MONITORING CHILD WELL-BEING

A SOUTH AFRICAN RIGHTS-BASED APPROACH

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Foreword

South Africa has a proud history when it comes to the struggle for child rights. It was young black South Africans, many of them children, who played a leading role in the country's liberation. The denial of children's rights under apartheid, and the brutal treatment of those who resisted, spawned a deep child rights consciousness in those who were to make the new state, as well as a commitment to putting children first so as to ensure their well-being and positive development. The South African Bill of Rights is unique in granting children in South Africa specific rights that are aligned with international instruments such as the United Nations Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (AC). Law reform in the interests of children has followed these developments and Save the Children has played its part in supporting these developments. As this piece is written, the first section of the new Children's Act has been approved by Parliament, and subsequent sections over which provinces have authority will now be dealt with by the House of Provinces – the nation's second legislative chamber.

All these developments are to be celebrated. However, it remains the case, as this book will show, that the majority of children in South Africa still face serious threats to their survival, health, development and participation. More than 50 per cent live in poverty, and infant mortality is reversing past gains as AIDS takes its toll. Significant numbers of children are affected by abuse and violence, and services intended to assist them are stretched beyond the limit. In spite of massive injections of funding, the education system still fails to produce good outcomes in areas such as literacy and mathematics – both key areas for child and national development.

It is not sufficient for children's rights to be legislated. We need to know how well the country is doing in meeting its obligations to children. That requires indicators and a system for monitoring the situation of children that is rigorous, rights oriented and evidence-based.

Both the CRC and the AC require countries to report in this regard but, more important than international surveillance, the country needs to monitor its progress in regard to the well-being and development of children. Indeed, this has been a major focus of the South African government's call for improved monitoring of both the situation of children and of service delivery.

This volume is dedicated to supporting that process. It provides a framework for monitoring the situation of children, the quality of the environments in which they live and grow, as well as their access to services and their quality.

Save the Children has supported the research and publication of this volume in partnership with the Child, Youth, Family and Social Development Research Programme of the Human Sciences Research Council of South Africa. It has been a long road over several years, with contributions from scholars, government stakeholders and many others. The system designed and presented here is unique

in going beyond monitoring child status or outcome. It is designed to monitor the performance of duty-bearers as well – a crucial component of a monitoring system that seeks to bring about change in children's lives and development. This is a reference work. Unlike other multi-authored collections, the editors have ensured that the chapters are all aligned to the indicator framework presented in Chapter 2, making for a coherent system across all the domains covered in this comprehensive volume.

Eva Carhall
Regional Representative, Southern Africa Regional Office,
Save the Children Sweden

Preface

Background

Perhaps the first question to ask of a book of this nature is, why do it? The answer is simply that if we want to know how our children are doing and the extent to which our policies and interventions are making a difference to their well-being and outcomes, we need a conceptually grounded and evidence-based approach. South Africa has never had a consistent and comprehensive approach to monitoring the situation of children.

The primary objective of the volume is to fill this gap. We set out with our many collaborators (see Acknowledgements) to develop a conceptual framework and recommendations for a comprehensive set of indicators for monitoring the well-being of children (including adolescents)[1] and to contribute to the development of reliable indicator data at all levels of government.

Our approach is of course not the final word. Indeed, other conceptual frameworks exist from which we can learn and which can be compared with what we have developed here. The indicators we recommend are not fixed. Indicator systems are dynamic – they must respond to change in the policy and research environments as well as in society at large.

Policy-making is an ideological business. People in government who develop policies and programmes are guided by the political ideologies of the day, whether these be neo-liberal, social democrat or socialist. The same applies of course when it comes to making law and policy for children and families.

The United Nations Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) is an unashamedly ideological instrument that seeks to change the way in which the world conceptualises childhood and the manner in which State Parties to the Convention provide for the survival, health, social security, protection and development of children. The very act of fixing the end of childhood at 18 years in the CRC and the South African Constitution is an ideological rather than a technical move. The many changes to law and policy for children in South Africa since the end of apartheid are the product of the strong child rights ideology that took root in the period following the Soweto youth uprising of 30 years ago. These changes were consolidated in the development of a National Programme of Action for children in the mid-1990s, the ratification of the CRC, and the inclusion of specific children's rights in the Constitution. Most recently, the Children's Act (No. 38 of 2005) and the associated Children's Amendment Bill (No. 19 of 2006), and the Child Justice Bill (No. 49 of 2002), are examples of a legislative programme that foregrounds children's rights and a particular ideology of childhood – an ideology that carries with it an image of what childhood should be like as well as provisions for the reciprocal obligations of the state in making this childhood possible (see chapters 1 and 2 in this volume).

During the apartheid era, policies for children and conceptions of childhood were grounded in racist ideology. Notoriously, black children were considered to need far less support for development than white children – mainly because their capacities were regarded as inferior – hence the provision of inferior and separate education for black children.

The post-apartheid constitutional order ensures the rights of all children to the same dignity and equality within a single approach to childhood. Enormous strides have been taken by government to improve children's situation.

This volume takes its ideological cue from the child rights ideology that is rooted in the South African Constitution, the CRC and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3 in this volume). In taking a rights-based approach we make clear that it is not just the status of children (or child outcomes) that is important to measure, but also the contexts within which children grow and develop. For it is only through looking carefully at how these contexts shape child outcomes that we learn where intervention is needed (where and how action should be taken). A key element of that context is the policy environment. As will be seen, the indicators developed for all the domains covered in the volume include both the policy environment and children's developmental contexts.

The timing of this initiative is important. We are a new democracy in rapid social and economic transition with many challenges for children and those who care for them – particularly in the spheres of education, poverty and the HIV/AIDS epidemic. These conditions will have a major impact on family and community well-being, and the ability of these structures to provide the basic conditions for child survival and the promotion of positive child outcomes. Under such conditions, data to inform targeted service and programme provision will become increasingly important.

At the same time, the new political order has the potential to present far more developmental opportunities for children as systems of delivery are strengthened and developments in health, education and social services proceed.

It is therefore equally important to monitor whether these initiatives are reaching children and households and the extent to which the situation is improving as desired in policy goals.

Finally, Cabinet has charged all levels of government with monitoring policy and delivery. In our view, the monitoring system must ensure that the state and its officers are held accountable for responsibilities as duty-bearers in regard to the legislative and policy environment they have constructed for children.

In this regard, we require indicators and an approach to monitoring the situation of children that can ascertain whether initiatives of the state are:

- Effective – they have the outcomes intended, promote children's rights in line with the Constitution and other relevant instruments, and are doing more good than harm;
- Efficient – are using limited public resources to best effect; and
- Service orientated – to meet citizens' needs and expectations for children's well-being and development.

This volume seeks to contribute to such a venture.

The story behind the book

It has been a long and complex, but most rewarding journey. The idea for the project took root a number of years back in the editors' concerns about the availability and quality of data on children in South Africa, as well as its relevance to our ability to monitor the situation of children and the state's response to the predicament of children. These concerns were shared by several colleagues with whom many discussions were held. Among them, the more prominent were Linda Richter of the Human Sciences Research Council (HSRC), Theresa Guthrie (formerly with the Children's Institute and the University of Cape Town), Marian Jacobs (also formerly at the Institute and now Dean of Health Sciences at that university), and Rose September (based at the University of the Western Cape). An initial scan of the data environment provided by Guthrie was presented at a meeting held in Cape Town in early 2003. Further work on available data sets was carried out by Rachel Bray (2002). Bray notes that there are missing links in existing data and methods. Her points remain germane. For example, she states:

> we have no national survey data on the health status of children aged 6–14 years. Consequently there is a significant gap in knowledge about the risk factors to health faced in middle childhood associated with economic poverty, living conditions or social stability. There are no national data on the health and safety of certain groups of children known to be particularly vulnerable such as homeless street children and children living in institutions. One reason for this is that national household surveys exclude homeless and institutionalised children because they do not belong to 'households' as defined in the survey design. (2002, p. 24)

She notes further that the 'consequences of these gaps are severe limitations on our ability to analyse relationships between children's social and physical environment, and outcomes in terms of short and long-term well-being' (2002, p. 48).

Furthermore, household surveys do not take sufficient account of the need to establish the way income is spent and the extent to which children benefit.

One of the reasons we have limited data for understanding children's lives is that they have largely been excluded from the research process. South Africa lags behind many other areas of the world in terms of including children in research. Thus, children themselves need to be included as participants in surveys. It is most commonly the practice for adults to respond on behalf of children (in part because of ethical considerations), and it is well known that the accounts of children and adults often differ – particularly in sensitive areas such as sexuality. Importantly, Bray cautions that:

> the extent to which children are able to engage with the topics under research is constrained firstly by the logistical demands of very large surveys and secondly by the use of methods that do not allow children to define problems as they see them. (2002, p. 49)

Richter reinforces a number of Bray's points, noting that:

> it is clear that there are a large number of indicators of children's health, development and well-being that we, in South Africa, do not yet have any

> mechanisms to measure, especially more qualitative or subjective indicators generally associated with children's well-being. (2002, p. 2)

She goes on to cite the National Programme of Action's *End of Decade Report on Children*:

> Continued data collection and research on children is a vital initiative. Little reliable data is available from the past and South Africa is committed to creating and monitoring relevant data and information on children. (2002, p. 17)

At the outset of this project, it was quite clear to us that the data environment of relevance to child policy was very limited (although improving all the time), and that conceptual, technical and methodological work was required to improve the state of research policy and programme-related data on South African children.

During our process, contact was made with members of national government (including the Office on the Rights of the Child) and provincial government, particularly the Office of the Premier in Gauteng, and the Department of Social Services and Poverty Alleviation in the Western Cape. These engagements increased our understanding of the priorities of government and the administrative data environment.

Studies conducted on behalf of the Gauteng premier (Dawes, 2003) and the Western Cape government (Dawes, Biersteker et al., 2006; Dawes, Willenberg et al., 2006) were invaluable in shaping our model and familiarising us with administrative data systems. They also assisted us to become more familiar with how government works. Coming from academia, we still have much to learn, but we were able to begin to build the bridge that is necessary in this work between the research and policy communities.

Our encounters with the administrative data environment were sobering indeed, forcing us to become more realistic as to what we imagined could be achieved using administrative data sources. Although there was a lot of promise and efforts under way to improve the situation, problems with information systems, as well as data accessibility, collection and quality, were all very evident.

Interactions with university colleagues both in South Africa and abroad, as well as engagements with local and international non-governmental organisations such as the United Nations Children's Fund (UNICEF) – in South Africa, East Africa and New York – and Save the Children Sweden, all contributed to the project as it unfolded over the past three years.

A project of this nature costs money. We were most fortunate that Linda Richter, Executive Director of the Child, Youth, Family and Social Development Research Programme, supported the project and the allocation of seed funding from the HSRC parliamentary grant to get the project off the ground and cover a range of networking and other development costs. This is a most appropriate use of the grant – the production of social science research in the public interest. Save the Children Sweden provided the funding (sourced from the Swedish International Development Cooperation Agency) required to commission the research to bring the project to completion and publication. Save the Children Sweden is an inspirational world leader in the child rights field. Dialogue with these colleagues was deeply informative and influential.

The development of the volume

As will be evident from the introductory chapters, the volume does not purport to be the definitive text for monitoring *children's rights* in South Africa. That would be a task for child rights lawyers and related specialists, which we are not. Rather, it is well-being that is the primary focus, and the volume presents a *rights-based approach* to monitoring child *well-being*. Where the rights base enters the picture is when indicators are developed to monitor government's delivery of services to which children have a right and which are required to promote their well-being and development.

The volume differs from the usual format of an edited collection. All the domains for which indicators were developed (and hence the chapters) followed an identical approach, as outlined in the conceptual framework developed for the purpose (see below and Chapter 2). The indicators in all the chapters use the same indicator types and, where appropriate, the same indicators are incorporated across domains. For example, the same measures of poverty, adult literacy and disability incorporated in the Early Childhood Development (ECD) and home-care domain are included in other contributions.

The first step in our process was to develop the conceptual chapters (chapters 1 and 2).

Next, experts were commissioned to provide contributions that drew on this conceptual base to ensure a common structure. Each was to be informed by the conceptual framework and to cover all five indicator types (see below) where possible. Authors were requested to provide a concrete and practical proposal for the most conceptually sound, practical and cost-efficient way to measure and monitor the indicators for a specific domain. A brief policy and rights review and an evidence-based rationale for the indicators and measures included were required for each chapter, and local reliable and accessible data sources were to be cited as far as possible. This was a very challenging task which, for many domains, could not be achieved due to the state of the data environment.

Authors were required to provide two indicator sets: core and additional (in some instances only a core set was appropriate). The core set for each chapter captures priorities that must be measured, and for which at least some data should be available from administrative sources. The additional set includes less high-priority indicators, for which data are more difficult to obtain. Authors were also asked to supply comment on data availability and quality as well as recommendations for improvements.

Once the chapters were submitted, each was subjected to peer review and then revised in light of the reviewers' comments.

It is a bad idea to develop indicators in a vacuum. The next step of the project involved sharing indicators in each domain with colleagues in the policy environment through a series of intensive round-table meetings specific to each domain (for example child education). The author, the reviewer of the chapter, policy-makers and the editors participated. The proceedings were summarised and provided to the author for further revisions as needed.

Once the revisions were complete and the editors were sure that the child well-being aspects of the volume had been rigorously reviewed, each contribution was scrutinised by child rights legal experts. They provided comment on the extent to which the chapters were informed by the appropriate legal and children's rights. This was an interesting process which revealed the considerable differences in approach used by the child rights community and those who study children's outcomes and situations, be they psychiatrists, economists or paediatricians. On rare occasions we found a blend of expertise. Where necessary, the chapters were revised a third time to incorporate these comments.

Finally, the entire volume was subject to review (see Acknowledgements) by international experts and final tweaks to content were undertaken.

As we were wont to say, this is the most reviewed volume on the planet! Despite the effort and seemingly endless circle of reviews, all the commentaries were of considerable value in strengthening the final outcome.

We believe that this contribution has been subject to sufficient review and consultation to provide a starting point for a rights-based approach to monitoring the situation of South African children and their well-being.

The structure of the volume

The volume is divided into two parts. Part 1 offers rationales for indicator development, and Part 2 provides the indicators themselves. Part 1 comprises four sections. Chapters 1 and 2 of Section I provide the conceptual underpinnings of the volume. In Chapter 3, the authors review different approaches to child poverty measurement and comment on their relative merits. The chapter argues for the use of a multidimensional, child-centred approach that incorporates both absolute and relative poverty components, as well as measures of multiple deprivations for children (rather than simply income poverty). This model has subsequently informed small-area indices of multiple deprivation for children in South Africa.

A number of contributions to the volume point to poverty as a major risk to child well-being and outcomes. This is particularly evident in the context of child health, injury, ECD, education, and in the child protection section of the volume. In these instances a generic poverty indicator has been included. The indicator does not take into account multiple deprivations as described in Chapter 3. This is because provinces currently use a variety of approaches and we wished to leave the definition open.

All children live in households that are situated in some form of community, be that an urban neighbourhood, an informal settlement, or a village. Families and children are affected by the nature of the human environment that surrounds them. The influence of the family is displaced to an extent by other sources as children grow up and occupy other social spaces and institutions, such as schools. Older children, particularly adolescents, spend increasing amounts of time outside the home environment, and in their neighbourhoods. While neighbourhoods may have many positive features for child development, some create risks for children. Chapter 4 explores these issues and draws on international literature to examine the role of the neighbourhood quality in either supporting or undermining children's development.

It draws on the sociological literature relating to community structure and transition as well as on the psychological research on neighbourhood effects on children's development at different points in the lifespan. The evidence is clear that interventions to support vulnerable families in high-risk areas to improve child protection and promote positive outcomes are gaining recognition. Indicators for monitoring the key positive and negative neighbourhood level factors are most useful for providing information on areas that require particular targeting for intervention, including the availability of services to support family and child well-being and development.

In subsequent sections of the volume, domains are grouped in terms of their complementarity. They were chosen because they include issues of key concern for children in South Africa, and because they are all required for monitoring purposes by the UN Committee on the Rights of the Child, the AC, and UNICEF's State of the World's Children reports. The sections reflect rights domains of survival, health, development and protection, and the indicator domains are those commonly deployed internationally (see chapters 1 and 2).

Section II (Child survival and health domain) includes chapters on child health, child mental health, and children's exposure to injury and violence.

Section III (Education and development domain) includes ECD and the home and institutional settings (ECD facilities) that support children's development. Also included in this group are education, specific difficulties of learning and children with disabilities. The cluster provides indicators for monitoring children's capacities and abilities starting in early childhood, and taking into account the particular difficulties of those children whose development is challenged by disability. The section also explores the key issues of monitoring access and quality of services to children from ECD facilities (Chapter 9) through schooling (Chapter 8) and including learning and other supports for children with special education needs (chapters 10 and 11). This group is particularly important to track given the neglect of children with disabilities.

Section IV of the volume provides indicators for the child protection domain. As is well known, appallingly high numbers of children in South Africa are exposed to violence and abuse, and significant numbers enter the justice system. Here we draw on the approach of UNICEF in clustering categories of very vulnerable children together – those who are abused and neglected (Chapter 14), working children and those subject to commercial sexual exploitation (Chapter 13), children living on the streets (Chapter 12), and those in trouble with the law (Chapter 16). Apart from those in the judicial and correctional systems, those subject to abuse, neglect and exploitation require particular support and services. Many will require the intervention of the state. Chapter 15 provides a comprehensive approach to monitoring children in statutory care. The statutory care indicators are designed both to track the numbers of children involved, and the quality of services and care they receive. This section of the volume draws strongly on the Child Justice and the Children's Act (No. 38 of 2005), and the associated Children's Amendment Bill (No. 19 of 2006) to inform indicators for monitoring the performance of duty-bearers.

The HIV epidemic is increasing child mortality in South Africa (see Chapter 5). Monitoring this indicator provides important information of the extent to which the

country is managing the epidemic and the extent of its ability to meet the needs of infected children.

We deliberated long and hard about including a chapter on this topic. We did not want to separate out children affected by HIV/AIDS from the many other very vulnerable children. With this in mind, indicators relevant to children affected by AIDS are included in virtually every chapter.

Notwithstanding this point, many thousands of children are infected or otherwise affected by the epidemic (through living with sick carers or through orphanhood). We recognise the need for good indicators developed specifically for children made vulnerable by AIDS, given the nature of the illness and its associated consequences for households and children. In order to address this issue, we have included a discussion of this topic in the Chapter 17. This is in accordance with the UNICEF approach to child protection, which includes children affected by the pandemic.

The indicators are located in Part II, and should not be seen as locked into a particular domain; they can be lifted out and used as appropriate. For example, child mortality is a health indicator. However, it is strongly associated with poverty, and also with the availability of preventive services to young children.

We turn now to an illustration of how the indicator system works. The next section provides a route map to the system.

How it works: our approach to indicator development

Our approach to indicator development is represented in Figure 2.1 in Chapter 2. The indicators draw on evidence as to what children need to survive, be healthy and protected; to develop their potential; to be economically secure; and to participate in society.

The model is rights-based, drawing on international and national legal provisions and policies. It contains five distinct types of indicators (discussed further in Chapter 2) that take into account the need to measure child outcomes as well as the contexts that support or challenge children's development, and the provisions for children through law, policy and, ultimately, services.

Type 1: Child status indicators

These measure the status of the child. Examples include child mortality, reading ability, immunisation status, and whether the child has been a victim of abuse.

Type 2: Family and household environment indicators

These measure the structure and quality of the child's primary home-care setting. Examples include children's access to services such as electric light, sanitation and potable water; and the economic and health status of the caregivers (for example TB or HIV infection). Structural variables could include whether the household is headed by a child, and whether the children are cared for by an elderly person or a single mother. They include risks of injury such as paraffin stoves.

Type 3: Neighbourhood and surrounding environment indicators

These measure specific geographical spaces such as neighbourhoods, enumerator areas, and so on. They are the spaces outside the home where children grow up. They include services such as clinics and playgrounds, as well as roads. They include people who can support children and others who put them at risk (criminal elements). This indicator set permits small-area indices of child risk and well-being to be constructed in order to provide information for policy targeting.

Type 4: Service access indicators

These describe children's access to child protective services.

Type 5: Service quality indicators

These measure service inputs. They measure the provisioning (for example, the supply of money) for the services, and could include whether the care of children in residential settings for children is up to standard in terms of the regulations. As is evident from Figure 2.1, the indicators are informed by rights that are granted to South African children that draw on three bodies of law. The first includes international instruments ratified by the country (for example the CRC), the second is the South African Constitution, and the third includes Acts and regulations that speak to the situation of children. Indicators are also informed by bodies of research evidence and, finally, by the specific policies and programmes of the sector for which indicators are developed. The most important piece of legislation affecting children is the Children's Act and the associated Children's Amendment Bill, which should come into effect in 2008. Until that time the Child Care Act (74 of 1983) remains in force.

It will be evident that there is considerable unevenness in the number of indicators provided in each table of recommended indicators. There is also variation in the level of detail provided as regards indicator definitions, measures and data sources. This is due to differences in the complexity of the issue to be measured as well as the availability of data. A third reason is that some chapters (particularly in the child protection section) have to provide for indicators in several policy sectors (for example health and social development).

All the indicators provided in this volume should be seen as recommendations. Stakeholders should populate the tables provided in Part 2 with different indicators where appropriate.

In order to assist distribution of the indicators to policy-makers and members of civil society, short core indicator sets have been created for those described in chapters 4 to 17 of the volume. These documents contain a brief explanation of the indicator framework and the core indicator table for each area. The core indicator sets can be downloaded from the Human Sciences Research Council Publisher's website.[2]

Notes

1 Throughout this volume, 'child' and 'children' refer to all persons who are under 18 years of age.

2 See <www.hsrcpress.ac.za>.

Acknowledgements

The editors are most grateful to Save the Children Sweden for their support, without which completion of this project would not have been possible. Save the Children has made enormous contributions to the promotion of children's rights throughout the world. We hope this volume will also advance that agenda. In particular the editors wish to acknowledge the support of Anna Schnell and Trine Naeraa-Nicolajsen of the Southern African Regional Office of Save the Children Sweden for walking this road with us.

Funds from the parliamentary grant to the HSRC were used to support this project from its inception. We believe this to have been good use of resources that are intended to fund social science that makes a difference to all who live in South Africa. Professor Linda Richter, Executive Director of the Child, Youth, Family and Social Development Research Programme of the HSRC, believed in this project and gave us her full support.

The editors would like to thank Lameez Alexander for her invaluable assistance in editing this volume. We would not have managed without her thorough and precise inputs, for which we are very grateful. We would also like to thank René Brandt for her editorial assistance, her thoughtful feedback on all chapters and her support during the finalisation of the volume.

Every chapter of this volume was reviewed by external experts. We extend our thanks to all who participated in this process. Every chapter was also subject to review by child rights experts. The editors are grateful to Paula Proudlock and Mira Dutshcke at the University of Cape Town's Children's Institute who assisted in this task. We would also like to thank representatives from government departments, non-governmental organisations and academic institutions for their involvement and very useful feedback in expert round-table consultations on the technical aspects of indicator development. Finally, initial drafts were scrutinised by Professor John Bradshaw of York University in England. He introduced us to his own work on the well-being of children in the UK and the European Union. It has been invaluable to us. The entire volume was reviewed by Professor John Pinkerton, head of the School of Sociology, Social Policy and Social Work at the Queens University, Belfast, Northern Ireland. He also provided valuable suggestions at various points in the closing stages of the work.

Many thanks to John Daniel, Garry Rosenberg, Mary Ralphs, Utando Baduza and Karen Bruns for the advice and support they provided in the process of developing and publishing this book.

Finally, this volume is the product of the collective effort of a group of scholars whose academic work is driven by a commitment to excellence and a desire to contribute to the well-being of children through rigorous research. Thanks to all of you for your contributions, and for bearing with us through the long process of review and revision.

Acronyms and abbreviations

AC	African Charter on the Rights and Welfare of the Child
ADHD	attention deficit hyperactivity disorder
AFP	acute flaccid paralysis
AU	African Union
BCEA	Basic Conditions of Employment Act
CAPFSA	Child Accident Prevention Foundation of South Africa
CBCL	child behaviour checklist
CBD	central business district
CCA	Child Care Act
CCSE	child commercial sexual exploitation
CDG	Care Dependency Grant
CEDC	children in exceptionally difficult circumstances
CGAS	Children's Global Assessment Scale
CGE	Commission on Gender Equality
CHAOS	Confusion, Hubbub and Order Scale
CHILD	Child Health Indicators of Life and Development
CIS	Canadian Incidence Study
CJB	Child Justice Bill
CLAP	Child Labour Action Programme
CPA	Criminal Procedure Act
CPR	Child Protection Register
CRC	UN Convention on the Rights of the Child
CRS	Census Replacement Survey
CSA	Correctional Services Act
CSG	Child Support Grant
DAP	developmentally appropriate practice
DBD	disruptive behaviour disorders
DISC	Diagnostic Interview Schedule for Children
DoE	Department of Education

DoH	Department of Health
DoL	Department of Labour
DoSD	Department of Social Development
DoT	Department of Transport
DQA	Developmental Quality Assurance
DSM	Diagnostic and Statistical Manual
DTP	diphtheria, tetanus and pertussis
ECCD	Early Childhood Care and Development
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECERS	Early Childhood Environmental Rating Scale
EDS	essential data set
EFA	Education for All
EMIS	Education Management Information System
EU	European Union
GDP	gross domestic product
GHS	General Household Survey
HSRC	Human Sciences Research Council
ICD	Independent Complaints Directorate
ICF	International Classification of Functioning, Disability and Health
IDASA	Institute for Democracy in South Africa
IDD	iodine deficiency disorders
IDP	Integrated Development Plan
ILO	International Labour Organisation
IMC	Inter-Ministerial Committee on Young People at Risk
IMCI	integrated management of childhood illness
IMR	infant mortality rate
INDS	Integrated National Disability Strategy
INP	Integrated Nutrition Programme
IPV	independent prison visiting
IRI	informal reading inventory
ISPs	internet service providers
KTS	Kampala Trauma Score

LBS	Leisure Boredom Scale
LBW	low birth weight
LSEN	learners with special educational needs
MDG	Millennium Development Goal
ME	monitoring and evaluation
MRC	Medical Research Council
MTCT	mother-to-child transmission
MTG	Monitoring Task Group
MUD	moral underclass discourse
NCRC	National Children's Rights Committee
NEPAD	New Partnership for Africa's Development
NFCS	National Food Consumption Survey
NGO	non-governmental organisation
NIMSS	National Injury Mortality Surveillance System
NPA	National Programme of Action
NPASC	NPA Steering Committee
OBE	outcomes-based education
OECD	Organisation for Economic Cooperation and Development
OIJ	Office of the Inspecting Judge
OPCAT	Optional Protocol to the Convention Against Torture
ORC	Office on the Rights of the Child
ORS	oral rehydration solution
OVCs	orphans and vulnerable children
PERSAL	Personnel Administration System (the Personnel Salary System)
PHC	Primary Health Care
PIMD	Provincial Indices of Multiple Deprivation
PMTCT	prevention of mother-to-child transmission
PNMR	perinatal mortality rate
PPIP	Perinatal Problem Identification Programme
QLP	Quality Learning Project
RDP	Reconstruction and Development Programme
RED	redistributive discourse
RTIs	road traffic injuries

SACMEQ	Southern and Eastern African Consortium for Monitoring Education Quality
SADHS	South African Demographic and Health Survey
SAHRC	South African Human Rights Commission
SALRC	South African Law Reform Commission
SAPS	South African Police Services
SASAS	South African Social Attitudes Survey
SAVACG	South African Vitamin A Consultative Group
SAYP	Survey of Activities of Young People
SDLs	specific difficulties of learning
SID	Social Integrationist Discourse
SOA	Super Output Areas
SOCPEN	DoSD's Social Pension Database
START	Strive Towards Achieving Results Together
Stats SA	Statistics South Africa
TB	tuberculosis
TECL	Towards the Elimination of the Worst Forms of Child Labour
TOP	termination of pregnancy
U5MR	under-five mortality rate
UNCAT	UN Convention Against Torture
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
WFCL	Worst Forms of Child Labour
WHO	World Health Organisation
WMISSD	Welfare Management Information Systems Subdirectorate

PART I

Rationales for indicator development

SECTION I

Concepts and contexts

CHAPTER 1

Monitoring the well-being of children: historical and conceptual foundations

Rachel Bray and Andrew Dawes

Introduction

Since the 1980s, systems for monitoring the situation of children have emerged in countries with very different economic and political profiles. The United Nations Convention on the Rights of the Child (CRC – see Appendix 1 in this volume), adopted in 1989, provided a major stimulus. Rights-based monitoring inspired by the CRC has been pioneered in a number of developing countries through partnerships between state actors and international agencies (particularly the United Nations Children's Fund [UNICEF], the Save the Children Alliance, and Childwatch International). The motivation behind such initiatives stems from the requirement placed on all signatory countries to the CRC to measure progress towards fulfilling children's rights and to report to the UN Committee every five years (Miljeteig, 1997). UNICEF has also played a key role and the State of the World's Children reports provide a range of internationally comparative indicators on the situation of children and the extent to which their rights are supported or violated (e.g. UNICEF, 2005c).

Other recent initiatives include monitoring for reporting on achievements in relation to the UN Millennium Development Goals and the goals of the New Programme for African Development (see Chapter 2 in this volume), as well as the development of a European Union (EU) system for monitoring children's well-being and well-becoming that draws on the CRC (Bradshaw et al., 2005).

Apart from the use of the CRC to hold governments to account on the situation of their children, at a country level, monitoring initiatives seek to provide data to influence policy development. Without good data on the well-being of children and the quality of their developmental contexts, decision-makers do not have the necessary information for policy implementation and targeted resource allocation. Monitoring enhances our understanding of the links between macroeconomic processes, poverty reduction strategies, investments in improving children's lives and the achievement of broader development and equity goals.

It is well known that investment in child health and capacities (particularly in early childhood) is an investment in the production of human capital and the future well-being of the nation as a whole (Heckman & Forum, 1999). Thus, apart from its importance in describing their current well-being, monitoring is an essential way of tracking the outcomes of our investment in children's development, pointing to areas of deficiency and success, and identifying the conditions that are associated with each.

This chapter, together with the next, lays the foundation for the volume. It has two main components. First, a brief history of attempts to establish a child well-being monitoring system for South Africa is outlined. Thereafter, the conceptual foundations that underpin child well-being and rights monitoring systems are reviewed.

Monitoring the situation of children in South Africa: from past to present

The apartheid years

The CRC was finalised in 1989, the year prior to Nelson Mandela's freedom and the beginning of open negotiations toward a democratic state. The strong push for rights-based systems for monitoring child well-being on a national level has emerged since that time.

From the 1960s onwards, grand apartheid policy fragmented South Africa into so-called (black ethnic) 'homelands' and 'independent' states, and the majority of black children were deemed to be citizens of these creations (for example, the Transkei and Ciskei). The situation and life chances of these children and those who were included in 'South Africa' were profoundly determined by their racial classification (Wilson & Ramphele, 1989).

The South African state did not provide systematic accounts of the situation of its children during these years. However, there was plenty of evidence, reported by such groups as the South African Institute of Race Relations, to show that conditions and outcomes for black children were largely abysmal (Dawes, 1985; Dawes & Donald, 1994).

It is of interest that the one time that the attention of the state was drawn to the situation of children in a major way, was when the Carnegie Inquiry into white poverty was conducted in 1928 (Louw, 1986). One of the foci of the inquiry was the health and educational circumstances of white children living in poverty. These were primarily children of Afrikaner families who had been displaced from their land by the South African War of the turn of the century, and who had become more impoverished by the Great Depression. The data collected on the status of these children showed that their well-being and development were in a precarious situation. Recommendations for huge public works programmes to reduce poverty followed, and these children were targeted for improved access to health services, schooling and school meals.

Not surprisingly the same steps were not taken for impoverished black children whose situation was likely to have been similarly challenged. Indeed, school feeding for black children was cut in the 1950s, and as late as 1984 education expenditure on black children was 14 per cent of that for white children (Wilson & Ramphele, 1989).

The second Carnegie Inquiry conducted in the mid-1980s focused on poverty dynamics and did not have a significant child component. However, referring to malnutrition, Wilson and Ramphele (1989) noted that there had been no nationally co-ordinated reports on this threat to child well-being for over 20 years – this despite many independent scholarly reports attesting to the seriousness of the problem in

black children. For example, the inquiry reported that 43 per cent of rural black children were underweight for their age in 1985. Malnutrition was never a notifiable disease during these years – therefore it was not captured by government health statistics (no doubt because it was not a white problem).

Later, during the height of the resistance to apartheid by young black South Africans, UNICEF (1987) produced a report entitled *Children on the Front Line*. This document provided some data on the health, nutrition and education of children in the context of the anti-apartheid struggle and regional destabilisation. Papers in local anti-apartheid journals such as *Critical Health* and *Psychology in Society* also contributed to a critical appraisal of the impact of apartheid and political repression on the well-being of children, but these were often commentaries rather than representative surveys of the situation.

As the apartheid era drew to a close, and building on the existing active child rights movement, the National Children's Rights Committee (NCRC) – comprising over 200 child-focused non-governmental organisations (NGOs) – was formed in 1990. Its purpose was to advocate for the rights of children and draw up co-ordinated plans for action towards fulfilling these rights. The NCRC worked with UNICEF in conducting research on the situation of children and women in South Africa. The study produced two reports in 1993: *Children and Women in South Africa: A Situational Analysis,* and *The State of South Africa's Children: An Agenda for Action*.

Despite huge gaps in the data on children's lives, these documents served as a starting point for discussion amongst governmental and NGO representatives that led in 1993 to the *Thembisa Declaration*. That document outlined nine main points for action towards improving the lives of South African children, including the need for a co-ordinated National Programme of Action (NPA) (September, 1997). To this end, the NPA Task Force was created with the primary objective of preparing a national programme of action for children to present to the first post-apartheid government by 16 June 1994 (NCRC, 1994).

The post-apartheid years and the NPA

The first post-apartheid government made a range of commitments to children. They included ratification of the CRC and a promise to draw up and implement an NPA for children, as a means of achieving both international and national goals for children's livelihoods and rights. Both the Interim and the final Constitutions of the Republic of South Africa were to include specific provisions for children's rights (Section 28) which were aligned with the CRC.

The first government structure to be set up to co-ordinate children's rights in 1995 was the NPA Steering Committee (NPASC). In 1998, the Office on the Rights of the Child (ORC) was established in the South African Presidency as the secretariat for the NPASC. Provincial programmes of action for children were also introduced. The NPASC was mandated to oversee the NPA and ensure that the concerns of children were included in broader development strategies. These bodies also co-ordinated the compilation of the first report to the Committee on the Rights of the Child. A Monitoring Task Group (MTG) was established in the NPA to assist with this process. This was not to be a permanently staffed body; rather, it was advisory.

For the first time in the country's history, a commitment to monitor the situation of children had been made and a structure put in place to ensure that this would happen. However, the promise of the time was only partially fulfilled.

