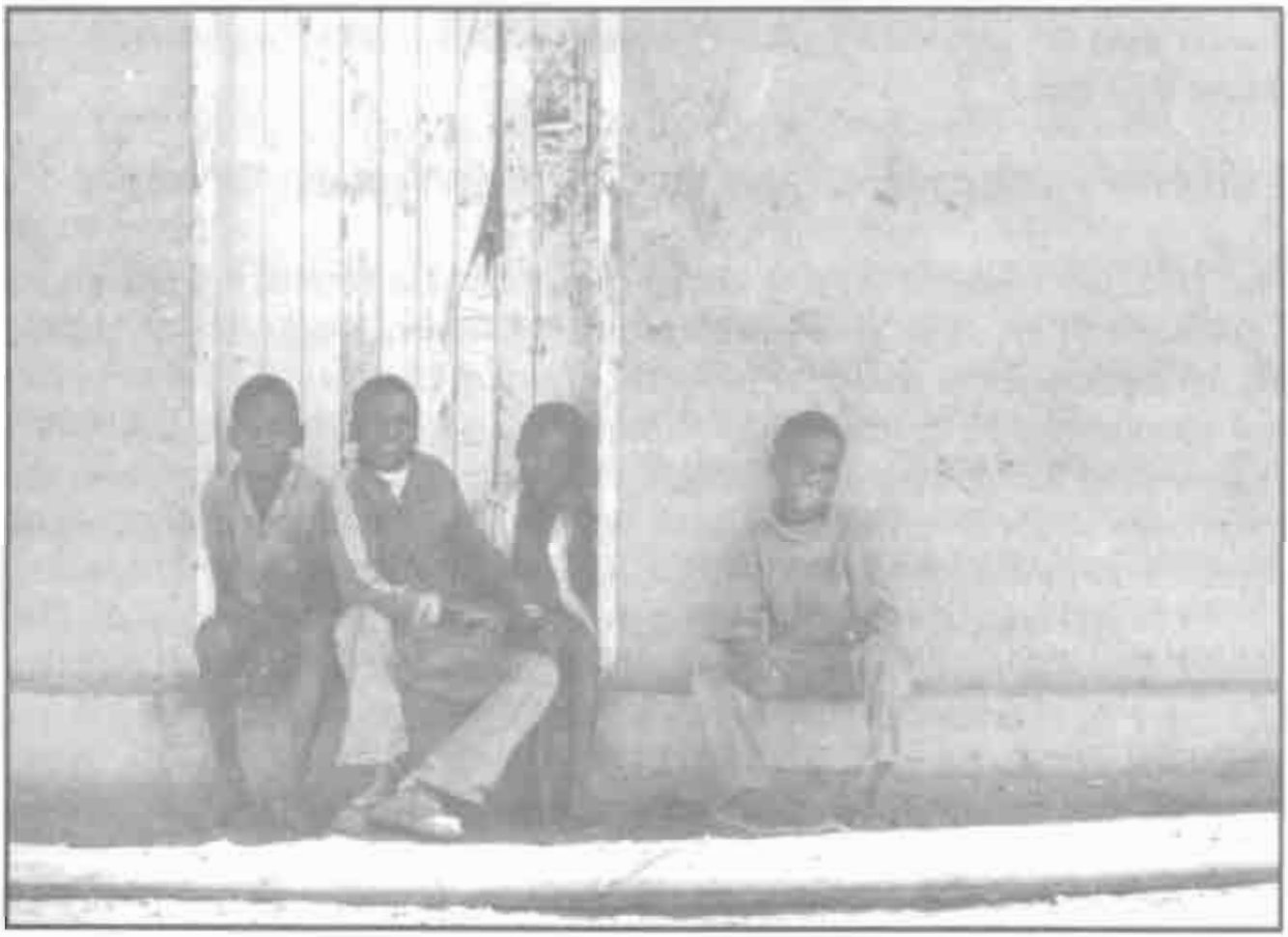
The primary health care system is overloaded and understaffed. Screening for children at risk is, therefore, very limited. Unless a disability is visible, little or no intervention is offered. 'Invisible' disabilities such as deafness often go undetected until the age of 2-3 years. As a consequence, untreated chronic ear infections, because of a lack of medication, leads to unnecessary disability. A well staffed, sufficiently financed and comprehensive rehabilitation and disability prevention policy would contribute tremendously towards prevention of

disability at a primary level. This would include orientation and training of PHC staff at all levels in disability prevention, effective referral systems and affordable intervention therapy through community based rehabilitation programmes.

## Constraints on Early Intervention

The minority of disabled children that are referred to hospital by the local clinics are seen by a medical practitioner who follows up on the medical aspects only. The severe lack of para-medical staff in rural areas delays therapeutic, educational and functional intervention until school going age. The shortage of para-medical staff also prevents effective early intervention because of a lack of time, inappropriate training of staff to cope with conditions pertaining in rural areas, and poverty of parents. The perception that only 'professionals' have the knowledge and skill to intervene also adversely affects early intervention programmes.

The only successful early identification programmes are usually research programmes focused on the incidence of disability. These are often linked to



**The lack of staff in rural areas prevents therapeutic, educational and functional intervention before school-going age.** ***Photo: Afrapix***

post-graduate studies. These studies are seldom coupled with service provision, with the result that thousands of disabled children are identified, labelled and then forgotten. The only ones who benefit are the graduates who can boast a new title and salary increments. Deciding on priorities in research should be done in direct consultation with organisations of disabled people. It should lead to empowerment and skills transfer to the communities affected by research. Parents of disabled children have reached a point of refusing to participate in any professional research, which has brought them little more than unfulfilled expectations and broken promises.

The National Welfare Council has neglected rural areas in their scope of work in the past. It is only recently that it has started investigating ways and means of rendering services to children in rural areas. Concern, however, exists over how appropriate this intervention will be if based on urban experiences. It has to be pointed out that a tremendous industry has been created on the backs of disabled people and children. This can only be justified if the benefits to consumers of services exceed those of the benefits to the service providers. Mothers of disabled children in a rural area of the northern Transvaal recently pointed out that they can acquire 15 to 20 wheelchairs for the price of a social worker over the period of a year. The actual waiting list for wheelchairs was longer than this.

## Parents Respond: Disabled Children Action Group

The Disabled Children Action Group (DICAG) was formed by parents of disabled children. They have embarked on an intensive programme to change the perceptions, laws and discriminatory practices clouding the development and advancement of children with disabilities. The programme concentrates on empowering the parents of children with disabilities, to instill in them the knowledge and will to transform society in a way which accommodates them. Parents have mobilised and are establishing day care centres all over the country.

DICAG has established seven regions and is governed by a council. This council is made up by two representatives from all regions of DICAG. An executive takes care of the day to day running of the movement.

## The Rural Disability Action Group (RURACT)

RURACT seeks to contribute to the equalisation of opportunities for disabled persons from rural areas, through the facilitation of effective, participatory and empowering service provision.

RURACT was formed in 1986 by people working with disabled people in extremely isolated conditions in the rural areas. In 1989 disabled people living in rural areas started organising themselves with the assistance of RURACT members. RURACT has achieved something unique by creating a forum where disabled people, parents of children with disabilities and services providers can communicate freely on issues affecting the lives of disabled adults and children living in rural areas.

The empowerment and mobilisation of disabled people and parents of disabled children have been an important part in the process of development. This has enabled disabled people to discuss issues affecting their lives and to organise around theses issues for the first time. It has also enabled them to participate much more effectively in forums in which they represent themselves.

This has taken place in line with the United Nations document, *The World Programme of Action Concerning Disabled Persons.*. The purpose of this programme is, "to promote effective measures for prevention of disability, rehabilitation and realisation of the goals of full participation of disabled persons in social life and development, and of equality".

## Community Based Rehabilitation (CBR)

RURACT has been actively campaigning for the recognition of CBR as an alternative rehabilitation model to the traditional institution based model since the mid-eighties.

CBR is a process of facilitating change in society through the transfer of skills to the community-at-large that will bring about equal opportunities and recognition of the rights of people with disabilities. It enables people with disabilities to access resources of their choice in their communities.

Both the Department of National Health and Population Development and the progressive health sector have adopted the CBR approach as the most viable rehabilitation model for South Africa. This response comes as a direct result of RURACT's relentless lobbying for the acceptance of CBR. Their commitment is, however, not backed by sufficient allocation of resources. The CBR worker training programmes at Alex Health Centre and Tintswalo Hospital, for example, still rely on private funding. Very few posts exist for community based rehabilitation workers, including categories, such as community speech and hearing therapists, community workers, mobility instructors, etc. Slow progress is, however, being made through local community lobbying as a result of an increased community awareness of disability, and the rapid growth of the disability rights movement in rural communities.

**Barriers in rural areas. Disability is a socio-economic problem, not a health and welfare problem.** ***Photo: Ismail Vawda***

It is important to note that CBR cannot exist in isolation. It has to be backed up by appropriate institution based services, and it has to be an integral part of an overall rehabilitation policy, covering the health, welfare, education and employment sector. The establishment of a national health forum will facilitate at least some progress in this field.

The role of CBR within the PHC system is being debated and investigated by RURACT and various other players at present. Some of the concerns that have been expressed is the selective way PHC has been implemented in South Africa. The main causes of ill-health and disability in rural areas are still caused by lack of sufficient clean water, lack of land, sewerage systems, lack of infrastructure, poor education etc, despite extensive PHC programmes in these areas. One therefore finds that even 'model programmes' severely lack vision of comprehensive PHC.

Disability in rural areas is not a health and welfare problem. It is a socio-economic and development issue. The mobilisation of parents has pressurised policy-makers and service providers to address the crisis of disabled children, especially those living in the rural areas of South Africa, in a holistic way that recognises that all children have the same rights.

