

Child health: HIV/AIDS

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Section 27 of the Constitution of South Africa guarantees everyone's right to have access to health care services.

In addition, Section 28 (1) (c) gives children "the right to basic nutrition ... basic health care services ...".

The United Nations Convention on the Rights of the Child says that State Parties should recognise "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" (Article 24).

THE LEADING CAUSES OF DEATHS AMONG CHILDREN UNDER-FIVE YEARS OF AGE IN SOUTH AFRICA

The South African Medical Research Council's National Burden of Disease Study found that the leading causes of death for children under-five years of age for the year 2000 was due to HIV/AIDS, diarrhoeal disease, lower respiratory infection and low birth weight (Bradshaw, Nannan, Laubscher, Groenewald, Joubert, Norman, Pieterse & Schneider 2004). The latter three causes of deaths fall in a category commonly referred to as diseases of poverty. These conditions are directly attributable to poor living conditions and account for nearly 30% of all under-five child deaths (Bradshaw, Bourne & Nannan 2003).

Injury-related causes of death feature more prominently as a

leading cause for older children (Bradshaw, Bourne & Nannan 2003). Statistics South Africa's latest mortality report (2006) shows an increase in the number of reported deaths, as well as changing patterns of natural versus non-natural (injuries) causes of death. The level of non-natural causes of death decreased from 17.0% of all deaths in 1997 to 11.1% in 2001 (Statistics South Africa 2006).

Vital interventions such as prevention of mother-to-child transmission and antiretroviral (ARV) treatment for children; neonatal care as well as comprehensive primary health care and poverty reduction initiatives are required to enhance child survival prospects in South Africa. (For more details about this indicator refer to page 85.)

TABLE 13: The proportion of leading causes of deaths among children under-five years of age in South Africa in 2000

| Province | HIV/AIDS | | Diarrhoeal diseases | | Lower respiratory infections | | Low birth weight | |
|----------------------|-----------|----------|---------------------|----------|------------------------------|----------|------------------|----------|
| | % Male | % Female | % Male | % Female | % Male | % Female | % Male | % Female |
| Eastern Cape | 27 | 30 | 15 | 17 | 7 | 7 | 5 | 6 |
| Free State | 40 | 43 | 11 | 10 | 8 | 8 | 7 | 7 |
| Gauteng | 46 | 49 | 5 | 6 | 5 | 5 | 5 | 5 |
| KwaZulu-Natal | 49 | 52 | 10 | 10 | 6 | 5 | 5 | 4 |
| Limpopo | 37 | 40 | 16 | 15 | 6 | 5 | 7 | 6 |
| Mpumalanga | 47 | 50 | 11 | 11 | 6 | 6 | 7 | 4 |
| Northern Cape | 25 | 28 | 17 | 15 | 5 | 8 | 10 | 9 |
| North West | 40 | 43 | 11 | 13 | 8 | 9 | 7 | 6 |
| Western Cape | 20 | 23 | 10 | 11 | 7 | 6 | 11 | 6 |
| South Africa* | 40 | | 10 | | 6 | | 11 | |

* The national estimates do not correspond exactly with the provincial estimates.

Source: Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojlana B, Norman R, Pieterse D & Schneider M (2004) *South African National Burden of Disease Study 2000 – Estimates of Provincial Mortality*. Cape Town: South African Medical Research Council, Burden of Disease Unit.

SOURCES

- Actuarial Society of South Africa (2005) *ASSA2003 AIDS and Demographic Model*. Available: www.assa.org.za.
- Bradshaw D, Groenewald P, Laubscher R, Nannan, Nojlana B, Norman R, Pieterse D & Schneider M (2004) Initial estimates from the South African National Burden of Disease Study, 2000. *MRC Policy Brief 1 of 2004*. Cape Town: South African Medical Research Council.
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- The Constitution of the Republic of South Africa. Act 108 of 1996*.
- Office of the High Commissioner for Human Rights (1989) *Convention on the Rights of the Child, United Nations General Assembly Resolution 44/25*. Geneva: United Nations.
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THE HIV-PREVALENCE RATE AMONG CHILDREN IN SOUTH AFRICA

The HIV-prevalence rate refers to the proportion of children, at a given period, who have HIV infection. South Africa is currently experiencing an overwhelming HIV pandemic. Many children are infected with HIV or have become ill and died due to AIDS. The majority of children are infected before and during the birth process, and during breast-feeding. Children may also become infected through being sexually abused by an HIV-positive person or through sexual intercourse. It is of critical importance to know the number of children that are infected with HIV.

The estimates from the ASSA2003 model suggest an overall prevalence of 1.2% in 2000 has almost doubled to 2.1% in 2006 for children under the age of 18 years. The prevalence rates differ across age groups and it is clear that the younger children in the 0 – 5-year age group are most at risk of infection. The rate in the 0 – 5-year olds is 1.8 times more (almost double) than the overall rate for all children (0 – 17 years).