During this period, the Reconstruction and Development Programme, with assistance from UNICEF, carried out a second child situation analysis, *Children, Poverty and Disparity Reduction* (UNICEF, 1995).

In their account of this report, Rama and Bah noted that:

> The RDP Office commissioned the National Institute of Economic Policy (NIEP) to undertake a second situation analysis of children in South Africa (which was published in 1996)…*The report argued that a major constraint was the lack of reliable, representative national and provincial data on children*… (2000, p. 6, emphasis ours)

Arguing for Statistics South Africa (Stats SA), the national statistics agency, to be a key support for child monitoring initiatives, Rama and Bah noted that in 2000:

> no budget exists for funding the activities of the MTG and Stats SA initiatives. So in order to deepen its involvement in the monitoring of child rights at national, provincial and other levels, Stats SA and the MTG would have to secure external funding for its activities. The establishing of a children's unit (in Stats SA) would be the way to go if Stats SA is to match the importance the Government has placed on children's issues (in its establishment of the Office on Child Rights in the President's Office). (2000, p. 12)

South Africa's first report to the UN Committee on the Rights of the Child was produced in 2001 (NPA, 2001a) with the assistance of UNICEF and Stats SA. Aiming to summarise the well-being of children across the country according to the targets set at the 1990 World Summit for Children, this publication represents 'the most comprehensive attempt to list and report on child indicators' to date (Richter, 2002, p. 1). It draws attention to many significant gaps in information owing to an absence of data in many areas (for example child mental health, child abuse and neglect and the health status of 6–14-year-old children [Bray, 2002]).

These gaps remain because there is no state policy (or practice) to routinely survey issues of specific importance to child development outcomes and child monitoring. Moreover, South Africa lacks both an integrated child information system and the data collection strategies necessary to supply reasonably accurate and sufficiently disaggregated data on children. The children's section of Stats SA is no longer in operation, and regular ring-fenced funding for monitoring purposes is still not available. No doubt this situation accounts in part for the constraints placed on the capacity of the NPA to gather data and produce analyses of the situation of children.

At the time of writing (November 2005), South Africa's second report to the Committee on the Rights of the Child was three years overdue. Reporting on time is a State obligation (see Chapter 2 in this volume for a discussion of child rights monitoring in relation to the CRC).

The ORC has recently undergone restructuring, and there are currently proposals under discussion for improving the oversight of children's rights. It is proposed that

a National Advisory Council on Children's Rights is established in the ORC with structures to be duplicated at provincial and local levels. The council is tasked with monitoring the performance of the NPA for children. In order to undertake this function, they will need good information both on inputs for children and their outcomes (see Chapter 2 in this volume).

In the proposed new framework, the ORC is responsible for 'monitoring and evaluating children's rights delivery in government' (at all levels) (ORC, 2005, p. 18). The document refers to 'Technical Teams' that inter alia 'provide technical support to the ORC and the National Advisory Council' (2005, p. 18). No further detail is provided on these teams in the document.

Attempts to agree on child rights and well-being indicators for South Africa

In the mid-1990s, a group of academics and policy-makers[1] gathered in Johannesburg to discuss the establishment of a framework for monitoring child outcomes in South Africa and the necessary accompanying co-ordinating strategy (see September, 1997). The group proposed that this process should be guided by the CRC and the NPA for children, given the latter's remit to develop monitoring indicators and mechanisms for assessing performance.

The group engaged in a process of consultation, designed an NPA strategic planning and monitoring framework and spent three weeks training those who were to be tasked with implementing the monitoring system.

The system was never carried through. There is unlikely to be a single reason for its failure. The group had already anticipated significant problems, including the absence of procedures by which to measure the selected indicators, a lack of reliable information systems and electronic databases, difficulties in conceptualising different aspects of 'child well-being', the limitations of traditional outcome measures, a proliferation of goals relating to child outcomes, and limited skills in evaluation and research amongst those tasked with implementing the system (September, 1997).

It is valid to ask whether these same threats exist today and, if so, whether and how they might be overcome. While there remain considerable challenges, in part due to the dearth of child-focused researchers in the country (Richter & Dawes, in press), the climate is currently more favourable than it was ten years ago.

Since that time, we have seen an increase in research on relevant aspects of child well-being and child rights. Several separate but complementary initiatives relating to monitoring children's rights are under way, including the Government-Wide Monitoring and Evaluation process which is run out of Stats SA.[2] The University of Cape Town's Children's Institute has initiated an annual publication, *South African Child Gauge* (Jacobs et al., 2005), that tracks specific aspects of the situation of children to highlight the challenges related to the promotion and protection of their rights. The first in the series focuses on HIV/AIDS. The institute has a website, Children Count[3] – Abantwana Babalulekile – which makes this information available electronically. Colleagues at the University of the Western Cape have been engaged in participatory research with children on their rights to inform indicator development (Willenberg & Savahl, 2004).

Progress is being made around particularly difficult conceptual and practical areas, for example the definition and measurement of child poverty (e.g. Cassiem & Streak, 2001; Guthrie, 2003; Streak, 2004; see also Chapter 3 in this volume).

Several windows of opportunity for the collaborative development of a system for monitoring the situation of children have opened. Monitoring government progress has recently received the particular attention of the state. Thus in his State of the Nation address in 2004, President Mbeki stated that monitoring of the impact of government policy and programming is to be mainstreamed through all departments:

> The government is in the process of refining our system of Monitoring and Evaluation, to improve the performance of our system of governance and the quality of our outputs, providing an early warning system and a mechanism to respond speedily to problems as they arise.

In the light of the president's speech, the ORC has recently reviewed the situation of monitoring and evaluation (ME) in the children's sector. The Presidency, through Cabinet and departmental cluster systems, will be responsible for co-ordinating the overall ME framework. Although each department will develop its own ME framework, the ORC has begun a process of considering preliminary indicators and measures for child well-being that can be tracked through the system. The ORC has identified the acquisition of accurate information on children as a key factor in improving the state and well-being of South Africa's children, and is undergoing a restructuring process as outlined previously.

These moves on the part of national government bode well for a serious attempt to develop a sound monitoring system. In addition to this national thrust, provincial governments are commissioning research on the situation of children. An analysis of the situation of children in Gauteng (Dawes, 2003) enabled scoping of the extent, the gaps, the quality and the degree of co-ordination of information on children in that province. For the most part, major limitations were evident. The province has embarked on a process to improve its child outcomes monitoring capacity. In addition, the Umsobomvu Youth Fund[4] commissioned the Human Sciences Research Council to produce a report on the status of South African youth (16–35 years of age) (Emmett et al., 2004). More recently, a situation analysis of the children affected by crime and violence in the Western Cape has been undertaken (Dawes, Long et al., 2006).

In spite of recent government initiatives, at the time of writing it appeared from the absence of public documents at least, that there remains no co-ordinated process for the development of child rights and well-being indicators for monitoring children at national or provincial levels of government. It is hoped that new initiatives in the ORC will assist this process. This volume is also intended to support such an initiative.

Information on South African children is available from a number of sources (cited in Bray, 2002; Richter, 2002). Administrative child data are routinely collected by government departments at all levels. Statutory agencies such as Stats SA conduct periodic surveys that include important information on children and their family or household circumstances. They include the Census, the Labour Force Surveys, the Income and Expenditure Surveys, and the General Household Surveys (GHS). Food

Consumption Surveys and the Demographic and Health Surveys are also crucial sources of data. The Census cycle has recently been changed to run every decade, the next being in 2011. A new survey, currently known as the Census Replacement Survey (more extensive than the GHS), is being considered. If implemented, it will run every three years and will provide information at district council and, in some instances, at municipality level.

The recent development of Provincial Indices of Multiple Deprivation is a major step towards being able to describe household poverty multidimensionally at small-area level (see Chapter 3 in this volume).[5]

While these surveys do not have child issues as their focus, the last ten years have produced a number of large-scale studies concerned with particular aspects of child and adolescent behaviour and development. Examples include studies of adolescent risk behaviour (Flisher, Ziervogel, Chalton, Leger et al., 1993; MRC, 2003), the status of South African youth (Emmett et al., 2004), youth civic development (Emmett, 2004), intergroup orientations of adolescents (Dawes & Finchilescu, 2002), and HIV prevalence in children (Brookes et al., 2004).

There is a range of other work that can support the development of child indicators and programme monitoring systems for South Africa. A few examples include: education (Chisholm, 2004a; Seleoane, 2004), child abuse (Dawes, Borel-Saladin et al., 2004; Dawes, Biersteker et al., 2006), child labour and domestic work (Budlender & Bosch, 2002; Bray, 2003a), early child development (Biersteker, 2003b; Dawes, Bray et al., 2004), child health (Saloojee, Afadapa et al., 2003; Shung-King et al., 2004), social security (Leatt, 2004), as well as the well-being of orphans and other children made vulnerable through HIV/AIDS (Giese, Meintjies et al., 2003a; Meintjies et al., 2003; Richter, Manegold et al., 2004).

The Medical Research Council[6] provides a wealth of online data on child health, the burden of disease, child morbidity and mortality, child injury, violence and other relevant issues. The Birth to Twenty longitudinal cohort study[7] is the longest running cohort study in Africa and has a range of demographic, child health, and psychosocial data on children who are now in their fourteenth year. Other university-based research programmes such as the KwaZulu-Natal Income Dynamics Study, the Cape Area Panel Study, and the Africa Centre research programme[8] are examples of initiatives that can provide data and inform indicator development.

Collectively, these sources offer considerable potential for improving our understanding of the relationship between child outcomes and the broader environment. At present their potential cannot be realised because information from the various sources is not integrated at a single point that allows easy access by a variety of stakeholders and decision-makers. As noted, the University of Cape Town's Children's Institute has attempted to fill this gap with Children Count.

In addition, different administrative systems and surveys may collect data using different questions to shed light on the same issue (for example, child labour), and may use different approaches to disaggregate the data by age or geographical region. Moreover, there are no mechanisms in place for checking the reliability and validity of the various data collection methods in use for the purpose of documenting particular changes in child and adolescent outcomes.

Many questions remain to be answered,[9] yet there is no doubt that we are in a stronger position now to launch systematic child outcome monitoring than we were ten years ago.

The nature and function of indicators

Indicators literally point to and stand for something else. Thus:

> childhood indicators are statistical time series data that measure changes (or consistencies) in the conditions of children's lives, and in the health, achievement, behaviours and well-being of children themselves. They are numbers that tell us something significant about how today's children live and how we as a society are raising them. (Zill et al., 1983, cited in Ennew, 1999, p. 202)

As is evident from the quote, indicator information is based on population level data.

Ennew (1999) suggests that a monitoring system should include three kinds of indicators, which are not necessarily exclusive.

First, a limited set of *high-level priority* (we prefer the term 'core') indicators is required that provide a reliable reflection of the situation of children in key areas of concern. It is useful to construct a short list of core indicators that are easy to measure and that are important to government and other monitoring agencies. They offer a reference point (or baseline) for future monitoring. Such indicators normally provide a relatively coarse picture of the status of children and their situation. Examples would include the number of children living below the poverty line (an indicator of a range of risks to child well-being); the number of children enrolled in primary school (an indicator of *access* to schooling); and the infant and child mortality rates (indicators of the effectiveness of supports for child health and survival).

Second, *monitoring* indicators are normally more fine-grained. Provided they are sensitive enough to measure desired policy outcomes, certain core indicators serve for monitoring purposes. Monitoring indicators must be carefully linked to the inputs and goals of the policy as implemented. They must be designed to measure specifically desired outcomes that relate to the intended gains of the policy. This is not a simple matter as it is often difficult to separate out the effects of the policy implementation from other factors that may influence the situation. Monitoring indicators and measures need to be precise and designed to show change over time. For example, an intervention could be designed to prevent children from being excluded from school for inability to pay fees. The intervention would be designed to help principals to be more sensitive to the situation of such children, and to encourage parents/guardians to seek fee exemptions if they cannot pay. Indicators of the success of this intervention could be based on a survey of relevant parents/guardians to ascertain whether or not they have been approached by the principal, and whether or not children previously excluded for non-payment have returned to school. A further refinement would be to compare this group with others whose principals have not been given this input.

Third, *early warning* indicators are required. They are designed to provide danger signals of deteriorating conditions for children in situations of sudden or unexpected change. Early warning indicators are commonly selected on the basis of known risks to child well-being and survival. These indicators may or may not measure the status of children; for example, they could include the threat of civil war which would pose significant risks to children. Another is change in the HIV infection rate in specific groups of the population (for example, women of childbearing age). Early warning indicators provide vital information to stakeholders.

Key terms relating to indicators and monitoring are displayed in Appendix 4 at the end of this volume. In contrast to the core and additional stratification used in Appendix 4, the EU uses three indicator levels, with Level 1 being equivalent to core indicators, and Level 3 being the most difficult to obtain and the least necessary for high-level reporting. Initially, the current project used the EU approach. However, following discussions with South African stakeholders, it was felt to be more effective to proceed with a two-tiered system.

Approaches to monitoring child well-being: the international experience

A review of the international literature shows differences within and between countries in the language used to describe their approaches to monitoring the lives of children. We provide a summary that does not intend to be exhaustive.

Broadly speaking, approaches may be characterised by an emphasis on child well-being, well-becoming, child welfare, social development and/or child rights, or a combination of these orientations.

In some instances, considerable conceptual overlap is hidden by the use of different terms with similar meanings. In others, foundational concepts have been adopted in line with the broader social policy environment and dominant thinking around childhood and youth that exist within a particular country.

For example, the Best Start Initiative mounted by Victoria State, Australia, adopts a *developmental* perspective, placing the situation of the child in the context of the functioning and resources available to families and communities (Department of Human Services, 2001). The state seeks to account for child outcomes (at least in part) with reference to cultural differences and access to resources.

Examination of global trends in measuring the state of children shows that, historically, researchers 'concerned themselves with measuring children's basic survival needs; they focused primarily on the deviant and negative aspects of children's lives; and were mainly interested in children's well-becoming' (Ben-Arieh et al., 2001, p. 50).

Monitoring using an exclusively *welfare or child development* perspective tends to approach children purely as dependent members of households or recipients of benefits, thereby omitting data collection on a range of aspects of children's everyday experiences (including contributions to the household and community) and failing to interrogate the relationship between the environment and child outcomes.

Recently, there have been four major shifts in thinking around monitoring child outcomes (Dolev & Habib, 1997; Ben-Arieh et al., 2001):

- From monitoring survival to monitoring well-being;
- From a focus on negative outcomes to include positive outcomes;
- From an emphasis on well-becoming[10] to one on well-being; and
- From traditional to new domains.

International monitoring frameworks designed to enable cross-country comparisons, such as UNICEF's Multiple Indicator Cluster Survey and the State of the World's Children Basic Indicators (e.g. UNICEF, 2005c), tend to have a relatively narrow survival, health, protection, poverty and education oriented perspective (in large part due to the practical constraints on collection of a wider range of data and the limited information available). We acknowledge that complexity should be avoided in international surveys, but draw attention to their limitations in reflecting areas of childhood vulnerability relating to social inequalities, or children's interrelationships with their social and physical environments. In the late 1990s, UNICEF attempted to address this by developing a composite Child Risk Measure. However, it has apparently never been utilised again (personal communications with UNICEF headquarters staff).

While we have not conducted an exhaustive search for countries that have an institutionalised practice to regularly compile reports on the well-being and rights of their children, our scan has shown that no African country has such a practice (although all do capture data on children to varying degrees). UNICEF's State of the World's Children reports and Multiple Indicator Surveys do help to provide data for most countries. But the data on the relevant reports should not suggest that the countries in question actually have child data collection policies that regularly feed into such documents.

At the end of the 1990s, the UN adopted a set of indicators for monitoring the World Summit for Children goals. A set of additional indicators was included to monitor children's rights, HIV/AIDS, the Integrated Management for Childhood Illness Initiative and malaria.

Systems for monitoring the situation of children in the US (which has not ratified the CRC), Australasia and many European countries approach the measurement of child outcomes from a well-being perspective. In some developing countries and Scandinavia, a rights orientation has been more prominent. The EU child well-being indicator framework is informed by the CRC and UNICEF's framework on child poverty and well-being (Bradshaw et al., 2005).

In the US, the Federal Interagency Forum on Child and Family Statistics produces a regular report entitled *America's Children: Key National Indicators of Well-Being*. This practice is very recent, having only started in 1997. American NGOs such as Kids Count and Child Trends[11] play a very important role in making data on the situation of children accessible to a wide audience. They draw on a range of sources including government, research studies and NGOs.

Since 1999, the UK has produced an annual report, *Opportunity for All*, which reports information on 24 child indicators – the focus of the report is on poverty monitoring. However, the UK does not have a regular child survey. As is the case in

South Africa, there are, however, a number of official sources of child data that may be obtained from the Office of National Statistics, and there are a range of surveys and longitudinal studies from which child data may be extracted (Bradshaw, 2002).

Supported by Save the Children Sweden, Bradshaw (2002) produced the first comprehensive report on the situation of British children entitled *The Well-Being of Children in the UK*. The second in this series was published in 2005 by Bradshaw and Mayhew. These volumes cover a range of domains of child well-being, including their population characteristics, health status, education outcomes, juvenile crime, poverty and child maltreatment. The new edition of the volume takes the analysis further, including matters not covered previously (child rights, child asylum seekers and children with special educational needs). Bradshaw and Mayhew (2005) note that while the countries of the UK are working toward monitoring systems for children, the UK government still does not collect data for the purpose of compiling a comprehensive report on the situation of children.

An important UK policy document with relevance for South African initiatives is the Green Paper 'Every Child Matters' issued by the Department for Education and Skills in 2003. The document provides an outcomes framework with five domains designed to monitor the situation of children in the UK. They include the following (from Bradshaw & Mayhew, 2005, p. 3):

- *Economic well-being:* having sufficient income and material comfort to be able to take advantage of opportunities.
- *Being healthy:* enjoying good physical and mental health and living a healthy lifestyle.
- *Staying safe:* being protected from harm and neglect, and growing up able to look after themselves.
- *Enjoying and achieving:* getting the most out of life and developing broad skills for adulthood.
- *Making a positive contribution:* developing the skills and attitudes to contribute to the society they live in.

Indicators may then be clustered in these domains for monitoring purposes. The Every Child Matters outcomes-based approach has much merit in specifying links between outcomes, supports for the outcomes (services), and targets linked to indicators. Note the active formulations used above which signal the importance of a present and future well-being orientation.

Bradshaw and Mayhew (2005) comment on the importance of separating indicators of well-being (how children are now) from well-becoming (how these children will do as adults) when monitoring the situation of children. The last outcome above is of this kind. Well-being and well-becoming indicators are often in conflict. They reflect a tension between child-centredness on the one hand and investment in the future on the other. Thus an overemphasis on building the intellectual capital of the future society can result in a reduction of current well-being for children due to the stresses of long hours of studying, the accompanying anxieties, and the reduction of opportunities to play. For example, in some Japanese and South Korean communities, schooling and its importance in the production of future adults is arguably taken to extraordinary lengths. Pupils as young as seven years go to night

school to improve their languages or mathematics, despite the emotional cost to the child (Field, 1995; Hae-joang, 1995).

The EU Laeken Summit adopted a set of 'primary' and 'secondary' indicators designed to track poverty and social inclusion, mainly concerned with employment and income distribution in member states. None of the indicators concerned the well-being of children. The EU has a Community Health Monitoring Programme which includes health indicators for children (Rigby & Köhler, 2002). In a broader initiative, the EU is currently taking a pragmatic, normative, data-driven and multidimensional approach to the development of child poverty and well-being indicators that is informed by the CRC and UNICEF's framework on child poverty and well-being. The most recent data are used and are drawn from a range of sources of data on EU countries (not necessarily collected at the same point in time).

The EU approach includes a number of variables organised into a number of indicator sub-domains, located in 12 domains that are in turn organised into 4 clusters for child well-being, each of which is awarded a score (Bradshaw et al., 2005). The clusters and associated domains are as follows:

- Cluster 1: Children's personal resources
  - Child health (a range of indicators including the infant mortality rate, life expectancy, immunisation status, weight in relation to body mass, etc.);
  - Subjective well-being (self-defined health, educational, and financial well-being).
- Cluster 2: Education
  - Educational attainment;
  - Educational participation;
  - Educational aspirations.
- Cluster 3: Family and immediate environment
  - Family relations (family structure and quality of family relations);
  - Economic situation (child income, poverty and deprivation);
  - Safety (accidental death, maltreatment death, suicide and violence);
  - Housing and Environment (housing problems, homelessness and safe neighbourhoods).
- Cluster 4: Children's social resources
  - Quality of peer relationships (having friends, spending time and communicating with them, and perception of peers);
  - Civic participation (participation, for example in school councils and voluntary organisations);
  - Risk behaviour (sexual activity and teenage fertility, alcohol and tobacco use and drug use).

In spite of these considerable recent advances, there remains no comprehensive set of EU indicators for child poverty and well-being that is populated with data (Bradshaw et al., 2005). In addition, the framework is not clearly linked to rights and does not permit an analysis of the impact of deprivation on children's lives. As is the case in most contexts, availability and comparability of data remain major challenges.

Rights-based approaches to monitoring child well-being

Unlike monitoring based purely on notions of well-being or quality of life, rights-based monitoring places the measurement of outcomes within the context of moral authority to entitlement and policies put into operation to ensure this entitlement. The interest is therefore not only in children who have rights, but also in those who are duty bound to ensure that these rights are upheld. Such an approach strengthens the hand of those acting on behalf of children to demand from these duty-bearers the provision of sufficient good quality services that make a difference to child well-being (Theis, 2003).

It is important to remember that although the state has ultimate responsibility for securing children's protection through the legal system, and in providing the basic social and economic conditions in which children's rights can be fulfilled, family and community members are also duty-bearers who 'have greatest awareness of, and interest in, the "whole" needs of each and every child' (Reynolds, 2003, p. 9).

A further advantage to a rights-based approach to monitoring is its consistency with broader development goals (see Melton, 2005a). Increasingly, both international and national macro development goals are tied to human rights goals. The South African government makes explicit reference to human rights objectives, particularly empowerment, across its policies. For example, the original draft of the South African Children's Bill (2003) had as its cornerstones: poverty alleviation strategies; an interdepartmental approach to caring for children's survival, development and protection needs; a comprehensive social security system; and an overall foundational commitment to the prioritisation of children's rights (Bower & Proudlock, 2003). A number of these important provisions were removed from the final draft of the Bill.

According to Bentley (2003), rights-based monitoring requires three stages of measurement:

1. *Specification* of rights to children (what the state and other duty-bearers are committed to deliver);
2. *Provision* for delivery of these rights (policies to allocate resources or provide protection, and the programmes or processes in place to honour these commitments through distribution and/or law enforcement);
3. Child *outcomes* (measured through scientific analysis in relation to a set of minimum standards and/or with reference to proven models of cause and effect, as well as through the opinions of children and their carers/service providers).

Each stage has implications for the design of a monitoring system.

However, these matters are not simple (see also Chapter 2 in this volume). First, the nature of the state's obligations to children must be clarified. South Africa has constitutional obligations in the Bill of Rights (see Appendix 2 at the end of this volume). However, careful scrutiny of the wording reveals that the government's duty to fulfil certain social and economic rights is conditional on the availability of resources (limitations of this kind also apply in the CRC). For example, the 'right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance' (Section 27 (1)(c)) is dependent on the resources of the state at the time. In addition, South Africa has stated its

commitment to children within the Bill of Rights (Section 28 of the Constitution). In contrast to other sections, there are no limitation clauses here, which implies that the state has a duty to allocate resources towards the realisation of *children's* rights to nutrition, shelter, basic healthcare services, and social services *immediately* rather than progressively (Cassiem & Streak, 2001; Streak & Wehner, 2004). It also suggests that the allocation of scarce resources to poor children should be prioritised over allocations to all other categories of poor people (Streak & Wehner, 2004).

Second, a decision must be made regarding the appropriate policy documents to use in specifying the rights of South African children. In addition to the Constitution, the country has also ratified both the CRC and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3 in this volume). Ratification places obligations on the state to promote the rights and well-being of children in terms of international law. As we would expect, the relevant sections of the Constitution mirror articles of the UN Convention and the AC. Therefore, we suggest that a monitoring strategy should in the first instance be based on the South African Constitution but also be informed by the CRC.

Third, monitoring of child outcomes within a rights-based framework demands the measurement of concrete and observable phenomena to assess whether minimum standards are being upheld. This is not a simple matter and Ben-Arieh et al. (2001) warn that certain indicators used to measure children's well-being may not be powerful enough for the purpose of rights monitoring.

A rights perspective incorporates a number of *foundational principles*, laid down in the South African Constitution (for example, sections 11 and 12) and the CRC, which are not normally considered within a well-being framework.

Melton (2003) draws attention to the following principles, to which we have added practical implications for the development of monitoring systems in South Africa:

- *Respect for dignity:* Indicators, measures and data collection methods should all respect the dignity of children and their families. Although not explicitly defined in the CRC, the right of children to be properly researched is derived from this principle. Ethical issues therefore require careful consideration.
- *The right to personality:* Acknowledgement of and respect for children's personhood and their right to self-expression must be accounted for in the monitoring process. For example, efforts should be made to find appropriate methods for children to convey their experiences and express their opinions. This means tackling sensibly the challenges of time, expense, capacity of enumerators and prevailing opinion that such data will be 'unreliable' (see O'Kane, 2002, for guidance on this process). Child participatory methodologies are emerging as an important approach that strengthens this right as well as the right to participation. For example, children's views on threats to their development and rights can be incorporated in more quantitative approaches once children have been consulted (see for example Save the Children Sweden, 2002; Willenberg & Savahl, 2004; Clacherty et al., 2005).
- *The right to personal security:* There is a need to learn from recent child well-being monitoring systems and survey designs that pay greater attention to issues of personal safety than was popular in the past. Conceptually, there are challenges in incorporating solid indicators of the physical and psychological

dimensions of personal security, as it is clear that intra-personal, intra-familial and community-wide factors all play a role. Notwithstanding the challenges, improvements in child abuse and neglect incidence reporting systems would be one example of efforts to track more serious forms of maltreatment of children. Other indicators of children's sense of security would be children's responses to questions regarding their own safety both at home and in the neighbourhood. Adult surveys are conducted on such issues, but it is rare for children to be participants.

- *The right to a family environment* (protection of intimate relationships): This foundational principle is not laid out in a specific article of the CRC, but appears in the preamble as a core right of children. Its position in the document means that it is often inadvertently neglected or reduced to something of lesser importance than the rights defined in the articles that follow. Alongside the preceding three principles, this one demands that a monitoring system is able to capture and respect a *variety of forms of 'family' and 'family-like' intimacy* (such as can be found amongst street-living children). Indicators and measures that prejudge the quality or legitimacy of alternative family forms should be avoided.

An approach to monitoring that forefronts children's rights has the advantage of consistency with broader national development frameworks based on empowerment and human rights, as well as with the international momentum around the CRC.

Such an approach is not without its considerable difficulties. Thus, some protest the adoption of a 'rights approach' on the grounds that it imposes a set of standards developed in socio-cultural, environmental and even ideological contexts far removed from those of South Africa.

Some of these points are valid, particularly when prescriptions for appropriate childhoods are exported (and warranted with reference to the CRC) from the north to other cultural contexts (Boyden, 1990). Such unreflective practices may verge on a form of ideological colonialism and may cause unintended harm. While the CRC is a culturally constructed instrument rooted in modernity, and while it must therefore be interpreted with that understanding, it was never intended to provide a blueprint for each and every country to follow. Rather, it offers a set of guiding principles to be interpreted locally and used to identify appropriate indicators and measurements.

In spite of the desire to embed monitoring in rights, in many instances the data environment will make this very difficult. For this reason an overly legalistic approach that seeks to monitor each element of law and regulation as it applies to the child would be far too ambitious (even though it might be an ideal). There is little point in designing a system for which data are very unlikely to be available for reasons of cost, among others. The probable data environment and burden of measurement must be considered.

Child rights and the development of indicators

The following points about the manner in which child rights and indicators might be linked apply to all the chapters in this volume and will not be repeated elsewhere. They are informed by the work of Ennew (1999), Bentley (2003, 2005) and by reviews of this volume provided by Paula Proudlock and Mira Dutshcke at the

University of Cape Town's Children's Institute.[12] We are grateful for their most helpful inputs.

When working with the Convention, it is important that the preamble be taken into account. This section of the CRC provides the context within which the rights are framed. In its several clauses, the preamble makes mention of certain key points that are relevant to the present discussion:

- The inherent dignity and equality of 'all members of the human family';
- That UN members (through international legal instruments) seek to 'promote social progress' (which recognises the need to take steps to improve living conditions, and promote the well-being and developmental outcomes of children);
- By virtue of their immaturity, children require special care and protection, and should 'grow up in a family environment, and in an atmosphere of happiness' (and recognises that families require support if they are to be able to carry out their responsibilities);
- Also by virtue of their immaturity children need special safeguards 'including appropriate legal protection, before as well as after birth'.

The first point lays down the principle of non-discrimination, and suggests that data should be disaggregated in ways that permit monitoring of discrimination on grounds of, for example, gender, race, religion and disability (Ennew, 1999). The second point indicates that monitoring systems should be designed to provide regular reports on the same phenomena over time so that the progress of the state in improving the situation of children can be tracked. The third takes into account developmental timing (see Chapter 2 in this volume). The fourth point is particularly important because the law provides the enabling environment for rights. States have a responsibility to enact law that will give effect to all these points.

The CRC seeks to bind ratifying states to a body of international law with which local law must be aligned. To this end, the first five articles lay the foundation principles that flow through the rest of the provisions:

- Article 1 defines a child as under 18 years of age;
- Article 2 ensures that no child shall be discriminated against in the application of the Convention (and local law);
- Article 3 seeks to ensure that the best interests of children are considered in all decisions that affect them;
- Article 4 relates to the final point in the preceding list, and obliges state parties to enact legislation and take other steps to give effect to the rights in the Convention 'to the maximum extent of their available resources';
- Article 5 recognises the responsibilities of parents (widely defined) and communities in regard to the care and development of children, but also provides for 'appropriate direction' to these duty-bearers.

We also draw attention to Article 6 (the right to life, survival and development), as well as Article 12, which states that it is the right of children to participate in decisions that affect them and express their views in this regard (in accordance with their capacities). The implication of Article 12 for child rights and well-being indicators' research is that children's perspectives on indicators should be taken into

account. There are several examples where this has occurred in South Africa (see Chapter 2 in this volume for more details).

These articles have received attention from the Committee on the Rights of the Child (the implementation body of the CRC) because, when taken together, they provide a guide for states in the execution of rights-based approaches to implementation and monitoring.[13]

For example, the committee has determined that states are required to identify individual children and groups of children whose rights may demand special measures. For this to be possible, data must be disaggregated to describe the situation of vulnerable groups (for example, the disabled) and to enable discrimination or potential discrimination to be identified (Van Bueren, 1999).[14]

Rights-based indicators should therefore go further than counting the provision of services or identifying the extent to which needs are fulfilled (i.e. sufficient provision to maintain the well-being of the general child population). They should distinguish groups of children who cannot gain access to a particular service owing to other aspects of their lives (for example, disability, inability to pay for the necessary transport, having to work long hours).

According to Ennew (1999), a rights-based system to monitor children's well-being and their outcomes should have three core features.

First, as noted, the indicator system should identify *particular groups* of children for whom rights could be compromised, rather than solely providing a general description of proportions of all children for whom certain criteria of well-being apply. Such groups could include age, ethnicity, gender, area of residence, disability and poverty levels. Others could include refugees and ethnic minorities known to be particularly vulnerable, such as the San. In South Africa, where redress related to past discrimination is central to policy, the use of the apartheid era population group labels may be appropriate in some circumstances (but not in all).

Second, and for the same reason, the system should be designed to track these groups using *disaggregated* data. Stratification of population data allows one to identify which groups of children are not having their natural rights fulfilled, and to show inequalities between them. To enable such disaggregated data to be representative, it is necessary to include the stratifications in major national surveys.

Third, in order to be rights-based, there should be an explicit link between articles of the CRC, the AC in particular (there are other relevant instruments), and the relevant articles of the South African Constitution so as to focus on factors that are likely to promote children's access to their rights (Rama & Bah, 2000). A good example of this practice is evident in the collection of papers that discuss monitoring of children's socio-economic and related rights in relation to the Constitution and the CRC (Coetzee & Streak, 2004). However, as these authors note, and as we mentioned at an earlier point, constitutional provisions are by no means clear as to the precise meaning of certain rights for children. The same applies to the CRC.

This becomes a particular issue when we try to specify the services to which children might have a right. For example, the CRC in Article 18(3) states that all appropriate

measures should be taken to ensure that children of working parents have the right to benefit from childcare services. Does this mean that every child of a working mother has the right to attend a crèche or an Early Childhood Development centre? Few countries in the world, including South Africa, would be able to ensure such a right. However, under the Convention, all should strive to make some provision for such children, or at least take steps to ensure that they are not at risk while their parents are working. Other articles rights are more specific regarding services, particularly those that apply to healthcare (Article 24) and education (Article 29). It is of note that Article 29 specifies that children have the right to free primary education. This is not strictly the case in South Africa (see Chapter 8 in this volume).

When countries strive to implement rights in relation to services, and when countries seek to set up a rights-based monitoring system, it is useful to be guided by the first five CRC articles and the recommendations of the Children's Rights Committee, while noting the provision in Article 4 that states should strive to give effect to the rights in the Convention 'to the maximum extent of their available resources'. In effect this gives leeway for progressive realisation of rights. Of course Article 4 can be used in mischievous ways by governments who seek to avoid responsibilities that they are well able to afford.

Finally, it is necessary to establish empirical links between children's rights and their status (well-being).

The rights framework, as with any set of principles, provides the broad context for monitoring and one that must be interpreted where provisions are not absolutely clear. For example, the principles do not give rise to the detail that might be included in local law and services provision. These would be guided by the first five articles and the twelfth, but would depend fundamentally on resources, as well as evidence (for example in health and education services) in regard to what is best for children (well-being) and their development (their well-becoming). In particular, Article 3 – acting in the child's best interests (all other constraints considered) – would be a key consideration.