*Lidia Pretorius is the co-ordinator of RURACT*

# Grants for Disabled Children
## A Desperate Need

*Vuyo Mahlati*

The gross neglect and marginalisation of people with disabilities, especially children, is in dire need of redress in this country. People's initiatives and creativity, some of which are as a result of survival or coping mechanisms to address the plight of these children, cannot be sustained if not adequately supported by the government and the private sector. The compounding effect of racist laws and insensitive social legislation, as well as the unwillingness of the authorities to promulgate or enforce legislation has devastated a large proportion of potentially active members of society.

Parents of children with disabilities see grants and subsidies contributing to the survival, protection and development of a child with a disability. In workshops run nationally with the majority of participants from rural areas, parents and people with disabilities shared experiences which show that:

Firstly, a child with a disability cannot have access to centralised health care facilities without financial assistance. For example, a mother in Tyolomnqa, a Ciskei village, told a story about her 14 year old daughter who had an appointment at East London's Frere Hospital, approximately 60 km away. This child has a mental disability. The mother, with the little money she had, arranged with a taxi driver to transport the child to and from the hospital. The mother could not accompany the child for lack of money. Unfortunately, the taxi driver could not locate the child on his way back. She was found a few days later, after having been sexually molested by strangers.

Secondly, parents are compelled by lack of facilities to stay at home and look after their disabled children (This not only affects the child but the whole family. Special schools are few and inaccessible to most families. Reportedly, only 20% of African children were in special schools in 1987. Arranging transport and assessment for placement in schools is costly, especially in rural areas).

Where parents started their own home-based centres to facilitate normal development of their disabled children, they found no support for their initiative from the government.

## Single Care Grants

Single Care Groups (SCG's) are paid in terms of the Mental Health Act of 1973 for children with severe or profound intellectual handicap. Severe handicap, according to the Potgieter Committee Report, 1988, refers to children with "an IQ of between 30 and 50, and profound handicap indicates those with an IQ at 30 or lower, who are unable to benefit from general, specialised or special education or training and who are usually cared for in a care and rehabilitation centre". Unlike disability grants for adults received for all disabilities and paid as social grants under the Social Pensions Act, SCG's are paid to those who "incur expenses for medical treatment" among those eligible for the SCG. The Committee headed by magistrate de Meyer recommended that the grants be paid out in terms of the Social Assistance Act, rather than the Mental Health Act. It also recommended that the involvement of the Department of Justice be dispensed with, and called for a simplified assessment proceedure and uniform criteria of payment for all races. There is, however, no recommendation for the extension of this service to all disabled. As a result, parents are still not satisfied and are unclear about what steps will be taken to address the committee's recommendations and to deal with concerns that have not been addressed by De Meyer.

## Subsidies for special day care centres

As a result of these problems, informal home-based centres are mushrooming countrywide. Yet no measures are being taken by the government to enhance the initiative taken by parents. This is shown by the recent commission of enquiry on special day care centres headed by Van Niekerk which did not address the issue at all. Recently representatives of Disabled Children's Action Group (DICAG) in the Western Cape met the Cape Provincial Administration to discuss subsidisation of DICAG centres. The meeting was fruitful as both sides explained their situations and policies clearly. This, however, did not solve the problem. A number obstacles stand in the way. One of these is the fact that groups need to be affiliated to a registered welfare organisation like the Cape Mental Health or the Association for Physically Disabled to qualify for a subsidy. Another obstacle is the requirement that children be severely or profoundly mentally disabled. If a group applies for a creche subsidy, the children must be of a preschool age. Parent's initiatives are also required to have clear structures.

These posed problems for parents as the centres they started were interim

**Only 261 black mothers in the whole of South Africa receive single care grants.** ***Photo: Afrapix***

structures to accommodate all disabled children on waiting list for formal schools. Some of them have even organised monthly visits from doctors and therapists to assess children and refer them to relevant centres and schools. These centres accommodate all disabilities, with the average age of children between 3 to 14 years. They are in 'rondavels' in villages, in churches, community halls, shacks, containers and backyards, etc.

When asked why they do not want to affiliate to welfare organisations mothers said "we started these for a purpose because our children were on these *welfare waiting lists for years, if we left them at home and looked for work they* were neglected and raped, sometimes there will be space for a child in a centre but you will be told that their transport does not enter some squatter areas like Crossroads. You wait and wait by the time they take the child they say he/she is too old or too stupid. Once they take over they find other disabilities but they do not give them any option. We are here to help all the disabled children and we have therapists, rehab workers and doctors who show us how to group the children and what to do with them. The government has failed and we are now doing their job, they (government) must help us. We are prepared to do the job."

These voices need to be heard, as the solution will not only come from a government that will deliver, but a government that listens first to the voices and

together with them find a solution.

A frustration for black mothers is the fact that the SCG is not available to the majority, only 261 children in South Africa receive the grant and 'homelands' like Gazankulu, Lebowa, KaNgwane do not offer SCG.

The confusion and red tape one has to go through is an additional problem. Part of this confusion arises from a mistake made in the manual made by magistrates which states that grants are paid out from age six to sixteen instead of three to sixteen. When this was questioned, magistrates were given the mandate to "use their own discretion". This confusion was also witnessed from the lack of uniformity in amounts paid to children. When black children were supposed to receive R150 at the beginning of 1992, some received R80, R100, R130, and R150 respectively.

In a workshop held in KwaZulu, a government representative explained to parents the proceedure for applications. This was stated as follows: "First the parent sees the problem in the child, and takes the child to the doctor. The doctor confirms the disability. The parent then goes to the social worker who applies for the SCG. The parent then goes to the magistrate, who sends it back to the social

**Women already play the role of care-givers. Why isn't the state assisting them?** ***Photo: UNICEF***

worker to assess the home situation. The social worker sends the report to the attorney general in Pietermaritzburg. The attorney general processes the application and sends it back to Ulundi (KwaZulu). Ulundi ensures that all the correct documents are there, in order, and then advise the local magistrate to pay grant out. The magistrate decides when and how payment starts. The health department of Ulundi is responsible for processing grants."

This means that in areas where there are no social workers, children cannot receive grants. In general, it takes almost a year and even longer for grants to be processed, depending on the urgency of the case and the extent to which the social worker pushes.

Parents of disabled children on 26 October 1992 marched to the CPA to hand over a memorandum with demands to correct the above issues. They then sent representatives in January 1993 to a government welfare Interdepartmental Consultative Committee in Pretoria to discuss their demands. These included the call for government recognition of the parents' movement, DICAG, an affiliate of Disabled People of South Africa (DPSA) which aims to protect and promote the rights of disabled children. The representatives demanded that no changes should occur without consultation with parents. Unfortunately, the government did not honour this request. The appointed commission of enquiry after the parents' march and calls from the mental health societies to address the issues, published their findings and recommendations without consultation with DICAG. This raises concern especially when there are new initiatives to facilitate consumer participation in policy issues like the National Co-ordinating Committee on Disability which involves organisations for and of disabled people including the government.

*Vuyo Mahlati is the national co-ordinator of the Disabled Children Action Group*

# Early Intervention for the Mentally Disabled Child

*Babette Katz*

A 1988 estimate of the number of disabled people in South Africa (excluding the TBVC states) suggests that there are 125 000 people with an IQ of 50 or less and 1 185 000 with an IQ of 70 or less. Looked at in relation to the services available for the mentally disabled, these figures are overwhelming.

In 1988 a study, by Cartwright and others, of the provision of services for the mentally disabled children on the Witwatersrand shows the paucity of services for preschool mentally disabled children, especially among African children. According to this study, the proportion of needs met were as follows: African - 7,6%; coloured - 9,3%; Indian - 26%; white - 69,7%. Economic recession and the shortage of professionals, compound the problem. In rural areas and among more destitute urban families, only few benefit from the services provided.

Available services cater for three broad categories; special care centres for profoundly and severely handicapped people, training centres for children with moderate handicap and work and occupational centres for handicapped adults. Although there are other services offered at a local level, including toy libraries and home training programmes, these are dependent on local resources and are not readily available to those who require them.

## The START Initiative

With the aim of facilitating greater service provision, home and community based programmes have been developed by Strive Towards Results Together (START). These programmes, currently in Eldorado Park and Kwathema, actively involve parents and the community.

START is an early intervention programme run by Sunshine Centre Association in collaboration with the Transvaal Memorial Institute for Child Health and Development (TMI). START, in association with Toy Library, is part of a community outreach service of Sunshine Centre Association. At Kwathema, START is based at Phelang School for Mentally Disabled. In addition, parents in the area have set up their own day care centre where they use START for stimulation activities. START is also training community based

family support workers.

START and Toy Library collaborate at the Harvey Cohen Centre in Eldorado Park. With the assistance of a START worker, families find an activity relevant to their child and borrow toys to continue their activities at home.

Training courses are also run regularly at TMI. Course participants return to their places of employment and assist their workers in the use of the START kit which comprises books and manuals.

## The Advantage of Early Intervention

Early intervention which aims to enhance the development of infants and young disabled children has been seen to be of benefit to both the parents and their child. Parents benefit from reduced feelings of helplessness, frustration, depression and guilt about the child, an improved sense of support and acceptance of the child, improved self-worth and confidence as a parent, and an improvement in child rearing practices.

As parents know their child best, their role in the START programme is indispensable. By their involvement they gain skills, and often perform as better therapists than professionals.

The child benefits from the holistic approach of the programme. START focuses on the developmentally delayed child. The programme comprises a case of books and a manual, with an approach to all aspects of development. This includes physical development, small movement of the hands and concept development, understanding and expression through use of gestures or language, toileting, dressing and feeding, etc.

## Programmes Abroad for Disabled Children

Worldwide, similar programmes, involve professionals sharing their skills. They become facilitators of learning for others who may be more accessible to people who otherwise might be denied access. One example is Step By Step in Guyana, South America, initiated in response to the needs of families and their disabled children. Step by Step was set up by a public meeting in which people volunteered to work with disabled children and their families. Volunteers came from a wide range of occupations, such as, teachers, clerks and students.