The HIV-prevalence rate in the 0 – 5-year age group increased from 2.2% in 2000 to 3.6% in 2006. For children in the 6 – 12-year age group, the prevalence increased from 0.1% to 1.0% during the same time period. The prevalence rate for the 13 – 17-year age group stayed almost the same for this period – 1.0% in 2000 and 1.1% in 2006. Based on the demographic statistics of 2005, approximately 215,000 children under the age of five years and close to 55,000 children between the ages of six and 12 years are currently living with HIV infection. In total the model estimates that approximately 360,000 children are living with HIV infection.

HIV-prevalence rates across provinces differ quite substantially, with KwaZulu-Natal having the highest rates. The lowest prevalence is in the Western Cape in the 0 – 5-year age group, which is an indication of a well-functioning prevention of mother-to-child transmission programme in the province. (For more details about this indicator refer to page 85.)

TABLE 14: The HIV-prevalence rate among children in South Africa from 2000 to 2006

| Province | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---------------------|------------|------------|------------|------------|------------|------------|------------|
| | % | % | % | % | % | % | % |
| Eastern Cape | 1.0 | 1.2 | 1.4 | 1.6 | 1.7 | 1.9 | 2.0 |
| Free State | 1.5 | 1.7 | 2.0 | 2.2 | 2.3 | 2.5 | 2.6 |
| Gauteng | 1.4 | 1.7 | 1.9 | 2.1 | 2.2 | 2.4 | 2.5 |
| KwaZulu-Natal | 2.1 | 2.4 | 2.6 | 2.8 | 3.0 | 3.1 | 3.2 |
| Limpopo | 0.8 | 0.9 | 1.1 | 1.2 | 1.3 | 1.3 | 1.4 |
| Mpumalanga | 1.8 | 2.0 | 2.2 | 2.4 | 2.5 | 2.6 | 2.6 |
| Northern Cape | 0.5 | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 | 1.1 |
| North West | 1.3 | 1.5 | 1.7 | 1.9 | 2.0 | 2.1 | 2.2 |
| Western Cape | 0.4 | 0.4 | 0.5 | 0.6 | 0.7 | 0.7 | 0.8 |
| South Africa | 1.2 | 1.5 | 1.6 | 1.8 | 1.9 | 2.0 | 2.1 |

Source: Actuarial Society of South Africa (2005) ASSA2003 Aids and Demographic Model. Available: www.assa.org.za.

THE PROPORTION OF CHILDREN STARTING ANTIRETROVIRAL THERAPY (ART) IN SOUTH AFRICA

The HIV pandemic is the most serious infectious disease affecting children in South Africa and many children are themselves infected. Infected children need antiretroviral medication to delay the onset of AIDS. This indicator shows how many children who should be accessing ART do in fact receive the treatment.

While the ART programme has been in place for three years, the roll-out began much later in some provinces than in others. The modelled estimates indicate that the ART roll-out has escalated remarkably after 2003, as the estimates for the proportion of new children who received ART in 2004 and 2005 were 23% and 30% respectively. This estimate stood at only 8% in 2003.

There are also wide provincial variations in this indicator, with the estimates indicating that 61% of new cases of children requiring treatment in the Western Cape are getting it. This province is

followed by Gauteng and the Northern Cape, who are estimated to be providing ART to 39% of new cases of children in need of it. The government's *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment* and the escalation in ART provision from 2003 are commendable, though much hard work is still required to get treatment to all the children who need it.

Children, unlike adults, do not have a long window period for progressing from HIV-infection to AIDS, and most children who are unable to access treatment die before their second birthday. Therefore, the roll-out rate for children should be much higher than for adults. The ASSA model suggests that the current roll-out rate is similar for children and adults. Monitoring the extent to which children are prioritised in the ARV roll-out is a critical child rights issue. (For more details about this indicator refer to page 85.)

TABLE 15: The proportion of children starting antiretroviral therapy in South Africa from 2000 to 2005

| Province | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---------------------|----------|----------|----------|----------|-----------|-----------|
| | % | % | % | % | % | % |
| Eastern Cape | 1 | 2 | 4 | 4 | 22 | 27 |
| Free State | 2 | 5 | 7 | 8 | 17 | 25 |
| Gauteng | 3 | 5 | 8 | 9 | 28 | 39 |
| KwaZulu-Natal | 2 | 3 | 4 | 5 | 19 | 26 |
| Limpopo | 4 | 7 | 10 | 11 | 22 | 29 |
| Mpumalanga | 3 | 5 | 8 | 9 | 16 | 24 |
| Northern Cape | 1 | 2 | 3 | 6 | 37 | 39 |
| North West | 1 | 2 | 2 | 3 | 22 | 27 |
| Western Cape | 3 | 6 | 9 | 39 | 57 | 61 |
| South Africa | 2 | 4 | 6 | 8 | 23 | 30 |

Source: Actuarial Society of South Africa (2005) ASSA2003 Aids and Demographic Model. Available: www.assa.org.za.