United Nations agencies have been central in advancing systems for monitoring both the status of children and the performance of duty-bearers. One example is the set of core indicators for global monitoring of child rights that were considered at a meeting convened in Geneva by the UNICEF Division of Evaluation, Policy and Planning (UNICEF, 1998). Those present recognised the many challenges of such a process, particularly as regards measurement and data sources. Nonetheless the domains constructed are a useful point of departure in pointing to the areas that should be measured in a rights-based system. The following indicator domains were recommended:

- Indicators for monitoring the implementation of the CRC;
- Indicators for monitoring budgets and resource allocation for implementing the CRC;
- Indicators for monitoring children's active participation (articles 12–17);
- Indicators for monitoring the right to a name, nationality and identity (CRC articles 7 and 8);
- Indicators for monitoring protection from torture and other cruel, inhuman and degrading treatment or punishment (CRC Article 37(a));

- Indicators for monitoring care outside the home (CRC articles 20, 21 and 25);
- Indicators for monitoring adoption and tracing (CRC Article 21);
- Indicators for monitoring income support (CRC articles 26 and 27);
- Indicators for monitoring family environment (CRC articles 18 and 19);
- Indicators for monitoring basic health and welfare (CRC articles 6 and 24);
- Indicators for monitoring children with disabilities (CRC Article 23);
- Indicators for monitoring standards of living and social security (CRC articles 18(3), 26 and 27);
- Indicators for monitoring education (CRC articles 28 and 29);
- Indicators for monitoring leisure and cultural activities (CRC Article 31);
- Indicators for monitoring children in armed conflict (CRC articles 22, 38 and 39);
- Indicators for monitoring child exploitation (CRC articles 32, 34, 35 and 36);
- Indicators for monitoring children involved in the juvenile justice system (CRC articles 37, 39 and 40).

All are relevant to duty-bearer monitoring, but the first two are perhaps most fundamental. The chapters in this volume engage with these domains and the recommended indicators to a greater or lesser degree.

The responsibilities of duty-bearers

A rights-based system should not only be concerned with the rights accorded to the child, but also to their reciprocal – the duty-bearer's responsibility to enable the child's access to her rights. As noted in the CRC and the AC, and as mandated by the South African Constitution, children's enjoyment of and access to their rights is made possible by actions of certain duty-bearers. These persons range from those closest to the child (parents or other legal guardians), to more distant personalities and systems (for example, clinic staff or teachers, local governments, ministers and finally the president).

The state has the responsibility for ensuring that the rights provided to children in the CRC are given life at the country level. In order to monitor the performance of the state, the following indicators were suggested at the Geneva meeting for monitoring the implementation of the CRC:

- Existence of a comprehensive national strategy for children;
- System for regular reporting on the implementation of the national strategy;
- Existence of a body for co-ordinating and monitoring the nation's strategy for children;
- Representation of non-governmental groups on this body;
- Provision of adequate resources for this body to function effectively;
- Government reservations to specific provisions of the CRC, which would limit its scope in the country concerned;
- Compatibility of national law with the CRC;
- Existence of systematic analysis of the impact on children of draft legislation and policy;
- Existence of a formal, independent office for children;
- Education about children's rights and inclusion of the CRC in the school curriculum;

- Existence of training activities on the CRC for professionals working with and for children, including teachers, judges, social workers and law enforcement personnel;
- Discussion in Parliament of the recommendations of the Committee on the Rights of the Child.

Implementation requires funds, and the following core indicators were suggested for monitoring resource allocation for implementing the CRC:

- Existence of a children's budget (a published analysis of government spending on children, at central, provincial, district and municipal levels);
- Proportion of the Budget spent on primary healthcare;
- Proportion of the Budget spent on education (primary and other levels);
- Whether the 20/20 initiative has been applied as extensively as possible (the commitment to dedicate 20 per cent of government spending and 20 per cent of aid to basic social services);
- Proportion of the government Budget spent on defence, for comparison purposes;
- Proportion of income taxed;
- Proportions of national income going to the richest 5 per cent of households and the poorest 40 per cent.

A number of these indicators could be monitored in South Africa without great difficulty.

Duty-bearers at various levels of government also have responsibilities to uphold the rights and ensure the well-being of the child in the home, the neighbourhood, and in institutional settings (schools, residential care).

While parents/guardians have the primary responsibility for the well-being of their children, in the high-risk poverty contexts inhabited by the majority of South African families, this is a considerable challenge. As noted, poor child outcomes cannot and must not be laid solely at the door of struggling caregivers. Duty-bearers have a key responsibility to support vulnerable families and caregivers to carry out their roles to the best of their ability (CRC Article 5).

Therefore, from a rights monitoring perspective, it is as important to link child outcomes to appropriate household and family parameters as it is to construct indicators and measures of supports for those caregivers and families whose children are not doing well, and who are struggling to carry out their responsibilities. If this does not occur, the monitoring approach focuses solely on caregivers and an unintended outcome is a system that blames the poor for child outcomes that may be largely beyond their control. In order to target these vulnerable families and children, the monitoring system should draw on data that are appropriately stratified using a particular risk indicator of concern, and gathered at small-area level (for example, suburb or enumerator area). An example would be alcohol and drug abuse in households with children. We know that partner violence and child abuse are more likely under situations of substance abuse (Dawes, Kafaar et al., 2004). Therefore an indicator of the risk to children of intimate violence and the need for supports for families and children could be provided by small-area data on households whose members report alcohol and/or drug abuse. If there are very few services to families and children in such areas, this could suggest that duty-bearers

who are responsible for child protection are not fulfilling their responsibilities (Dawes, Biersteker et al., 2006; Dawes, Willenberg et al., 2006).

Linking rights and child well-being

A linkage of rights and well-being concepts is particularly useful because it encompasses a 'concern for the whole child' and is familiar to the different policy sectors. This point is well made by the group of scholars brought together by the Chapin Hall Center for Children (Chapin Hall, 2002) at the University of Chicago to develop a comprehensive system of child well-being indicators that would be applicable across countries. A well-being approach permits one to focus on key areas of children's health, capacity development and participation that are known to be essential for the child's overall positive development.

A well-being approach also benefits from being informed by theory and empirical research on the factors that promote or threaten child development in different domains (Huston, 2002). For this reason, the well-being approach lends itself to the development of evidence-based indicators and measures for policy implementation and programme monitoring. For example, knowledge of the physical and behavioural correlates of chronic under-nutrition permits one to monitor the effects of nutrition programme outcomes reliably and accurately (given the appropriate measures). Huston's schema is presented in Table 1.1.

It is our view that an approach to monitoring which integrates concepts of child well-being and children's rights is both possible and desirable in the current South African context. Indeed, in practice there are large overlaps between popular understandings of 'child well-being' and the rights of children specified in the CRC and the South African Constitution.

The inclusion of rights-based thinking adds a crucial contextual (and political) dimension to the measurement of child outcomes because it focuses on both the rights-holders (children) and the duty-bearers,[15] for example their legal guardians, local authorities, service providers, and the state (see also Streak & Wehner, 2004).

A set of key criteria for effective indicators for rights-based monitoring of child well-being is presented in Appendix 5. In order to construct the entries, we have drawn on a range of sources. They include the comprehensive collection of child indicators compiled by Hauser et al. (1997) and a range of other scholars (Brown, 1997; Bowers-Andrews & Ben-Arieh, 1999; Ben-Arieh, 2000; Ben-Arieh et al., 2001). Additional sources include Child Watch International (Miljeteig, 1997); Childwatch International Research Network, 1999; the Australian Best Start Initiative (Department of Human Services, 2001); the US government reporting system on children; Child Trends;[16] the Chapin Hall Centre (Chapin Hall, 2002); and the work of Bradshaw (2002) and Bradshaw and Mayhew (2005) in the UK.

The challenge of bringing together national, provincial and local level information is a considerable one, and requires careful consideration of both conceptual and practical issues. A number of questions arise, including:

- Are the indicators defined and measured in the same manner across these levels and even across sectors within levels (where this occurs)? Are the data needed to track children captured? For example, the District Health Information Systems

Table 1.1 Goals for child well-being and well-becoming, and their indicators

Goals	Indicators
'Health and physical comfort, including shelter, nourishment, freedom from pain and abuse, and medical care.'	'Housing stability versus homelessness; food sufficiency and nutrition; freedom from child abuse, use of foster care; healthcare and immunisation; absence of physical disability.'
'Family or adults who care, are reasonably constant and reliable, and who provide love and encouragement. Consistency of caregivers and settings.'	'Child living out of home; parent-child relationship; parenting warmth; social supports from other adults.'
'Development of intellectual and other capabilities to their fullest, such as language skill; school achievement; and skill in athletics, music, or art.'	'Language; cognitive ability; literacy; school achievement (short and long term); achievement in other domains.'
'Emotional well-being and mental health, including self-worth, sense of personal control, and freedom from depression and anxiety.'	'Low internalising problems and anxiety; high perceived self-worth; low referrals for mental health problems.'
'Skills in relating to others, both adults and peers, including, for example, assertiveness without violence, sociability, co-operation, understanding others' perspectives, complying with adult expectations, and leadership.'	'Positive social behaviour; low externalising or behaviour problems; social skills with peers; social skills with adults; social cognitive skills.'
'Responsibility and morality, including the ability to guide one's own behaviour and act in accord with societal standards of right and wrong.'	'Absence of delinquency and antisocial behaviour; conformity to social expectations; sexual responsibility.'
'In adulthood, ability to support self and family, be a good parent, contribute to society, be mentally and physically healthy, and not commit crimes or abuse substances.'	'Educational and occupational attainment; absence of criminal activity or substance abuse; mental and physical health.'

Source: Huston (2002)[17]

collect no data on child and adolescent mental health at primary service level (Dawes, Borel-Saladin et al., 2004).

- Are the computer systems in place and are staff trained to capture the information accurately? In many instances this is not the case. For example, a recent study of police data on child abuse entered into a Geographical Information System revealed a range of key gaps (Dawes, Borel-Saladin et al., 2004).

As the last point illustrates, while government administrative databases are potentially very useful sources of information on children, they present a number of accuracy and quality problems (Goerge, 1997; Hotz et al., 1998). Administrative data are normally compiled by government departments rather than independent agencies. There are threats to reliable data collection and reporting, particularly if a government department is anxious to present a bad situation in a better light. Independent scrutiny is essential in order to validate the quality of administrative information.

Monitoring processes are intended to track well-being over time. If this purpose is to be realised, it is essential that a regular system of reporting be established for this country. Decisions need to be made as to who will collect, collate and analyse data at each level of government, and how the various strands of information will be brought together to produce an appropriately disaggregated national picture. And perhaps most crucially, who will pay for this activity?

Conclusion

This chapter has covered a broad spectrum of issues relating to the history and development of approaches to monitoring child rights and well-being. As we have noted, South Africa has struggled with this challenge, but there are now a number of opportunities for the process to be taken forward.

We have argued that it is not enough to monitor child well-being without a rights orientation. Monitoring children's access to their rights is, however, a considerable task in itself. Combining rights monitoring with well-being monitoring adds further challenges because, as we have noted, the specific services to which children have a right are commonly far from clear. Where they are, the responsibilities of duty-bearers can be tracked if the monitoring system takes the appropriate legal and regulatory provisions into account.

In the approach we develop further in Chapter 2, we have found it helpful to see our process as a rights-based approach to monitoring the situation of children. We draw on rights, well-being and well-becoming approaches. Critically, this permits us to monitor the status of children with reference to their rights as well as to the supports needed to realise the achievement of well-being. Chapter 2 presents the framework for implementing this approach.

Notes

1 The group was brought together by the Childwatch International Indicators for Children's Rights Project and consisted of senior representatives of South African state bodies (the NPA, Stats SA and relevant government departments), UNICEF and international academics with considerable experience in the field of monitoring children's rights.

2 The Institute for Democracy in South Africa plays a key role in monitoring the policy situation of children affected by poverty (Coetzee & Streak, 2004).

3 Children Count, <http://www.childrencount.ci.org.za>.

4 The fund is a government body established in 2001 and tasked with promoting entrepreneurship, job creation, skills development and skills transfer among persons aged 18 to 35.

5 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.

6 See <www.mrc.ac.za>.

7 Birth to Twenty longitudinal cohort study, <http://www.wits.ac.za/birthto20/>.

8 KwaZulu-Natal Income Dynamics Study, <http://sds.ukzn.ac.za>; the Cape Area Panel Study, <http://www.cssr.uct.ac.za/ssu_surveycaps.html>; the Africa Centre research programme, <http://www.africacentre.org.za/>.

9 A particular challenge is defining 'child poverty' within the South African context and identifying measurements that are conceptually and practically appropriate within a broader system for monitoring child rights (see Chapter 3 in this volume).

10 The problem of the well-becoming position is that it signifies a future orientation (for example, in a human capital approach), and therefore risks neglecting the present situation of children.

11 Kids Count, <http://www.aecf.org/kidscount/>; Child Trends, <http://www.childtrends.org/>.

12 University of Cape Town Children's Institute, <http://web.uct.ac.za/depts/ci>.

13 Committee on the Rights of the Child, General Comment No. 5, 'General measures of implementation of the Convention on the Rights of the Child' (Thirty-fourth session, 2003), U.N. Doc. CRC/GC/2003/5 (2003) at paragraph 12.

14 Committee on the Rights of the Child, General Comment No. 5, 'General measures of implementation of the Convention on the Rights of the Child' (Thirty-fourth session, 2003), U.N. Doc. CRC/GC/2003/5 (2003) note 7 at paragraph 12.

15 The language of rights-holders and duty-bearers is used in a number of departmental policies relating to children. For example, recommendations made within the Department of Social Development's report on the 2002 conference on co-ordinated action for children affected by HIV/AIDS included a process 'for identifying orphans, vulnerable children and duty-bearers, and creating a database' (DoSD, 2002, p. 3).

16 Childwatch International Research Network, <www.childwatch.uio.no/cwi/projects/indicators>; the US government reporting system on children, <childstats.gov/americaschildren>; Child Trends, <www.childtrends.org>.

17 Available at <http://www.futureofchildren.org>.

CHAPTER 2

A rights-based approach to monitoring the well-being of children in South Africa

Rachel Bray and Andrew Dawes

Introduction

The previous chapter provided some history of attempts to establish a system for monitoring child rights and well-being in South Africa, and laid out some of the key conceptual issues that need to be addressed. The purpose of this chapter is to move to the next and more practical stage of the design process. Here we propose a framework to guide the design of a rights-based and well-being monitoring system for the country, including criteria for the selection of indicators and measures. It is our intention that the model be refined during a series of consultations with policy experts and government.

The chapter begins with a discussion of current internationally agreed monitoring priorities. It is necessary that a South African system be aligned with them. We then highlight two prominent concerns for South Africa that have a critical impact on child rights and well-being: child poverty and HIV/AIDS. Any local system should address these issues. In our approach, poverty and HIV/AIDS are cross-cutters – they impact on all spheres of life. The final section of the chapter presents our conceptual framework for a rights-based approach to monitoring the well-being of children living in South Africa. Note that we include all children living in the country, not just South African children. The rights afforded by the UN Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) apply to all children, regardless of nationality, as long as they live here.

Alignment of South African child monitoring systems with national and international priorities

Adding to the rights arguments on behalf of children that we outlined in Chapter 1, it is both conceptually appropriate and politically strategic to make explicit links between international and national social and economic development goals and the fulfilment of children's rights – for example, the Millennium Development Goals (MDGs) and New Partnership for Africa's Development (NEPAD) goals.

In Chapter 1, we noted that it is essential that a child rights and well-being monitoring system articulates with the monitoring and evaluation processes being developed by government to track policy delivery. This does not mean the system

should be confined to parameters determined by the state but, rather, that they should be included. Indeed it may well be the case that the state's indicator system will not contain all those that it might be desirable to have in a comprehensive rights-based and well-being reporting system.

The first benefit of such explicit links is that they provide the context of broad social, economic and political changes (and policy directions) in which child outcomes must be understood. A child-specific monitoring system may not assess these adequately unless the link is made explicit. Secondly, a rights-based monitoring system can contribute to the overall monitoring of development progress in South Africa, and reveal sectors and geographical areas where greater investment in children's lives stands to significantly reduce poverty amongst the current and future generation. Third, support from those in positions to influence child outcomes through macro development policy is more likely to be forthcoming when a clear link is made between observed changes (or stasis) in child outcomes, and the policy-making and implementation process (at all levels of government).

The implication of these benefits in the South African context is that we should pay particular attention to the indicators selected to monitor the achievement of international MDGs that relate to children and their rights (Table 2.1), and to NEPAD's peer review mechanism indicators (see later). Unsurprisingly, the MDGs and their indicators relate to states' progress towards meeting basic needs, including nutrition, education, health and service provision.

Table 2.1 Millennium Development Goals and indicators that apply to child rights and well-being

Goal	Indicator
To eradicate extreme poverty and hunger.	Prevalence of underweight children under nine years of age.
To achieve universal primary education.	Net enrolment ratio in primary education, and literacy rate of 15–24 year olds.
To achieve gender equality in education.	Ratio of girls to boys in primary, secondary and tertiary education.
To reduce child mortality.	Under five mortality; infant mortality; proportion of one-year-old children immunised against measles.
To improve maternal health.	Proportion of births attended by skilled health personnel.
To combat HIV/AIDS, malaria and other diseases.	HIV prevalence by age, gender, race and province, and condom prevalence rate for 15–24 year olds.
To improve access to basic services.	Proportion of population/households with access to potable water, sanitation, electricity, health services and public transport.

The first four MDGs and number 6 are measured using primary data on children (in that case, adolescents). The other two rely on data on women or households. The aim of the MDGs and their indicators is to identify a small but powerful set to measure overall human development, while including critical directly measured child indicators and others that measure risks to child well-being and survival.

Apart from the education indicators, the MDG indicators are orientated towards child survival rather than development. Consequently, they fail to capture outcomes

relating to broader notions of children's rights and well-being (for example, social roles and citizenship) or, more important perhaps, to the contextual data required to understand the relationship between children's environments (inputs for development) and child outcomes in the short or medium term. For example, school enrolment is a flawed measure of the amount of education received by a young person because enrolled children may not attend (see Chapter 8 in this volume).

While the MDG indicators are insufficient alone, their inclusion within a national child rights monitoring system is required in terms of our international obligations, and is an effective means of producing regular and accurate data on how children are faring, at least in these domains.

These are the NEPAD indicators that apply to child rights and well-being:

Objective 8: Promotion and protection of the rights of the child and young persons. The three indicators are:

1. Effectiveness of constitutional provisions and institutions to advance the rights of the child and young persons;
2. Accession to and ratification of the relevant international instruments on the rights of the child and young persons, and the measures taken to implement them;
3. Consequential steps taken to ensure the realisation of the rights of children and young persons.

It is very important that child rights have been inserted in the NEPAD goals, given the massive challenges facing the continent's children.

However, although helpful for identifying ways to monitor the specification of children's rights, the NEPAD framework is of limited use because it neither contains measures of provision nor specifies child outcomes. Clauses one and three are extremely vague and difficult to operationalise (essential for monitoring purposes). These serious omissions weaken the African Union's (AUs) ability to monitor the situation of children and track outcomes related to the implementation of the rights provisions.

The African Charter on the Rights and Welfare of Children (AC – see Appendix 3 in this volume) was discussed in Chapter 1. The AC makes provision for an African Committee of Experts on the Rights and Welfare of the Child (Article 32), 'to promote and protect the rights and welfare of the child'. The Committee is an organ of the AU, and in terms of Article 43 of the AC, signatory countries are required to submit reports on the situation of their children through the Secretary General of the AU within two years of ratification, and every three years thereafter. The Committee is charged with reporting on its activities at each Ordinary Session of the Assembly of Heads of State and Government every two years. The report is to be published once it has been considered by the Assembly of Heads of State and Government, and States Parties are obliged to make the Committee's reports widely available to the public in their own countries.

Note that countries are required to report every three years *in addition* to the five-year reporting cycle required by the Committee on the Rights of the Child. However, no member countries had submitted reports at the time of writing (pers. comm.[1]). The frequency of reporting is no doubt an excessive burden on countries that have a

limited knowledge management infrastructure and expertise. There is no readily available commentary on these challenges and, as Gose (2002) notes, there is very little literature on the AC and its implementation. The AU website is not helpful in this regard.

The inclusion of specific goals for monitoring the situation of Africa's children in the NEPAD process would go some way toward supporting the monitoring functions of the AC and provide the beginnings of a way of holding governments to account for the situation of their children. Consideration should therefore be given to the advantage of linking broad development goals for the continent to more specific measures of support for child development and child outcomes.

Across the continent, and particularly in South Africa, a key challenge to this process lies in ensuring that the goals and accompanying indicators are meaningful across diverse cultures and do not inadvertently impose a set of northern standards and values. Careful thought should be given to the point at which goals relating to child development are best incorporated into the process of defining indicators, and the means of measuring each indicator. One possibility is to use understandings of child development that exist in South Africa to define indicators required for different ages of children.[2]

In addition, of course, there is the challenge of paying for and collecting good data for these purposes. Monitoring is not inexpensive and where other priorities have first call on funds, this activity will be sidelined. However, states need to appreciate that paying for cost-efficient monitoring systems is an investment that can pay dividends as an aid to planning and service targeting. Clearly, systems would have to be designed that are cost-efficient enough to implement in countries with low support bases for this kind of initiative.

An important consideration when developing a monitoring system is to ensure that it is aligned with national and international priorities. Two of these will be highlighted here: child poverty and HIV/AIDS.

Child poverty through a child rights lens

Child poverty is a critical issue both in South Africa and the rest of the continent. There are empirically established connections between investment in child well-being, fulfilment of basic rights, and improved outcomes in adulthood (Heckman & Forum, 1999). Poverty reduction strategies are a case in point (Harpham, 2001).

Every country that has seriously attempted to monitor the rights or well-being of children has grappled with difficult questions around the definition and measurement of child poverty. South Africa is no exception, and may indeed prove to have additional challenges owing to the nature and depth of past and present inequalities.

The extensive discussion required to guide the design of workable monitoring systems in South Africa is beyond the scope of this chapter and is covered elsewhere (e.g. Coetzee & Streak, 2004; Chapter 3 in this volume). Our intention in this chapter is simply to alert readers to some key points regarding child poverty that have been raised in international research and practice.

Firstly, for most poor South Africans, poverty is not a transient event. It is deep, chronic, and in many cases transgenerational. It is well established that enduring conditions of poverty are likely to have more profound effects on a wide range of developmental outcomes than passing or transitory episodes of deprivation (McLoyd, 1998). Similarly, children who live in conditions of chronic poverty are more likely to be denied a range of rights than children who live in situations of sufficiency.

Hence, a monitoring system that can document the forms, depths and distribution of poverty amongst children, and can link causes to child outcomes, is vital to sensible policy development. Achieving such a system requires verification of the links between conditions of poverty and child outcomes using sound analytical frameworks. No empirical tests of child poverty formulations (relative or absolute) have been conducted in South Africa to establish which are able to discriminate between those children who face the prospect of poor developmental outcomes and those who do not.

In addition, we must bear in mind that even short-term deprivation (and poverty) can have long-term consequences that may manifest themselves in later childhood and/or adulthood (Harpham, 2001). A monitoring system able to track these processes must therefore be based in child development theory that draws on proven links between developmental stages and particular vulnerabilities.

These points make good conceptual sense, but their translation into a workable system of indicators and measurements raises some difficult questions. The first relates to the *definition of poverty employed* (see Streak, 2004; Chapter 3 in this volume). Extensive research within the last 20 years has demonstrated that poverty is a historically structured and multifaceted phenomenon. Models of economic poverty imported from other parts of the world may be limited in their ability to capture the experience and implications of 'being poor' in South Africa. We must therefore ask ourselves whether we can achieve a measure that accurately reflects South African children's experience of poverty with sufficient conceptual clarity to distinguish experience from the causes and consequences of poverty, yet at the same time provides the data to examine the relationship between cause, effect and experience.

At this point, it is helpful to review decisions made in other countries towards defining and measuring child poverty within a broader monitoring system.

The approach used in the US focuses on economic deprivation rather than on a broad spectrum of physical, social and psychological factors. The standard definition of economic poverty used in guiding monitoring frameworks in the US is *inadequate resources to meet basic needs* (food, shelter and clothing), a definition that emphasises material well-being and the notion of a set minimum standard of living (Aber & Jones, 1997). Like rights-based approaches, the American definition is based on a notion of entitlement to resources. The difference seems to lie in its restriction to economic means of resource access, an approach that would ignore the role of social networks, ascribed social roles, local power hierarchies and other aspects of social capital that profoundly affect children's ability to access resources.

In contrast, European definitions of poverty tend to be orientated around concerns about inequality and social exclusion (Aber & Jones, 1997). In practice, this has

meant that Europeans have used *a relative poverty line* in assessing proportions of poor people, whereas America developed *an absolute poverty line* that is adjusted by family size (to allow for potential economies of scale) and by an index of inflation (Aber & Jones, 1997). These matters are taken further in Chapter 3 in this volume.

It is vitally important that both international experience in monitoring child outcomes and local knowledge of childhoods and poverty in South Africa guide future work in this area. At this point, we offer some preliminary guidelines to the next stage of thinking and research on these issues.

A poverty measure for South African children would require specification of their social security rights. Recent research by the Institute for Democracy in South Africa (IDASA) has attempted to pin down the state's precise financial commitments to children. The right to an income through social security, for example, is not clearly spelled out in the Constitution. Yet the IDASA team have argued that the combination of statements around rights to basic nutrition, healthcare, social services, adequate housing and education can be understood as conferring to children the right to social security as a means of meeting basic needs (Cassiem & Streak, 2001; Coetzee & Streak, 2004). Agreement around the economic rights ascribed to children is necessary before a decision can be made about whether and how to measure children's income. The Child Support Grant (CSG) is the official provision for children. Its positive impact on improved child outcomes is clear (Hunter, 2002; Samson et al., 2004; Budlender & Woolard, 2006; Carter et al., in press), even if it is used to meet a range of household expenses that are not directly child related. These other improvements (for example improved food security) may also have the effect of improving the situation of the children in that household (Case et al., 2003; Leatt, 2003). Old age pensions have also been shown to play a key role in supporting children, particularly in meeting educational expenses (Barbarin & Richter, 2001a).

Having identified what South African children are entitled to, the next challenge is to identify ways of measuring provision to children that can be linked to outcomes. Unfortunately there are gaps in our knowledge around cause and effect in relation to child outcomes. For example, although research in South Africa suggests a correlation between income poverty and physical vulnerability and abuse (e.g. Dawes, Borel-Saladin et al., 2004), and between lack of income and social exclusion (e.g. Cassiem et al., 2000), we know little about the relationship between economic factors and family structures, their impact on adult and child behaviour, and the processes underlying these connections.

It is therefore difficult to isolate reasons why some children in some families thrive despite high levels of income poverty, and why some families respond to economic poverty by accessing services while others do not. Factors such as differences in mental and physical health status, ability and personal qualities (which have been shown to be important in determining responses to poverty) are likely to play a role here, yet often remain unmeasured (Huston, 2002). For example, poverty and income loss may affect children through a change in the socio-emotional climate in the home. Here the mediating factor may be parental psychological distress that results in lower levels of warmth expressed to children and harsher punishments (Huston, 2002). Clearly, such gaps in knowledge should be noted in the process of indicator design in order to avoid inappropriate conclusions.

One way of addressing the problem is to conduct controlled studies to establish whether differences in child outcomes are due to the policy 'treatments' or other confounding factors (Huston, 2002). Given that surveys cannot be used for such purposes, Huston recommends complementary data collection in the form of direct observation, in-depth testing and interviewing, and ethnographic techniques. Practically speaking, this would suggest identifying a few sentinel sites for data collection of this nature.

Chapter 3 in this volume provides a thorough account of different approaches to child poverty measurement and will not be repeated here, save to say that poverty should be conceptualised as *multidimensional*, and careful thought given to the range of economic, social, physical and psychological aspects of *child* poverty across South Africa. Both empirical measures of insufficiency and measures that reflect the lived experience of poverty will fall within such a definition.

An important contribution to the measurement of poverty using a multidimensional approach in South Africa has recently been published by Noble and his collaborators and is known as the Provincial Indices of Multiple Deprivation (PIMD) (Noble, Babita et al., 2006; see also Chapter 3 in this volume). The PIMD takes into account several domains of deprivation based on Census data, and is used to map the distribution of deprivation down to small-area level. At the time of writing, work was under way to construct a PIMD for children with child-centred indicators and domains. This tool will facilitate intervention targeting for children.

HIV/AIDS

The HIV/AIDS epidemic is another national and continental priority issue that will be with us for many years. Conditions of poverty coupled with high rates of HIV/AIDS compromise caregiving environments and child outcomes. The quality of care children receive strongly determines their psychosocial development, including their intellectual achievement and social and behavioural adjustment (Richter, Manegold et al., 2004). In turn, positive child development outcomes contribute to national development.

In the current South African context, it is vital that we are able to monitor accurately the relationship between poverty, HIV/AIDS and child outcomes. Research with children and their carers shows that HIV/AIDS in the family and community gives rise to similar, but often exacerbated, compromises to child outcomes as those produced by endemic poverty (Giese, Meintjies et al., 2003a). In order to respond to children's needs, a monitoring system should ideally be able to track the well-being and rights of children affected by the epidemic, as well as by poverty, so as to permit analysis of effects of these distinct but related factors. It should also be able to provide data on the probable numbers of children orphaned by HIV/AIDS and those living with caregivers who are ill. Such data can, of course, be obtained through household surveys.

However, although we take the view that the situation of these children must be monitored if welfare, education and health planning are to be based on sound evidence, we advise *against* monitoring systems that isolate 'orphans' or even 'AIDS-affected children' from broader issues of poverty and social exclusion.

Our reasons are threefold. Firstly, such monitoring systems risk neglecting the multiple causes of vulnerability and social exclusion that may accompany the effects of AIDS, and secondly, they may unwittingly feed into a misrepresentation of AIDS orphanhood as a unique and separate experience to that of many other children affected by the epidemic but not defined as 'AIDS orphans'. Such misrepresentations stand to negatively affect both AIDS-affected children and orphans through stigma, as well as other needy children through the allocation of resources using only AIDS-related criteria.

Finally, while these children face particular challenges when living with sick carers and when orphaned, we must be aware that significant numbers of children are likely to be orphaned for other reasons (for example, due to motor vehicle accidents and other illnesses) and also live in households with carers who are ill but do not have AIDS. It is therefore preferable to analyse child outcomes in relation to a range of contributory environmental factors including, for example, poverty, illness, school quality and working conditions.

That said, there will be circumstances when purposive enquiries will be necessary and when the AIDS-affected child population will need to be considered in its own right (see Chapter 17 in this volume).

Learning from elsewhere

It is worth noting the lessons learned in other countries regarding similar processes to those we propose. A number of developing and middle-income countries (for example, Senegal and Thailand) worked with Childwatch International during the 1990s to produce child rights monitoring systems that were workable in their own policy and cultural context (Miljeteig, 1997). Their experiences show the importance of a consultative process to define indicators and their groupings using existing national policy goals for children and local understandings of the rights enshrined within the CRC. Where consultation with key members of government and other agencies is not successful, it is unlikely that these design initiatives will lead to a well-informed, technically sophisticated monitoring system that is adopted by the necessary stakeholders.

As noted in Chapter 1, during the mid-1990s, Childwatch assisted South Africa by providing a forum for debate and training on the development of a monitoring system informed by the CRC. Unfortunately that process did not gather sufficient momentum to inform the subsequent work of the National Programme of Action in a deep manner, and what started as an important child rights and well-being initiative did not realise its potential. It is very probable that a major reason for this failure was that key persons in government did not embrace the initiative.

The present initiative has attempted to take that earlier process into account and advance the technical discussion on an appropriate system for the country. Consultation and the degree of buy-in by government and other stakeholders will eventually determine its success. Even if our approach is not adopted as a system, it nonetheless has the promise to guide both the state and organisations concerned with child rights and well-being in their approach to monitoring.

The UK and European Union (EU) systems we referred to in Chapter 1 have informed the current framework. For example, the Every Child Matters outcomes framework[3] provides four child well-being outcome domains: health, safety, social connectedness and capacity development. These are similar to those described below in our approach. The UK system also links outcomes to supports for development. These are dealt with by our input indicators, but our system is more clearly rights-based than that of the UK.

While not explicitly mentioned, the EU child well-being clusters (personal resources, education, family and immediate environment, and social resources) are all captured in our framework. For example, where the EU refers to indicators within the 'family' environment, we have referred to the 'child's home' environment (because of the many forms of care in South African households). In addition, as will be seen, we have separated out what the EU approach calls the 'immediate environment' and called it the 'neighbourhood' so as to draw separate attention to the need for monitoring this aspect of children's situations.

The supports to children's development provided by services are clearly identified, and will be in each chapter of the volume as they relate to a particular area. As indicated in Figure 2.1 (see later in this chapter), the child's personal resources, health, safety, education and social security/economic well-being are captured in the outcomes for children.

As will be evident below, high-level international and national legal provisions regarding children provide the *broad framework* within which children's rights may be monitored. However, they do not provide definitive guidance as to *what* should be monitored, particularly with respect to duty-bearer responsibilities for service provision and related inputs for development. Nonetheless, evidence as to what is good or bad for children provides key content to rights arguments and to informing the monitoring process. It is also essential to bear in mind that the CRC and the South African Constitution make it clear that children *have* rights. They are neither granted nor to be earned.

Establishing a conceptual framework

Given the challenges inherent in establishing a viable monitoring system, a robust conceptual framework that takes into account data availability is a useful starting point. The framework should be theoretically and empirically grounded, should marry with the understandings and approaches familiar to user groups, and give rise to variables relating to children's lives that are measurable and are able to perform the function of indicators.

A sound theoretical basis is best achieved through analysis of international monitoring experience (as outlined in Chapter 1) as well as close attention to South Africa's history, cultural diversity and current socio-political landscape. In addition, and as will be noted below, a knowledge of the factors that influence child well-being must inform the framework. In that sense it is evidence-based.

The principles outlined below are informed by these points. Guiding theoretical frameworks include models of child development based on recognition of the

interactions between children's immediate and proximal contexts and developmental outcomes (Dawes & Donald, 2000), and sociological theory that positions children as social actors whose lives are influenced by, and have an influence upon, the social and physical environments in which they live (Boyden, 1990).

Principle 1: incorporate the child's present while using a developmental perspective

A well-being approach to monitoring the situation of children holds that a positive quality of life during childhood is a legitimate goal in itself, rather than only a means to a better adulthood as articulated in a well-becoming orientation to monitoring. In an era of rights-based thinking, this point seems entirely obvious. Yet it is worth saying given a recent history of welfare-orientated thinking in which the onus was often on children's futures and issues relating to 'proper' socialisation into adulthood.

That said, research shows that the achievement of certain competencies during childhood is arguably the best preparation for adulthood (see, for example, the positive attributes, or '5Cs', as defined by Lerner et al. [2000] and outlined below). For this reason, investment in children is critical to improving future adult well-being, reducing poverty and achieving social and economic development goals.

A developmental perspective acknowledges that children undergo physical, social and psychological changes with age. For this reason they occupy a special, and often (but not always) particularly vulnerable, position in any given society. The challenge inherent in developing a conceptual framework for monitoring is to incorporate socio-cultural understandings of children's roles and culturally specific definitions of the maturation process, in a manner that is consistent with established child development theory (Dawes, Bray et al., 2004).

Principle 2: assess both positive and negative outcomes for children

A balanced assessment of child well-being and the provision of children's rights will include the measurement of positive outcomes for children, as well as negative outcomes and related risk factors (Aber & Jones, 1997; Ben-Arieh et al., 2001). While this may seem an obvious point, it is worth raising for two reasons. Firstly, many assessments of child rights and well-being, including national surveys, focus primarily (and for some age groups, exclusively) on risk and negative outcomes (Dolev & Habib, 1997; for South African examples see Bray, 2002).