These volunteers were trained over 15 months. Training was co-ordinated by a psychologist and a phsyiotherapist. The volunteers worked with one or two children and a family member who performed activities with the child. The children were identified by house to house visits and referrals from professionals

**The first five years are the most important for children's development.**
***Photo: UNICEF***

and parents.

The programme was judged on the child's progress, on checklists and in terms of participants' evaluation. The majority of mothers found the programme to be helpful. The children were seen to be happier, better behaved and motivated. One of the key features of the programme is the involvement of the wider community.

In Jamaica, a programme called 3D makes special effort to recruit parents onto their staff. Parents are trained over three to four week courses and are encouraged to form a parent organisation.

Early intervention is beneficial in helping to dispel negative attitudes towards disability. It is also helpful in preventing dysfunctional families, further handicaps and preparing children to integrate into society. By adopting an holistic approach, hopefully, the physical, mental and social well being of the child and his family can be developed to maximum potential.

*Babette Katz is the manager of the Outreach Community Service, Sunshine Centre Association, Johannesburg*

# The Home Instruction Programme for Pre-school Youngsters (HIPPY)

*Marion Stewart*

The HIPPY programme was developed in 1968 at the Hebrew University in Jerusalem. An appraisal of the educational difficulties experienced by poor and immigrant communities in Israel (Palestine) plus awareness of the potential of early intervention in the life of children, their families and communities led to the development of this unique programme. Today HIPPY operates in a number of countries.

Since starting in 1988, HIPPY (South Africa), in common with many other progressive pre-primary school programmes believes that investment in education should start as early as possible. HIPPY is, however, distinct from other pre-school programmes by virtue of its home based approach.

## Holistic Child Education and Development

The HIPPY programme, therefore, works with the child in a family context. It is a holistic developmental programme founded on the belief that poverty causes a variety of losses for individuals, families, communities and society at large. It is believed that intervention at the level of the pre-school child offers a significant opportunity to move successfully out of a cycle of poverty.

HIPPY's emphasis is not only that of achieving 'school readiness'. The focus is on the capacity of the programme to rebuild the potential of families as arenas for receiving and providing health, support and fulfilment within the context of empowered and viable communities. HIPPY, not only helps in building skills in the child, but also empowers the parent who is then in a position to engage in the concerns of the community. HIPPY seeks to rebuild that which poverty and disadvantage have destroyed.

## The Child/ Parent Relationship

In intervening with parents HIPPY recognises that the child/parent relations is the nucleus of a child's life. It is often the most consistent element in the child's

experience. There is an inherent educative function in the relationship between parent and child. Parents teach their children, informally, the basic life skills they will use and build on for the rest of their lives. Most of this occurs before the child is four years old.

HIPPY is actively providing support for the legitimate role of parent as educator. This role is often undermined by the formal school system. Parents are left feeling inexperienced and irrelevant to the education of their children. Through HIPPY parents are encouraged to define a role for themselves in the education of their children throughout their schooling. Intervention with the parent enables successive children to benefit from the programme.

HIPPY is an intervention requiring parents to utilise a structured programme to stimulate and educate their 4 and 5 year old children. Parents are supported in the implementation of the programme by home visitors. Home visitors are themselves parents of children of a similar age. They are drawn from the same community. They visit families on a weekly basis.

## Home Visitors

Home visitors are key to the programme. They are drawn from the community, acting as role models for parents. The process of recruiting, training and supporting home visitors is important to creating opportunity, capacity and self reliance within communities. Parents are linked to one another through regular parent meetings facilitated by the home visitors. These enable parents to support one another, and learn more about their children's needs. The meetings offer a comprehensive range of informal adult education activities for parents who are themselves educationally disadvantaged. The meetings are forums for addressing wider community problems.

Home visitors are supported by programme co-ordinators. Co-ordinators are professional teachers and social workers, but parents and home visitors are encouraged to become co-ordinators.

In-service training, over two years, of home visitors is the responsibility of the programme co-ordinator. This year, formalised training of co-ordinators has also developed. The curriculum covers development, adult education and community work. Training is geared to providing staff with a wide range of skills with which to cope with a multitude of situations that could inhibit a child's learning. Emphasis is placed on role play, as a way of directing the transfer of learning at all levels. This serves not only to guarantee that content is absorbed, but also to impart confidence to the educators.'

**What childhood should be about.** ***Photo: Ismail Vawda***

## Community Support

Each programme is, in addition, managed by a HIPPY community committee. The committee is made up of key figures in the community such as teachers, parents, church leaders, business people etc. The committee offers support to the co-ordinator and ensures that the programme is accountable to the community. Publicity and fund raising are also the function of the committee. Two representatives of each community committee are elected to a general forum. This meets every three months. In collaboration with the board of HIPPY (South Africa), the community committee representatives on the board formulate overall priorities and objectives for the organisation. South Africans are trying to establish a non-racial, non-sexist democracy which would end decades of apartheid. Although political settlement is important, its validity will be tested by its delivery of well being. This will lead to inevitable, intersectoral competition over scarce resources. We plead that educare receives the highest priority and that both the state and the private sector assume responsibility for funding it.

The education of young children in isolation of their families is of limited value. The family must be encouraged to become an equal partner in the education process. If educational programmes continue to exclude parents, they disempower these parents as mediators and advocates for their children.

*Marion Stewart is the national director of HIPPY*

# Reaching Out
## A Development Centred Approach to Educare

***Community Development Trust***

The Chatsworth Early Learning Centre, run by the Community Education Development Trust, was launched in 1980 on the initiative of community workers there. Operating from a small community building, the project concentrated its activities in promoting the development of early childhood activities in Chatsworth's Unit 5. Over the years, the programme came to embrace all 14 units of the township which is about 20km south of Durban.

## The Centre's Area of Action

With growing expertise, the Centre faced an increasing demand to provide services to adjoining townships around Durban including Phoenix, Tongaat, Merebank, etc. The Centre's work has grown to such an extent that its services are available to several townships and adjoining informal settlements. Project staff are involved in all major disadvantaged communities in the southern Natal region. The Centre's geographical spread includes the Valley of a Thousand Hills (near Pietermaritzburg), Phoenix and Tongaat on Durban's north coast, Pinetown and its satellite township, Claremont. Informal settlements serviced by the Centre are within the Durban functional region. This includes settlements around Marianhill, in which there are three informal settlements, 'Uganda' settlement (near Isipingo), and settlements around the townships of Chatsworth, Lamontville and Umlazi. The Centre's services are spread as far south as Port Shepstone and its environs. Contacts in KwaZulu, as far afield as Nongoma, have resulted in the Centre providing training services to the KwaZulu Child Care Centre Project there.

Despite the project extending geographically, it has maintained its organisational base at Chatsworth, providing early childhood education services in the various schools within the area. Initially serving about 154 children, the project now works directly with 2763 children and indirectly reaches out to a further 3500.

## National Input

The project has gained in knowledge, experience and expertise in the development of a unique community based model for the provision of pre-school services in residential urban settings and informal settlements. The project is involved in refining and sharpening presentation on its approach, and making this information available for national discussion.

The project's director, Mr Roy Padayachee, co-ordinates the ANC educare policy working group, and is national chair of the National Interim Working Committee (NIWC). NIWC is involved in establishing a democratic and representative mass based organisation for educare. NIWC has a large number of welfare affiliates, and has operational linkages with COSATU affiliates, NACTU, Women's Forum, National Education Crisis Committee, the National Children's Rights Commission, the Independent Development Trust and the South African Council of Churches. With the Centre for Education Policy Development (CEPD) and the World Bank, Mr Padayachee is the team leader of a South African educare study formulating recommendations to be put to the newly elected interim government. The Centre's staff are involved in NIWC and the southern Natal Children's Rights Committee.

## What's Unique About the Centre's Approach?

The Trust's experience suggests that western models of educare are inadequate for local conditions. Western models exclude traditional patterns of socialising children, thereby excluding the role of parents and extended families, who in an African context play a vital role in a child's development. Western models also require the setting up of centre-based approaches, which as an initial step involve the building and running of costly formal school. We need to pursue an approach which involves building on parental self confidence and developing community skills of self reliance.

From the experience of establishing a purely educare programme in Chatsworth, it has been learnt that child care cannot be adequately addressed without trying to engage in improving the quality of life of parents and communities as a whole. It was found that if our work with children was to be successful, we would need to work with the community too.

Thus, the Trust has two aspects. The Community Education and Development Institute which focuses on improving the environment in which children and their families live, and the Centre, which engages in educare. The Institute's role is to assist communities in lobbying for facilities such as proper water and

sanitation provision. It helps people secure land and facilitates community contact with self help organisations. Forums have been set up involving community members in discussion around their various problems. The Institute has assisted in developing civic structures.

The Institute liaises closely with the Centre. For example, when the Centre receives requests for its educare services from parents in informal settlements, it may find that lack of water or sanitary services are a hindrance to its work. It then consults the Institute to find ways of securing these facilities. The Institute, for its part, when it enters a settlement, does a survey of the community's needs. Where educare facilities are lacking, it consults the Centre.

In communities such as informal settlements, where there is a total lack of educare services, we have learnt that, in the interim, non-government organisations can try alternatives to more costly, formal schools. The centre has reached out to children in communities far beyond its original base in Chatsworth, through its play bus, play group and child minding programmes. The play bus approach involves converting buses into mobile classrooms, which provide classes once a week at each area visited. These visits involve two hour sessions. The constraint on having longer sessions is the fact that the play bus programme is an attempt to cover a large number of children over a wide area. As a backup to this service, the Centre tries to involve parents in workshops and encourages them to continue activities of the play bus after hours.

Play groups operate from people's garages and backrooms. A trained home visitor, usually a parent, goes to these homes and meets with groups of children. Where it is feasible, parents are encouraged to attend. In the end, however, we find as parents' expectations change they begin to prefer more stable educare structures.