Such an orientation suggests that those designing reports and surveys have, wittingly or unwittingly, subscribed to an approach that is more concerned with what children will become and what this will mean for society as a whole, than with the lives of children here and now. Secondly, although a reduction in negative outcomes may often be reflected in data showing related positive outcomes, this relationship cannot be assumed.

Principle 3: generate child-centred statistics

Effective monitoring of children's lives requires measures that can reflect reality as experienced by children. Child-centred statistics are measures for which the unit of

analysis is the child, as opposed to the child's carer, household or institutional environment. Given that such statistics are rarely generated through regular statutory processes, an important question is whether current household survey questions can actually generate child-centred statistics. In most cases (including South Africa), the answer is no. Surveys tend to capture data on children only as members of families, or alongside their mothers. For example, it is common to count *households* with access to clean water and proper sanitation. A child-centred statistical approach would count the *proportions of children* who have access to such facilities (using household survey data). We need to know this because poor water and sanitation pose risks to children's health.

Given that the generation of child-centred statistics often requires re-analysing existing data, there are clear implications for the development of a workable monitoring system. Most obviously, the choice of measures to be used for each chosen indicator will be influenced by the feasibility of generating child-centred measures from existing national and provincial survey instruments and administrative data. Of course if we wish to generate such data from household surveys, the format of the instrument must make it possible for children to be examined as a unit of analysis. This would not be a complex matter.

A clear understanding of the potential for producing child-centred statistics from established data sources is thus a crucial step in the development of a monitoring system.

Principle 4: document the relationship between the quality of children's environments and child outcomes

Although the South African context demands close attention to issues of survival and access to basic resources, investment must be made in monitoring the contexts that determine specific outcomes in terms of children's quality of life, for example, the role of community cohesion and parental attitudes in protecting or exposing children to abuse (see Chapter 4 in this volume). An understanding of these relationships is important because they determine both children's own life chances and their ability to contribute to future society and prosperity (White et al., 2002).

Principle 5: consider the timing of data collection

Two distinct issues arise when considering the point at which data are to be collected. First, there is the practical matter of working within the timetable set for major administrative exercises or surveys, such as the Census and other national surveys. In the light of the considerable challenges inherent in collecting comprehensive and accurate child-centred data, it is practical to make maximum use of regular surveys, to collate parallel administrative data and, as far as is possible, to organise the synchronous collection of any additional area-specific data. Decisions around the timing of data collection may also reflect the optimal point at which a policy might be expected to begin to show an impact.

The second issue relates to the fact that children are growing and developing over time. Careful thought should be given to determining appropriate points for measuring particular aspects of well-being within the child development process, and to the time intervals between each measurement. Research findings demonstrate the sensitivity of children to different stimuli or deprivation at particular points in

the life cycle. Thus measurements of certain indicators must be collected more frequently for particular age groups. For example, some early childhood-related survival indicators must be measured annually to identify critical risk areas to young children, particularly in the context of threats to survival such as under-nutrition, violence and HIV/AIDS.

A large proportion of monitoring indicators are likely to reflect change only over a two- to five-year period. However, indicators that are predictive of crisis situations ('early warning indicators') should be measured frequently, perhaps even annually. For example, in the context of the HIV epidemic, one should consider monitoring school attendance (rather than enrolment) in each grade in areas with a high prevalence of HIV on an annual basis. A drop in numbers relative to the number of children in the area who should be in school could signal an increase in the number of children affected by illness or losses in the family that cause them to drop out or migrate to stay with relatives elsewhere or move onto the streets.

Where the measurements provide critical indicators of change at provincial and local level, there is a strong argument for their more regular collection and collation (where possible through existing administrative systems) at these levels. These data are then available for aggregation at national level at wider time intervals.

In summary, a sound monitoring system should be able to:

- Incorporate and link different aspects of children's lives in ways that can explain both positive and negative outcomes in terms of a variety of environmental factors operating at individual, family and community levels;
- Articulate and examine the links between developmental stages in individual children, environmental conditions, and child outcomes (short and long term);
- Include measures of the physical and social environment, and of poverty, as experienced by children;
- Disaggregate data across a number of key lines (gender, age, population group, residential location, birth location, disability, education);
- Attune to the South African historical and current socio-political context, in order to show change and constancies in the lives of children and adolescents that can be analysed against wider change;
- Track the nature and scale of impact of major epidemics such as HIV/AIDS on children's lives, and the effectiveness of various responses to conditions brought about by AIDS;
- Produce and integrate data sets that are as cost-effective, accessible and uncomplicated as possible.

Design challenges

As child development processes are not made explicit in the Constitution or the CRC, it is important to keep sight of these when designing a monitoring system. Broadly speaking, there are three groups of relationships that must be considered when explaining child–context interactions and the influence of social environments on child outcomes (Dawes & Donald, 2000).

The first addresses the influence of proximal settings in which the child is in close and enduring contact with actors such as caregivers, teachers, neighbours and other associates.

The second refers to the way in which family, friendships and community can mediate the impact of the wider social and physical environment on child development outcomes.

The third group of relationships concerns the interaction between children's responses to environmental stressors and their immediate and long-term development outcomes. Concepts of coping or resilience may be useful here. However, these must be carefully defined before use, particularly within the context of HIV/AIDS where they tend to be liberally employed without clear definition.

At this point, we should emphasise that a monitoring framework based on a rights-based approach would not aim to measure child development per se, but would use models of child development to inform decisions about what aspect of development is to be measured at which point in time. For example, this process would involve the application of child development knowledge to the choice of indicators and measures of child outcomes in specific developmental domains (for example, cognitive, emotional or social functioning), as well as to the child's environment (see for example Chapter 9 in this volume). The data generated by these indicators would then need to be examined in relation to children's rights in order to answer this question: to what extent do the data reflect success or failure in our efforts to improve the situation of children and advance their rights?

The challenge lies in translating these principles into workable monitoring strategies. In the paragraphs that follow, we alert readers to some of the practical implications of aligning child development theory with a rights-based approach to monitoring.

Identifying vulnerability through disaggregated data

A rights-based approach to monitoring is consistent with developmental theory because it prioritises a disaggregated approach to data collection and analysis that enables links to be established between children's situation, developmental outcomes and the fulfilment of their rights. Such an approach is particularly valuable when we consider that the most vulnerable children are those who are exposed to multiple disadvantages (either simultaneously or successively), and that a primary goal of monitoring is to identify where and why children are under acute or chronic stress.

Distinguishing outcome indicators from mediating environmental indicators

Measurements (and hence their associated indicators) do not always easily divide into outcomes and mediating factors. For example, if we take a child-centred approach to measuring the quality of children's home environment, we would want to measure more than its physical characteristics (for example, sanitation, pollution and quality of shelter), and include factors such as parental attention, learning resources, opportunities for play and contact with carers. Here it becomes clear that 'the family is a mediating factor in child life chances, and that the quality of the parent–child relationship is an outcome measure and right of the child itself' (White et al., 2002, p. 19).

Moving beyond health and survival

In terms of the definition and measurement of positive child outcomes, our attention must stretch beyond health and survival to incorporate psychosocial attributes critical to a child's current and future well-being.

Lerner's model of five competencies (known as the '5Cs') that are associated with positive development is a useful starting point (Lerner et al., 2000). The competencies include *competence* (intellectual ability and social and behavioural skills), *connection* (positive bonds with people and institutions), *character* (integrity and moral centredness), *confidence* (positive self-regard, a sense of self-efficacy and courage), and finally *caring or compassion* (humane values, empathy, and a sense of social justice). It is worth noting that these attributes relate directly to the social and psychosocial aspects of well-being that are incorporated into some contemporary approaches to child poverty analysis.

Recent appraisals of the quality of child monitoring systems suggest that a range of indicator domains relating to safety, social inclusion, psychosocial competencies, participation, citizenship and children's subcultures are added to the core areas of well-being (Dolev & Habib, 1997; Richter, 2002).

Our challenge is to consider the significance of each of these in understanding the changes in South African children's lives, and to find sensible and practical means of measuring each factor alongside the relevant environmental factors.

Applying a rights perspective to different developmental stages

As children grow older, different areas of risk emerge, and different risk reduction strategies become appropriate. Huston's (2002) framework identifies a number of goals for development and related indicators that should be measured at different stages of the development process. She places considerable emphasis on the immediate caregiving environment of the child, asserting that in early childhood, stability of care is found to be more consistently related to social and emotional well-being than the type or quality of care (Huston, 2002). Moreover, the American data show firstly that 'the cognitive and social environment provided in the home predicts children's language development, intelligence, school readiness, and school achievement in reading and math', and secondly that 'maternal intellectual ability is also a strong predictor of children's academic performance suggesting both genetic and environmental contributions to children's performance' (Huston, 2002, p. 64).

In applying a rights perspective that is tuned to the South African context, we need to ask whether the South African data support such links and, if so, how these link to the rights ascribed to children through legal and cultural means (for example, 'the right to a positive and nurturing home environment' is a more plausible standard than 'the right to an intellectually able mother').

While the particular character of the immediate caregiving environment changes as children mature, their participation in positive social settings in both the immediate home context and the community remains crucial to positive outcomes. For example, studies in north America 'suggest that preschool children who receive care in formal centre-based settings show better cognitive and language development on average than do those cared for by relatives or non-relatives in home-based settings. Youths who participate in structured activities approved by adults have better school performance and less deviant behaviour than do those who spend after-school time in unsupervised activities with peers, especially in low-income families and neighborhoods' (Huston, 2002, p. 66).

As children get older, they have greater control over where they spend their time, who they associate with and what activities they experience. Here we see the bidirectional links between children's out-of-school environment and positive developments. For example, youths who are more attached to school and non-deviant peers select more positive activities which in turn reinforce positive behaviour. For these reasons, Huston (2002) suggests that the choices young people make about how and with whom they spend their time may be an important development 'outcome'. The development of measurement techniques to assess time use[4] would require an analysis of surveys that have attempted similar measures, and consideration of the scope and feasibility of child-centred, participatory methods to assist the interpretation of quantitative data.

Huston's (2002) model also points to the significance of parental work to child outcomes, both in terms of the potential for increased risk amongst young and school-aged children who do not receive care while their parents are working, and in terms of the model of 'working life' presented to children and its influence on their decisions and actions. She suggests that if parents' jobs are repetitious or are very poorly paid, children can conclude that work is dull and boring. On the other hand, parents who derive skills and social interaction (in other words, human and social capital) from work and regular decent pay can convey positive messages about work. It is worth asking whether we have evidence to support this link within and across different communities in South Africa, and enquiring as to whether existing surveys on the transition from school to work (for example, the Cape Area Panel Study) are collecting data that would shed light on such issues.

The significance of the antenatal environment and the early months and years of childhood in relation to future child well-being is well documented (St Pierre & Layzer, 1998). For this reason early childhood education programmes have been prominent among efforts to improve the outcomes of disadvantaged children. High-quality centre-based and intensive early childhood development programmes do make a difference to learning, language and cognition in the short term (and for longer if there is follow-up input) (St Pierre & Layzer, 1998). These high-quality programmes also improve school readiness and grade retention once the child is in school (Anderson et al. & The Task Force on Community Preventive Services, 2003). However, the findings are complex, and other interventions are required to complement the early education programmes. St Pierre and Layzer conclude that pre-school programmes 'alone are not enough to ameliorate the impact of poverty' (1998, p. 6).

As children spend much time with caregivers at home, it is often advocated that programmes that provide training (in parenting skills and child development knowledge) will lead to better child development outcomes. However, this is easier said than done, and for a variety of reasons. While some programmes have shown positive changes in parenting behaviour and knowledge, these do not always translate into significant improvements in child outcomes. Rather, the weight of the evidence suggests that it is direct inputs to children that make the difference (St Pierre & Layzer, 1998, 1999). Parenting programmes alone are not powerful enough to produce the gains one requires to overcome the deficits of a disadvantaged situation. Evidence from the US suggests that many low-income parents who are targeted in these programmes 'simply do not believe that their children require

special parental input to develop well' (St Pierre & Layzer, 1998, p. 8). We have no data on these issues from South Africa (see Chapter 9 in this volume).[5]

These comments are not to suggest that early intervention is inappropriate – far from it. The challenge is to design interventions with enough intensity, quality and duration, and which target the necessary domains of development and parenting behaviours, to make sufficient difference to overcome the deficits produced by poverty. The evidence is clear that direct inputs to children produce the best outcomes.

A recent review of nine country reports to the Committee on the Rights of the Child conducted by Anderson-Brolin and Radetsky (2002) found a focus on risks rather than positive aspects of well-being and development. One example of positive development during youth (which is not evident in these reports) is the extent of their participation in social and political processes (Bray, 2002; Emmett, 2004).

The review also points out that much of the information is ad hoc and this may be a result of the fact that young people are very rarely invited to participate in the monitoring process. Apart from being required by the CRC, the participation of young people in indicator development permits the inclusion of issues that are of concern to them and which have not been considered by adults who construct monitoring systems. Important contributions in this regard have been made in South Africa. Child participatory research to inform indicator development has been conducted in relation to child protection (Willenberg & Savahl, 2004), HIV/AIDS (Giese et al., 2001; Giese, Meintjies et al., 2003a), child poverty (Streak, 2004), and corporal punishment (Save the Children Sweden, 2005; Clacherty et al., 2005).

We turn now to the framework developed for the current research process, and unpack it in a series of steps.

Making it work: a proposal for South Africa

The framework presented here (see Figure 2.1) includes a series of levels from legal and policy frameworks related to child rights down to the lowest level depicting five types of indicators. This level contains the categories of indicator that are inserted into the child rights and well-being monitoring system, and for which appropriate measures must be developed.

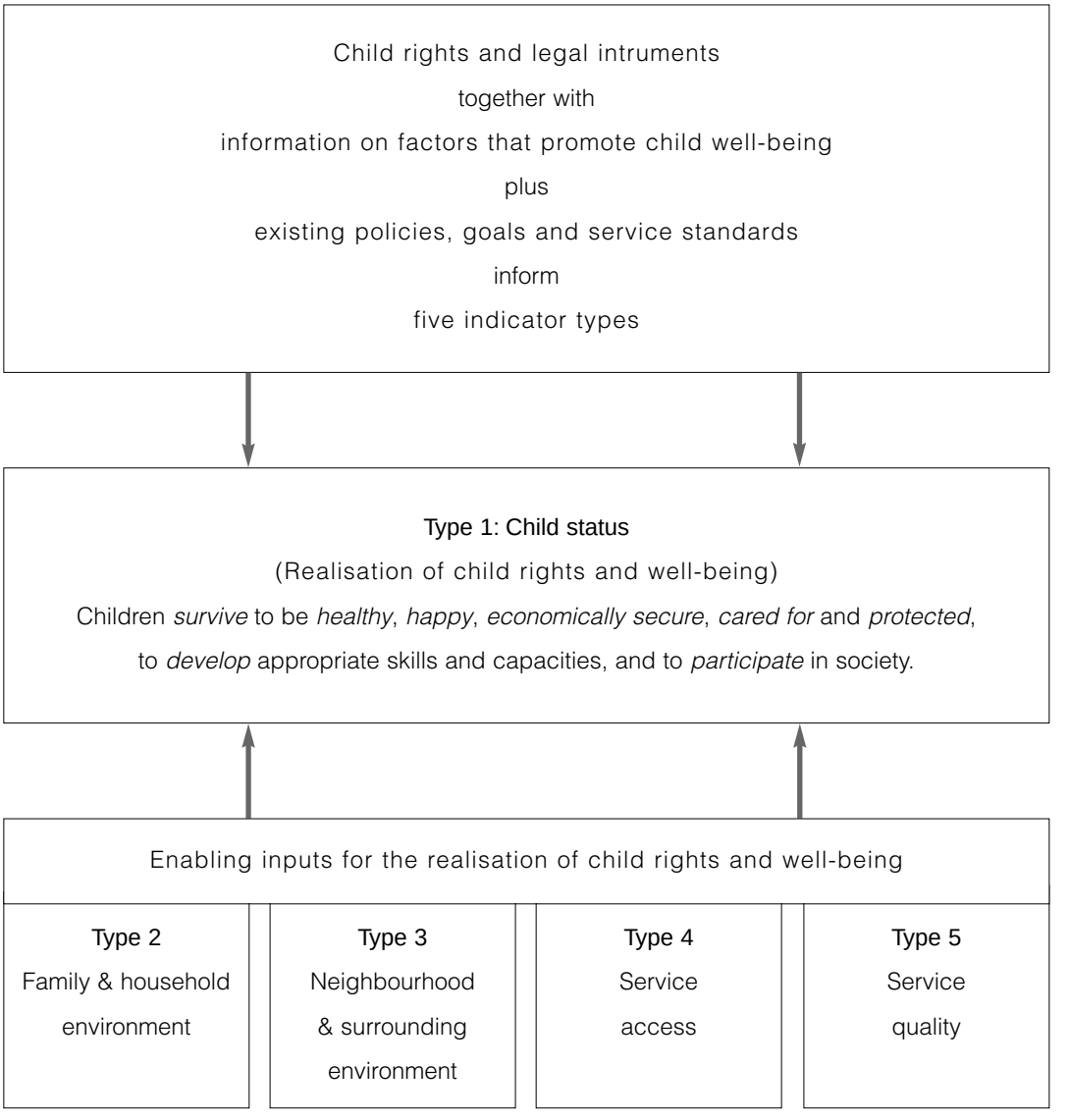
A key feature is that the indicators address more than just child well-being and include indicators of the quality of the child's developmental context, the care situation and the services which she has a right to access. It therefore includes both inputs for well-being as well as child outcomes.

Two approaches to the development of the framework were possible. One would have been to work from the bottom, and start with what is already recommended by agencies such as the United Nations Children's Fund and the Committee on the Rights of the Child, proceed to establish data availability, and finally recommend the addition of data to cover empirically known facts about what benefits or causes risks to child well-being and well-becoming. An advantage of such an approach is that one does not invent a high-level model only to discover it is of limited use because the data required to measure the indicators do not exist and are not likely to be

obtained any time soon. However, the disadvantage is that this way of proceeding is not *prospective* in being linked *ab initio* to a set of principles that guide data collection.

Our framework takes the conceptually driven route, but with an acute awareness of data availability. This is a challenging enterprise, but we believe more rigorous in its ability to reflect the range of domains that should be monitored if the promise of a rights-based approach is to be fulfilled. Our approach draws on the British and EU experience, but is more strongly normative (i.e. rights-based) in its orientation.

Figure 2.1 A conceptual framework for a rights-based approach to monitoring child well-being



Step 1: the specification of children's legal rights

Based on international experience, we suggest that the first step in designing a monitoring system should be to identify the rights that are granted to children by drawing on three bodies of law. The first includes international instruments ratified by the country, the second is the South African Constitution, and the third is relevant Acts and regulations that address the situation of children. Examples of the third category would include the Child Care Act (No. 74 of 1983) and its replacement the Children's Act (No. 38 of 2005), and the Children's Amendment Bill (No. 19 of 2006).

We call this step the *specification* of children's rights (see the top of Figure 2.1) (Bentley, 2002, 2005). As argued in Chapter 1, we strongly recommend that rights specification be based primarily on the South African Constitution and other accompanying national policies (which of course are aligned with the CRC). Regional and international frameworks such as the AC and the CRC are best used to guide indicator definition for areas of children's rights or aspects of child well-being that are not covered in national policy (for example, the rights to participation and representation covered under articles 12 and 13 in the CRC).

Step 2: incorporating policy frameworks

Policies and legislation designed to protect and provide for children are informed by the Constitution (particularly Section 28) and other overarching policy frameworks. In Step 2, it is necessary to identify South Africa's provision of children's rights as reflected in national policy and law (also noted in the first level in Figure 2.1). This step requires examining not only the policies and laws that relate specifically to children, but also others geared to broader goals such as the reduction of poverty and inequality.

Although we can expect that legislative frameworks will endure for some time ahead, changes do occur, and tracking changes in policy and legislation affecting children is an important aspect of rights-based monitoring. An indicator system must therefore be flexible enough to adjust to these changes when they occur. As a consequence, some indicators and measures will change.

A critical dimension to this second step is the identification of appropriate means to monitor the allocation of *resources* to children on the basis of the specified government policies and laws, as is currently carried out by institutions such as the IDASA Children's Budget unit and others (e.g. Case et al., 2003; Leatt, 2003; Streak, 2004). Regular data collection at national, provincial and district levels is required to track changes in the nature and scale (coverage) of resource allocation (Dawes, Biersteker et al., 2006; Dawes, Willenberg et al., 2006). These could be direct investments (for example, through the CSG and school feeding schemes), or indirect investments at family, community and even societal level. Examples include initiatives to raise the standard of living in poor households, to improve the social and physical environment of neighbourhoods and schools, or to enhance children's access to and participation in the national media.

Provided the systems are accurate, reliable and operational, a large proportion of this data should be available from national and provincial departments, as well as local

level service providers. However, owing to the fact that a significant proportion of service provision to children is contracted out to non-governmental organisation service providers, documentation of their programme coverage and related data would also be required. Again, the quality and consistency of these data would have to be ascertained. For example, the same indicators, definitions and measures must be used in each agency to enable aggregation.

It is necessary to see rights and law as enabling instruments for children. They do not have direct impacts on child well-being and development; rather, they exert their effects through duty-bearers and the conditions that are created for children as a consequence of the law. Child outcomes are a product of these conditions (poverty reduction, good schooling, etc.) but, more fundamentally, they are a product of individual biology, socialisation, peer relations and a host of other factors. An approach that is too legally reductionist misses this important point.

Step 3: grouping rights

The next component of the system requires identification of appropriate domains into which child *rights* can be clustered. Arguably the most important and the most challenging, this step involves organising the rights and well-being in a way that fits into existing understanding and practice (for example, as reflected in the organisation of policy documents). Then there is the challenge of ensuring that the data are available and can fit the parameters for indicators.

Internationally, children's rights are usually grouped into four domains: survival, protection, development and participation (Ennew, 1999), as illustrated in Figure 2.1 under 'Child Status'.

Opinions differ with respect to their use in monitoring. White et al. (2002) argue that they can be used to structure indicator development and to reinforce the need to monitor both process (inputs) and outcomes (particularly with respect to protection and participation).

In contrast, Ennew (1999) argues that these categories of rights should only be used in theoretical analysis, and should be avoided for practical purposes such as monitoring. She notes that they 'can introduce distortions and obstacles to implementation' (1999). The conceptual basis for her argument is that *each* right should be looked at in terms of *related* rights, within the specific country context – rights should not be monitored in isolation and out of context. While we concur with Ennew's caution and support the prevailing approach of the Committee on the Rights of the Child that rights should not be viewed in isolation, it is our view that these categories are useful as a guide to *indicator selection* because they help ensure that we move *beyond* more traditional approaches that monitor *only* child survival and protection. They permit us to monitor the extent to which children are healthy, feel safe, are economically secure and participate positively in society as they develop.

A rights-oriented approach is as concerned with changes in equality, non-discrimination and participation, as it is with the expected areas of change in child survival (Theis, 2003). The challenge is how to measure these dimensions of children's environment and experience, a point that relates to the last step in the framework.

Step 4: the five-type approach to indicator design

We turn finally to the lowest and most concrete level of the framework – the point at which measurement is carried out. Our approach contains five distinct types of indicator, following Kagan's (2004) approach to the development of indicators and standards for Early Childhood Development (ECD).

The framework seeks to enable the description of the status of the country's children (stratified in appropriate ways) in terms of five types of indicator that take into account the child's status, the home-care environment, the quality of the neighbourhoods in which children live, the extent to which they are able to access services, and the quality of those services. Each may be used to measure duty-bearer performance. All five types of indicator are represented in Figure 2.1. Definitions for each type follow. Our ability to use the system effectively depends on data availability, which is the most serious challenge.

In the presentation that follows, it is very important to note that the same indicator may be included under more than one type, depending on the purpose. For example, *immunisation* is a Type 1 indicator that measures the *health status* of children. However, it can also be used to point to children's access to services and then it is a Type 4 indicator. This is because the immunisation coverage of the population reflects the extent to which they have been provided with the necessary service. Many other examples are evident throughout the volume.

Type 1: Child status

These indicators measure the status of the child, whether this be in the domain of health (for example, immunisation status), safety (for example, whether the child has been a victim of abuse), education (for example, school enrolment or language ability), economic and social security (for example, poverty status), or participation (for example, membership of a youth group such as a choir).

While most indicators at this level would be derived from population studies and administrative data, it is important to note that qualitative information *based on child participation* is also of great importance. On the one hand, qualitative information is necessary to complement and make sense of data gleaned from population studies and can provide a much more nuanced picture of children's situations. Apart from providing information from the child's perspective, data derived from child participation plays a useful role by informing the construction of indicators and measures for quantitative survey purposes (Giese, Meintjies et al., 2003a; Streak, 2004).

Type 2: Family and household environment

These indicators measure the quality of the child's primary home-care setting. They include measures of care quality and social indicators such as services (electric light, sanitation, etc.), income and employment for a particular household. Such data permit the construction of child-centred statistics such as the proportion of school-age children who have access to electric light (rather than the proportion of households that have electricity). This type of indicator is similar to the cluster described under 'Family and immediate environment' in the EU approach (minus the neighbourhood component in that approach).

There are two components of importance: the human and the physical components of the environment. The human characteristics of the childcare environment would include measures of the quality of childcare and supports for child development provided by those who care for the children. Chapter 9 in this volume captures a range of childcare quality indicators.

Household structure and membership is important for child development and well-being. Analysis of such data enables us to explore who children live with. Are they cared for by biological parents, grandmothers, other kin, or are they without adult care and supervision? Children are known to move between households (both with and without biological kin), and there is great concern about orphaned child-headed households (Bray, 2003b). Caregiver resources would include their education levels, financial and employment status, and social network quality.

Physical components of the developmental niche (Harkness & Super, 1994) also play a major role in the quality of care available to the child. Therefore social indicators (see Type 3 below) are pertinent. Thus the child's health is compromised by poor household sanitation; stress due to inadequate income may impact on the caregiver's mental status, compromising the capacity to attend to the child's emotional and health needs. Therefore, when monitoring the quality of the home-care environment, it would be necessary to measure such aspects as the availability of clean water, appropriate sewerage and electricity, and housing quality. Electricity is needed for the use of computers, and also to provide light for studying. Telephone lines are needed for Internet connectivity – now becoming a key resource for child education and skill development.

As noted in Chapter 1, child poverty is obviously important to measure owing to the fact that it produces a clustering of the factors that negatively impact on child development (see Chapter 3 in this volume). In this country our efforts to measure the impact of poverty on child outcomes have commonly not been sophisticated. Our indicators should draw on the relevant evidence to specify and measure a set of key risks to well-being and development, enabling us to link poverty status to a number of such factors operating simultaneously and interactively (Kvalsvig, 2003). On the other side of the coin, protective factors promoting resilience should also be included. The resilience literature tells us that a significant proportion of children who are raised in poverty environments emerge with strengths and positive attributes despite their hardships (Wandersman & Nation, 1998; Luthar et al., 2000).

The home is also the site of injury and exposure to partner violence, alcohol and drug abuse, child abuse and maltreatment. These are important to measure to obtain an indication of the extent to which children are affected by these conditions at home.

The child's home could include a foster home, but not a children's residential care institution (this would be assessed under Types 4 and 5 as a service to children).

Type 3: Neighbourhood and surrounding environment

These indicators also consist of factors that affect child well-being and include a number of variables referred to above in the family and household environment (Type 2). However, in this instance, household level information is aggregated for a

specific area and used to describe the spaces in which a population of children resides. As in the EU approach, the idea is to designate a small area in which the child spends time – the 'immediate environment' or neighbourhood. Units of measurement are not easy and would have to be chosen with care. Depending on the purpose, they might include census tracts, place names, sub-place names, health districts, police precincts, social services districts and so on (see Chapter 3 in this volume). A major challenge in South Africa is that census tracts and place names do not coincide with the areas within which administrative data are collected (for example, police zones or health districts) (Dawes, Biersteker et al., 2006; Dawes, Willenberg et al., 2006). So it is sometimes difficult to overlay data that have been developed within different boundaries – for example, police crime data and census information.

It is at this level that small-area indices of child well-being can be constructed in order to provide information for policy targeting. For example, indicators of services provision (electricity, water and sanitation) could be combined with poverty indicators and with measures of community safety. Chapters 3 and 4 in this volume elaborate on these issues in relation to the measurement of child poverty and neighbourhoods respectively.

Type 4: Service access

These indicators describe access to services to which children may have a right, and which support their well-being and development (as illustrated in Figure 2.1). Examples include access to schools, to transport to get to school, to clinics, to judicial services and social welfare services (including access to grants). This category of indicator would include both the existence of facilities as well as service coverage (for example, school enrolment and attendance).

Type 5: Service quality

These indicators also relate to service inputs, but measure the quality of these services. Examples include health or education services, including levels of staff training, quality of staff interaction with children (for example, the quality of teaching), the quality and appropriateness of treatment (for example, in a clinic, a police station or a court), and the quality of relevant infrastructure (for example, courts provided with appropriate facilities for child testimony). Child service quality would also include residential settings for children placed in care, as well as those detained in the justice system. In these instances, measures of both the human and physical environments would be appropriate, as is the case in Type 2.

Conclusion

The framework we have presented strives to take into account both inputs for well-being and development as well as the outcomes we wish to track. We address children's *lived contexts*, such as their family and socio-economic situation and the quality of their community life.

However, this is not a system for monitoring child rights. It is a rights-based approach to monitoring child well-being.

We have formalised and 'mainstreamed' the incorporation of child rights into the monitoring system through including the obligation of duty-bearers to support the child's development in various ways. Thus the framework system provides a way of tracking the *performance* of duty-bearers.

Monitoring of duty-bearer responsibilities is not well developed in the literature on the subject of children's rights. As outlined above with respect to service access and quality, the monitoring framework captures such obligations in three ways:

- First, by measuring critical child outcomes that can be clustered under the headings of the right to survival, protection, development and participation;
- Second, by assessing the extent to which children are served by specific constitutional and other statutory and regulatory provisions; and
- Third, through regular monitoring of children's access to services, their quality and the extent to which services achieve desired outcomes. In this regard, certain measures of child status can provide a proxy indicator of service quality where direct measures are not available (for example, the maternal mortality rate is an indicator of obstetric service quality; low pass rates in science may be an indicator of poor teaching quality).

All those legally responsible for the well-being of children are duty-bearers, including parents and other caregivers, service providers (for example, teachers, nurses), the administrative system and political authorities. Given the chronic poverty and low-resource environments in which many South African caregivers and service providers find themselves, it is essential that appropriate resources are made available to them so that they can fulfil their responsibilities to children.

Too often we blame caregivers for their failure to provide for their children's development, and for the risks to which the child is exposed. Of course this is sometimes appropriate, but it is more likely that the vast majority of caregivers try to provide the best for their children in spite of their circumstances.

As will be evident from subsequent contributions in this volume, it is important to establish the indicator data that should be collected in each domain, and to ascertain what data are available and where gaps exist. Indeed, the whole system is dependent on the availability and quality of the data. Data are expensive to collect, and existing administrative systems run by government departments provide very important sources of routinely collected data. However, the quality of the data is not always sound, and the information collected is commonly limited (Dawes, Biersteker et al., 2006; Dawes, Long et al., 2006; Dawes, Willenberg et al., 2006). These authors point out that it is important for government at all levels to design administrative data systems that are reliable and appropriate for monitoring the situation of children across a number of domains. Education and health departments at national and provincial levels collect and report on a range of child indicators. However, this is not necessarily the case in other sectors (as noted by Dawes and colleagues in reference to child protection and ECD). This is a major task, but it is likely to pay off in terms of cost-efficiencies in the long run.

The regular Census and other national social household surveys are key sources of data, even though their focus is not on children. They offer opportunities for collecting a range of information relevant to the contexts within which children live, including their socio-economic well-being and access to services such as water and electricity.

However, there are many important aspects of child well-being and rights that national household surveys do not capture. Regional surveys focused on children and young people can contribute valuable information, but stop short of a national picture. Studies of specific groups are also needed – for example children with disabilities and those directly affected by HIV/AIDS.

Beyond enthusiasm for monitoring child well-being, a commitment in terms of staff, technical expertise and finances is required to avoid proceeding as we have done in the past – without an agreed monitoring framework, without agreed indicators and validated measures, and without strategies and time periods for monitoring and reporting on the situation of children.

The final point we wish to make is that serious consideration should be given to designing and running a regular national child survey specifically to collect information on the situation of South African children that is not otherwise readily available through administrative systems. It would not be necessary to undertake the survey annually. To maximise efficiency, it could be linked to another regular household survey such as the Census or the Demographic and Health Survey. The advantage of the Census is that it permits one to disaggregate the data down to small-area level. This would be of significant value to local planners (see chapters 3 and 4 in this volume). Adult household data could be collected at the same time as that obtained from children in the same household. Such a survey would complement the information available from other sources such as the administrative system and other purpose-built surveys designed to tap specific aspects of children's situation (see for example MRC, 2003).

We regularly measure the well-being of the economy. Is the status of children not equally important? We believe so.

Notes

1 December 2005, Stefan van der Swaluw, Manager Programmes and Partners, African Child Policy Forum, Addis Abbaba, Ethiopia

2 Useful data on this topic have recently been generated in the United Nations Children's Fund study – Going Global with Indicators of Child Well-Being – that examined local understandings of the development of children under ten years of age amongst lay and professional people from different cultural settings in South Africa (Dawes, Bray et al., 2004).

3 The Every Child Matters outcomes framework, <www.everychildmatters.gov.uk>.

4 The addition of an indicator domain to capture children's time use and range of activities undertaken has been suggested by some researchers (Ben-Arieh et al., 2001).

5 For a useful table summarising theoretical assumptions around ECD interventions and available research evidence on effective strategies, see St Pierre and Layzer (1998, p. 13).

CHAPTER 3

Conceptualising, defining and measuring child poverty in South Africa: an argument for a multidimensional approach

Michael Noble, Gemma Wright and Lucie Cluver

Introduction

The purpose of this chapter[1] is to explore a new approach to the conceptualisation and measurement of child poverty in South Africa.[2] A child-focused, multi-dimensional model is presented which is applicable to the South African context, consistent with the South African Constitution and its emphasis on social rights, and rooted in international theories of poverty and social deprivation. There are inevitably overlaps between child poverty and child well-being, and indeed certain indicators of child well-being do sit within a model of child poverty. This is particularly the case when child poverty is considered more broadly in terms of multiple deprivation, as in this chapter.

The South African Constitution identifies an extensive state commitment towards children: to provide for basic needs of nutrition, shelter, basic health-care services and social services.[3] Section 28 of the Bill of Rights (see Appendix 2 in this volume) further establishes a role in protecting children against maltreatment, neglect, abuse and labour which is exploitative or detrimental to health or development. South Africa also ratified the UN's Convention of the Rights of the Child (CRC – see Appendix 1, this volume) in 1995, and the African Charter on the Rights and Welfare of the Child (see Appendix 3, this volume) in 1999. It is also a signatory to Convention 138 and 182 of the International Labour Organisation regarding child labour. South Africa's commitment to these national and international frameworks is welcome, but creates obligations which have not always been met (Coetzee & Streak, 2004).