## Aspects of Educare Work: Training

The Centre has grown from initial contact with children and parents into the establishment of home-based mother and child play groups and the provision of a toy-lending library. The Centre regularly offers various training programmes, such as:

* a pre-school orientation programme which is an introductory and orientation course aimed at new entrants into the field of pre-school work;
* a nursery aid orientation programme which is a higher level course aimed at resident teachers of nursery schools and creches;
* a pre-school teachers' forum which, by way of workshops, serves teachers' term-by-term practical and theoretical development in the programmes of their specific schools; and

* a parent training/home visitor's play group training course which is tailored to the needs of community home visitors who serve as play group organisers in the community.

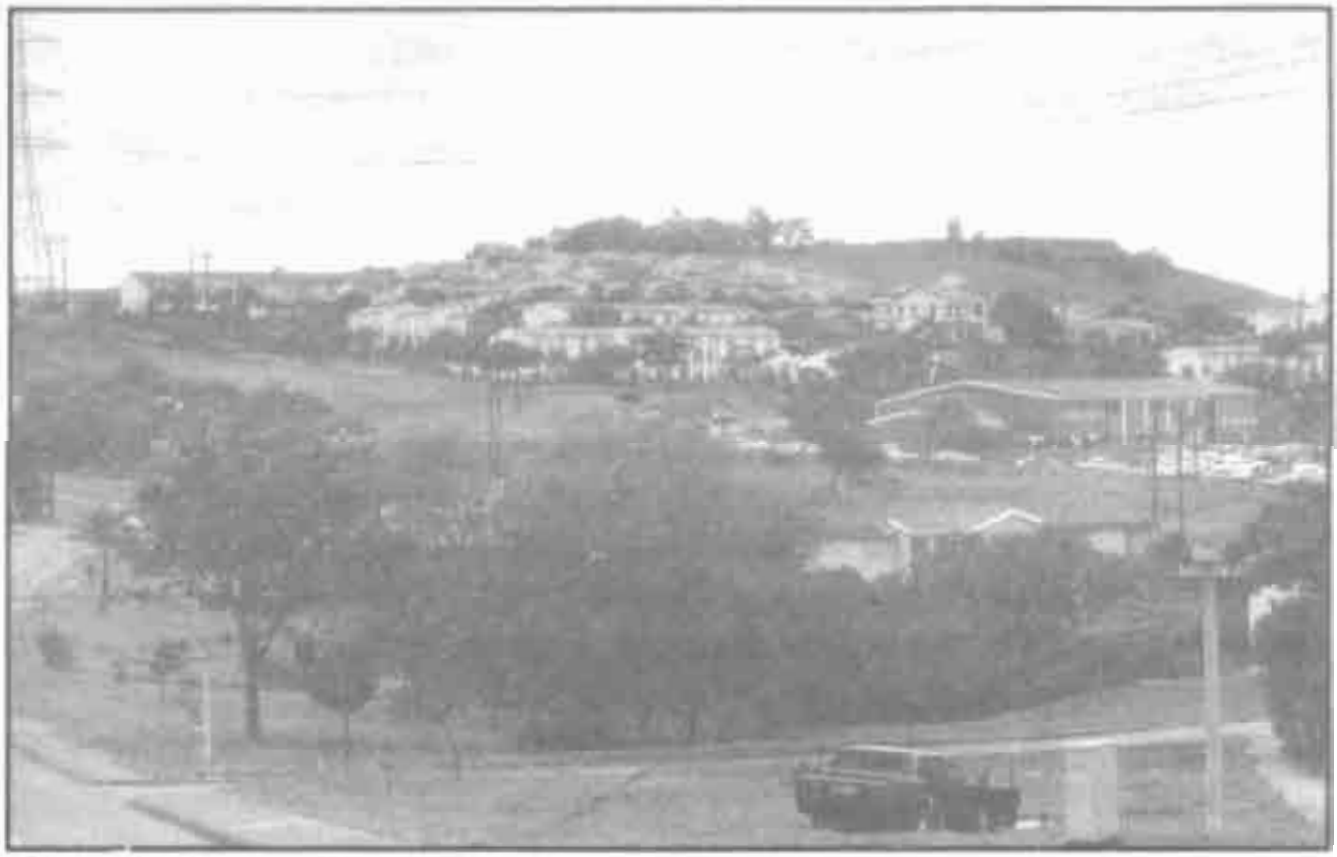
## Parent Volunteer Programmes

Another programme, a parent volunteer programme is an introductory course aimed at community volunteers wishing to be involved in pre-school development work. The wide focus of the course enables community volunteers to grasp the essentials of early childhood educational work, while offering parents basic theory and practical skills so they can play a more informed role in their children's development at home. This course is held on request, and whenever a sufficient number of candidates are available.

An on-site training programme provides innovative training, tailored to the needs of organisations and agencies that have large functioning early education programmes. The training events are held on or near the hosting institution.

This programme aims at:

* examining the needs of pre-school projects and their teaching personnel;
* taking the programme to the location of trainees;



**Phoenix lies next to the largest and fastest growing informal settlement in the country, Inanda.** ***Photo: Ismail Vawda***

* examining the hosting institutions general aims and looking at how early childhood programmes could give meaningful support to these and the growth of the institution;
* deriving an understanding of the hosting institution's organisational culture and the interactions of personnel to support the development of early childhood education initiatives within the organisation;
* helping identify human resources for the hosting organisation; and
* developing appropriate training initiative that could respond to these needs.

## Concluding Remarks: The Need for Networking

The majority of South Africa's children grow up in an environment of poverty, deprivation and emotional stress. A system of educare provision could give these children a better start by giving them access to education, health and nutrition. It would provide for the needs of working parents. Unfortunately the educare field has been low on the priority of national negotiations. Disadvantaged communities by their own efforts have established localised organisations which have been struggling over the years to provide services to young children. As commendable as these efforts are, they have been unable to overcome the scale of services needed. They have been unable to fundamentally change the reality of deprivation that young children face.

By and large, these efforts have been fragmentary, unco-ordinated and minuscule in a sea of disadvantage. A competitive pursuit for limited resources has, in most cases, produced uneven levels of service provision. Some organisations attain high levels of proficiency while others lag behind. The Community Education Development Trust has developed a pilot networking programme in the areas of its operation. This networking programme aims to create a co-operative system of educare. Given the conditions generated by competition for scarce resources and the inability of parents to afford the costs of educare services, it is necessary for the collective efforts of communities to be pooled. This would contribute to building stronger community organisation and achieving self-reliance and sustainability. At 'Uganda' settlement, for instance, the Trust is involved in a co-ordinating committee which demarcates roles, pools resources, especially that of agencies, such as the Child Welfare Society, which has access to state funding.

The Trust's networking programme aims, in the long run, to provide training for community educare motivators, community development officers, fieldworkers and teachers; to address the needs of participating communities to improve conditions for young children; to build and share skills and resources;

**Children, Phoenix - Durban.** ***Photo: Ismail Vawda***

to develop co-operative forums through which research and policy for educare can be developed; to promote community awareness and participation around educare; to promote non-racialism by breaking down apartheid division and identity; to develop cross cultural interaction through joint participation of children and parents; to provide the opportunity for more developed projects to support lesser developed projects; and to mobilise the educare field at grassroots level and provide the link between regional and national structures.

Within the context of wider political transformation, the Trust also anticipates the development of wider social advocacy and lobbying around issues concerning younger children. The project anticipates that as more communities begin to see the need for services to young children, it will be confronted with a rising demand to meet these communities' needs. Consequently, the project will be pressurised to develop a wider geographical and community outreach.

*Community Development Trust*

# COSATU's Jabulile Ndlovu Educare Centre

*Debbie Mbete*

The Jubulile Educare Centre opened on 1 October 1992. It is seen as an attempt to develop a model which could be used when negotiating for workplace educare centres.

The impetus for the formation of the Jabulile Ndlovu Educare Trust and the setting up of the first centre, arose from a resolution on gender empowerment taken at the eighth congress of the South African Communist Party (SACP) in December 1991. Participants argued that practical measures should be taken to assure the rights of women, especially that of working class women. Follow-up meetings were held, involving women from the SACP, COSATU and its affiliates. Initially, representatives from the ANC's Women's League were also involved. The objective of these meetings was to push for a programme of establishing workplace creches as part of a campaign for parental rights.

There are seventy five children at the centre, aged between six months and six years. The emphasis of the centre has been on educare - caring, nurturing, teaching and preparing the older children for the first school year and school entrance exams. Workshops on health care have been held for staff and parents by the South African Health and Social Services Organisation. Past workshops have dealt with issues like nutrition and malnutrition, child illness and diet. Additional workshops are planned to run throughout the year.

## Supportive Parents

Mothers and fathers have shown a great interest in and support for the educare centre and its objectives. The COSATU Gender Forum is also kept abreast of developments at the centre. This has generated great interest among women workers, and a concern for the expansion of the centre in Johannesburg and the setting up of similar centres in other regions. At present, we have a waiting list of 184 children.

All activities of the Centre - parents meetings, our first Christmas party and our first anniversary celebration have been well supported by parents. The Centre also held a small celebration with For the Love of Children (FLOC) and Kiddie's Corner on International Children's Day, 1 June at the Johannesburg

City Hall. The event was covered on CCV TV news that evening. All in all a very successful first year.

After the initial meeting with union members, the present co-ordinator, Debbie Mbete, was asked to do a feasibility study on the needs and resources for setting up the project. She networked with a number of child care organisations and contacted local funders to obtain initial funding for the project.

## Setting Forth

On 17 July 1992, the centre opened its doors to four children, aged between seven months and three years. Estelle Holtzan, a trained educare teacher, joined the project. The period until October was a time of learning for both the trustees of the project and staff. Eight additional members of staff were recruited, with varying levels of training and experience in the field of child care. A number of these had been retrenched or were unemployed.

Positive responses for the funding of the centre were received from Liberty Life and Gencor, to see the centre through its first few months. Contact was made with the international trade union movement, and international


***Photo: Afrapix***

government and non-government organisations. Not all responses were positive. This was also a process of learning, however, about dealing with funders, and setting clear tasks for the project which would contribute to continued local and international support. Clear goal setting is also essential to meeting the objectives of the project and ensuring its continued existence.

On 1 October, the centre opened on a single floor. This had previously been occupied by a diamond cutting factory and required a fair amount of cleaning and renovation. During the course of the past year, partitions have been put in, the kitchen and toilets have been replumbed and security bars have been placed around the outside play area on the roof. The play area has plastic sand-

**Workers are fathers, care-givers and role models.** ***Photo: Afrapix***

and-water pits, some swings and other equipment. But most of the work of making the centre look homely and bright has been done by the staff and the children.

Parents pay a fixed amount of R100 a month as fees, plus R5,00 a month for fruit. Parents have also contributed a number of once-off costs like mattresses, sheets and aprons. Fathers and mothers have worked together to photograph and video-tape activities at the centre. They organised a fund raising music concert in April 1993. Fathers were centrally involved in this event, which was organised by Anthony Stevens, a parent and musician. Male workers in COSATU have also been supportive of the initiative, particularly in approaching employers for funding.

## The Future - Campaigning for Workplace Educare

The next major goal of the centre is to develop the area of training and skills in educare. The availability of people with suitable skills is a must for the development and expansion of the project over the next five to ten years. Such skills would include skills in organisational development, group dynamics and project management.

The present staff at the centre are women. We had one male on our staff, who remained with us for only three months. The centre intends to recruit male educare workers in the future. A good gender balance is seen to be important for the welfare of the children.

We have also established a relationship with Johannesburg City Health, where four staff members attend training classes two afternoons a week. City Health is also willing to make a contribution towards the financing of the centre, on receipt of an audited financial statement.

The future of the project in educare depends on many things - the dedication of parents and staff, campaigning for workplace centres, funding from local employers and local government and support from interested members of the public. Any person is welcome to visit the centre. Prior arrangements can be made with Debbie Mbete at 402 9436.

*Debbie Mbete is co-ordinator of COSATU's Jabulile Ndlovu Educare Centre*

# Resource List

## National Bodies Involved in Education & Welfare

There are hundreds of bodies involved in health and welfare work for South African children. Articles in this edition give a sense of the scope of people's initiatives in working with children. To complement this, we provide short inputs on national networking or co-ordinating bodies serving the needs of children.

### Childline

Childline aims to fight child abuse. It is an emergency telephone referral service, which provides:

* immediate intervention/counselling;
* short term follow-up; and
* referral to a welfare agency for long term management.

Childline:

* serves all people, children and adults;
* operates 24 hours a day;
* provides help to victims of child abuse;
* provides assistance to children in danger/distress;
* provides help to parents who experience difficulty with their children or fear that they may abuse their children;
* aims to give concerned members of the public the opportunity to report cases of suspected child abuse; and
* aims to act as a referral resource for professionals (eg. doctors, teachers, psychologists, social workers) who want guidance in handling the problem of child abuse.

Childline exists in Cape Town, Durban, Johannesburg and Port Elizabeth.
Dial 0800055555, toll free.

### Life Education Centre

Life Education Centre is a community based project and each centre or mobile unit is initiated, owned and operated by its community with support from Life Education headquarters.
Life Education is not designed for rehabilitation, but for educating children, and protecting them against pressures of drug abuse, alcohol, analgesics, nicotine, unsafe sex and violence. Education also includes handling relationships. The children learn to develop a healthy respect for their bodies, themselves and others. They are given information and encouraged to make their own decisions. Life Education encourages self esteem and awareness within the child.
Dr M. F. Gerber
PO Box 8800, Edenglen · 8 Mopedi Road, Sebenze, Edenvale
Tel: (011) 809 4166 Fax: (011) 452 6163

### National Interim Working Committee on Early Childhood Educare

The National Interim Working Committee (NIWC) is a response to examing and addressing the challenges facing the educare field during and after transition. This movement was borne out of a consultative workshop called by the NECC to discuss the state of the Educare field. NIWC

was set up to accomplish the following tasks:

* to bring about a united, nationally representative early childhood educare movement based on the principles of non-racialism, non-sexism and democracy within a unitary South Africa;
* to ensure that such an organisation has a national character, in terms of national development objectives, membership, regional representation;
* to strive towards meeting the basic needs and rights of young children and educare workers, and the provision of good quality educare;
* to work towards greater participation of all within the early childhood educare field through local, regional and national structures; and
* to initiate a process for the establishment of a Declaration/Charter for Educare.

Natal Regional Office: PO Box 45221, Chatsglen, 4012
Tel: (031) 439 195

### Network Against Child Labour

The Network emerged in 1991, in response to attempts by organised agriculture to entrench the legal right to employ children.
Aims include:

* bringing together concerned organisations in a national lobby against the exploitation of child labour;
* educating the public and mobilising public opinion against child exploitation;
* providing information and offering policy guidelines on child labour;
* lobbying for legislation, enforcement mechanisms and social policies aimed at eliminating child labour; and
* actively reporting cases of abuse.

The Network may be contacted at the same address and telephone number as the NCRC (*see below*).

### National Association of Child Care Workers (NACCW)

The NACCW is a specialist education, training and consultancy organisation providing adults with the skills to treat and manage children and youth at risk. The NACCW is able, through its community based members, to identify needs and priorities within communities.
The NACCW povides a range of other services to child and youth care agencies including: hosting seminars and conferences;

* producing a monthly publication for local and overseas subscribers;
* providing consultation services to welfare bodies and the state;
* conducting research and development of new models of child care;
* participating in official commissions;
* advocating on child care legislation and subsidies; and,
* establishing vital links between local and international child care organisations.

National office: P O Box 28323, Malvern, 4055
Tel: (031) 463 1099 Fax: (031) 441 106
Transvaal Office: Jacqui Michael · PO Box 95129, Grant Park, 2051
Tel: 011 484 2928

### The National Children's Rights Committee (NCRC)

The NCRC was established after consultations between the United Nation's Children's Fund (UNICEF), the liberation movement in exile and various South African NGOs involved in the situation of women and children in South Africa. A consultative conference, under the auspices of UNICEF, was convened in Gaborone, Botswana in April 1990, to review the plight of children

under apartheid.

The NCRC's strategy is to influence policy and to facilitate the development of a specialist network of NGOs working in the area of children's rights and needs, locally and nationally.

The NCRC is committed to:

* lobbying at the highest level, for recognition of the needs of the child, in particular, that the United Nations Convention on the Rights of the Child be ratified by South Africa;
* informing social and economic policy makers to enhance children's health and nutrition and their optimal growth and development;
* working to strengthen the role and status of women, and providing support and respect for the family in its role of nurturing children;
* working for programmes that reduce illiteracy and provide education opportunities for children irrespective of their background or gender and that prepare children for productive employment and life learning opportunities;
* promoting the values of peace, understanding and dialogue in the community and in the education of children, so as to give children a peaceful and secure future; and
* working for an economic policy that promotes economic growth, while ensuring the well-being of the most vulnerable sections of the population, especially children.

The NCRC's objectives and priorities are:

* advocacy for children's rights by raising the awareness of local and international communities about the plight of South African children, and entrenching the rights of women and children in a non-racial, non-sexist democratic South Africa, through a Bill of Rights and Constitution;
* to develop a comprehensive information base on the situation of children and women; and
* to support NGOs dealing with homeless children in order to improve their capacity, to support their specific programmes, and facilitate the development of a national network of NGOs working with homeless children.

In June this year, the NCRC and UNICEF released a report, *Children and Women in South Africa: A Situational Analysis*, as well as a summarised version, *State of South Africa's Children: An Agenda for Action*, which includes *the 1990 World Summit Goals for Child Survival, Development and Protection by the year 2000.*

Shirley Mabusela
PO Box 30803, Braamfontein, 2017

## South African National Council for Child and Family Welfare

The South African National Council for Child and Family Welfare is a guiding, co-ordinating and enabling body to 184 autonomous child welfare societies and 80 dependent 'embryo societies'. With the launch of its community development programme, the council is community based with each of over 400 groups involved in setting their own priorities.

The Council is actively involved in:

* informal learning among adults, youth and pre-school children;
* ensuring the highest level of educare and safety of children in day care;
* protecting the rights of children through sound and relevant legislation;
* developing and disseminating knowledge and skills in identified areas of practice and management to enable service providers to render an effective service; and
* guiding the child welfare movement in terms of this sensitive area.

Mrs Venessa Partington
P O Box 30990, Braamfontein, 2017 · 6th Floor, Melhof Building, 2 Melle Street, Braamfontein
Tel: (011) 339 5741 Fax: (011) 339 8123

### South African National Institute for Crime Prevention and Rehabilitation of Offenders (NICRO)

NICRO is a national, private welfare organisation whose objectives are:

* to advocate and promote a fair and accurate criminal justice system;
* to promote and secure the welfare, rehabilitation and reintegration/aftercare of adult offenders and their dependents;
* to promote crime prevention, with a particular focus on youth; and
* to support victims of crime and violence.

Dr Ester Lategan
PO Box 10005, Caledon Square, 7905
Tel: (021) 461 7253/4 Fax: (021) 461 5093
Tel: (011) 403 38771/2 Fax: (011) 403 3870

# Drugs and Children: Starting the Habit of a Lifetime

### Health Action International

Health Action International (HAI) is an international network which monitors and challenges the multinational pharmaceutical industry (for more information on HAI, see *Critical Health* no.43). This year, it published an information package, titled '*Problem Drugs*'. The package includes a section on drugs and children.