To some extent the existence of widespread child poverty in South Africa can be regarded as a failure to realise these rights. Child poverty is important for a number of reasons. First, a child's development, opportunities and experiences will impact on their functioning as adult citizens. Economic investment in childhood is an opportunity to address and prevent future poverty, for example, through education (Klasen, 2001). Futhermore, children are part of the intergenerational poverty equation (Atkinson & Hills, 1998). As poor adults, they are likely to have children who are excluded from opportunities, and socially excluded children are at high risk

of becoming poor adults themselves (Bradshaw, 2001). A further and increasingly recognised dimension to child poverty relates to the intrinsic importance of childhood. The experience of childhood matters, irrespective of its effects on the future, and children should be seen as social actors in their own right rather than as 'adults-to-be' (Ridge, 2002). A childhood experience of poverty should be seen as intrinsically unacceptable.

There are a number of competing poverty discourses, both within South Africa and internationally. These are further confounded by the introduction of the term 'social exclusion' into the debate. Before the model itself is presented, the first part of this chapter focuses on making clear distinctions between the conceptualisation, definition and measurement of poverty and social exclusion as experienced by children. By 'concepts', we mean the theoretical framework out of which definitions are developed (see also Lister, 2004). 'Definitions' distinguish 'the poor' from the 'non-poor', within the framework of the concepts. 'Measurements' operationalise the 'definition'. Following on from this section, the model is presented and some exemplar dimensions of deprivation are discussed in more detail. Key methodological issues are then considered. The chapter concludes with recommendations for putting the model into practice.

Absolute poverty

Absolute concepts of poverty

The concept of 'absolute' poverty refers to impoverishment which is defined independently of any reference group. It does not change according to prevailing living standards of a society, or over time, or according to needs of different groups in society. Absolute poverty is described as an 'objective, even scientific' notion (Alcock, 1997, p. 68), and is associated with the early British social reformers Booth and Rowntree (e.g. Rowntree, 1901). Absolute poverty is frequently defined in terms of basic subsistence and, in both literature and political discussion, the concept has become synonymous with subsistence poverty. However, many commentators have argued that all so-called absolute concepts do in fact, to a certain extent, reflect the general living conditions prevailing at the time and are therefore to some extent relative (Alcock, 1997).

Defining absolute poverty

Though not necessarily the case from a theoretical perspective, definitions which flow from absolute concepts of poverty tend to have two characteristics. First, they are resource-based (i.e. based entirely on income or expenditure measures) and second, they are restricted to the minimum required for subsistence or meeting basic needs. Child poverty would be typically defined as a headcount of children living in households where the resources fell below the minimum subsistence level (or an equivalent depth measure). Rowntree's 'primary poverty' would be an example of this subsistence definition of absolute poverty: 'families whose total earnings are insufficient to obtain the minimum necessaries for the maintenance of merely physical efficiency' (1901, p. 86).

The World Bank has adopted an absolute concept and subsistence definition of poverty in the context of the developing world, which has led to the World Bank poverty line of 'a dollar a day' (World Bank, 2000). Although this has been accepted as a poverty line within the Millennium Development Goals, it has been heavily criticised for its narrow approach (Townsend & Gordon, 2002). Furthermore, the use of a subsistence poverty line overlooks many of the needs of vulnerable groups such as children.

Many of the definitions of poverty in South Africa have been based on an absolute concept and a subsistence definition (for example, the Poverty Datum Line and the Household Subsistence Level; see examples in Woolard, 1997). Typically, the definition has not been multidimensional and is simply based on per capita (or other equivalised) household expenditure. For a comprehensive discussion of these, see Streak (2004).

Absolute concepts of poverty do not, however, need to be defined simply in relation to resources. An alternative, and multidimensional, definition of absolute poverty was given at the 1995 World Summit for Social Development in Copenhagen:

> a condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to social services. (UN, 1995)

Relative poverty

Relative concepts of poverty

In contrast, the concept of 'relative' poverty specifically relates poverty to a reference group. In its narrowest sense, poverty is conceptualised relative to the national distribution of income/expenditure (e.g. May, 1998). More broadly, relative poverty is conceptualised by reference to the general living standards of the society as a whole or in terms of resources required to participate fully in that society. For example, Galbraith stated that:

> People are poverty stricken when their income, even if adequate for survival, falls markedly behind that of the community. Then they cannot have what the larger community regards as the minimum necessary for decency; and they cannot wholely [sic] escape, therefore, the judgement of the larger community that they are indecent. They are degraded, for, in a literal sense, they live outside the grades or categories which the community regards as respectable. (1958, p. 323)

This was further developed by Townsend:

> Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions which are customary, or at least widely encouraged or approved, in societies to which they belong. Their resources are so seriously below those commanded by the average family or individual that they are in effect excluded from ordinary living patterns, customs and activities. (1979, p. 31)

Critics of the concept of relative poverty have argued that this means that, in every society, some people will be poor compared to others, as there will never be absolute

equality. More importantly, in very poor countries (where the majority of people are very poor) a definition relative to that majority would be inappropriate (Sen, 1983). For this reason, Sen argues for an absolute 'core':

> There is, I would argue, an irreducible absolutist core in the idea of poverty. One element of that absolutist core is obvious enough…If there is starvation and hunger, then – no matter what the relative picture looks like – there clearly is poverty… (1983, p. 159)

Defining relative poverty

Income and expenditure

Defining relative poverty, that is, drawing the distinction between poor and non-poor, is more complex for most relative conceptualisations of poverty. Even relative conceptualisations which relate to national income or expenditure distributions have a number of definitions associated with them. In South Africa, this resource-based conceptualisation of relative poverty is usually defined by reference to the bottom 20 per cent or 40 per cent of the expenditure distribution. So, for example, the approach used in the report *Poverty and Inequality in South Africa* is to define the bottom four deciles of the distribution as 'poor':

> Recognising that poverty lines will differ over time and space and that deciding where to draw the poverty line is ultimately something of an arbitrary decision, the practice adopted by the earlier RDP [Reconstruction and Development Programme] study has been followed. 'Poor' has been defined as the poorest 40% of households and 'ultra poor' as the poorest 20% of households. (May, 1998, p. 27)

By contrast, the poor are defined in Organisation for Economic Co-operation and Development countries as those below various percentages of mean or median equivalised household income. Relative poverty in relation to children has been defined in terms of children living in such households (Bradbury & Jantti, 1999).

The selection of the bottom 20 per cent or 40 per cent of the income/expenditure distribution is particularly problematic as, inevitably, 'poverty' so defined could never be eradicated. Furthermore, with the current income distribution of South Africa, Haarmann (1999) found that income per capita in the poorest 40 per cent of South Africa's households is insufficient to give household members sufficient income to purchase goods required to meet basic needs. Even refining the definition to refer to mean or median equivalised household income is problematic as there is no empirical basis for arbitrary cut-offs.

Furthermore, the use of household income to define the poverty levels of individuals within that household is problematic. Streak suggests the use of adult equivalent income, which adjusts for the positive impact of size and youth, age and economies of scale (Streak, 2000, 2001). Equivalising income does not, however, address the question of how resources are actually distributed within households. Thus Haarmann (1999) and Bray (2002) challenge the assumption that household income is divided equally and altruistically between all household members. There are questions around the roles of duty, kinship, sharing and conflict in the distribution

of income within a household (Posel, 1997, cited in Bray, 2002). Qualitative evidence suggests that there may be intra-household inequalities according to gender and relationship of children within the family. For example, there is some evidence that fostered and non-biological children in Africa may be receiving lower levels of resources (Webb, 1995; Foster et al., 1997).

Participation in society

Relative concepts of poverty in the sense of Townsend's articulation of the inability to 'participate in the activities and have the living conditions that are customary in societies to which they belong…' (1979, p. 31) have been defined in a number of different ways. First, Townsend himself created an index of participation based on his own normative judgements. However, this was criticised mainly on the basis of the selection of components of the index (Piachaud, 1981). Such criticisms led to the development of the consensual or democratic approach to defining relative poverty.

Mack and Lansley (1985) pioneered the 'consensual approach' through the Breadline Britain Survey in the UK. This method surveys the general population in order to determine an inventory of 'socially perceived necessities' in terms of possessions, activities and access to services. The method has been replicated and extended both in the UK and elsewhere (Hallerod, 1994; Hallerod et al., 1997; Gordon et al., 2000). The consensual approach implicitly assumes a broad agreement (or at least a shared core) across groups within society, in both aspirations and perceived necessities. In the UK, this was empirically supported in both the Breadline Britain Survey (Mack & Lansley, 1985) and the UK Millennium Poverty and Social Exclusion Survey (Pantazis et al., 1999; Gordon et al., 2000), across population groups, class and economic groups.

The question remains whether such a consensus exists in South Africa. An ongoing research project by the Centre for the Analysis of South African Social Policy is currently using focus-group research and a large-scale survey to explore a consensual definition of poverty and social exclusion in South Africa, for adults of all ages (Noble et al., 2004).

Although socially perceived necessities will change over time, it is not the case that eradicating poverty depends on achieving total equality. A consensus on what constitutes such necessities, though addressing the inequalities agenda, will almost certainly fall short of total equality. Nevertheless, consensual definitions are 'democratic' in that poverty is defined by the views of the people as a whole (at least as represented in a sample survey) rather than by elite 'experts'. Moreover, consensual approaches have the potential to capture more aspects of social exclusion than minimal, absolute approaches.

Capabilities and commodities approach

The capabilities approach to the conceptualisation of poverty combines both absolute and relative concepts and frames poverty in terms of human capacity. The approach was introduced by Amartya Sen who viewed poverty as 'absolute in the space of capabilities' (such as nutrition, shelter and the capacity to move from A to B), but relative in the space of resources and commodities required to meet or

undertake them. For example, it is necessary to have the capability to get from A to B, but in different societies this would require differing commodities such as a car, a bicycle or a pair of shoes (see for example Sen, 1983). Sen also touches on the idea of participation in mainstream society as a capability: the capability of 'avoiding shame from failure to meet social conventions, participating in social activities, and retaining self-respect' (1983, p. 167). The operationalisation of this concept has been undertaken by constructing a capability list (Desai, 1995; Nussbaum, 2000).

Social exclusion

Concepts of social exclusion

Much of the academic discourse around social exclusion has been based in Europe (e.g. Room, 1995; Atkinson & Hills, 1998; Cousins, 1998; Levitas, 1998; Byrne, 1999; Burchardt, 2000; Hills et al., 2002). Social exclusion theories arise in part from concerns that 'the typical policy response to income poverty, social grants that lift people to the poverty line, is "not adequately addressing" the social policy problem of poverty, long-term unemployment and deprivation' (Klasen, 2001, p. 414).

There are many competing conceptualisations of social exclusion. In an attempt to categorise them, Levitas (1998) identifies three, often coexisting, discourses: redistributive discourse (RED), social integrationist discourse (SID) and moral underclass discourse (MUD). RED underpins concepts which are concerned with inequalities and redressing these. SID underpins concepts which emphasise social cohesion and people's capacity to function as citizens. MUD underpins concepts which equate the socially excluded with an 'undeserving underclass' (Murray, 1995).

Townsend (1979), with his emphasis on participating in the activities and having the living conditions customary in the societies to which they belong, and Sen (1983), with his emphasis on capability of avoiding shame, both heralded the conceptualisation of social exclusion within the RED/SID frameworks.

There are several key characteristics to the way in which exclusion is generally presented. Room (1995) highlights multidimensionality, agency, relations[4] and relativity as key aspects of social exclusion. Atkinson and Hills (1998) and Rodgers (1995) also see exclusion largely in these terms, highlighting agency, relativity, dynamics and multidimensionality. These four characteristics – multidimensionality, agency, relativity and relations – tend to be set out at the heart of many general descriptions of social exclusion.

There are at least two ways in which social exclusion can be seen as a concept distinct from even a broad notion of poverty. First, it can be argued that material resources – typically income – lie at the heart of what we understand poverty to be. On this reading, whilst poverty can be multidimensional in the space of outcomes, by its nature poverty is unidimensional in the space of causal factors because income dominates. Indeed, Townsend's (1979) project combined the use of a multi-dimensional deprivation list with the desire to discover the location of the income threshold necessary to achieve these goods (Nolan & Whelan, 1996). This is not the case with social exclusion, which can be multidimensional at both levels. Second, some see exclusion as related to the rights of citizenship, so that poverty may exist

only as a subset of the condition of exclusion. Rodgers (1995), Bergham (1995) and Room (1995), for instance, each use the Marshallian citizenship framework to outline a rights-based approach to social exclusion. Whilst poverty is restricted to a lack of disposable income in these accounts (Bergham, 1995), the concept of social exclusion fundamentally addresses the non-realisation of citizenship rights and the malfunctioning of the societal systems which should guarantee those rights (Bergham, 1995; Gore et al., 1995; Rodgers, 1995; Room, 1995).

Defining social exclusion

Burchardt et al. provide a working definition of social exclusion for use in empirical work:

> An individual is socially excluded if (a) he or she is geographically resident in a society but (b) for reasons beyond his or her control he or she cannot participate in the normal activities of citizens in that society and (c) he or she would like to so participate. (1999, p. 229)

This approach can be contextualised within a rights-based approach (e.g. Room, 1995), or a capabilities-based approach (Sen, 1983; Nussbaum, 2000).

South African academic work and government reports on poverty are increasingly engaging with the concept of social exclusion (DoE, 2001b; Beall et al., 2002; Taylor Committee, 2002; Du Toit, 2003). However, where social exclusion is explicitly addressed in South African policy and research, its definition usually focuses on marginalised subgroups within the broader group of the 'socially excluded' (Gore, 1994). These include the elderly, homeless people (Aliber, 2001), people with disabilities (DoE, 2001b), rural poor (Hemson, 2003), HIV/AIDS-affected people and women (Policy Co-ordination and Advisory Services & The Presidency, 2003). There has been no national level research on the extent of social exclusion due to poverty in South Africa.

Social exclusion can be defined using researcher judgement (e.g. Gordon et al., 2000). However, as indicated above, defining social exclusion also lends itself to a consensual approach (Noble et al., 2004).

From definitions to measurements of poverty

The term 'measurement' is used here to mean the technical operationalisation of a particular definition of poverty. Definitions of absolute poverty almost always use a basket of goods (otherwise known as the 'budget standards') approach (Rowntree, 1901; Potgieter, 1997). In this approach an inventory of goods and activities is drawn up and costed to a money-metric where possible.

The measurement of relative poverty will depend on the definition employed. Definitions constructed by reference to the income/expenditure distribution will of necessity be derived from an income/expenditure survey or some other general household survey which collects such data. Consensual definitions of relative poverty will be operationalised using a nationally representative sample survey to establish the definition (that is, the list of socially perceived necessities, activities and access to services). These socially perceived necessities would become key indicators

of poverty and social exclusion for monitoring purposes. The indicators could be grouped (perhaps according to some hierarchy similar to the European Union's primary and secondary indicators of social exclusion [Social Protection Committee, 2001]), presented separately, or used to construct composite indices of multiple deprivation. It would also be possible to cash-out the necessities (in combination with other information) using a non-minimalist, budget-standards approach for certain indicators (see the work of the Family Budget Unit at the University of York[5] for examples).

A proposed way forward

The post-1994 transformation project in South Africa is underpinned by commitments to tackle not only poverty and destitution, but also the extreme inequalities that are the legacies of apartheid. In order to address the inequalities agenda it is essential to have poverty conceptualised in a way which references living standards across all communities. The deprivation and inequalities are not limited to income and material deprivation and so any model developed must be multidimensional. Nevertheless, there is no doubt that there are large numbers of children who are living below subsistence levels. Taking Sen's (1983) point of safeguarding these children whatever their relative position happens to be, means that the 'relative' model needs an 'absolute' core.

Characteristics of a model of child poverty

The model of child poverty should:

- Have at its core a multidimensional absolute poverty component complemented by a relative multidimensional component based on the ability to participate fully in society;
- Contain different dimensions or 'domains' of deprivation;
- Take into account access to good quality services;
- Be child-focused, i.e. the child will be the unit of analysis, the poverty that is measured must be relevant to the life of the child, and children should be involved in defining poverty;
- Take into account applicability for different age groups of children.

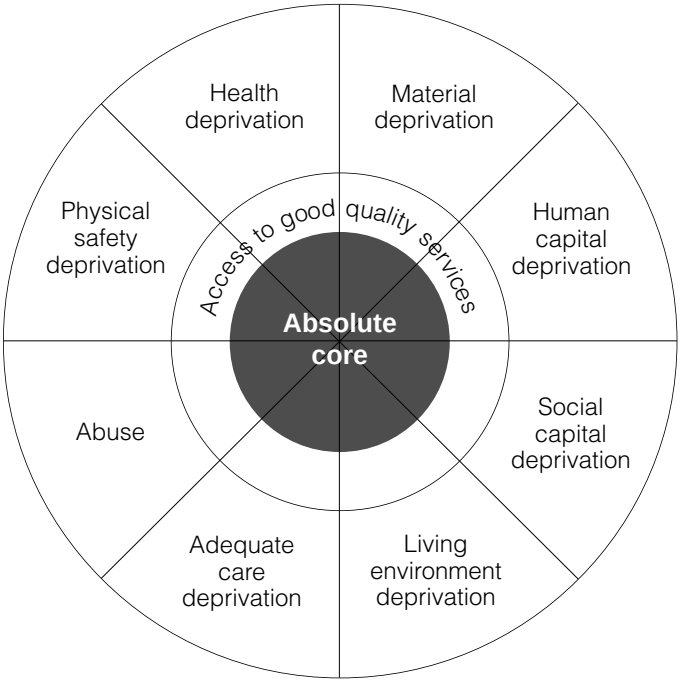
At the 'core' of the model is an absolute, multidimensional conceptualisation of poverty. This should take into account the Copenhagen Declaration on Social Development (UN, 1995).

This is complemented by a relative, multidimensional conceptualisation of poverty which is based on the ability to participate fully as a child in South African society. Two approaches will be used to define the relative component of the model. For indicators requiring specific expertise which neither children nor their caregivers could be expected to know (for example, issues relating to health status), evidence-based research on child well-being should be used. All other indicators should be defined by children themselves or, where appropriate, by their caregivers.

It is likely that the dimensions or 'domains' for both the absolute core and the relative aspects would be the same. What will be different is that the absolute core

will contain a narrower, more basic set of indicators which will not be determined by reference to full participation in society. The precise location of the boundary between the absolute core and the relative component will differ according to domain. For example, in the health, human capital, and physical safety domains almost all indicators will fall within the absolute core. In others such as the material deprivation domain this will not be the case. Figure 3.1 presents a diagrammatic representation of the model which contains some exemplar domains.

Figure 3.1 A multidimensional conceptualisation of child poverty



Access to good quality services

As can be seen, there is a 'ring' of indicators that relate to access to good quality services. This is placed at the interface of the relative and absolute components of the model, as it is equally relevant to both. This reflects the fact that in order to address poverty and social exclusion, services need to be both accessible and of good quality. For example, within the health domain, it is imperative that very young children should have access to clinics and that these clinics should be of a high standard. There is therefore a two-step measurement process to take into account first the presence and then the quality of a service.[6]

Child-focused model

The model of child poverty should be child focused. This is manifested in three ways:

- The unit of analysis should be the child;

- The domains of deprivation and the indicators within the domains should relate specifically to children; and
- Children should, wherever possible, participate in the definition of child poverty.

These criteria are to some extent interrelated – moving to children as the unit of analysis increases the scope to include child-centred domains of poverty. Most existing models of child poverty retain the household or family as the unit of analysis and define child poverty as a subset of household poverty. However, whilst poverty and exclusion amongst children is linked to the exclusion of their parents (Machin, 1998), Micklewright (2002) identifies child-specific dimensions of exclusion, such as child development, education, health and institutionalisation (see also Ridge, 2002).

As well as having the child as a unit of analysis, the dimensions of poverty must be relevant to children. This will mean that in addition to the domains of deprivation which apply to both adults and children, there will be specific domains relevant only to children. So, for example, recent research suggests that child abuse, loss of caregivers and unsafe environments are of great importance to children (Berry & Guthrie, 2003).

Indicators within the other domains will also need to be child-specific. Micklewright (2002) and Adelman et al. (2003) criticise the lack of specific indicators intended to capture exclusion amongst children. 'What is needed to assess child exclusion in the area of current living standards is systematic measurement of what children actually consume or do' (Micklewright, 2002, p. 23). In South Africa the need for child-focused measures is also widely articulated (e.g. Woolard, 2001). A child-focused approach also relates more closely to the measurement of child well-being and has synergies with the proposals contained in Chapter 2 in this volume.

Children also need to be involved as informants in the definition of child poverty. Participatory research with South African children has identified human capital issues such as exclusion from and within school as being important to children, including financial concerns about lack of school fees, uniforms and books (May, 1998; Giese et al., 2001). Children in the ACESS (2002) and SA-PPA (1997) research identified concerns including vulnerability to physical and sexual abuse, substance abuse, stigma against those affected by HIV/AIDS (Giese et al., 2001), violence, lack of leisure activities and overcrowded housing.

The study undertaken for the Children's Budget Unit at the Institute for Democracy in South Africa (IDASA) (Coetzee & Streak, 2004) provides a good starting point for developing those aspects of a consensual definition of relative poverty and social exclusion as defined by the children themselves. Such qualitative work is an important precursor to quantitatively establishing socially perceived necessities.

It is also necessary to take into account the varying needs of children as they become older. The proposed model could be seen as having a different 'layer' for various age groups. The model would then have different indicators (or at any rate, different thresholds for the same indicators) for those age groups, within any given domain. This would relate to both the absolute and relative components of the model, and in a sense would make the model three-dimensional.

Relevance of the model to developing countries in general and South Africa in particular

Multidimensional approaches to measuring child poverty and social deprivation have been articulated for the developed world by a number of researchers (e.g. Micklewright & Stewart, 1999; Plewis et al., 2001). The approach was also found to be relevant in the developing world in a recent review of comparative perspectives on child poverty (White et al., 2002).

It is crucial, however, that the multidimensionality of the model, and the indicators within it, accurately reflect the situation of children in South Africa. Invaluable research in this field has been conducted by the Children's Institute of the University of Cape Town (e.g. Berry & Guthrie, 2003), Idasa (e.g. Cassiem et al., 2000), and the Human Sciences Research Council (e.g. Bray, 2002; Dawes, 2002a). Such research, as well as current examples presented elsewhere in this volume, is reflected in many of the indicators and domains described below.

Relationships between domains and common themes across domains

Though the domains are depicted as distinct aspects of deprivation in the model, there can be complex causal relationships between them. For example, overcrowding in the living environment domain increases the likelihood of sexual abuse in the physical safety domain (Dawes, 2002a, 2002b), which in turn increases the likelihood of HIV infection and poor mental health in the health domain. However, it is not intended that the model of child poverty should explain causal relationships between indicators or domains. If a child is sexually abused and this has resulted in HIV infection for the child then *both* the abuse and the infection will be picked up as two aspects of multiple deprivation.

Some themes occur in more than one domain. This is especially true of HIV/AIDS, and recent research has demonstrated the impact on children of living in families affected by HIV/AIDS across many domains (Giese et al., 2001; Berry & Guthrie, 2003), ranging from stigma at school to increased economic instability and higher risk of contracting opportunistic infections from unwell family members. Attention has been focused largely on HIV-positive children, children orphaned by AIDS, and to a lesser extent those living with sick and dying caregivers. However, recent research suggests that the effects of economic and social instability caused by the AIDS epidemic may be having serious adverse effects on a far wider group of children (Richter, 2001; Meintjies et al., 2003).

Examples of domains of poverty and indicators

In this section we look at both the absolute core and the relative aspects of poverty. We present examples of the dimensions or 'domains', and the sorts of indicators which might fall within either the absolute core or the relative components. The domains and indicators presented below are not intended to be comprehensive, but merely indicative. Indeed, the very nature of a consensual approach for the relative components is that many of the indicators will only emerge following appropriate research.

Material deprivation

The material deprivation domain would contain issues relating to material possessions and financial resources. The absolute core would contain indicators such as adequate food, clothing and warmth. Food has particular relevance for young children in terms of developmental milestones. High levels of food insecurity in South Africa (30 per cent of households) are reflected in stunting due to malnourishment amongst children (Mvulane & Proudlock, 2002).

The relative component might have indicators such as a television in the household; clothing and footwear which are fashionable enough to indicate that the young person 'belongs'; and the ability to have an occasional treat such as a trip to a shopping centre, cinema or swimming pool.

Human capital deprivation

Human capital approaches to poverty emphasise the importance of education in determining a child's prospects. A number of indicators can be used, relating to both school and non-school-based education. It could be argued that most of these indicators would fall within the absolute core.

Child education indicators might include attendance at primary and secondary school.[7] While the latest *Human Development Report* suggests that for 2001–02 net primary enrolment was 90 per cent, children reaching Grade 5 was estimated to be 65 per cent, and net secondary enrolment was 62 per cent (UN Development Programme, 2004, p. 24). However, enrolment can disguise the picture (see Chapter 8, this volume): better indicators might include the proportion of children in a grade appropriate for their age, school attendance levels (this would include children working on farms (Cassiem et al., 2000), qualification attainment (including vocational qualifications), and attendance at tertiary education institutions.

For younger children, a key indicator might be attendance at and availability of good quality Early Childhood Development facilities. Attendance at such facilities is currently estimated to be very low: less than one-sixth of 0–6 year olds (DoE, 2000a, p. 1).

Particular groups should be monitored in terms of both access to education and attainment. This would include school-aged mothers, young carers, and learners with special educational needs (LSENs). In 1999 there were only enough school places for 16 per cent of LSENs (DoE, 2001b, pp. 16–17; see Chapter 10 in this volume).

For children, attendance at school is frequently dependent on having school uniforms, school shoes and school fees. These issues would fall within the material deprivation domain. There is also a need for space and peace at home to do homework, which would fall into the 'indoors' living environment domain.

Other human capital indicators might include the acquisition of employable skills through apprenticeships and other forms of training, although it is important to be aware of the ongoing debate around paid work for children and its effect on education and development (see Chapter 13 in this volume).

Social capital deprivation

Social capital reflects much of social exclusion theory regarding the ability to participate within a society and is crucial to the 'relative' component in our model. It is reflected in the South African principle of ubuntu. It is important to be aware that 'society' for children is different from that of adults, and consensual definitions can play a crucial part in identifying what social capital means for children, and how we can measure it (Ridge, 2002; Warburg et al., 2002).

Community cohesion is an important aspect of social capital. Possible indicators include extended family support and support from neighbours and local friends. Religious institutions were described in research with HIV-affected children as a source of both support and stigma (Giese et al., 2001). Social connectedness has been identified as a particular issue for children with disabilities (see Chapter 10 in this volume). Research with poor children in the UK (Ridge, 2002) found that children identified friendship with peers as a safeguard against bullying and so friendship was an important aspect of social capital. Child friendship networks are themselves an important indicator of well-being. Research also raises the issue of children's need to have trusted adults, as well as access to information and social settings that provide non-violent alternatives to dealing with problems (see Chapter 4 in this volume).

Living environment deprivation (both 'indoors' and 'outdoors')

A crucial aspect of the living environment domain for children includes adequate shelter. Living environment deprivation will extend beyond street homelessness (see Chapter 12 in this volume) and will include insecure informal dwellings and overcrowding. The absolute core is likely to comprise indicators of a more basic housing type than the relative component. The absolute core will also comprise access to basic services such as water, sanitation and electricity. For example, 17 per cent of South African households had no toilet facilities in 2001 (Stats SA, 2001). Children are particularly affected by distance from water and fuel, as they often travel to collect these supplies. It is also important that the home should have the capacity for food to be prepared and stored safely.

This domain will also contain indicators on the features of the neighbourhood such as air pollution, noise pollution, and prevalence of crime in the neighbourhood. Participatory research with children in both South Africa and the UK suggests further services which children identify as needs (which might form part of the relative component), such as transport and safe play areas (ACESS, 2002; Ridge, 2002). Qualitative research suggests that children place importance on access to recreational activities, and this is supported by research on the value of play in child development and socialisation (see Chapter 4 in this volume).

Adequate care deprivation

Extensive research has emphasised the importance of caregivers in promoting child well-being at all ages. Thus, inadequate care is an indicator of deprivation for children. Inadequate care can be due to loss of caregivers through HIV/AIDS, other illnesses or violence, and has a number of possible outcomes for children. Studies

indicate that fostered children in households may experience increased levels of discrimination, neglect or abuse (UNAIDS et al., 2002). Children may also become street children (Richter & Van der Walt, 1996) or members of child-headed households, about whom there is very little research evidence but the likelihood of extreme difficulties. Adequate supervision is also important to prevent accidents and abuse. For children in state care, monitoring of adequate care is particularly important (see Chapter 15 in this volume).

Where caregivers are alive, inadequate care can be measured by a number of indicators particularly relevant to the South African context. These include neglect (both intentional and neglect due to poverty), exploitation and abuse. A specific South African feature in this domain is evidence of multiple caregiving environments. For example, a child may be cared for by their grandmother during the day, a family friend in the evening, and by their relatives living elsewhere at the weekend or during school holidays. Adequate care is therefore crucial in all settings.

A further area of importance for children is the 'opportunity to be a child'. This means that children should not be forced to take on adult roles of caring for dying parents, siblings, or full-time employment. This is a complex area as children become older. For example, Bray (2002) points out that many teenagers in South Africa are effectively leading adult lives, and that rigid distinctions between childhood and adulthood may be unhelpful.

Berry and Guthrie's research identifies a group of rights stipulated in the CRC, which they categorise as the 'right to special care, special protection and assistance' (2003, p. 37). This relates to particularly vulnerable groups such as refugee and asylum-seeking children; children in need of state accommodation; and children deprived of, or removed from, their family environment (articles 20 and 22, and Section 28(1)(b)). Further vulnerable groups identified are children affected, infected and orphaned by HIV/AIDS; street children; abandoned children; disabled children; and children in trouble with the law. Possible indicators include the quality and availability of institutional and foster care, and access to specialised services for children with particular needs.

Abuse

Abuse of children is a key indicator of deprivation and due to its prevalence in South Africa, the proposed model contains an abuse domain rather than subsuming it within other domains. Child abuse can take place within the home, at school, or in the neighbourhood more broadly. There is extensive research evidence of the negative outcomes of childhood abuse in areas such as mental health and education, both in childhood and in later years. Childhood abuse is categorised as physical, emotional, sexual or as intentional neglect (see Chapter 14 in this volume).

Rape and child prostitution have the additional concern of risk of HIV/AIDS infection and, despite unreliable and patchy data, appear to be rising (Dawes, Long et al., 2006). Indicators include sexual abuse, incest and rape within the household (Dawes, 2002a), and infant rape. Child abduction, trafficking and prostitution have all been found by recent research to be perpetrated by parents, gangs, teachers and police officers (Molo Songololo, 2000; see Chapter 13 in this volume). A particular difficulty in measuring rape is prevalent under-reporting (Rape Crisis South Africa, 2004).

Researchers such as Giese et al. (2001) and Dawes (2002b) identify high levels of corporal punishment and abuse within schools. Rape and sexual abuse within schools have been found to particularly affect girls, and are perpetrated by both other students and teachers (Human Rights Watch, 2000).

Physical safety deprivation

These indicators would fall within the absolute core in the proposed model.

Crimes against children are significantly higher in poorer areas (Dawes, 2002b, using South African Police Service data). These include a range of threats to the physical safety of children, such as firearms and sharp-object injuries and deaths. The high prevalence of gangs in urban areas (Redpath, 2001) also leads to injuries and deaths due to being caught in gang crossfire or in drive-by shootings.

Accidental injury and death are also key indicators, including falling, trauma, poisoning, drowning, burns and road traffic accidents (Matzopoulos, Norman et al., 2004). See Chapter 7 in this volume for a comprehensive review of these issues.

Health domain: physical and mental health

Indicators within this domain would fall within the absolute core in the model (see Chapter 5 in this volume). Primary indicators used for child health are often those of infant and child mortality rates. These are rising rapidly in South Africa, probably due to the HIV/AIDS pandemic (although causes of death are rarely recorded as HIV/AIDS). For example, 53 per cent of children infected by mother-to-child transmission (MTCT) in Africa die before the age of two (Newell et al., 2004). Therefore, HIV infection must also be included as an indicator of child health deprivation, relating both to MTCT and subsequent infection.

Other indicators of physical health relevant to children in South Africa include respiratory problems due to passive smoking and fumes from burning fuel. Berry and Guthrie (2003) highlight lead poisoning, diarrhoea, sexually transmitted diseases, tuberculosis, meningitis, malaria, and typhoid. Others would include intestinal infection and measles (see Chapter 5 in this volume).

Further indicators include whether the child suffers from chronic illnesses and from disabilities, including foetal alcohol syndrome, of which South Africa has the highest prevalence in the world (Child Health Policy Institute, 1999).

Developmental indicators for children include stunting due to malnutrition, as well as proportions of children reaching appropriate developmental milestones, and are also aspects of health deprivation.

Child mental health is also a key consideration, and one for which there are no national prevalence figures. Mental health has been found in international research to be closely interconnected with many other indicators, such as abuse, caregiving and witnessing domestic violence (Cohen & Work Group on Quality Issues, 1998; Carlson & Ruzek, 2001; Breslau, 2002). Bullying has also been found to adversely affect the mental health of children. Qualitative and international research suggests that children orphaned by AIDS may suffer from poor emotional health, and research in South Africa has confirmed this (Cluver et al. in press; Wild et al., forthcoming). Alcohol and substance misuse amongst children and

young people are also potential indicators in this domain (see Chapter 6 in this volume).

Further methodological issues

Children and consensual definitions of relative poverty

The importance of giving children a voice in the definition of poverty resonates with the CRC. Article 12 gives children the right to express views freely in matters affecting them. The relevance of child-centred participation is outlined by Johnson and colleagues:

> If we are unaware of the problems and issues that concern children and young people we cannot hope to devise strategies or solutions that will address their concerns. (Johnson et al., 1998, p. 299)

Whilst there is a large body of research focusing on the outcomes of childhood poverty and exclusion on adulthood, Ridge (2002) identifies a lack of child-centred research methods which engage directly with the meanings and perceptions of poor children themselves. Ridge argues that it is important to engage directly with poor children in order to understand what it means to them to be poor. Similarly, in South Africa, the South African Participatory Poverty Assessment (SA-PPA, 1997) and the South African Child Research Network (Guthrie et al., 2003) recently called for research that involved asking children themselves about their experiences of poverty.

A question that is sometimes raised in this regard is whether children are competent to express themselves with regard to poverty and social exclusion. Ridge (2002) found that children are effectively able to have insight into issues of poverty and exclusion. Where they do express such views, research in the UK has found 'a remarkable degree of consensus in the concerns expressed by young people' (Warburg et al., 2002, p. 3).