HAI stresses that too many drugs are given to children. It is common practice to prescribe drugs for self limiting diseases such as diarrhoea, coughs and colds. Pharmaceutical companies play on parents' concerns to boost sales of appetite stimulants, despite the lack of evidence on their supposed effect. Company representatives attend schools to promote the routine use of vitamins. Many companies make unfounded claims that their products improve intellectual performance.

The inappropriate use of drugs represents a waste of resources and also leads to unnecessary adverse drug reactions. Aspirin is associated with Reye's Syndrome and the administration of some antidiarrhoeals can be life threatening. For most drugs, there is a lack of research as to their effects on children.

The HAI publication also highlights the long term effects of the promotion of excessive drug use. The drug industry creates a highly profitable market by ensuring that children develop a habit of taking unnecessary medicine. Children may believe that drugs will solve many of life's problems and can suffer psychological and social consequences.

The publication is available from:
HAI Europe, Jacob v. Lennepkade 334T, 1053 NJ Amsterdam, The Netherlands

# National Education Policy Investigation

The National Education Co-ordinating Committee (NECC) was established in 1985 to co-ordinate and lead the struggles of teachers, parents and students against apartheid education. The changing political climate in the country led to the need for concrete policies on education and, in 1990, the NECC set up the National Education Policy Investigation (NEPI) to look at

policy options. Twelve areas of research were identified, including research into early childhood educare and special education to support children with difficulties. The research findings were published in 1992.

# Early Childhood Educare

The Early Childhood Educare report assesses the shortcomings of existing pre-school provision and makes alternative suggestions. It rejects past and current privatisation strategies and asserts the need for increased state subsidisation of community based educare, from less than 1% to 5% of the education budget. Subsidies should be graded in favour of the poorest. NEPI emphasises a development approach to meet the needs of the whole child within a community development context. Health and nutrition programmes are an important component of educare. The report suggests options such as educare centres providing feeding schemes, growth monitoring and medical checks. In this context, it expresses concern at the current lack of co-operation between various sectors and state departments which impact on child development and asserts the need for central state involvement and planning to ensure redistribution and co-ordination between different departments and sectors. It is suggested that inter-sectoral co-ordination be achieved through an overarching ministry.

## Support Services

Support services in education should involve prevention and cure of various difficulties experienced by students, including special learning problems, physical health problems, emotional difficulties, career education needs, lack of skills and poverty related issues. The Support Services report notes that these services have been given marginal attention and have been administered in a fragmented and racially discriminatory manner. The existing services do not include an adequate preventive component. NEPI suggests restructuring support services on five principles: accessibility to all children of school going age, equity, prioritising the greatest need, non-discrimination, unified administration of services and community participation.

A summary of all 12 reports is included in the final NEPI report, National Education Policy Investigation: The Framework Report, Cape Town, Oxford University Press/NECC, 1993. Detailed reports on each of the 12 areas have also been published.

We must be at the same school. We must Work together to get more things we want. Our freedom must be as we want. We dont want that people must say that they dont want other people that they want. We must no their language. We Want that South africa to be rich as it could. We mus ~~Co~~ work together as the same people. We must be~~e~~ een ~~S~~ about wat we are doing. We must not have problems about wat we are doing. We must have many thing that we want. We must do things we real We must not care about people wat their doing. And our freedom must be as we want.

Dolores (13 years)

# SECTION D:
# Topical Issues

# What is Development?
## The Community Worker's Dilemma

*Johannesburg Child Welfare Society*

People working in the welfare field are starting to acknowledge that a purely curative approach is not enough to break the cycle of welfare related problems in communities, and that more emphasis needs to be placed on preventive work. Community development has become the new catch phrase to describe work which attempts to address underlying problems such as unemployment, lack of or inadequate housing, criminal and political violence and widespread substance abuse.

What is development? Is it something done by experts with the technical know-how on behalf of the less privileged, or is it a process whereby we equip communities to develop themselves? Our interpretation of development has important implications for our role as community workers, the methods we adopt, the impact we have on communities, the type of projects set up, decision making processes, and the ownership of projects. A top down approach tends to result in community members remaining passive, whereas a grassroots approach is more likely to involve participants actively in the process of transforming themselves, their families, their communities and broader society.

## Maintaining Control, Feeling Good

Turton identified three different approaches to development, namely 'growth centred', 'spend and service' and 'people centred'. The 'growth centred' approach is characterised by: a focus on production; measuring development in terms of quantitative growth; co-option of local leaders to implement the plans and goals, resulting in manipulation of the community; and lack of focus on basic power relations.

The characteristics of 'spend and service' are as follows: programmes are based on material indicators such as poverty, homelessness, unemployment, malnutrition and poor health; programmes are designed and implemented by the developer; there is community participation, but not in the decision making and planning processes; certain material needs are redressed, but insufficient resources go into building the capacity of local communities; and projects depend on funding and are unable to continue once the funding stops.

The 'people centred' or 'community centred' approach has the following characteristics: a focus on process rather than on projects; empowering people and communities with skills, knowledge and the capacity to act and engage effectively at the community level; community participation to gain greater control over resources; and meeting basic needs and continuously improving the lives of as many people as possible.

State structures and welfare organisations generally adopt a 'growth centred' or 'spend-and-service' approach. These approaches maintain the status quo and can be seen as a form of social control. They are used to fit people into the system even though the problems people experience may arise out of that very system. They are top down in nature and people are not equipped with the bargaining and negotiating skills to address power imbalances themselves. Communities are discouraged to take ownership of projects by being excluded from aspects such as planning and control. There is a lack of training in organisational and financial skills. Consequently they remain dependent on the welfare organisations, and eternally grateful for what these organisations are doing for them. This, in turn, allows the predominantly middle and upper class welfare committees to feel very good about the projects they are maintaining, while ensuring control over the poor at the same time.

## By People, Not To People

According to Hope and Timmel, "development and education are first of all about liberating people from all that holds them back from a full human life. Ultimately, development and education are about transforming society." Clark adds that development is "a process of change that enables people to take charge of their own destiny and realise their full potential. It requires building up in people the confidence, skills, assets and freedom necessary to achieve this goal. True development is done by people, not to people".

The 'people centred' approach ensures that people participate in planning, making decisions and implementing projects, according to their needs. The ownership of the projects by the community is encouraged from the very start. The skills for managing the project are developed in the process, and consequently empowerment is more likely to become a reality. This process enables people to shape their own destiny.

It is important for us to question whether the approaches we use maintain the present situation and the problems inherent in it, or whether they lead to positive transformation.

## Conflicts and Dilemmas

A lot of the work done in the name of development is top down, in spite of many community workers seeing the need for a grassroots or bottom up approach. This contradiction draws attention to the conflicts and dilemmas experienced by community workers. Often workers are employed within a top down bureaucratic system. They are inevitably left with the question of how to implement real grassroots work within the parameters and policies of the existing structure.

A community worker is accountable to the community as well as to the agency. When there is a clash of interests between the community and the agency, she is faced with a dilemma. For example, agencies often hold on to projects when it is in the interests of communities to work independently. Agencies hold on because they need to show funders what they are doing, while funders want to see the results of their financial input according to their own indicators of success.

Welfare organisations tend to favour consensus models of community work. Is this appropriate when many problems arise from conflicts of interests, discrepancies in the distribution of resources, and power imbalances? The way in which this dilemma is resolved has important implications for the community worker.


**Development should revolve around a process, not an end product.**
***Photo: Ismail Vawda***

## The Facilitator Must Empower

The community worker's role is defined to some extent by the development approach that is adopted. Roles such as advocacy, organising and consciousness-raising are consistent with grassroots approaches, where unequal power relations and economic, social and political injustices are seen as impacting negatively on communities. Top down approaches are inclined to view the role of the community worker as that of expert and long term co-ordinator of projects.

Roles such as facilitator are generally included in all approaches. However, the way in which these roles are interpreted depends largely on the approach. The top down interpretation of these roles is linked to the view of community worker as expert. Facilitation is geared towards assisting people to adapt to existing social structures, or to new structures that are decided on by the developers. Community members are regarded as 'empty vessels' needing to be filled with the expert's knowledge. However, this stops short of the transfer of the skills needed for communities to take over the management of projects.

A grassroots approach interprets the facilitative and educative roles as empowering people to take control over the decisions that affect their lives and to define the nature of the changes they want. Active participation, critical thinking and creative problem solving are regarded as essential.

## Contradictions and Challenges

It is important for community workers to be aware of the contradictions inherent in engaging in development work within the parameters of the welfare system, in order to identify the limitations and constraints that impede effective development work. We as community workers also need to look at ourselves, to question our assumptions about the communities we work in, to examine our own feelings about change, and to assess the extent to which we hide behind the policies of welfare organisations.

We assume that communities need education and training, but have we considered the possibility that colleagues, welfare organisations and funders need to be educated about development?

We often claim that we are using a grassroots approach, yet our approach to needs assessment presupposes the specific projects we have in mind, and the projects we implement reflect our assumptions of what the community needs. When the projects we implement are not well utilised, we blame the community for being apathetic. When participants remain dependent, even though the project may be well attended, we try to justify our belief that communities are

incapable of managing their own affairs.

We sometimes hand over the running of projects to communities when funding dries up, without adequately preparing them with the necessary skills, and we despair when the projects collapse. Alternatively we maintain control over resources such as equipment and finance, thereby ensuring the continued dependence of the community. If we are really serious about adopting a grassroots approach to development, it is necessary to address these issues. Grassroots development requires that we involve the community in planning and decision making from the start, and that we develop the capacity of the community by equipping members with the necessary organisational and administrative skills.

## Build Capacity to Take Control

If community work is to fulfil its preventive role, it is necessary to address broader social problems such as unemployment, lack of housing, violence, unequal power relations and economic, political and social injustices. We must also aim to break the cycle of dependence that results from top down welfarist approaches, otherwise we are making a mockery of development and we are merely paying lip service to it. Community development is a farce unless it aims at empowering communities by building the capacity of community members to take control of their lives.

*This article was written by the Community Organising and Development Department of the Johannesburg Child Welfare Society*

# AIDS and The Unions
## A Reassessment

*Rehad Desai*

A useful article on trade union responses to AIDS, by the Workplace Information Group (WIG), appeared in the last issue of *Critical Health*. It presented an overview of the successes and limitations of prevention work in the unions. However, the authors were perhaps too self congratulatory in terms of achievements in AIDS education. They point out, "unions began to develop AIDS education programmes which look at basic AIDS information and policy and workplace issues. Thousands of workers have been through these training programmes". But the article fails to address the limitations of information based education programmes.

## Information Is Not Enough

It has been shown, the world over, that the mere process of providing statistics, a medical history of the virus, an explanation of how the virus works and an examination of who is susceptible to the disease is not enough. Educators have to accept that there is no such thing as an empirical truth or fact that will outweigh misinformation and bigotry. The simple matter is that correct information can easily be denied, re-interpreted or just ignored.

In Britain, a year after the intensive government campaign under the slogan "Don't Die of Ignorance", up to 93% of teenagers knew how AIDS was transmitted. But 33 to 50% of 16 to 24 year olds said that not having a condom would not prevent them from having intercourse. Allan Brandt, author of a major work on the history of STD control programmes in the United States, says there is a strong consensus that AIDS education is urgent, but cautions against those who put forward education programmes as the panacea for AIDS. He says "I think there's considerable evidence that these measures will fail."

## Education Towards Safer Sex

It follows, therefore, that the whole process of education in the workplace needs to be examined. Essentially, AIDS education is concerned with effecting behavioural change. Any education in the AIDS field that fails to increase the

learners' ability to understand, influence and shape their own lives is questionable. It is actual behavioural change, not a cerebral understanding of the complexities of the virus, that will stop the virus.

AIDS education must, therefore, take into account sexual behaviour. It must be sensitive to existing sexual practices. In Tanzania, when a 35 year old man read a poster explaining that, to avoid infection with AIDS, he should have sex with one faithful partner, he burst into laughter, "What am I going to do with my other wives?" A ward chairperson of the ruling party in Lusaka argued, "It is wrong for anybody to forsake their culture for the sake of AIDS." The Ugandan campaign now recognises the existence of polygamy in local culture and seeks to avoid prescriptive comments in regard to sexual practices.

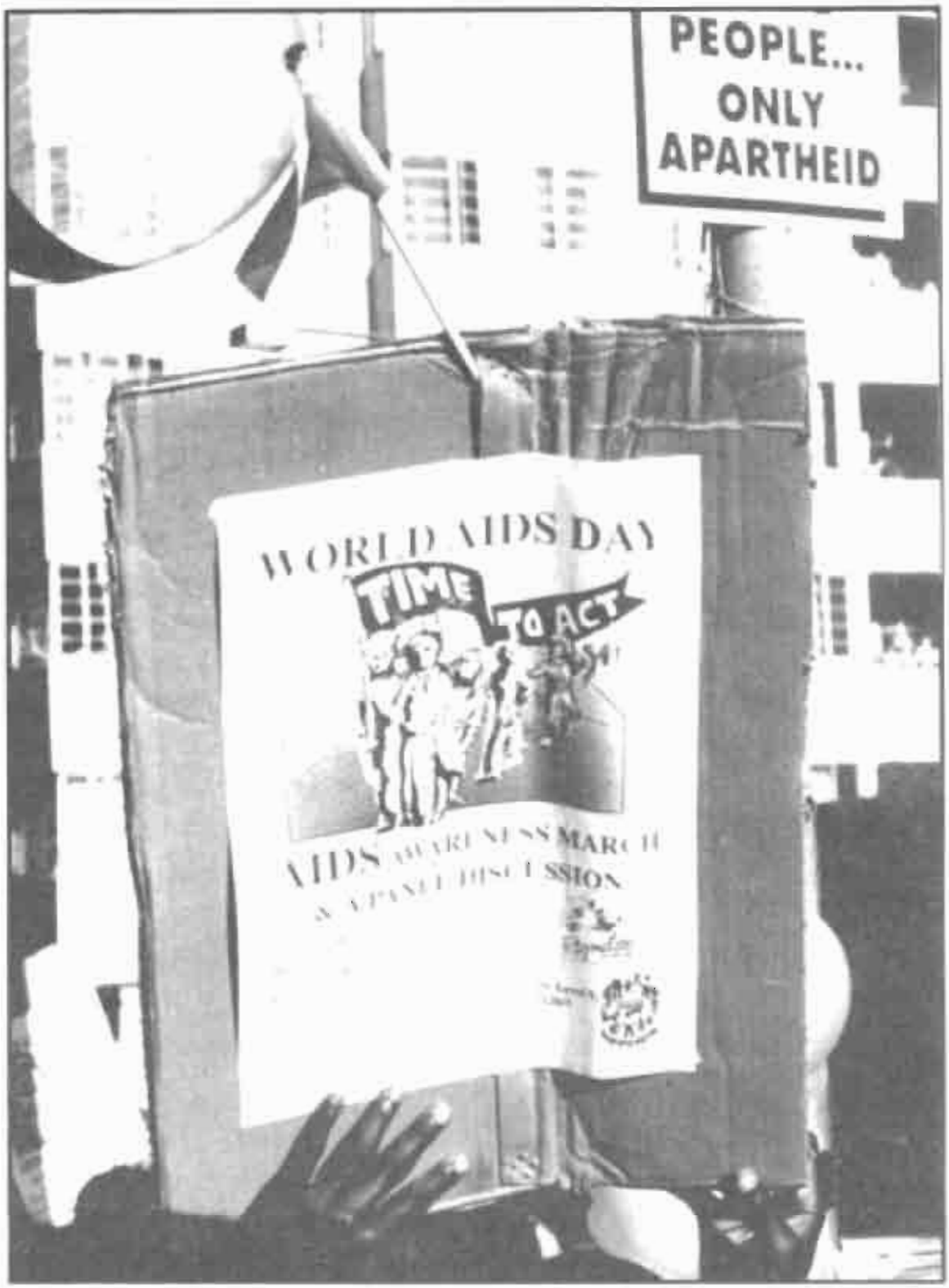
The WIG article states "the trade unions have placed the issue of AIDS firmly on their agenda. Awareness seminars and workshops are a regular feature of some unions' education programmes." However, the critical test of any HIV educational programme is whether it has empowered participants to become proactive around their own sexual behaviour with the view to practising safer sex. Success depends on people coming to their own solutions on a personal and collective level.

## Peer Educators, Aids Policy Negotiators

Training within the unions and workplaces needs to focus on developing a wide layer of peer educators among respected and, if need be, elected members of the workforce. Courses need to address the necessary basic HIV facts and myths, fears and concerns related to the epidemic. They must deal with the politics of health, including the importance of progressive primary health care. Discussion on sexuality, gender issues and the negotiation of safer sex, as outlined by Oskowitz and McKay in the last edition of *Critical Health*, is essential.

Training programmes need to address the essential elements involved in negotiating comprehensive workplace policies with management, for inclusion in collective bargaining agreements (CBAs). This includes union controlled and management financed workplace education, free and freely available condoms, counselling services, medical aid, provident and pension funds, lifestyle clauses that address migrant labour and other relevant issues, and the general rights of HIV positive workers. Where policies are as yet not fully developed, workers need to know how to utilise the unfair labour practices legislation in defending themselves from unfair discrimination.

The above components are critical in any attempt to equip and motivate participants to become health cadres in the unions, workplaces and in commu-




**Fortunately no one dies from verbosity.** ***Photo: Ismail Vawda***

nities in which they live. Appropriate education programmes are essential in order to mobilise the strength of the unions to combat the epidemic. The WIG article makes the very important point that functional health and safety structures need to be established before AIDS work can really begin to take root. But it is necessary to start running pilot training programmes in the unions as soon as possible and to integrate this work into the structures once they are established.

## COSATU Moves Forward

The WIG article in question also states "NUM, FAWU, MEWUSA, SACWU and TGWU began to engage employers on the issue of an agreement." However, to date, there are only a handful of CBAs that include AIDS policies, namely between NUM and the mining industry, between Premier Food Division and FAWU, and between TGWU and a few companies in the transport sector. At its recent Health, Safety and Environment Policy Conference, COSATU faced up to this grim reality. It is finally addressing the general relegation of health and safety issues to paper policy. The conference charted a way forward to develop a fighting strategy around HIV prevention and HIV discrimination. Delegates used the Organisation of African Trade Union Unity (OATUU) resolution on HIV/AIDS as a guiding document and adapted it to suit the South African context. Delegates also recommended that the section dealing with economic issues be included in COSATU's Reconstruction and Development Programme.

The conference represents an important advance in that an attempt is being made to utilise the democratic and fighting tradition of the trade union movement to lead the struggle to contain the HIV epidemic and the plague of panic it has given rise to. The intention to develop union cadres into peer educators is a vital step forward. It is now up to the affiliates to put the resolution into practice, for it is only in practice that we will achieve success.

*Rehad Desai is the co-ordinator of the AIDS Education and Media Unit*

### COSATU Health, Safety and Environment Policy Conference Resolution

**Economic Rights**

Spreading of the epidemic can be limited by:

* employment and living wage;
* education;
* confidentiality of infected workers; and
* free comprehensive health care.

**Workplace Rights**

Workplace policy has to include:

* education for all workers done during company time;
* job security;
* awareness and information;

* training people to be able to talk to others openly (peer educators);
* test to be freely available at the workplace by choice; and
* health care that provides counselling services and free, freely available condoms.

**Social and Cultural Rights**

* rights to say no to sex;
* freedom of choice for sexual practices including the right of both partners to demand condoms; and
* right to education and information, in particular, making women aware of their rights and to provide training that allow them to assert these rights.