Challenges with consensual definitions

When one seeks to apply current thinking on poverty and social exclusion to the South African context, a number of challenges emerge. First, there is a potential difficulty of defining the nature of inclusion in a context where the majority of the population continues to live in what might be described as 'marginalised society'. It could be argued that, unlike western industrialised societies, the *majority* of the population in South Africa should not be equated with the 'socially included'.

Second, if it is to be accepted that there should be a single multicultural South African society – and not multiple 'uni-cultural' societies – it is first necessary to elucidate in broad terms the kind of society that South African people wish to belong to. However, in defining this desired society, there is the possibility that many people may have limited experience of more prosperous sectors of society. This could lead to a lack of detailed knowledge of the lifestyle of the socially included, and thus limited understanding of items or activities which are necessities to ensure full participation, and lower expectations or 'adaptive preferences' (Nussbaum, 2000;

Burchardt, 2004). Just as excluded adults may have bounded realities and 'adaptive preferences' (Noble et al., 2004), so also may children.

The need for a multi-source approach to indicator selection

Though there is considerable merit in a child-centred consensual definition of poverty, there are areas of need which children themselves cannot, or should not, be expected to tell us about. Apart from the indicators which require an expert's knowledge, mentioned above, there are indicators which it would not be appropriate to expect children to identify. An example might be young children identifying necessities regarding healthy food. In these cases it might be *appropriate* to consider surveys of caregivers (Pettifor et al., ongoing). Where expert opinion is required, this should have a strong basis in good quality international research, such as Cochrane systematic reviews on risk factors in child health, which are available online[8] and have stringent standards of research methodology for inclusion in reviews. South Africa-specific research on child well-being will also have a crucial role to play here, as will consultation with experts such as paediatricians, environmental health experts, social workers, mental health professionals, child welfare non-governmental organisations and the child rights movement. It is also important to take into account cultural applicability.

Data availability

The individual indicators which comprise both the absolute core and relative components of poverty vary in terms of availability of data and quality of data (see Bray, 2002, for a detailed review of data availability and gaps in the South African context). As identified in other chapters, there is inevitably a tension between a theoretical model and what is available in practice, but it is important to be 'concept-led' rather than 'data-driven'.

Single indicators or composite measures?

Having selected appropriate domains of deprivation, and identified indicators which measure these dimensions of deprivation, the question arises as to whether the indicators could simply be produced in their own right or be combined in some way. For example, indicators falling within a particular domain might be combined to form a composite score. Such a domain-level composite measure would no longer be a measure at individual level and so it would not be possible to identify whether an individual who was being counted in one indicator was also counted in a second indicator. However, the combination of indicators into domain scores can provide useful summary information for policy-makers on each of the dimensions of deprivation.

Geographical presentation

A strong advantage of the proposed model is that it has the potential to be produced at a number of different geographical levels, for example national, provincial and small-area levels (for example, district municipalities in rural areas, or Census Main

Place[9] in metropolitan areas). Each form of presentation has its merits: headline national indicators can be compared between years; resource allocation to provinces can be determined by relative levels of deprivation at province level; and small-area level data will enable provincial administrations to target resources most effectively. Though there are significant challenges in collecting data that are accurately geo-referenced in a standard way in South Africa, the international experience points to the enormous advantages of geo-referenced data, and progress is currently being made.[10]

A ward level index of multiple deprivation has been produced for each of South Africa's nine provinces using the 2001 Census. The Provincial Indices of Multiple Deprivation (PIMD) measure different dimensions of deprivation that affect the total population and therefore they include children (Noble, Babita et al., 2006). The PIMDs are limited to data that are available in the Census but they measure deprivation across five domains: income and material deprivation, education deprivation, employment deprivation, health deprivation, and the living environment deprivation. Work is now under way to produce a national South African index of multiple deprivation, also for the total population, as well as a child-focused South African index of multiple deprivation for children. This would draw from the model presented in this chapter.

Conclusions and recommendations

A model of child poverty and social deprivation has been presented in this chapter. The aim has been to underpin the model with a clear conceptual framework and appropriate definitions.

The model contains both 'absolute' and 'relative' components and is multi-dimensional and child-focused. Domains of poverty which might be relevant for children in South Africa were considered and possible indicators were presented. The need for both consensually defined indicators, and indicators supported by good quality research evidence, was argued.

One could question whether there is a need for such a multidimensional approach to child poverty, if in fact the indicators turn out to be highly correlated with each other and to the caregiver or household income and/or expenditure. There are two responses to this: first, it is an empirical question as to whether this is the case and, if so, what level of income/expenditure marks the borderline between the 'poor' and the 'non-poor'? Second, even if the correlations are high, there will almost certainly be situations where there is not complete overlap between the indicators. Indeed, international research suggests that such correlation will only be partial (Nolan & Whelan, 1996; Noble, Wright et al., 2006).

The model presented here is not set in stone; it needs to be tested empirically, domains agreed upon and indicators selected. These indicators can then be collected at regular intervals to provide a dynamic picture of multidimensional child poverty and social deprivation in South Africa, which could be reported in an annual or biennial publication that monitors child well-being (see for example Bradshaw & Mayhew, 2005). If cross-sectional surveys are used to generate indicators then changes in child poverty at an aggregate level can be measured. If persistent or

chronic child poverty is to be measured then the survey used must be capable of generating longitudinal data. If child poverty is to be measured at a small-area level then the future almost certainly lies in the harnessing of administrative data (Noble, Babita et al., 2006).

Many of the multidimensional aspects of poverty outlined in this chapter are expanded upon in the following chapters. Detailed indicators in each dimension monitor the extent of deprivation, accessibility and quality of services. As South Africa works towards fulfilling its commitments to children, it is crucial that child poverty is measured, and addressed, within the wider contexts of children's rights and child well-being.

Notes

1 The authors would like to thank Professor Andy Dawes, Dr Rachel Bray and Professor Jonathan Bradshaw for their comments and particularly Professor Francie Lund for her review of this chapter. We have endeavoured to incorporate their helpful suggestions.

2 An earlier version of this chapter was published in the *Journal of Children and Poverty* (Noble, Wright et al., 2006).

3 In line with the Constitution, we define 'child' as a person under the age of 18. We are aware that there are debates around this simplification of age distinction.

4 By 'relations', Room (1995) emphasises the way in which exclusion focuses on relationships between individuals and between individuals and the state. This is contrasted with poverty, which he sets out as based on financial criteria.

5 Family Budget Unit at the University of York, <http://www.york.ac.uk/res/fbu/>.

6 The access to services indicators correspond to the Type 4 indicators described in Chapter 2 of this volume, and the quality of services indicators correspond to Type 5 indicators.

7 Work being undertaken by Bray et al. (ongoing) in the South Peninsula of the Western Cape provides further evidence about issues relating to school attendance and their impact on a child's human capital.

8 See <www.cochrane.org>.

9 A Statistics South Africa geographical unit.

10 For example, the South African Post Office's address file is currently being developed.

CHAPTER 4

Neighbourhood indicators: monitoring child rights and well-being at small-area level

Catherine L. Ward

Introduction: neighbourhood level processes and children's rights

There is a plethora of studies, chiefly from North America and the United Kingdom, showing that the extent to which children's and adolescents' rights are protected and their well-being achieved, varies by neighbourhood (Leventhal & Brooks-Gunn, 2000). In these developed world contexts, there appear to be key connections between children's survival, protection, development, and participation, and the state of the neighbourhoods in which children live. Based on these studies, several proposals have been made for indicators that identify neighbourhoods in which children (and adults) are likely to have poor health, be unsafe, and have poor educational outcomes, work and leisure opportunities (Coulton, 1997; Leventhal & Brooks-Gunn, 2003).

However, there is very little South African literature examining the association between small areas and children's well-being. In the developed world contexts, particular economic dynamics have led to movements away from inner cities to suburbs, leaving behind these concentrated areas of disadvantage; in the US context, these areas are often those where racial minorities are concentrated (Power & Wilson, 2000). In South Africa, the formation of neighbourhoods has been heavily influenced by apartheid policies such as the Group Areas Act (No. 41 of 1950), and neighbourhood dynamics in this context may thus differ from those shaped by the particular contexts of the developed world: South African neighbourhoods have been more shaped by political forces than economic ones. Given the paucity of relevant South African literature, however, the approach I have taken here is to review what is known about neighbourhoods in the developed world and, where possible, to complement this with South African studies. On the basis of this literature review, I have developed indicators that may be useful in identifying South African neighbourhoods where children's well-being is compromised or promoted. However, these indicators are, at this stage, only suggestions; they will need to be tested before they can be used with confidence.[1]

One of the first areas to be investigated in terms of neighbourhood effects in the USA was delinquency (Shaw & McKay, 1942), an outcome which implies a failure of the social environment to assist the child to develop responsibility and morality, or a failure to meet the child's right to development (Huston, 2002). While delinquency does of course involve individual children making individual choices, children who

engage in delinquent behaviour are embedded in environments which fail them in a number of ways – environments which model, reward and do not deter delinquent behaviour, which fail to help children develop attachments to pro-social activities and groups, and which provide them with opportunities for delinquent acts (Shaw & McKay, 1942; Sampson & Lauritsen, 1994; Catalano & Hawkins, 1996; Le Blanc, 1997). The Shaw and McKay (1942) classic study suggested three indicators that identified, in their context, neighbourhoods likely to be high in delinquency: neighbourhoods with high poverty rates, high ethnic heterogeneity, and high residential instability. They proposed a theoretical perspective – social disorganisation, a breakdown in the social fabric – to account for the social processes that caused the high delinquency rates. Shaw and McKay's three indicators thus served as proxy indicators of both the hypothesised causal social processes and of the child outcome (delinquency).

Subsequently, many of the same or similar neighbourhood processes and characteristics have been found, in developed world contexts, to be related to child rights in other domains. In the survival domain, for example, child injuries (Haynes et al., 2003), mental health problems (Chase-Lansdale et al., 1997) and youth's poor dietary habits (Lee & Cubbin, 2002) have been found to be associated with disadvantage in the neighbourhood, independently of individual and family factors. In the area of protection, child maltreatment has been shown to vary in relation to neighbourhood level factors (Coulton et al., 1995). School dropout (Harding, 2003), children's social competence (O'Neil et al., 2001), and teen pregnancy (South & Baumer, 2000), key outcomes in terms of children's development, have all been shown to vary in accordance with neighbourhood structures and processes. While as yet neighbourhood effects on children's participation have not been investigated, there is evidence that poor child outcomes (such as high rates of child labour or illiteracy) are likely to reflect low participation rates for children (Johnson & Ivan-Smith, 1998). The reverse is also true: there is evidence that children's participation in research and in community development initiatives can raise issues that would otherwise go unnoticed by adults, and lead to results that are better for all in the community (Johnson & Ivan-Smith, 1998). This has been documented in areas as diverse as security crises (Coomaraswamy, 1998), educational options (Hill, 1998), town planning efforts (Horelli, 1998), and community development and environmental care (Hart, 1997).

In many cases, too, a neighbourhood that is characterised by one poor outcome is likely to be characterised by others, suggesting that poor environments simultaneously compromise children's rights and well-being in many domains. For instance, neighbourhoods with high rates of child abuse are also likely to have high rates of crime and of low birth weight babies (Sampson, 1992). Social organisation theory suggests that, in these areas, there has been a rupture of the social fabric, and that it is this breakdown that leads to these results (Sampson, 1992). There is some evidence for this in a South African study of Cato Manor, which found disrupted social relations to increase vulnerability to a range of deviant and high-risk behaviours (Petersen et al., 2004).

There is some debate as to whether an area effect does exist (whether it is in fact neighbourhood dynamics that affect children's outcomes), or whether the observed effects are merely the consequence of a number of similar people living in the same

location (Dietz, 2002; Lupton, 2003). For instance, neighbourhoods with poor housing stock are more likely to attract poor residents, who will be less able to afford good schools; therefore, it is possible that poor school outcomes have less to do with the neighbourhood and more to do with the aggregation of poor people in the area from which the school draws. Much of the criticism of the current state of neighbourhood studies is based on the failure of large quantitative studies to take into account the physical and social complexity of neighbourhoods, and it is to be hoped that future studies will be able to clarify the size of the area effect, which may be either larger or smaller than previously found (Lupton, 2003). In addition, a focus exclusively on neighbourhoods often overlooks the impact of broader socio-economic factors on the relationships between neighbourhoods themselves (Lupton, 2003). This latter point may be particularly important here, where neighbourhood formation (and neighbourhood poverty levels) has been so strongly influenced by apartheid. South African neighbourhoods can hardly be viewed in isolation from broader structural factors.

In terms of child well-being, the developed world literature finds that neighbourhood level factors impact on most of the areas identified in the Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3, this volume). The relevant articles are listed below (quotations are from the CRC unless indicated), with some examples of how neighbourhoods play a role in the fulfilment of these rights.

- Article 3 (CRC) addresses the need to ensure 'the child such protection and care as is necessary for his or her well-being'. As outlined in the examples above, neighbourhood level factors play a role in outcomes in the child protection domain and in many domains of children's well-being.
- Article 6 (CRC) and Article 5 (AC) state the right to life, and the duty of the state to ensure the survival and development of the child. Article 19 (CRC) and Article 16 (AC) address the state's duty to take 'all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse', an article which includes reference to prevention measures. Neighbourhood level factors influence rates of child maltreatment (Garbarino & Sherman, 1980; Coulton et al., 1995) and of child injuries (Haynes et al., 2003).
- Article 18 (CRC) and Article 20 (AC), which deal with the state's duty for 'the development of institutions, facilities and services for the care of children', and particularly refer to the right of working parents to benefit from childcare services, is also relevant as (at least in the developed world) disadvantaged neighbourhoods tend, often despite greater need, to have fewer such services (Queralt & Witte, 1998). Other services, too, are essential for children's well-being, such as accessible supermarkets, health services and other businesses, which also may be missing in disadvantaged neighbourhoods (Perloff & Jaffee, 1999; Tolan et al., 2003).
- Article 24 (CRC) and Article 14 (AC): the state's duty to ensure 'the right of the child to the enjoyment of the highest attainable standard of health' and to provide healthcare facilities. Again, many studies show that child health

outcomes are influenced by neighbourhood level factors, including mental health (McLeod & Edwards, 1995; Van der Linden et al., 2003), cardiovascular risk behaviours (Lee & Cubbin, 2002), birth defects (Carmichael et al., 2005), injuries (Reading et al., 1999; Haynes et al., 2003), and low birth weight (O'Campo et al., 1997; Pearl et al., 2001). In addition, healthcare tends to be less accessible in disadvantaged neighbourhoods (Perloff et al., 1999; Reading et al., 1999; Tolan et al., 2003).

- Article 28 (CRC) and Article 11 (AC) describe the right to education. Children's ability to participate in education has been shown to be influenced by neighbourhood level factors. These might include learning disabilities resulting from high neighbourhood lead levels (from neighbourhood concentrations of lead-based paint in poor housing stock and of industries using lead) (Margai & Henry, 2003) and from high traffic density (Gunier et al., 2003), to the effects of neighbourhood disadvantage on the development of cognitive skills (Kohen et al., 2002) and on school dropout rates (Harding, 2003).
- Article 31 (CRC) and Article 12 (AC) describe 'the right of the child to rest and leisure, to engage in play and recreational activities'. In the AC, states are actively encouraged to provide opportunities for leisure and recreation, and this is contained in a separate article from that addressing child labour. That is, children have two related rights in this arena: the right not to work, and the right to play. Neighbourhoods that do not have suitable recreation facilities for children are indicating that the state has failed in its duty to promote this right. Having safe places to play is also likely to fulfil rights to protection and survival, as this may decrease injuries because (for instance) children will be less likely to play in the road or in dangerous places in the home, such as the kitchen.
- Article 33 (CRC) and Article 28 (AC): the duty of the state to 'take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances' and to 'prevent the use of children in the illicit production and trafficking of such substances'. Neighbourhood level factors also predict drug activity (along with other types of crime) (Sampson, 1993; Sampson & Lauritsen, 1994).
- Both the CRC and the AC (especially the latter in Article 18) recognise the family as the fundamental building block of society, and the AC in particular requires the 'protection and support of the State for its establishment and development'. Article 20 of the AC extends this to ensuring that 'domestic discipline is administered with humanity and in a manner consistent with the inherent dignity of the child'. There is a growing literature addressing neighbourhood level effects on family life, particularly on parenting and including discipline (Leventhal & Brooks-Gunn, 2000; O'Neil et al., 2001; Ceballo & McLoyd, 2002; Hill & Herman-Stahl, 2002; Kotchick & Forehand, 2002; Martinez et al., 2002; Silk et al., 2004).

Neighbourhood effects therefore appear to be pervasive across many rights domains in children's lives. Both the CRC and the AC place emphasis on the role of the state as having responsibilities to ensure that children's rights are fulfilled – Article 4 of the CRC, for instance, indicates that states 'shall undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognized'. In terms of neighbourhoods, the state – or national, provincial and local government –

is clearly the duty-bearer in this regard. Government policies and strategies can affect both how neighbourhoods form, and what may be done to support positive neighbouring once they have formed. Although the state is the ultimate duty-bearer, other civil society bodies such as residents' associations and community development organisations can and should also play a role in contributing to neighbourhoods that promote children's development.

Monitoring neighbourhood level factors, and monitoring outcomes at neighbourhood level, will make it possible to distinguish between geographically-based groups of children who are and who are not having their rights fulfilled. This enables an important disaggregation of statistics that may have been collected at national or citywide level, thus fulfilling criteria of rights-based indicators (see Chapter 2 in this volume). Reciprocally, this makes it possible to identify the geographic areas where duty-bearers (town planning departments, education and health authorities, and the like) have fulfilled their responsibilities towards children and their families.

Following the indicator typology outlined in Chapter 2, the indicators described in this chapter are Types 3 and 4. They relate to the extent to which the neighbourhood context in which children live affects child outcomes and the ability of caregivers to provide a suitable environment for children to thrive. These indicators are essentially proxy indicators for neighbourhood social and environmental processes. Throughout, it should be borne in mind that they are based largely on the developed world literature, because of the paucity of relevant South African literature; because of this, they will need to be tested to see if they are, in this context, indeed related to child outcomes. These indicators should also be disaggregated by age group (early childhood, middle childhood, and adolescence), as different aspects of the neighbourhood social context will apply at different ages. For instance, teenagers have more need of the role models that employed persons provide than infants; while parents of infants have more need of childcare than parents of older teens. In addition, when indicators are used to describe neighbourhoods, they should be used to describe both how things are and how they will be in a few years. For instance, if there is a paucity of leisure opportunities for teenagers, but very few teenagers in the area, that is of little concern now – but it would be cause for concern if there is a large cohort of pre-teens who will need leisure opportunities in a few years time.

In addition to the indicators proposed here, it is key that child outcomes (such as delinquency or low birth weight) also be measured by neighbourhood, as these can identify neighbourhoods where particular groups have particular needs. So while this chapter addresses the context in which children and their families live, it is also important to track outcomes by neighbourhood. For the latter purpose, indicators developed in other chapters should be disaggregated by small area. They can also be used to test the more contextual indicators suggested here.

Theories of neighbourhood effects on children and families

In their seminal review of the then literature, Jencks and Mayer (1990) suggest four models for the mechanisms by which neighbourhoods may influence children and families:

- *Epidemic models:* the more exclusively people interact with others in enclosed communities, the more their beliefs and behaviour will become alike.
- *Collective socialisation:* behaviour that is approved of is modelled by adults in the community, and together with the use of social controls, this discourages undesirable forms of behaviour.
- *Institutional resources:* schools, police protection, and other community services give opportunities for good behaviour and prevent bad behaviour.
- *Presence of affluent neighbours:* children who perceive themselves as being less advantaged than their peers in the neighbourhood may be less motivated to conform, they may be less able to succeed in competition for scarce resources, and they may be subject to negative labelling by their advantaged peers.

The first three of these mechanisms suggest that disadvantaged children will do better in more advantaged neighbourhoods, where they will have 'access to conforming peers, successful adult role models, and abundant resources' (Furstenburg & Hughes, 1997, p. 348), while the last suggests that they may do less well in affluent neighbourhoods. These processes could well be complementary, rather than alternatives, and theoretical perspectives that propose links between communities' characteristics and child outcomes typically include several mechanisms (Furstenburg & Hughes, 1997).

Social disorganisation theory is one of these theories. It was originally developed to understand the mechanisms underlying the spatial organisation of delinquency and its empirical association with population turnover, ethnic heterogeneity and poverty in urban US neighbourhoods (Shaw & McKay, 1942), and has been extended by others (Kornhauser, 1978; Bursik, 1988; Sampson, 1992) to integrate several theories and bridge disciplinary differences in studies of neighbourhood effects on child development (Gephart, 1997). Community social organisation 'may be conceptualised as the ability of a community structure to realize the common values of its residents and maintain effective social controls' (Sampson & Lauritsen, 1994, p. 57). Theories of social disorganisation are all based on a systemic view of communities (Bursik & Grasmick, 1993), that is, they view the community as a complex set of networks based on friendship, kinship and associations. New residents and new generations are assimilated into this system, so that the community has a life cycle of its own (Kasarda & Janowitz, 1974).

Another important theoretical perspective that has relevance to neighbourhoods is the notion of social capital (Coleman, 1988). To quote, 'Coleman uses the term "social capital" to refer to social relationships that serve as resources for individuals to draw upon in implementing their goals. He identifies three forms of social capital: norms, reciprocal obligations, and opportunities for sharing information' (Furstenburg & Hughes, 1997, p. 349). Socially organised neighbourhoods are high in social capital, through the neighbourhood networks (Sampson, 1992).

With particular regard to children's development, the following three dimensions of socially organised neighbourhoods seem to be most salient (Sampson et al., 1999):

- *Intergenerational closure:* the linking of adults and children to one another, particularly when parents know the parents of their children's friends. This gives parents the opportunities to draw on information about their child in contexts outside the home and from others, and to establish norms for children's

behaviour and for parenting. They can rely on other neighbourhood parents to monitor their children and to relay information about their children's behaviour.

- *Reciprocated exchange:* adults need more than just to know others in the neighbourhood. They need to have had enough reciprocal exchanges to develop social support that both they and their children can draw upon.
- *Informal social control and mutual support of children:* this occurs when neighbourhood residents intervene on behalf of children (for instance, to stop a child from misbehaving or to stop an adult mistreating a child). It depends on more than shared values among neighbours. This feature of neighbourhoods, which Sampson and colleagues term 'collective efficacy', is the 'shared beliefs of a collectivity in its conjoint capability for action' (Sampson et al., 1999, p. 635). It is distinguished from the notion of social capital by its emphasis on a sense of active engagement (Sampson et al., 1999).

How, then, do these mechanisms and processes link to indicators? While some measures of social disorganisation and collective efficacy do exist (Buckner, 1988; Robinson & Wilkinson, 1995; Coulton et al., 1996; Sampson, 1997; Seidman et al., 1998; Raudenbusch & Sampson, 1999; Sampson et al., 1999; Caughy et al., 2001), they are difficult and time-consuming to apply because they require collection of data from neighbourhood residents, data that are not typically found in administrative data sets. Indicators need to be feasible – accessible and easily collected. It is therefore the characteristics of neighbourhoods that can be assessed from administrative databases (such as the Census or crime statistics) that serve as indicators – indicators of the social processes. In addition, it is crucial that child outcomes be assessed at the neighbourhood level, as differences in rates of particular outcomes can also serve as indicators of neighbourhood processes.

The factors empirically identified in the Shaw and McKay (1942) study as related to delinquency (poverty, residential mobility and ethnic heterogeneity) are ones that, in the US context, interrupt the formation of cohesive networks. Population turnover and ethnic heterogeneity affect the ability of a community to maintain these ties (Bursik, 1988), because it is more difficult to establish relationship networks when people are constantly moving in and out of the neighbourhood (Berry & Kasarda, 1977), and ethnic differences impede communication, making it more difficult to solve problems and achieve common goals (Kornhauser, 1978). Community social disorganisation theory thus suggests links between the structural aspects of neighbourhoods (characteristics such as residential mobility, which are not in themselves social processes) and outcomes for children and adolescents (such as delinquency) – the structural features affect the community's social networks and processes, which in turn affect the families and individuals in the community.

While these structural factors have been identified in a number of US studies as being related to outcomes that are probably linked to the social organisation of communities, their relevance in other contexts has yet to be established. For instance, very low residential mobility may, in the South African context, be as problematic as very high residential mobility. Shifts in the US economy and the flight of relatively well-off families from the inner cities concentrated poverty in particular US neighbourhoods (Wilson, 1987). Thus, in US studies, both residential mobility and ethnic heterogeneity are indicators that community networks have failed to form in neighbourhoods, and that therefore the foundation for trouble

(such as the formation of gangs) has been laid. However, a different dynamic may be at work in South Africa. The US neighbourhoods are responding to economic pressures (Wilson, 1987), while South African neighbourhoods' levels of ethnic heterogeneity and residential mobility have been strongly influenced by apartheid. With the Group Areas Act (No. 41 of 1950), which forced certain population groups to live in certain areas, established networks were disrupted by placing people in neighbourhoods that were unrelated to kin or friendship networks (Pinnock, 1982; Kinnes, 1995). Similarly to US neighbourhoods, these new neighbourhoods were economically isolated, again because apartheid policies constrained the types of jobs that people from each population group could do. Because of the requirements of the Group Areas Act, movement from one neighbourhood to another was also constrained. Apartheid thus created economically isolated neighbourhoods with high ethnic homogeneity and low residential mobility, the opposite of what is seen in the economically isolated US neighbourhoods. The disruption of networks in the formation of these new 'group areas' may have led to a lack of value consensus that provided the breeding ground for gangs, as some residents reportedly viewed criminal activities as the only means to survive in a context of poverty and restricted economic activities, while others actively fought against such activities in order to preserve the safety of their neighbourhoods (Pinnock, 1982; Kinnes, 1995). In short, in South Africa high ethnic homogeneity and low residential mobility may actually be indicators of social disorganisation. The picture may be still more complicated, however, as some areas with high levels of migration (such as informal settlements) may also experience social disorganisation (Petersen et al., 2004). Thus *both* high and low residential mobility may be useful indicators in South Africa.

Concentrated poverty, the third of the three structural factors associated with the Shaw and McKay (1942) delinquency studies, appears to operate somewhat differently from the other two factors. Wilson (1987) argued that people living in neighbourhoods with high poverty levels become isolated from the role models, networks and institutions that are necessary for success, and instead were immersed in networks where joblessness was the norm. Work, he contended, gives a framework for daily life because it imposes structure and disciplines; without it, what is lost is not only income, but also a set of concrete expectations and goals that gives order to the present. Concentrated poverty, therefore, is more than merely a number of households with low income living in the same place; it is associated with a host of social processes that can affect opportunities and resources available to children, youth and families, as well as the way in which children are socialised.

In summary, what are the important factors that may need to be at work or available in neighbourhoods for the fulfilment of children's rights and well-being? The following all appear to be important (Leventhal & Brooks-Gunn, 2000, p. 322):

- *Institutional resources:* the availability, accessibility, affordability, and quality of learning, social, and recreational activities, childcare, schools, medical facilities, and employment opportunities present in the community. These all affect the opportunities available to families for having their needs met (for instance, for education, healthcare and development), and the quality of these resources will determine how well those needs are met.
- *Relationships:* parental characteristics (mental health, irritability, coping skills, efficacy, and physical health), support networks available to parents, parental

behaviour (responsivity/warmth, harshness/control, and supervision/monitoring), and the quality and structure of the home environment. All of these have been shown to be associated with neighbourhood structure, and thus mediate neighbourhood characteristics and outcomes. For instance, maternal depression has been found to be associated with living in an unsafe neighbourhood, and with inconsistent discipline. Maternal depression thus mediates the relationship between neighbourhood safety and discipline in the home (Hill & Herman-Stahl, 2002).

- *Norms/collective efficacy:* the extent to which community level formal and informal institutions exist to supervise and monitor the behaviour of residents, particularly youths' activities (deviant and antisocial peer-group behaviour) and the presence of physical risk (violence, victimisation and abuse of harmful substances) to residents, especially children and youth.

Different mechanisms are likely to affect different outcomes. For instance, norms and collective efficacy are most likely to be related to delinquency, institutional resources to achievement outcomes, and relationships for addressing community level processes.

What is a 'neighbourhood'?

While it seems intuitively obvious that a neighbourhood is a geographic area, the meaning of the term depends on the context in which it is used and the purpose for which it is used. Various operationalisations have been used in the literature, from blocks to block groups to census tracts (in the US literature), or postal codes or school districts (Korbin, 2003), or wards (UK Office of National Statistics, 2005), but these may or may not correspond with how the residents would define their 'neighbourhood' – and even residents may define 'neighbourhood' differently, depending on the context in which they use the term (Gephart, 1997).

Because operationalisations for the purposes of quantitative measurement are necessarily based on what is available in administrative data, they run the risk of creating definitions of 'neighbourhood' that are remote from residents' perceptions and actions. Hence, the likelihood of finding strong effects of neighbourhood structural features is quite low, and the search for stronger associations must rely on measures of neighbourhood social organisation (Gephart, 1997; Lupton, 2003). However, measures of neighbourhood social organisation are not found in administrative data (such as Census data) and therefore require active data collection in the neighbourhoods of interest. They are thus typically more costly and labour-intensive to gather. This conundrum has haunted studies of neighbourhoods and has led, typically, to weak operationalisations of neighbourhoods that do not reflect the ideas of 'neighbourhood' that are obtained from qualitative studies, and that, correspondingly, find weak neighbourhood effects (Lupton, 2003).

One possibility is to use small units (such as enumerator areas) as the initial unit by which the data are organised, and then to define neighbourhoods as a set of small units grouped differently for different needs, so that the operationalisation of neighbourhood is flexible and can be driven by the needs of particular projects (Kingsley & Pettit, 2000). However, even the Census is only a sample of the population and not the population itself. Combining small units in this way thus

amplifies the sampling error in the measures at the neighbourhood level. In addition, however one draws neighbourhood boundaries, one runs the risk of the modified areal unit problem: where one draws the boundaries modifies the outcome. Changing the neighbourhood boundaries can affect the rates of teen pregnancy, or delinquency, or injuries, in a neighbourhood, in the same way that election results can be affected by gerrymandering (drawing ward boundaries so as to concentrate a particular political party's supporters in one ward or another).

What one wants, in defining a neighbourhood for the purposes of an indicator system, is some way to identify relatively small, bounded areas that are meaningful to their residents, and which are stable over time (that is, the boundaries within which the data are collected are not changed, for instance, from one Census to another). Size is important because pockets of deprivation may exist but not be identified within larger areas (McIntyre et al., 2000). The meaningfulness of the area is also important, as the identified area should coincide to the extent possible with residents' networks. Stability is also important, as ideally one would like to be able to track changes in the neighbourhood over time. What one also wants, however, is to be able to do this using administrative data sets, as this makes an indicator system feasible.

One very useful solution being used by the UK Office of National Statistics (2005) is to define super output areas (SOAs). These are defined in three 'layers': a lower layer with a minimum population of 1 000 and a mean of 1 500; a middle layer with a minimum of 5 000 and a mean of 7 200; and an upper layer, yet to be defined, that will have a minimum size of approximately 25 000. Higher layers are produced by grouping lower layer units together. Lower layer SOAs are defined by taking into account population size, mutual proximity, and social homogeneity. Middle layer SOAs are similarly defined, but the computer-generated boundaries are then altered, in consultation with local authorities and other stakeholders, to establish SOAs that best meet local needs. Boundaries are then to be fixed, so that comparisons can be made over time, an advantage over systems such as basing neighbourhoods on electoral wards which change frequently. The areas are sized so that statistics can be produced, right down to the local level, without compromising the confidentiality of individual respondents. Enumerator areas, which are used in the South African Census, are too small (at 100–250 households) to represent neighbourhoods and use of statistics at that level would compromise confidentiality. In addition, from a statistical point of view, the size of SOAs is such that sampling error is minimised and statistical power maximised.

Some additional cautions are worth mentioning: the notion of a neighbourhood as a bounded unit misses the fact that neighbourhoods are embedded in a larger system of other neighbourhoods that together make up a city. While relationships forming social capital are likely to exist within a neighbourhood, they are also likely to cross neighbourhood boundaries so that residents in adjacent areas are also affected by these 'spatial externalities' (Sampson et al., 1999, p. 638). Thus a disadvantaged neighbourhood may be even more disadvantaged by its physical proximity to other disadvantaged neighbourhoods, or advantaged if it is contiguous with advantaged neighbourhoods. When approaching a system of indicators, one should bear in mind that neighbourhoods may affect and be affected by those adjacent to them; it is not only the processes within neighbourhoods that should be assessed (Lupton, 2003).

Indicators

A very wide range of operationalisations of concepts has been used in studies of neighbourhood effects on children's and adolescents' well-being. My approach here is to start with dimensions of communities that have been shown in studies in other countries to affect children, and then to identify possible operationalisations from data sets available in South Africa. All the indicators suggested here are drawn from administrative databases such as the Census or police data, and thus are relatively easy to access (as compared with collecting data in individual neighbourhoods themselves). I have followed the approach of identifying 'core' indicators, in other words, those that are both most likely to indicate neighbourhoods that will compromise children's rights and well-being and those that are most feasible to measure, and other indicators which may be important but are either not as essential or as feasible. Throughout, it should be borne in mind that the relationship between the structural factors and the child outcomes described below has been identified in studies in the USA and (in a few cases) the UK. While it is likely that in many cases the relationships between child outcomes and structural factors will be similar in South Africa, this should be tested rather than assumed.

In this section, therefore, I discuss possible indicators, together with some examples of the child outcomes with which they are associated. Neighbourhood level indicators also do not fall neatly into rights or indicator domains. For instance, neighbourhood poverty has been associated with outcomes in the survival domain, the protection domain, and the development domain; but often neighbourhood poverty is not sufficient on its own for this association to hold. It needs to be seen as part of a context of neighbourhood disadvantage, which also comprises (for instance) human capital and/or the childcare burden. Thus children's rights and well-being are most likely to be compromised in neighbourhoods characterised by several of these indicators. In addition, where the measures suggested here overlap with measures suggested by others – for instance, the census-based provincial indices of multiple deprivation (PIMD) for South Africa (Noble, Babita et al., 2006) – we use the indicators they suggest, in order to bring coherence to the ultimate set of indicators.

Core indicators

Income and socio-economic status

Both neighbourhood poverty and neighbourhood affluence have been shown to be associated with child well-being. Neighbourhood affluence has been shown to be related to young children's IQ and verbal scores (Chase-Lansdale et al., 1997) and to boys' likelihood of completing high school (Ensminger et al., 1996). Neighbourhood disadvantage has been associated with teen parenting (South & Baumer, 2000), with delinquency (Stouthamer-Loeber et al., 2002), with more restrictive parenting practices (Leventhal & Brooks-Gunn, 2000, 2003), with low birth weight (O'Campo et al., 1997), and with child maltreatment (Coulton et al., 1995). The socio-economic status of the neighbourhood thus affects children's survival, protection and development. A possible theoretical explanation for this is that affluent neighbours are likely to have professional and managerial occupations, and so

provide role models of work habits and evidence of the rewards of completing school. Concentrated affluence (together with residential stability) seems to be related to intergenerational closure and reciprocal exchange that promote effective child management, while concentrated disadvantage is associated with low expectations for shared child control (Sampson et al., 1999).