**Other Rights**

State to protect prisoners against forced sexual encounters and to ensure provision of condoms to all prisoners on demand.

**Union Action and Structure**

* Health and Safety co-ordinator
* COSATU AIDS Task Force
* Regional health and safety committees

**Shop-floor Health and Safety Committees**

* AIDS task force which must be composed of representatives from affiliates to monitor AIDS component of health and safety work;
* This structure to apply to affiliates;
* Health & safety co-ordinator to be appointed as a matter of urgency; and
* Endorse the proposal for the health and safety centre

**Education and Training**

* Regions to take the AIDS work forward; and
* Branch education committees and regional executive committees need to be won to the need for peer educator courses. This work is to become part of the health and safety structures, such training needs to be encouraged and take place as soon as possible.

**Alliances**

* COSATU needs to work in the National AIDS Committee of South Africa (NACOSA)
* NPPHCN NAP needs to be tapped to help conceptualise and facilitate training along with other progressive AIDS NGOs as well as occupational health and safety organisations who are involved in comprehen sive peer educator training.

# GaRankuwa Baby Deaths

## Victimise, Absolve, Justice Ever Evade

*Glenda Gray*

For workers in the public sector, 1990 was a historic year. More than 25 000 general assistants at state hospitals across the country went on strike for better wages and working conditions as well as recognition of their unions. From April to May that year, more than 12 000 hospital workers went on strike at 18 different hospitals in the Transvaal.

At GaRankuwa Hospital, 24 babies in the neonatal unit died during the strike. At various stages during the next 3 years, the Transvaal Provincial Administration (TPA) blamed the National Education, Health and Allied Workers' Union (NEHAWU) for these deaths and victimised NEHAWU shop stewards at the hospital. Shortly after the strike, it set up a commission of inquiry to investigate whether the deaths occurred as a result of the strike. It appointed Wessels, who was favourably disposed to the TPA, to head the commission. Later that year, he duly found NEHAWU responsible for the deaths of 11 of the babies and recommended that NEHAWU shop stewards at the hospital be charged with murder.

More than two years elapsed, but, in March this year, the TPA charged 5 shop stewards with the murder of the 11 infants. The shop stewards had been employed at Ga Rankuwa for many years. These people were committed health workers, who worked under bad conditions. Despite their length of service, they were still temporary staff, on low wages, without adequate benefits. In November, the TPA did an about turn and withdrew the charges.

## SABAX and Severe Infections

A review of the bed letters revealed a common thread connecting the 11 infants. They all received AFS solution produced by SABAX and they all died of severe infections. The babies were stable from a medical point of view before they developed the infections. In fact, two of the infants were in the discharge area, another was in the heating room. Significantly, none of the critically ill babies, such as the babies on ventilators in the neonatal intensive care unit (ICU), died. In other words, there were no deaths amongst the infants one might have expected to die if services had broken down due to the strike.

All 11 babies were on AFS solution prior to the discovery of the first signs of septicemia. All died within 48 hours of obvious signs of infection. One of the doctors who worked in the neonatal unit at the hospital, who gave evidence to the 1990 commission as a witness on behalf of the TPA, said she had not considered AFS as being involved in the deaths, "because most of the children were dead already and I would not be able to trace all those hyperalimenations." In other words, she rejected the solutions as the cause of death on the grounds that it would be difficult to prove, rather than that it was an unlikely explanation.

## Deaths Before and After Strike

The same doctor reported that, several weeks later, a number of babies died with signs of severe infection, and that bags of AFS were shown to be the source of this infection. The unit, furthermore, strongly considered the possibility of contaminated solutions in relation to deaths that occurred before the strike, in December 1989 and February 1990.

During this period, there was an investigation into the cause of death of a number of babies in a private hospital, who also received SABAX solutions. It was discovered that the strain of bacteria that was responsible for the deaths of the babies in the private hospital was identical to the bacteria in the bags of AFS in GaRankuwa. Therefore, the bacteria must have come from the same site. Notably, after these tragic events in 1990, SABAX was sufficiently concerned about their product to withdraw it from the market.

Professor Cooper, head of Paediatrics at Baragwanath Hospital, gave evidence to the commission in which he drew attention to the uniformity of the clinical pictures of the babies who died during the strike, after the strike and in the private hospital. He concluded that the strongest possibility was that all the babies died of a similar source of infection. The available evidence pointed to the AFS solution.

Wessels, however, ignored Cooper's evidence about the SABAX solution. He disregarded the deaths in GaRankuwa in December 1989, February 1990 and shortly after the strike. He did not take the deaths in the private sector hospital into account. He simply asserted that it was unlikely that the use of contaminated solutions coincided with the strike period.

## Poor Conditions for Patient Care

Hay, a doctor at the hospital, and Ellis, head of Neonatology, gave evidence to the commission that the neonatal ICU at GaRankuwa is more poorly staffed and

equipped than most equivalent units in the country. The unit has a high overall mortality rate. In their report, Hay and Ellis document their ongoing problems, including electrical power failures; failures in supply of medical air and oxygen, resulting in deaths; oil contamination of the air supply; inadequate levels of equipment and poor maintenance; problems with lab results; difficulty in obtaining supplies of emergency blood for transfusion; and inadequate numbers of trained staff.

In 1988, the head of Neonatology sent a letter to the chief superintendent in which he pointed out that there were 87 patients in the neonatal ward, meant for 40. He stated, "My staff and I cannot be held responsible for any misdiagnosis, inappropriate or inadequate treatment rendered in the neonatal service and we hold the authorities responsible for any legal action which may arise." At the time of the strike, conditions had not improved and the ward was still overfull.

Wessels made no attempt to compare the service provided during the strike to that under "normal" conditions at GaRankuwa. Instead, he demanded "ideal standards" during the strike that even the best neonatal wards and ICUs in the country cannot achieve. Having dismissed the likelihood that contaminated solutions were the cause of death, he found that the level of care did not meet up to his unrealistic standards and concluded that this was due to the strike.

## Trying to Weaken the Union

The commission and subsequent events raise a number of questions. Why did Wessels find Nehawu responsible in the face of so much evidence to the contrary? Why, once Wessels had paved the way for the TPA to charge the NEHAWU shopstewards, did the TPA not do so for two years? Why did the TPA eventually decide to press charges in 1993?

NEHAWU reached agreement with the TPA to end the 1990 strike on condition that the two parties meet to discuss NEHAWU's demands. The discussions broke down and NEHAWU's demands remained unfulfilled. This resulted in further strike action for an extended period of time, from June to October 1992. The TPA employed scabs to replace striking workers and resisted efforts to resolve the dispute for 4 months in a deliberate attempt to weaken the union. Perhaps the TPA took the GaRankuwa shop stewards to court in a further attempt to weaken the union. Public sector workers also won the right to strike under the Public Servants Labour Relations Act. It may be that the TPA wanted to win this case to set a precedent and thereby undermine any future strikes by threatening to press charges for neglecting essential services.

Why did the TPA do an about turn and decide to withdraw charges in November? Did the TPA suddenly realise that it would be impossible to prove that the workers were directly responsible for these deaths? In recent months, there has also been a general improvement in relations between the TPA and NEHAWU. Is the TPA trying to improve its image in the hope of securing a future for itself beyond the elections next year? Or is this an attempt by Rina Venter to regain some popularity?

However, one thing is abundantly clear. The TPA did not set up the commission and take the shop stewards to court in order to find the real cause of death and improve patient care. If the TPA really had the welfare of patients at heart, it would have investigated the deaths before and after the 1990 strike as well. It would have examined the potential danger of the SABAX solutions. It would have made an effort to improve the inadequate conditions under which the neonatal services operate. It would have provided reasonable working conditions for hospital staff and done everything to ensure the existence of acceptable dispute resolving mechanisms. During strikes, it would have made every effort to maintain emergency services.

During the 1990 strike, NEHAWU offered to make staff available so that critical areas of the hospitals could continue to function adequately. This was met with resistance by the hospital authorities and crucial services broke down. In 1992, the TPA's intransigent attitude was primarily responsible for the long duration of the strike. Only emergency surgery took place. Cancer patients, for example, were not treated as they were not viewed as emergency cases. Lots of patients requiring surgery were sent home.

## A Victory for NEHAWU

Clearly, on scrutinising and reviewing the TPA's allegations against the NEHAWU shop stewards, there is no way that a case for health worker negligence could have been proved. The dropping of this case should be seen as a turning point. Workers will no longer be glibly blamed for the inadequacies of a poorly staffed and badly equipped hospital. The withdrawal by the TPA should be seen as a victory for NEHAWU and all health workers who have fought to improve working conditions in state and privatised hospitals in this country.

*Glenda Gray is a member of SAHSSO.*

# NEXT EDITION

**South African society is currently undergoing a major geographical transformation. Millions of people are moving into a variety of new urban environments, including squatter settlements, backyard shacks, inner city areas and densely populated homeland sprawls. The government is falling well short of providing the basic housing, sanitary, water, and health requirements of the growing urban population. Patterns of disease are changing. The incidence of TB is increasing and outbreaks of typhoid are making the headlines. Ill-health resulting from violence, trauma and substance abuse is more common than before.**

* What health priorities must be met in reconstructing and developing our society?
* Have any of the political parties developed coherent policies to meet the health needs of our growing urban population?
* What are the views of the new squatter communities themselves with regard to their health needs?
* To what degree is the state responsible for providing the necessary health services for urban communities?
* What is the role of local government in health and development and how must we transform inappropriate local structures?
* Do NGOs have a role to play in large urban environments, or are they more suited to working with smaller, well defined communities?
* What are the dangers associated with loans for development from the World Bank?
* What can we learn from other rapidly urbanising societies such as Mexico and Brazil?

**In the next edition, we will explore the changing urban reality and the challenges this poses for the health sector.**

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