It is therefore important to assess low, medium and high income simultaneously, as low and high income (as compared with middle income) affect outcomes differently (Leventhal & Brooks-Gunn, 2000). A low-income operationalisation is already contained in the PIMD: the proportion of persons living in households with equivalent incomes below a certain level, and living in households without appliances such as refrigerators, TVs or radios. Neighbourhood affluence, however, may be best assessed in terms of the proportion of neighbourhood residents with professional or managerial occupations, as it may be the role modelling of those who have reaped the rewards of educational achievement that is related to educational outcomes (Ensminger et al., 1996). Coding of occupations in the Census follows the second edition of the South African Standard Classification of Occupations (Stats SA, 2004a), and – using the one-digit codes – occupations coded 1 and 2 may be regarded as professional and managerial for these purposes.

Human capital

This refers to the skills, knowledge and capabilities that community residents have (Coleman, 1988) – the presence of employed and educated people who can serve as role models for children and adolescents – and seems to be associated with educational outcomes in particular (Leventhal & Brooks-Gunn, 2003). Again, these measures are contained within the PIMD as: the proportion of people who are unemployed, and those who are not working because of illness or disability; also, the proportion of 18–65 year olds who have no education at secondary level or above.

Health

Health is seen as an outcome rather than an indicator itself. However, it is an important outcome that – although related to income, education and employment – should be monitored more directly than other proxy indicators would make possible. I therefore propose including the health indicator from the PIMD, Years of Potential Life Lost. While it remains something of a distal indicator because of its inclusion of deaths from all causes (AIDS, other illnesses, violence, suicide, traffic accidents), it does provide an indication of neighbourhoods with serious health problems, whatever the causes. It could also be disaggregated by age, at the non-core level, to investigate whether it is infants, children, adolescents or their caregivers who are dying.

Crowding

Crowding is closely related to income and socio-economic status, as those with more income can afford larger houses and are less likely to be crowded. However, it is worth measuring in its own right because of its association with poor child outcomes. It may, for instance, increase the likelihood of sexual abuse (Dawes, 2002b) or the transmission of diseases and infestations, such as pneumonia (Singh,

2005), meningitis (Deutch et al., 2004), and intestinal worms (Traub et al., 2004). Crowding is normally measured on a continuous scale. Richter (1989) uses a person–habitable room ratio and this measure is recommended for use, together with the Canadian national occupancy standards.

Childcare burden or age structure

An indicator of neighbourhood disadvantage that is particularly relevant to children's well-being is what is termed the 'childcare burden' or the age structure of the community. The choice of indicators here is driven by the hypothesis that where children are numerous in relation to adults and to men and where there are relatively few elderly people, the burden of child supervision falls on younger, single women (Coulton et al., 1995), and this may result in under-supervision of children, with younger children being more vulnerable to danger and older children and adolescents more likely to engage in problem behaviour (Leventhal & Brooks-Gunn, 2003). While the proportion of female-headed households seems to be an obvious indicator of this, some studies find that it is too strongly associated with poverty to indicate the childcare burden, and so other indicators have been suggested (Coulton et al., 1995): the ratio of children to adults; the ratio of men to women; and the proportion of neighbourhood residents who are elderly. All four indicators should be assessed in the South African context and tested empirically to see which is the best indicator or set of indicators of the childcare burden.

Violent crime rate

A key indicator of difficulties for children is the violent crime rate in the neighbourhood (Duncan, 1996; Akande, 2000; Barbarin et al., 2005). Although social disorganisation theory predicts that high violent crime rates will follow from the social disorganisation in neighbourhoods (Sampson & Lauritsen, 1994), violent crime in itself leads to disruptions in social networks (Garbarino & Sherman, 1980). As violent crime increases in a neighbourhood, people feel less safe and so tend to isolate themselves from their neighbours. They thus have lower levels of social capital, which is associated with lower levels of positive parenting (Dorsey & Forehand, 2003). In addition, parents in more dangerous neighbourhoods tend to use harsher parenting practices (Furstenburg, 1993) and less warmth and appropriate, consistent discipline (Pinderhughes et al. & the Conduct Problems Prevention Research Group, 2001). Because of its effects on behaviour, there is an argument for treating the crime rate as a structural indicator itself (Tolan et al., 2003). Rates of violent crime (murder, attempted murder, robbery, assault and rape) are obtainable by police precinct. Although all are valid, I recommend assessing rates of murder and attempted murder (both must be used, otherwise the data may be skewed towards those neighbourhoods with better healthcare), violent crimes to children, and child rape. An environment with high murder rates is likely to be one where children witness and experience high levels of violence, but police statistics should provide some indication of children's experience of crime as victims. Rape is qualitatively a different crime from other types of violence and should be assessed in its own right (Selner-O'Hagan et al., 1998). In addition, there is a great deal of public concern about child rape in South Africa, and for this reason alone it is worth tracking.

Access to institutional resources

Lack of access to services is another element of what makes an environment of community poverty disadvantageous to children (Sampson, 1992). Two types of services are essential: the institutions that provide essential services that every family needs, such as health and food, and support services for families with particular needs. Measures based on administrative data sets have included grocery stores per 1 000 residents, healthcare facilities per 1 000 residents, and other businesses per 1 000 residents (Tolan et al., 2003). In the area of health in particular, one study used office-based primary care physicians per 100 000 of the population as a measure of the 'healthcare opportunity structure', with areas identified as 'shortage areas' based on a convention of the USA's federal Health Resources and Services Administration (Perloff & Jaffee, 1999). Living in a shortage area was associated (albeit weakly) with late entry into prenatal care (Perloff & Jaffee, 1999). Lack of access to grocery stores, healthcare and other businesses was part of a set of community structural characteristics associated with parenting problems (Tolan et al., 2003).

Access to affordable, quality childcare services is another dimension of neighbourhoods that has been shown to have positive long-term effects on children's development (Leventhal & Brooks-Gunn, 2000). Schools are another key resource (Leventhal & Brooks-Gunn, 2000) that may be identified via administrative databases. In addition, the following resources have been identified as possibly related to children's development: learning activities (libraries, family resource centres, literacy programmes, museums); social and recreational activities (parks, sports programmes, art and theatre programmes, community centres, youth groups); and opportunities for employment (Leventhal & Brooks-Gunn, 2000). Of these, access to employment opportunities is particularly important for youth (Leventhal & Brooks-Gunn, 2000), but may have either positive or negative outcomes for young people. For instance, employment opportunities have been associated both with increased problem behaviour and (in low-income youth) with increased school engagement and decreased delinquency. Thus, while the presence of employment opportunities may be shaped by the neighbourhood, employment itself may have different outcomes, depending on the context: it may provide access to otherwise unobtainable social and material resources; adolescents may have different expectations of employment depending on whether they live in a neighbourhood where employment is the norm, or whether they need to reconcile a traditional understanding of education and employment with the facts of living in a neighbourhood where adults are rarely able to find employment (Leventhal & Brooks-Gunn, 2000).

Another important indicator of access to services is access to a telephone (from which one can call for help or find out about access to opportunities).

Additional indicators

Ethnic heterogeneity and residential instability

Measures of ethnic heterogeneity differ from context to context. Even within the US, measures differ according to the location – they may assess the proportion of community residents who are African American or who are Latino or foreign-born,

depending on the site of the study. Such studies find ethnic heterogeneity to be negatively associated with children's IQ and schooling, and positively associated with reduced adolescent sexual activities (Leventhal & Brooks-Gunn, 2003). Residential instability has chiefly been associated with juvenile delinquency (Sampson & Groves, 1989), but has also been found to be associated with child maltreatment (Coulton et al., 1995).

As noted above, however, ethnic heterogeneity and residential instability may have different meanings in South Africa, in terms of the social organisation of communities, from their meaning in the US. However, this should be tested empirically, using both quantitative methods and the qualitative methods that can assist in clarifying how the proxy indicators (the proportions of different ethnicities and language groups) affect the formation of neighbourhood networks (Lupton, 2003).

In terms of ethnic heterogeneity, one study has used measures that would be appropriate in South Africa, and that probably most accurately capture how this indicator relates to social disorganisation, i.e. that ethnic diversity leads to barriers to communication and so interferes with the ability to form neighbourhood networks. The two measures used in this study of youth violence were number of ethnic groups in the neighbourhood, and number of languages spoken (Tolan et al., 2003).

Residential mobility is often assessed by the proportion of residents who have lived in the same home (or same community) for some length of time, and by the proportion of owner-occupied homes. The proportion of owner-occupied homes may not be a suitable measure for the South African context, as the rental or owner-occupied status of informal housing will not be available in administrative data sets. What may work well is using several measures of residential instability together. The following are therefore proposed for empirical testing – those that were used by Coulton et al. (1995) and which are available in the South African Census: proportion of residents that have moved in the last five years, and the proportion who have lived in their current home for less than one year.

Relationships within communities

Since it is the relationships within communities that enable the use of social capital and that create social organisation, it may be helpful to assess this. Structural indicators are hard to identify, but one possibility is to index the presence of community groups such as neighbourhood watches, street committees and *stokvels*[2] (Leventhal & Brooks-Gunn, 2003).

Community development

Community development initiatives that boost housing and economic circumstances of a community may affect children and youth indirectly by altering families' financial circumstances and may improve neighbourhood safety (Leventhal & Brooks-Gunn, 2003). Indicators may include the number of development initiatives such as job training programmes.

Child outcomes

Outcomes for children and adolescents could (and should) be measured at the neighbourhood level, as these, too, will indicate the presence of neighbourhood factors that are either impeding or facilitating the fulfilment of children's rights. In fact, these may be the most direct way to assess children's rights and well-being at the neighbourhood level.

Neighbourhood effects that are not related to neighbourhood level social processes

The indicators described above are rooted in the theory of social organisation. However, it is important to recognise that some outcomes for children and adolescents may vary by neighbourhoods, but may not be related to low social organisation, particularly in the areas of health outcomes (Gephart, 1997). While some health outcomes, such as premature mortality, are associated with (low) social organisation (Cohen et al., 2003), there are others that are related to the physical geography or the sheer poverty of the neighbourhood, rather than to social processes within the neighbourhood (although they may be related to broader social processes, such as political decisions about where to site waste dumps). Environmental threats to health, such as air pollution, noise and high lead levels, tend to be concentrated in poorer communities (Evans & Kantrowitz, 2002). Air pollution from biomass fuels contributes a great deal to the burden of disease, and tends to cluster in poor neighbourhoods which do not have access to electricity for cooking and heating (Balakrishnan et al., 2002). Neighbourhoods where there are high rates of learning disabilities are strongly associated with sources of pollution from lead and other heavy metals, and air pollution (Margai & Henry, 2003). Even literacy may be affected by neighbourhood poverty – children in poorer neighbourhoods may have far less access to books and other stimuli for early reading (signs, labels, logos, public spaces conducive to reading) (Neuman & Celano, 2001). Conversely, it should be noted that neighbourhood poverty is not a sufficient cause for other child outcomes, such as child maltreatment. Some poor neighbourhoods have higher rates of child maltreatment than other similarly poor neighbourhoods; those with the poorer social organisation are the ones with the higher maltreatment rates (Korbin et al., 1998).

Measuring social processes directly

Use of administrative data sets is probably the easiest and least costly method to assess indicators. However, relying on administrative data has its limitations – they do not reveal 'unofficial' behaviour (such as disorder or crime not recorded in official statistics), and they do not reveal the social processes that are at work in the neighbourhood to affect children's development (Raudenbusch & Sampson, 1999). Observational methods address these concerns, and can be used to simultaneously assess both physical and social characteristics of the neighbourhood.

This is a newer and less developed approach to measurement, but several measures can be found in the literature (Leventhal & Brooks-Gunn, 2003). Essentially, three methods have been proposed for assessing collective efficacy: systematic social observation, key informant interviews, and surveys of neighbourhood residents (Leventhal & Brooks-Gunn, 2003).

In systematic social observations, trained observers use a structured format to assess dimensions such as territoriality or social control (presence of crime-watch signs, residents accost observers and inquire about their purpose in the neighbourhood), and social disorder (loitering adults, intoxicated people, drug sales) (Raudenbusch & Sampson, 1999; Caughy et al., 2001; Leventhal & Brooks-Gunn, 2003). Key informant interviews involve interviewing key community leaders such as prominent religious, political, business, and social leaders, to get ratings of community characteristics; and similarly, community surveys entail obtaining ratings from community residents (Leventhal & Brooks-Gunn, 2003). Various scales have been developed to address social cohesion, collective efficacy, and sense of community (see, for instance, Simcha-Fagan & Schwartz, 1986; Buckner, 1988; Sampson, 1988, 1997; Robinson & Wilkinson, 1995; Coulton et al., 1996; Sampson, 1997; Seidman et al., 1998; Sampson et al., 1999; Cantillon et al., 2003). Similarly, participants in research studies can also be surveyed for their perceptions of neighbourhood processes, but this is less desirable as it leads to same-source bias (the community indicators are confounded with individual level indicators also assessed by participant ratings) (Leventhal & Brooks-Gunn, 2003).

The other two aspects of communities that are key, relationships and institutional resources (Leventhal & Brooks-Gunn, 2000), can be assessed in similar ways, but even less attention has been paid to measuring them.

Given the focus of this chapter on easy-to-assess, accessible indicators of the fulfilment of children's rights and the attainment of children's well-being, focus on administrative data sets is retained, rather than on this more labour-intensive form of information gathering.

Measurement issues in the use of indicators drawn from administrative databases

The first issue is to choose a source of data that has a sampling strategy suitable to defining a neighbourhood. The most suitable source of administrative data is the Census, which draws from enumerator areas (typically 100–250 households, an area that can be assessed by a single enumerator within the specified time period) that cover the entire country (Stats SA, 2003). In other sources of data available from Stats SA, stratified random sampling is used, so that while large strata are representatively sampled, these data are unlikely to be sufficiently fine-grained to map differences between neighbourhoods.

Closely related to the issue of the source is the definition of the neighbourhood. Some sources of data, such as police crime statistics, are monitored by police precinct; health data may be monitored by health district; education statistics by school districts. These data sources may provide more current indicators of the environment for children and families than a decennial Census and so may be more sensitive to change (Leventhal & Brooks-Gunn, 2003). However, these administrative districts seldom overlap, either with each other or with residents' perceptions of the neighbourhood, which can make these data quite difficult to apply to a specific area.

In addition, neighbourhood effects possibly have more relevance for those who are less mobile (the poor, the elderly, the young) than for those whose access to transport means that their networks extend well beyond the geographic area in

which they live (Lupton, 2003). Older children and teenagers are more likely to spend time outside their families and in their neighbourhoods than younger children; girls are usually more protected while boys may have more access to street life than girls do (Furstenburg & Hughes, 1997). There are also studies suggesting that ethnicity affects the influence of the neighbourhood on outcome. For instance, although in general it appears that educational outcomes improve as neighbourhood affluence increases, for children in the US, disaggregating by race shows that this is generally only true for white children; black children are only similarly affected when there are also high numbers of other black people in the neighbourhood (López Turley, 2003). It is therefore important to disaggregate neighbourhood level statistics by subgroups such as age, race and gender (Leventhal & Brooks-Gunn, 2000).

While the use of SOAs is probably the best way to use administrative data to approximate a neighbourhood, there may be times when other units (such as a school or health district) may be used, in which case the following cautions are relevant (Coulton, 1997):

- Meaningful geographic units often differ greatly in population size, making it difficult to achieve valid comparisons between areas. Compensating by weighting (an approach used in statistical modelling) can be used for some purposes, but does not make sense for others, such as when indicators are being used for policy and planning.
- Outcomes that are rare may show great variations in rate that are due to rarity rather than to neighbourhood factors, and this should always be considered when interpreting differences between neighbourhoods.
- The development of indicators for small areas magnifies the effects of the reporting bias and error to which most administrative data sets are subject; and data sets such as the Census may also impute more data in disadvantaged neighbourhoods.

Two other cautions should be remembered when examining neighbourhood effects. First, neighbourhood influences are likely to be underestimated in quantitative studies because of suppression effects from other variables that have not been measured; and omitted-variable bias will be introduced because families have some degree of choice as to where they live – in other words, some of the neighbourhood effect may be because certain types of people have chosen to live in a certain location, thus the effect may be related to the clustering of people with particular characteristics, rather than to the neighbourhood characteristics per se (Duncan & Aber, 1997; Lupton, 2003). A similar limitation is that transactional theories, which hold that people shape their environments as well as being shaped by them, is ignored in most studies (Duncan & Aber, 1997; Furstenburg & Hughes, 1997).

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

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2 An informal group savings scheme that provides small-scale rotating loans.

SECTION II

Child survival and health domain

CHAPTER 5

Monitoring child health

Haroon Saloojee

Introduction

Objectives and scope

This chapter focuses on developing indicators for monitoring illness and disease during childhood and adolescence. Although access and quality of rehabilitation services are covered, they do not constitute the primary focus of the chapter. Indicators have been classified into core and additional categories, and further subdivided into five sections:[1]

- Mortality;
- Communicable and non-communicable diseases, including HIV/AIDS;
- Nutrition and anthropometrics;
- Adolescent health;
- Health services and programmes.

The chapter seeks to stimulate understanding of and commitment to the positive use of indicators by child health professionals and the broader public health community in South Africa. The desired outcome is that the indicators will aid planning, resource targeting and assessment of policy and programme impact at all levels, particularly the health district and local ward level.

Definitions

The term 'child health' encompasses child and adolescent health. In practice, infants, young children, older children, and adolescents are distinct subgroups, with different health priorities and problems, requiring different services, and sometimes needing distinct health indicators.

Rationale

A rights-based approach to monitoring child health

The right of the child to survival, development and protection is clearly articulated in the Convention on the Rights of the Child (CRC – see Appendix 1 in this volume). The CRC was ratified by the South African government in 1995, as was the African Charter on the Rights and Welfare of the Child (in 2000) (see Appendix 3, this volume).

Article 24 of the CRC enunciates children's rights related to healthcare. These rights include that State Parties recognise the right of children to the highest attainable

standard of health and access to medical services (Article 24(1)). In particular, the state is obliged to reduce infant and child mortality; to ensure the provision of necessary healthcare to all children with an emphasis on primary healthcare; to ensure appropriate prenatal and post-natal healthcare for expectant mothers; to ensure that parents and children have access to health education; and to develop preventive healthcare (Article 24(a–f)). In addition, the state is charged with the responsibility of taking effective and appropriate measures to abolish harmful traditional practices (Article 24(3)), and to promote and encourage international co-operation to progressively achieve all of the aforementioned rights (Article 24(4)).

In addition to the CRC, the International Covenant on Economic, Cultural and Social Rights (Article 12 and General Comment No. 14 of 2000), which refers to the right to the highest attainable standard of health, guides international law with regards to children's right to healthcare.

The right to healthcare services is provided for in three sections of the South African Constitution. These provide for access to healthcare services, including reproductive health and emergency services, basic healthcare for children, and medical services for detained persons and prisoners. Children's rights are enshrined in Section 28(1)(c) of the Bill of Rights (see Appendix 2, this volume), which provides for basic healthcare services for children.

Rights obligations place a legal responsibility on the South African state to develop, finance and effectively implement programmes that provide adequate services to children. Section 27(1)(b) of the Bill of Rights provides for the state to take reasonable legislative and other measures, taking resource availability into account, to achieve the progressive realisation of the right. According to the Limburg Principles on the implementation of the International Covenant on Economic, Social and Cultural Rights (UN, 1987), progressive realisation does not imply that the state can indefinitely defer efforts for the full realisation of the right. On the contrary, State Parties are to move purposefully towards the full realisation of the right and are required to take immediate steps to provide minimum core entitlements.

Monitoring the government's programming and budgeting for children's health is important in order to hold the government accountable for fulfilling its child rights obligations, and to advocate for effective and efficient programming and budgeting that advance children's health.

Reporting on children's health status

Monitoring the health status of children is not new. The United Nations Children's Fund (UNICEF) has published its annual *The State of the World's Children* since 1979, the most recent being the 2007 report (UNICEF, 2006).

Recently, many developed countries have produced national reports such as the US Federal Interagency Forum on Child and Family Statistics' report entitled *America's Children in Brief: Key National Indicators of Well-Being* (Federal Interagency Forum on Child and Family Statistics, 2004). In the US, many states produce their own reports such as those stimulated by the Kids Count project (Annie E. Casey Foundation, 2004).

South Africa has produced various reports on the health status of children. These include two recent publications: *End Decade Report on Children – South Africa* (NPA, 2001b) and *Children in South Africa: A Report on the State of the Nation's Children* (ORC, 2001). In 2003, the premier's office in Gauteng commissioned the Human Sciences Research Council (HSRC) to produce *The State of Children in Gauteng* (Dawes, 2003).

Developing indicators of child health has become a popular activity, a commendable example being the Child Health Indicators of Life and Development (CHILD) produced by the European Union's Community Health Monitoring Programme in 2002. Childwatch International[2] has played a significant role in encouraging the development of child rights indicators in some southern countries (Nicaragua, Senegal, Thailand, Vietnam and Zimbabwe). This work has recently extended to other regions.

Experience in monitoring progress, including the selection of indicators, is more widespread in the health cluster in South Africa than in most others, except education. However, while child health indicators are plentiful, they selectively cover only some of the child population. In particular, almost all the indicators involve younger children (under-five-year olds), and there are few indicators (for any age of child) covering health services. Furthermore, there are limited indicators for areas such as disability, social security and childcare, as well as standards of living.

Health goals and objectives in South Africa are guided by a set of international goals and objectives. In 2000, South Africa joined other nations in adopting the Millennium Development Goals (MDG). The MDGs include eight goals, 18 targets and 48 indicators that all members of the UN have agreed to implement by 2015 (UNICEF, 2003c). Regrettably, based on progress made as of 2006, it is predicted that more than half of signatory countries will fail to meet that goal if they continue at their current rates. The MDGs include at least four goals directly relevant to child health (see Table 5.1).

Table 5.1 Millennium Development Goals and indicators that apply to child health

Goal	Indicator
To eradicate extreme poverty and hunger.	Prevalence of underweight children under nine years of age.
To reduce child mortality.	Under-five mortality; infant mortality; proportion of one-year-old children immunised against measles.
To improve maternal health.	Proportion of births attended by skilled health personnel.
To combat HIV/AIDS, malaria and other diseases.	HIV prevalence by age, gender, race and province, and condom prevalence rate for 15–24 year olds.

Source: UNICEF (2003c)

In 2002, South Africa further committed to creating 'a world fit for children' by adopting several international goals, strategies and actions (UNICEF, 2002). These include the following:

- Reducing infant and <5 mortality rates by one-third by 2010 and by two-thirds by 2015;
- Reducing child malnutrition among children <5 years by at least one-third by 2010 with special attention to children <2 years;
- Reducing the proportion of infants infected with HIV by 20 per cent by 2005 and by 50 per cent by 2010;
- Ensuring that the reduction of maternal and neonatal morbidity and mortality is a health sector priority;
- Reducing child injuries as a result of accidents or other causes.

In addition, South Africa subscribes to the following international targets on childhood immunisation:

- 80 per cent coverage per district for each of the following vaccinations: oral polio vaccine 3; diphtheria, tetanus and pertussis (DTP) 3; and measles 1st dose;
- <10 per cent dropout rate between first and third DTP vaccine doses;
- <10 per cent dropout rate between measles 1 and 2 doses;
- 80 per cent tetanus toxoid 2 coverage for pregnant women.

The national Department of Health (DoH) has set its own priorities and targets for the period 2004–09 (DoH, 2004). These targets are guided by international child health goals, and go beyond concerns with survival. They include:

- Reducing perinatal morbidity and mortality;
- Reducing infant and child mortality and morbidity;
- Reducing HIV infection in children;
- Improving nutritional status in under-fives;
- Preventing and controlling non-communicable chronic diseases;
- Reducing violence towards women and children.

Several directorates in the DoH – child and youth health, nutrition, HIV/AIDS and sexually transmitted infections, chronic diseases and disabilities, women's health and genetics, oral health, and mental health and substance abuse – are responsible for programmes that affect the health of children. Their role includes developing national goals, objectives, indicators and policies for monitoring the attainment of national objectives and programme implementation. Further, they are responsible for providing support to provinces and districts in their implementation and monitoring of programmes.

It is disturbing that not a single of the 14 national child health goals set by the Primary Health Care Strategy for 2000 (DoH, 1997b) was achieved by 2005. It could be argued that these goals represented ideals and were never expected to be achievable. This argument, however, makes a mockery of the notion of setting goals.

Current status of child health in South Africa

Child mortality

Child mortality rates are commonly-used indicators to assess the performance of the health system in addressing the health needs of children. They also allow for comparisons between countries, and between provinces, regions and districts within a country. The national and provincial child mortality data generated by the South

African Demographic and Health Survey (SADHS) in 1998 provide the most reliable available statistics (DoH et al., 2002). The South African infant mortality rate (IMR) as determined by the SADHS in 1998 was 45.4 per 1 000 while the under-five mortality rate (U5MR) was 59.4 per 1 000 live births (see Table 5.2 for the provincial breakdown in mortality).

Table 5.2 Infant, under-five mortality and neonatal mortality rates, South Africa, 1998

Province	IMR	U5MR	Neonatal mortality rate
Eastern Cape	61.2	80.5	24.7
Free State	53.0	72.0	9.9
Gauteng	36.3	45.3	17.8
KwaZulu-Natal	74.5	52.1	23.2
Mpumalanga	63.7	47.3	23.6
Northern Cape	55.5	41.8	20.5
Limpopo*	52.3	37.2	18.3
North West	56.0	42.0	20.0
Western Cape	8.4	30.0	4.0

Note: * formerly Northern Province
Source: DoH et al. (2002)

Table 5.3 shows updated national and provincial data on IMR based on modelling. It is estimated that the IMR nationally increased in the period 1998 to 2002. The increase is approximated to be almost 14 additional infant deaths per 1 000 live births. This was almost exclusively the consequence of increased deaths from vertically acquired HIV infections.

Table 5.3 Predicted changes in South African infant mortality rates, 1998–2002

Province	1998 (1)	1998 revised (2)	2002 (3)
Eastern Cape	61.2	61.2	72.0
Free State	36.8	53.0	63.0
Gauteng	36.3	36.3	46.0
KwaZulu-Natal	52.1	52.1	68.0
Limpopo	37.2	37.2	53.0
Mpumalanga	47.3	47.3	59.0
Northern Cape	41.8	41.8	46.0
North West	36.8	42.0	56.0
Western Cape	8.4	30.0	30.0
South Africa	45.4	45.0	59.0

Sources: Bradshaw et al. (2000), DoH et al. (2002), Dorrington et al. (2002)

Concordant with the data about the rising IMR is evidence that the U5MR is also increasing in the country. The revised national estimate for 2002 was 100.0. This represents almost a doubling of the rate compared to 1998 (when the U5MR was 59.4 nationally). During the past ten years at Chris Hani Baragwanath Hospital in Soweto, deaths in admitted children (aged less than 12 years) have steadily risen from 3.9 per cent in 1992 to 11.1 per cent in 2001, despite the number of admissions remaining relatively static at 5 000–6 000 per year (Kala, 2003). Most of this increase is attributed to the increasing toll of the HIV/AIDS pandemic (Zwi et al., 1999).

The leading causes of death in children aged 0–14 years nationally, based on death notification data, are shown in Table 5.4. The top five underlying causes of death between 1997 and 2001, in order of frequency, were intestinal infection, lower respiratory tract infections, unnatural causes, HIV/AIDS and ill-defined illnesses (Stats SA, 2002). These causes were found across the nation with no specific regional variation (Stats SA, 2002). The proportion of children dying from HIV/AIDS approximately doubled during this period (Stats SA, 2002).

A Medical Research Council (MRC) team reported specifically on deaths in children *younger than five years of age* in the year 2000. HIV/AIDS was responsible for 40 per cent of all under-five deaths in that year. Low birth weight was responsible for 11 per cent of deaths. Diarrhoeal disease, lower respiratory tract infections and malnutrition, when adjusted for HIV/AIDS co-morbidity, only ranked third, fourth and fifth as causes of death, but together were responsible for 20.3 per cent of all under-five deaths in the year 2000 (Bradshaw et al., 2003).

Table 5.4 Leading underlying causes of death among children aged 0–14 years, South Africa, 1997–2001 (expressed as percentage of all deaths)

Cause	1997–2001			2001 only		
	Rank	Male (%)	Female (%)	Rank	Male (%)	Female (%)
Intestinal infection	1	15.4	16.1	2	13.7	13.7
Influenza and pneumonia	2	11.2	13.0	1	13.9	16.2
Unspecified unnatural	3	10.7	7.2	4	9.2	5.9
HIV	4	8.6	8.8	3	11.2	11.6
Ill-defined	5	7.8	8.4	5	7.5	7.7
Respiratory and cardiac (perinatal)	6	6.8	6.4	6	6.0	6.4
Malnutrition	7	6.5	6.1	7	5.4	5.2

Source: Stats SA (2002)

Communicable and non-communicable diseases

Acute respiratory tract infections

Worldwide, respiratory infection is responsible for a greater disease burden than any other condition, as measured by disability-adjusted life years (WHO, 2002a).

Diarrhoeal disease

In the 2003 SADHS of children less than five years of age, eight per cent of mothers reported their children having diarrhoea in the previous two weeks compared to thirteen per cent in the 1998 survey (DoH et al., 2002; DoH et al., 2004). Noteworthy is that this survey was conducted during low diarrhoeal disease months. District Health Information System (DHIS) data show that a quarter of all young children (268 children per 1 000) sought treatment for diarrhoea from Primary Health Care (PHC) facilities in 2005 nationally (Saloojee & Bamford, 2006). In the 2003 SADHS just under two-thirds (63%) of children were treated with some sort of oral rehydration therapy, with about 39 per cent receiving oral rehydration solutions and a similar proportion (40%) receiving a home-made solution (DoH et al., 2004). The 1998 SADHS also showed that diarrhoea was most common in the 6–24-month age group, and was associated with rural residence, lower maternal education and being black African (DoH et al., 2002).

Tuberculosis

There is a strong relationship between HIV infection and tuberculosis (TB). This has resulted in an increasing incidence of TB (by about 20 per cent annually) and limited success of the TB control programme (DoH, 2004). The cure rate in 2004 was 54 per cent whilst the international target is 85 per cent (DoH, 2004). Of equal concern is the increasing multiple drug resistance TB rate (which was estimated to be 1.8 per cent in 2004 against a target of less than one per cent) (WHO, 2006). Official data are not disaggregated according to age and consequently do not differentiate between childhood and adult data. About 16 per cent of TB cases in Gauteng province were estimated to be paediatric (children <12 years old), based on hospital data (Edginton, 2003).

Hiv/Aids

AIDS is the leading cause of death in the country, and in 2002 it accounted for 40 per cent of all deaths. Regional differences are evident, with 52 per cent occurring in KwaZulu-Natal, and 51 per cent in Mpumalanga (Stats SA, 2002). Similarly, as discussed earlier, it accounts for 40 per cent of deaths in children younger than five years of age, and adult deaths contribute significantly to orphaning (UNAIDS et al., 2004; see also Chapter 17).

At the end of 2003, 4.7 million people – over 11.5 per cent of the population – were living with HIV/AIDS, of whom 189 000 are children (Ramkissoon et al., 2004). The national antenatal HIV positivity rate in 2005 was 30.2 per cent, which is higher than previous years (DoH, 2006a). KwaZulu-Natal had the highest rates in the country, followed by Mpumalanga and Gauteng. Nationally, HIV prevalence among teenage girls dropped from 21.0 per cent in 1998 to 15.4 per cent in 2001, and has remained constant since (DoH, 2006a). It is estimated that 96 228 babies were infected with HIV during 2003 (250 a day) by mother-to-child transmission (Ramkissoon et al., 2004).

Stunting

Stunting is the most common form of malnutrition nationally (see Table 5.5). Stunting is defined as a low height for age when measured or compared to the normal height for that age group (Labadarios, 2000; UNICEF, 2005c). Stunting results primarily from poor feeding practices over long periods, repeated infections and poverty within households (UNICEF, 2005c). As such, the health system has little direct impact upon levels of stunting. However, it has a crucial role to play in ensuring that children's growth is monitored and that any faltering is appropriately responded to. The health system can also support families in providing optimal nutrition to infants and young children.

The World Health Organisation (WHO) has set a global target for stunting of ≤20 per cent for children over four years of age. However, the problem is greatest in children aged one to three years (UNICEF, 2005d). In response to the National Food Consumption Survey (NFCS) conducted in 1999, the national DoH has set a target of implementing regular growth monitoring and promotion for 75 per cent of all under-two year olds.

Underweight

Fewer children in the country are underweight or wasted than are stunted. However, the NFCS found little improvement in the nutritional status of young children when compared to the 1994–95 South African Vitamin A Consultative Group (SAVACG) survey (SAVACG, 1996; Labadarios, 2000). In the NFCS survey, one in ten children aged between one and nine years was underweight in the country. Malnutrition rates were higher in families with poorer housing or lower maternal education levels.

Overweight

As Table 5.5 shows, children in South Africa are not immune to the 'globesity' phenomenon with between 5 and 6 per cent of children between four and nine years of age in the country being categorised as overweight (Labadarios, 2000). There is a higher prevalence of obesity among children of better-educated mothers. A standardised analysis in 1995 of surveys from 94 countries indicated a global overweight prevalence of 3.3 per cent (6.5 per cent for southern Africa) in children aged under five years (De Onis & Blossner, 2000). Since obesity has been found to predispose individuals towards the development of diseases such as hypertension and diabetes in adult life, interventions to reduce childhood obesity in the country are worth considering.

Vitamin A

Although the prevalence of clinical signs of vitamin A deficiency is decreasing worldwide, the prevalence of marginal vitamin A deficiency in many developing countries is high, placing children at increased risk of infections and mortality. In the SAVACG study, exactly a third of children nationally had a marginal vitamin A status (SAVACG, 1996). According to WHO-accepted criteria, this prevalence of marginal vitamin A serum levels identifies the country as having a serious public health problem of vitamin A deficiency. A vitamin A supplementation programme was implemented towards the end of 2001 at all provincial and local government

Table 5.5 The anthropometric status of children aged 1–9 years, South Africa, 1999

Anthropometric parameter	1–9 years	1–3 years	4–6 years	7–9 years
Stunting	21.6	25.5	20.7	13.0
(% height for age ≤ 2SDs)	20.0–23.2•	23.0–27.9	18.2–23.3	9.8–16.1
Underweight	10.3	12.4	8.8	7.7
(% weight for age ≤ 2SDs)	9.1–11.4	10.5–14.2	7.0–10.6	5.2–10.2
Wasting	3.7	4.0	3.4	3.4
(% weight for height ≤ 2SDs)	3.0–4.4	2.9–5.1	2.2–4.5	1.7–5.1
Severe stunting	6.5	8.2	5.4	4.3
(% height for age ≤ 3SDs)	5.6–7.5	6.6–9.7	4.0–6.9	2.4–6.2
Marasmus	1.4	2.2	0.8	0.7
(% weight for age ≤ 3SDs)	1.0–1.9	1.3–3.0	0.3–1.4	0.0–1.4
Severe wasting	0.8	0.8	0.9	0.7
(% weight for height ≤ 3SDs)	0.5–1.2	0.3–1.4	0.3–1.5	0.0–1.4
Overweight	6.0	6.6	5.2	6.1
(% weight for height > + 2SDs)	5.1–6.9	5.2–8.0	3.8–6.6	3.9–8.4

Notes: • Confidence interval; SD = standard deviation
Source: NFCS (modified) (Labadarios, 2000)

health facilities for children under the age of five years. At present, there are no data on the uptake or success of the programme.

Iron status

The SAVACG (1996) survey found the prevalence of anaemia in children less than six years of age living in South Africa to be 21.4 per cent. The prevalence of moderate (6.8%) and severe (0.2%) anaemia was much lower. Iron depletion or deficiency was present in 9.8 per cent of children, and iron deficiency anaemia in 5.0 per cent of children nationally (SAVACG, 1996). These findings indicate that iron deficiency anaemia per se is not a serious problem in South Africa, except in 6–23-month-old children.

Iodine

Iodine deficiency disorders (IDD) result in illnesses such as cognitive and psychomotor impairment, and intellectual impairment (UNICEF, 2005d). The IDD Survey 2000 found that over 10 per cent of schools nationally had pupils with low median iodine concentrations, indicating a degree of dietary iodine deficiency (SAIMR, 2000). A national survey of iodine content showed that only 62 per cent of households adequately use iodised salt, considerably short of the international goal of 90 per cent (Joose et al., 2002).

Low birth weight rate

The low birth weight (LBW) rate is considered an indicator of the socio-economic status and health of the community in general. In developed countries, it is around 6 per cent, whereas rates of 16 per cent are average for developing countries (UNICEF, 2005c). The national LBW rate is estimated to be between 13.8 per cent

and 19.2 per cent (Pattinson, 2003b). The LBW rate in Gauteng was 19.2 per cent in 2001–02 (Pattinson, 2002). This relatively high LBW rate is congruent with the urban–rural differential noted in national data on this indicator (rural areas have fewer LBW babies).

Breastfeeding

Although the majority of mothers initiate exclusive breastfeeding in South Africa, only 10.4 per cent exclusively breastfeed during the first three months of life, and this drops to 1.2 per cent by six months of age (DoH et al., 2002). Almost 50 per cent of women surveyed nationally introduced commercial infant formula milk by bottle during the first three months of life (DoH et al., 2002).

Adolescent health

Termination of pregnancy services

The Choice on Termination of Pregnancy Act (No. 92 of 1996) continues to benefit women who choose to exercise this right. The demand for this service is declining, which is an indication of fewer women having unplanned and unwanted pregnancies. Buchmann et al. (2002) conducted a study in Soweto to determine the proportion of pregnancies that ended in termination of pregnancy (TOP), with special reference to maternal age, and to measure trends from 1999 to 2001. The TOP rate for teenagers decreased from 22.3 per cent to 16.3 per cent but was higher than that for older women (15.2 per cent in 1999 and 13.2 per cent in 2001) (Buchmann et al., 2002). When further disaggregated by age, findings show that TOP rates for teenagers aged 13–16 years decreased from 28.0 per cent to 23.0 per cent, and rates for older teenagers declined significantly from 21.0 per cent to 14.9 per cent (Buchmann et al., 2002).

Health programmes

Perinatal care

The perinatal mortality rate (PNMR) is probably the most sensitive indicator of obstetric care in the country. The South African PNMR is estimated to be 40/1 000 (Pattinson, 2003a, 2003b). There is evidence that 80–85 per cent of births occur under supervision of skilled health workers in health facilities (Pattinson, 2003a, 2003b). However, recent reports suggest that in some provinces supervised deliveries may occur much less frequently than this, particularly in under-served rural areas (Pattinson, 2003a, 2003b). The mean PNMR (2000–02) from the Perinatal Problem Identification Programme (PPIP) programme in 73 sentinel sites was 34 per 1 000 births. Disparities existed between metropolitan (36.2), town (38.6) and rural (26.7) hospitals. Population-based estimates of perinatal mortality are lacking. Facility-based estimates from hospitals participating in the PPIP may either underestimate or overestimate the PNMR in South Africa. Since population-based estimates are very difficult to obtain, improvement in the quality and completeness of facility-based data offers the best prospect for true measures of perinatal mortality in South African populations.

Prevention of mother-to-child transmission programme

The prevention of mother-to-child transmission (PMTCT) programme, which started in 2001, is now available in more than 3 064 public hospitals and community health centres throughout the country (DoH, 2006b). Services offered by the programme include voluntary counselling and testing for HIV; advice on infant feeding, including the use of milk formula; and continuous counselling, education and support for 18 to 24 months for mothers. Data from the national PMTCT programme indicate that the HIV transmission rate among the 55 per cent of children participating, and who were followed to 12 months of age, was 18 per cent, pointing to an approximate 28 per cent reduction in mother-to-child transmission of HIV (Doherty et al., 2003).

Immunisation

The Expanded Programme on Immunisation aims to decrease childhood morbidity and mortality from vaccine-preventable diseases. It has various programmatic dimensions, which include vaccine procurement and distribution, cold chain management, daily immunisation services at maternal and child health clinics, and surveillance (immunisation coverage; vaccine adverse events; incidence rates of acute flaccid paralysis, measles and neonatal tetanus).

Surveillance and management systems have been strengthened, resulting in the country being certified polio-free in October 2006 (DoH, 2006c). The goal of the SA-EPI was to attain 90 per cent immunisation coverage in the first year of life for all vaccines by 2005. Current DHIS data suggest that this target was achieved nationally in 2005, despite four of the nine provinces failing to attain the target (Saloojee & Bamford, 2006). This is significantly higher than the 63 per cent found by the SADHS in 1998.

Immunisation campaigns on measles and polio have generally been successful. For example, in the 1990s, 'measles remained endemic and epidemics continued to occur periodically, but the case fatality ratio decreased sharply at the beginning of the decade' (DoH Statistical Notes, 2005, pp. 1–2).

Baby-friendly hospitals

The Baby-Friendly Hospital Initiative launched in 1991 by UNICEF and WHO aims to improve breastfeeding practices at birthing centres. A maternity facility can be designated 'baby-friendly' once it has implemented ten specific steps to support successful breastfeeding. There are over 15 000 'baby-friendly' hospitals and clinics globally. There has been a doubling of such facilities in South Africa since 2003 with 178 centres certified as 'baby friendly' by September 2005. This represents 37 per cent of all birthing centres in the country (Saloojee & Bamford, 2006).

Kangaroo Mother Care

The Kangaroo Mother Care initiative is rapidly gaining popularity. This programme, focusing on preterm and LBW babies, aims to prevent the separation of mother and baby in the first few weeks after birth, and thereby improve infant outcomes (UNICEF, 2005d). The mother swaddles her baby directly to her chest for most of the day and night, providing warmth, nutrition and comfort, and the benefits for the

baby include fewer infections, better weight gain and earlier discharge from hospital (UNICEF, 2005d).

Integrated Management of Childhood Illness

The Integrated Management of Childhood Illness (IMCI) strategy developed by the WHO has been adopted by 109 countries, including South Africa. It targets major childhood illnesses and demands an integrated approach in their management. The national DoH sought to have at least one IMCI-trained staff member at all clinics in the country by the end of 2003. By 2006, over three-quarters (76%) of PHC facilities nationally were capable of implementing IMCI, whilst one-half (48%) of PHC facilities have achieved the WHO and DoH target of having 60 per cent of professional nurses working at the facility trained in IMCI (Saloojee & Bamford, 2006). It is clear that a further major commitment from the DoH regarding training and support for the initiative is required if it is to be successfully implemented.

Integrated Nutrition Programme

Given the relatively high levels of wasting and stunting found in the NFCS in 1999, a series of strategies to improve nutrition were implemented by the national DoH. These include fortifying maize meal and wheat, promoting exclusive breastfeeding, and implementing food-based dietary guidelines. The Integrated Nutrition Programme (INP) involves nutrition education, micro-nutrition supplementation, promoting community-based growth monitoring, strengthening nutrition interventions at facilities and community levels, poverty relief, and development of community gardens. Special attention is focused on children under two years of age and on pregnant and breastfeeding women. More effort has been directed at implementing the INP in recent years. Despite this, there is scant evidence of its success. While district data are kept on the numbers of children exclusively breastfed, those receiving breast milk substitutes, and those provided with food supplements at PHC clinics, these have neither been assimilated nor published. Anecdotal evidence indicates that food supplementation is available in very few districts around the country, with even better-resourced metropolitan areas such as Johannesburg failing to provide this service.

Child health data sources

Available data

Data on children in South Africa are available from a number of sources. These are summarised in Table 5.6. Existing administrative systems run by government departments are a major potential source of data. While these databases are potentially very useful sources of information on children, they present a number of challenges, including data accuracy and quality problems. Some of the opportunities and constraints in using administrative data for the purposes of child outcome monitoring are noted in Chapter 2 in this volume.

Description of data sources

The last few years have seen the development and refinement of national and provincial minimum indicator/data sets (also called essential data sets [EDSs]) to

Table 5.6 South African child health-related data sources

Data source	Responsibility	Data collection frequency	Indicator(s)	Example(s) of available data
Census	Statistics South Africa (Stats SA)	10 years	Vital statistics	Water and sanitation accessibility
Census Replacement Survey (CRS)	Stats SA	3 years	Vital statistics	Water and sanitation accessibility
General Household Survey (GHS)	Stats SA	Annual	Information on a variety of subjects including education, health, labour market, births, access to services and quality of life	Medical aid coverage; Health worker consultations
Hospital data	Hospital	Ongoing	Morbidity; Mortality	Malnutrition rates; Accidents and injuries; HIV deaths
Primary healthcare (Minimal data set)	DoH	Ongoing	Morbidity data	Diarrhoeal disease; Respiratory infections
Food Consumption Survey	Stats SA	Periodic	Food consumption and nutrient intake of children aged 1–9 years	Anthropometric status; Dietary intake of various micronutrients
Birth and death registration	Stats SA	Ongoing	Mortality rates; Cause-specific mortality	IMR; U5MR
PPIP (maternal)	MRC unit	Ongoing	Cause-specific mortality	Stillbirths due to syphilis
PPIP (child)	MRC unit	Ongoing	Cause-specific mortality	Gastroenteritis deaths
National and provincial health department records	DoH	Ongoing	Various	Baby-friendly hospitals; IMCI training
Notification data	DoH	Ongoing	Mortality; Morbidity	Polio, measles, TB incidence
Antenatal survey	DoH	Annual	HIV seroprevalence	HIV seroprevalence
HSRC HIV seroprevalence study	HSRC	Periodic	HIV seroprevalence	HIV seroprevalence
Demographic surveillance sites	Agincourt; Hlabisa	Ongoing	Mortality; Cause-specific mortality	U5MR; Cause-specific mortality

Data source	Responsibility	Data collection frequency	Indicator(s)	Example(s) of available data
National Health Care Management Information System	DoH	Ongoing	Information systems related to healthcare services, primarily for surveillance and management	Hospital beds; Patient record; Patient billing
Birth to Twenty	Wits/MRC	Ongoing	Various	Outcome of LBW infants
International surveys	Various	Ongoing	Various	World fertility survey

enable the calculation of key indicators. The DHIS is being implemented in all provinces using the provincial EDS. All nine provinces have developed their own EDS for both PHC facilities and hospitals. This EDS for PHC contains 20 compulsory and 18 optional items. More than 98 per cent of PHC facilities report data monthly (DoH, 2004).

Notification data depend on a passive surveillance system that requires the co-operation of health professionals in both the private and public sectors. HIV seroprevalence data are obtained from sentinel sites around the country. Both of these data sources are managed by the DoH. Additional data can be obtained from the SADHS. More recent data sources include the annual Confidential Enquiries into Maternal Deaths.

Statutory agencies such as Stats SA conduct periodic surveys that gather important information on children, their families and their household circumstances. These include the Census, the GHS, the NFCS and the SADHS. The adoption of the GHS and the CRS offers opportunities for data collection from a large sample of children across the country, particularly regarding their socio-economic well-being.

Demographic surveillance sites in Limpopo province (Agincourt) and KwaZulu-Natal (Hlabisa) allow for the collection of population-based data on a regular basis, which allows for the investigation of fertility and mortality trends, for example. The use of follow-up of a birth cohort (as is the case with the Wits/MRC Birth to Twenty project)[3] also enables the description of both cross-sectional and temporal trends.

The PPIP was developed by the Maternal and Infant Health Care Strategies Research Unit of the MRC. It is a simple, user-friendly computer-based programme that, once simple perinatal data are entered, calculates various perinatal care indices, analyses the medical conditions that led to the perinatal deaths, and describes any avoidable factors, missed opportunities and sub-standard care that may have led to the deaths. It aims to estimate a national perinatal mortality rate and to identify the causes of perinatal mortality. Its location within sentinel facilities limits the extrapolation of these estimates, causes and factors to all parts

of South Africa. It is, however, the most reliable source for national and provincial perinatal and neonatal mortality data.

Limitations of present data sources

Key limitations include the absence of procedures by which to measure the selected indicators, a lack of reliable information systems and electronic databases, the shortcomings of traditional outcome measures, and limited skills in evaluation and research amongst those tasked with implementing the system.

It is important to note that although the registration of deaths has improved considerably since 1994, particularly since the introduction of a new death notification form in 1998, data on causes of death for South Africa and the analysis thereof are compromised by:

- Under-reporting of deaths, particularly in the rural areas of South Africa;
- The absence of identity documents in the age group 0–18 years, which accounts for under-reporting when using the population register;
- Inadequate reporting on underlying causes of death and contributing factors, despite the improved death certificate; and
- Misreporting of deaths.

The International Classification of Diseases – Tenth Edition, or ICD-10, has been adopted as a standard for disease coding in both the public and private health sectors, but its implementation is a challenge. As noted, birth and death registration has improved with the introduction of the revised first page of the birth and deaths form.

Household surveys in general are limited by their conceptualisation and implementation strategies, including survey and sampling design, sample size, questionnaire design, the implementation of fieldwork, data-capture processes and editing. The extent of some errors, for example sampling errors, can be estimated, while others cannot – for example, non-sampling errors that occur during fieldwork, and the interpretation of the meaning of questions by respondents.

Implementation of the National Health Care Management Information System has been uneven, with provinces only applying the system in selected hospitals. One consequence of this is that the system is unable to track patients who use public health facilities in various provinces (DoH, 2004).

These data sources together offer considerable potential for improving understanding of the relationship between child outcomes and the broader environment. At present, their potential cannot be realised because information from these various sources is not integrated at a single, centralised point that allows easy access by a variety of stakeholders and decision-makers. Moreover, there are no mechanisms in place for checking the reliability and validity of the various data collection methods in use for documenting particular changes in child and adolescent outcomes.

Recommended indicators for monitoring child health in South Africa

Rationale for indicator selection

There have been significant shifts in thinking around monitoring child outcomes (Dolev & Habib, 1997). While it is important to develop indicators beyond survival (i.e. well-being rather than disease), in the interests of feasibility, the focus of this chapter has been on traditional health status measures (or 'survival' indicators). However, it is noted that health status measures alone are not sufficient to describe all phenomena pertaining to health and development (well-being), because many address negative aspects such as mortality and morbidity, which measure damage already suffered by a generation of children.

The categorisation of indicators as core or additional in the tables in Part 2 of this volume was based on whether the indicator:

- Is linked to an existing routine data collection system (computerised or other automated systems, especially national or provincial data sets, hospital administrative systems, disease registers, etc.), negating or minimising the need for extra data collection resources;
- Is based on substantial research connecting it to child well-being;
- Has the ability to be measured regularly so that it can be updated and show trends over time;
- Measures large segments of the population, rather than one particular group;
- Allows for affordable and cost-effective data collection;
- Has the potential to be effective in influencing areas such as policy development or service delivery;
- Is associated with current evidence of such effectiveness.

Further, indicators which satisfied the intrinsic characteristics of indicators described by the CHILD project were selected (European Union Community Health Monitoring Programme, 2002).

The policy goals listed for each indicator represent the target set by the national DoH in various documents, including *Health Goals, Objectives, and Indicators (2001–2005)* (DoH, 2001a), and a subsequent update (DoH, 2003a; DoH Stratplan, 2006).

Conclusion

There is a relative lack of good quality routine data to monitor child health status and track the progress of child health programmes in South Africa. This makes it difficult to fully assess the effectiveness of current programmes attempting to improve child health and wellness status. Further, there are major data gaps. Thus, for example, no reliable data exist on morbidity in children from TB, chronic diseases or accidents and injuries.

This chapter has attempted to present a proposal for the development of child health indicators as one component of a child rights and well-being monitoring system for South Africa. The suggested indicators in Part 2 represent a compromise, a balance

between the desired and the possible, in the nature, number and scope of indicators selected.

A summary of South African data on child health indicators is given in Appendix 6 at the end of this volume.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 Although specific health-related phenomena, for example, injury, disability and mental health are referred to in this chapter, they are not the focus here, and are covered in more detail in chapters 6, 7 and 10 in this volume.

2 Childwatch International, <http://www.childwatch.uio.no>.

3 Wits/MRC Birth to Twenty project, <http://www.wits.ac.za/birthto20/>.

CHAPTER 6

Monitoring child and adolescent mental health, risk behaviour and substance use

Alan J. Flisher

Introduction: objectives and scope

> Children and adolescents with good mental health are able to achieve and maintain optimal psychological and social functioning and well-being. They have a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximize growth. Moreover, the good mental health of children and adolescents is crucial for their active social and economic participation. (WHO, 2005, p. 2)

What about children and adolescents with poor mental health? Studies in South Africa (Kleintjies et al., 2006) and internationally (Bird, 1996) concur that the prevalence rate of mental disorders or psychopathology (including substance use disorders) in children and adolescents is of the order of 20 per cent. There is an enormous burden associated with mental disorders and substance use in children and adolescents, which is exacerbated by stigma and discrimination.

There are three compelling reasons to monitor the mental health of this population, with a view to developing and implementing effective mental health interventions (WHO, 2005):

- Specific mental disorders occur at certain stages of child and adolescent development, which implies that screening programmes and interventions for such disorders can be targeted to the stage at which they are most likely to appear;
- Since there is a high degree of continuity between child and adolescent disorders and those in adulthood, early intervention could prevent or reduce the likelihood of long-term impairment; and
- Effective interventions reduce the burden of mental health disorders on the individual and the family, and they reduce the costs to health systems and communities.

One manifestation of poor mental health is risk behaviour, which can be defined as behaviour which places the individual at risk for adverse consequences. These adverse consequences can be short term or long term, and can occur in the biological, social or psychological domains.

Substance use can be regarded as a manifestation of poor mental health, for example, when it is sufficiently severe to warrant a diagnosis of substance abuse or dependence. However, it can also be construed as a risk behaviour. In this case, the

focus is on the risk at which the person is placed through use of the substance. For example, a young person may use alcohol intermittently, but still be at risk for adverse consequences such as unprotected sex or traffic accidents. Such a person may not meet criteria for alcohol abuse or dependence. Because of the fact that substance use can be considered both as an aspect of poor mental health and as a risk behaviour, it will be addressed in the sections in this chapter involving both mental health and risk behaviour.

A comprehensive approach

Risk behaviour is considered in this chapter alongside mental health as the two are associated with each other (Flisher et al., 2000). The details of the causes for the association have not been clarified and almost certainly vary according to the specific psychopathology and risk behaviour under consideration. In some cases, the risk behaviour may cause the psychopathology, for example, alcohol use can cause depression through purely biological pathways. In other cases, the psychopathology may cause the risk behaviour, for example, the impulsivity that comprises an aspect of attention deficit hyperactivity disorder (ADHD) may cause unsafe sexual behaviour. Finally, both may be attributable to some other factor that causes both the psychopathology and the risk behaviour, for example, the absence of positive adult role models can cause both conduct disorder and tobacco use (King et al., 2003). Whatever the reason for the covariation between psychopathology and risk behaviour, it is necessary to take a comprehensive approach and consider both together when developing indicators of child rights and well-being. The importance of taking a comprehensive approach does not just apply to considering both psychopathology and risk behaviour. Indeed, there is a large amount of covariation between psychiatric disorders (Flisher et al., 1996; Angold et al., 1999). Also, a comprehensive approach should include intellectual disability, abuse, and neglect and injury. However, these are excluded from the current chapter as they are addressed in chapters 7, 10 and 14 in this volume.

The interests and needs of children and adolescents can be met in a range of settings, such as the school, the criminal justice system, and health services, all of which should be considered when developing indicators. In addition, the extent to which there is co-ordination between different sectors (such as health, education and social development) should be considered. This is more likely to be achieved if there is consultation with a wide range of stakeholders, as proposed by the national policy guidelines on child and adolescent mental health and adolescent and youth health (DoH, 2001b, 2003b). Those that are principally involved in a specific sector are well placed to address issues related to that sector. Educators, for example, are well placed to develop indicators that assess the extent to which schools are addressing bullying, alcohol and other drug use, and unsafe sexual behaviour in the school setting. The situation is further complicated by the existence of different levels of government, for example the national, provincial and local levels.

Rationale

A rights-oriented approach

It is essential to develop and maintain a rights-based approach to child mental health and risk behaviour, and to the interventions that address these domains. Rights to generic health and healthcare apply to the specific cases of mental health and mental healthcare. These and other relevant rights are provided for in the South African Constitution, which specifies the rights to:

- Freedom and security of the person, in particular, the right not to be treated or punished in a cruel, inhuman or degrading way (this is especially relevant to inpatient facilities) (Section 12(1));
- An environment that is not harmful to one's health and well-being (Section 24(a));
- Have access to basic healthcare services (Section 28(1)(c)) and social services (for example, substance use services, caregiver support services, trauma counselling for survivors of violence) (Section 28(1)(c));
- Appropriate alternative care when removed from the family environment (for example, inpatient facilities) (Section 28(1)(b); and
- Not be required or permitted to perform work or provide services that place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development (Section 28(1)(f)).

The Constitution also provides for the signing of binding international instruments. One such instrument is the Convention on the Rights of the Child (CRC – see Appendix 1 in this volume). The CRC binds the government, inter alia, to:

- Ensure that the child has access to information (Article 17), particularly information on health-related matters as covered in articles 24 and 33;
- Take all legislative and other measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation (Article 19(1));
- Put in place effective procedures for the establishment of social programmes which provide children and caregivers with necessary support (Article 19(2)); and
- 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 the rehabilitation of health (Article 24(1)).

The Committee on the Rights of the Child specifically addresses mental health and states that in terms of Article 24, children with mental health problems have the right to be treated, as far as possible, in the community in which they live. If children with mental health problems need to be placed in an inpatient facility or institution, such placements must be reviewed periodically according to Article 25.

Another instrument is the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3 in this volume). Article 14 of the AC provides that every child shall have the right to enjoy the best attainable state of physical, mental or spiritual health. It also provides that the state should ensure the provision of necessary medical assistance and healthcare to all children.

The denial of rights is intimately related to stigma, which includes bias, stereotyping, fear, embarrassment, anger, rejection, avoidance, denial of opportunities for education and training, and denial of civil, political, economic, social and cultural rights (WHO, 2005). Stigma is particularly relevant for children since they are least capable of advocating for themselves. Families may be ashamed of their children with a mental disorder, and may thus keep them locked up or isolated from the community. Such measures can have major deleterious effects on their physical or emotional development (WHO, 2005).

Some general challenges

There are a number of challenges, mentioned below, that arise when developing indicators and measures for child and adolescent mental health and risk behaviour.

For both mental health and risk behaviour, one generally relies on reports of internal states or behaviour, as opposed to direct observation which is the source of data for many other domains. However, younger children are not sufficiently mature to verbalise their thoughts, feelings and experiences. One thus has to rely on reports of adult informants, such as parents and teachers. However, there is very low concordance between the reports of children or adolescents and adult informants, even for older adolescents. The adult informant may not have access to the internal states of the child. Conversely, the child may not be sufficiently objective to report validly on her or his behaviour. For this reason, it is most appropriate to consider a particular symptom or behaviour present if either the child or the adult informant reports that it is present (Shaffer et al., 1996). The challenge for monitoring is that it can be cumbersome and expensive to obtain data both from the child and an adult informant.

Cultural factors are particularly relevant for mental health and risk behaviour. For example, most psychiatric measures implicitly subscribe to a universalist or 'etic' approach, in which it is assumed that psychopathology presents in the same ways regardless of culture or place, and that assessment measures are thus also globally applicable (Kleinman, 1988). This is in contrast to an 'emic' approach, in which it is assumed that culture plays an influential role in the presentation of psychiatric disorders, and that measures are thus not necessarily universally applicable. The challenges for monitoring are that, i) the same measures may not be applicable for diverse demographic and cultural subgroups in South Africa; and ii) one cannot assume that a particular measure is appropriate without establishing this through elicitation studies (which are qualitative) and reliability and validity studies (which are quantitative).

A developmental approach is essential when monitoring child and adolescent mental health and risk behaviour. Normal development should form a backdrop against which mental health and risk behaviour are assessed (Fonagy, 2002). For example, some characteristics which might indicate the presence of a disorder in an older child or adolescent (such as shyness and temper tantrums) may be normal for earlier stages of development. Risk behaviour also has different implications depending on developmental stage. Participation in sexual intercourse, for example, has different implications for a child of nine years compared to an adolescent a decade older. The challenges for monitoring are that, i) measures should ideally take account of

developmental stage (although they rarely do) (Fonagy, 2002); and ii) a developmental perspective should inform interpretation of the data generated by a measure.

As will become clear below, there is a dearth of data from existing data sources (especially for child and adolescent mental health), compared to some other domains covered in this volume. This can be addressed by an increase in the amount of research that sets out to fill these gaps. However, a more efficient and sustainable solution is to increase the amount and quality of data involving child and adolescent mental health, risk behaviour and substance use in existing information systems.

Recommended indicators for monitoring child and adolescent mental health, substance use and risk behaviour

Type 1: Child status

Type 1 indicators refer to outcomes at the level of the individual child or adolescent. For child and adolescent mental health and risk behaviour, such outcomes can be documented at three levels: the symptomatic, behavioural or diagnostic level; the functional level; and the mechanisms level (Fonagy, 2002). Each will be presented separately.

Symptomatic, behavioural or diagnostic level

Mental health

The ideal instrument to assess the presence of psychopathology should ideally:

- Be comprehensive in scope;
- Provide the means for determining the presence or absence of psychiatric disorders in the general population;
- Categorise psychiatric disorder using criteria that are in widespread use by mental health professionals;
- Capture data from both the child and an appropriate adult informant (generally a parent) using parallel forms that are easily understood by both the young person and the adult informant;
- Allow for different levels of certainty and severity;
- Have acceptable psychometric properties (for example, test–retest reliability and construct validity), ideally for the population for which it will be used; and
- Be practically feasible to use, for example, it should be brief, inexpensive and (if appropriate) equipped with computer-based scoring algorithms (Bird & Gould, 1995).

The most commonly used instrument to assess psychopathology is the Child Behavior Checklist (CBCL), which has forms for various ages and informants (parent, teacher and child) (Achenbach & Edelbrock, 1983, 1986). There are 112 behaviour problems, each of which is scored on a 3-point response scale. The instrument generates major scales for internalising and externalising problems, and subscales for areas such as delinquency, attentional problems and social withdrawal. The instrument can be completed in about 20 minutes. This scale is characterised by many of the ideal properties listed above. In particular, it is easy and inexpensive to

administer and excellent psychometric properties have been documented in many cultural settings. It has been used in at least one South African study (Barbarin et al., 2005). However, it is not able to categorise psychiatric disorder using criteria that are in widespread use by mental health professionals.

The South African Child Assessment Schedule was developed for use among South African children (Barbarin & Richter, 2001b). The items were patterned on several instruments commonly used in the US, including the CBCL. The schedule consists of five subscales: anxiety, depression, aggression, self-regulation and opposition. It has been used in two South African studies (Van der Merwe & Dawes, 2000; Barbarin & Richter, 2001b; Barbarin et al., 2005).

There are a number of structured, comprehensive, criterion-orientated instruments that are able to provide psychiatric diagnoses (Bird & Gould, 1995; Fonagy, 2002). However, the instrument that appears to be most suitable for the South African setting is the Diagnostic Interview Schedule for Children (DISC) (Shaffer et al., 1996). This conclusion is based on the fact that it is highly structured and has been designed for administration by a lay interviewer with minimal training. It generates diagnoses based on the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. It has a parent and child version. It takes at least an hour to complete, and is suitable for children aged 6–17 years. It has satisfactory psychometric properties (Shaffer et al., 1996). Furthermore, the Xhosa DISC was found to be feasible and acceptable in a survey conducted among 500 randomly selected children and adolescents aged 6–16 years in an informal settlement in Cape Town (Robertson et al., 1999). Thus, the DISC is recommended as an appropriate measure of psychopathology for children and adolescents in South Africa. However, it would need to be translated and its psychometric properties established before application in new settings.

In addition to structured instruments that assess a broad range of psychopathology in children and adolescents, there are a number of questionnaires that aim to assess specific types of problems. These instruments do not have many of the positive characteristics listed above (Bird & Gould, 1995), for example, they are not comprehensive and do not generally provide an indication of the presence or absence of psychiatric disorders. However, their psychometric properties may be acceptable and they are very much more feasible to use than instruments such as the DISC. Among those that have been used in South Africa and that have been found to have acceptable psychometric properties are:

- The Harvard Trauma Questionnaire (Mollica et al., 1992), which provides data about exposure to violence and the presence of post-traumatic stress disorder (Ward et al., 2004);
- The Beck Depression Inventory (Beck et al., 1961), which comprises 21 questions answered on a 4-point Likert scale (Ward et al., 2003); or the Child Depression Inventory (Kovacs, 1985), a 10-item instrument which has been used among Xhosa-speaking children and adolescents in the Eastern Cape (Suliman, 2002; Wild et al., forthcoming);
- The Self-Rating Anxiety Scale (Zung, 1971), which has 19 questions scored in the same way (Ward et al., 2003); and

- The Disruptive Behaviour Disorders (DBD) rating scale (Pelham et al., 1992), which assesses the presence and degree of ADHD-related symptoms, oppositional defiant disorder, and conduct disorder as formulated in the DSM-IV (APA, 1994). Only the psychometric properties of the ADHD scale have been assessed (but not in South Africa) (Meyer et al., 2004).

As mentioned above, children and adolescents provide more valid information for internalising disorders, whereas adults provide more valid information for externalising disorders. Of the scales listed above, the first three assess internalising disorders and the informant is the child or adolescent. The DBD rating scale assesses externalising disorders and the informant is an adult such as a teacher.

The use of the above instruments is recommended when data regarding specific problems are required and/or it is not feasible to use a comprehensive instrument such as the DISC. These instruments address the most common psychiatric disorders that are found in South African children and adolescents (Kleintjies et al., 2006). They have all been found to be appropriate for use in South African populations, although further development is required before they can be used in populations other than those in which they have been investigated.

Risk behaviour

Risk behaviour is defined as behaviour that increases the risk for adverse outcomes. Such adverse outcomes can be short or long term, and can be in the biological, psychological or social domains. Risk behaviour in the following domains has been associated with adverse outcomes:

- Alcohol, tobacco and other drug use;
- Interpersonal violence;
- Road-related behaviour;
- Sexual behaviour; and
- Suicidality.

A number of school-based surveys have documented self-reported risk behaviour in school-going populations. A questionnaire originally used in a Cape Town study in 1990 (Flisher, Ziervogel, Chalton & Robinson, 1993) has been used in five subsequent studies in Cape Town, as well as in Durban and Johannesburg, and three rural communities (Mankweng in Limpopo province, and Queenstown and Umtata in the Eastern Cape). It has been translated from English into Afrikaans, Pedi, isiXhosa and isiZulu. There is good evidence of test–retest reliability (Flisher, Evans et al., 2004; Flisher et al., 2005), and the fact that significant associations have been detected between the risk behaviours and a range of other variables (including psychopathology) provides convincing evidence of the construct validity of the items (Flisher & Chalton, 2001a, 2001b; Flisher, Brown et al., 2002; Morojele et al., 2002; Flisher et al., 2003; King et al., 2003, 2004; Liang et al., 2003; Wild, Flisher, Bhana et al., 2004; Wild, Flisher & Lombard, 2004; Wild, Flisher, Lombard et al., 2004). The items that we recommend for use are provided in Addendum A at the end of this chapter.

Other instruments have been used to document risk behaviour among South African children and adolescents. The studies that have had nationally representative samples are briefly introduced below. The first is comprehensive in scope (in that it

addresses a wide range of behaviour) while limited in depth (in that only limited data are provided about each risk behaviour). The others are limited in scope (in that they focus on only one domain of risk behaviour) while more substantial in depth (in that they obtain more detailed information about the behaviour of interest).

- *The South African Youth Risk Behaviour Survey* (Reddy et al., 2002). Data were gathered from 10 699 students in grades 8 to 11 from 23 schools per province regarding risk behaviour in the following domains: intentional and unintentional injuries, violence and traffic safety, suicide-related behaviours, behaviours related to substance use (alcohol, tobacco and other drugs), sexual behaviour, nutrition and dietary behaviours, physical activity and hygiene-related behaviours. The instrument was based on the instrument used in the Youth Risk Behaviour Surveillance System in the US. It is not clear whether this survey will be repeated or not. Further, there is no indication of the existence of reliability or validity data.
- *The Global Youth Tobacco Survey* has been conducted twice in South Africa, in 1999 and 2002 (Swart et al., 2004). It is a tobacco-specific survey which focuses on adolescents aged 13 to 15 years. It aims to document and monitor the prevalence of tobacco use, as well as knowledge, attitudes and beliefs related to a range of topics associated with tobacco use. In 2002, 8 935 students in grades 8 to 10 from 191 schools completed the survey. The South African version of the questionnaire consisted of 54 core questions and 39 country-specific questions. The authors intend to administer the instrument on a triennial basis.
- The survey entitled *HIV and Sexual Behaviour among Young South Africans: A National Survey of 15–24 year olds* (Pettifor et al., 2004) was conducted in 2003 with a national sample of 11 904 youth. The youth were interviewed face to face to obtain information, including about the following areas: self-reported sexual behaviour; contraceptive use; sexual coercion and violence; attitudes, norms and communication around HIV; and perceived risk of HIV and health-seeking behaviours. In addition, HIV testing was conducted on oral fluid. It is unclear as to whether the survey will be repeated, although the authors state that the findings provide a solid base for future assessment of trends (Pettifor et al., 2004).
- *The Nelson Mandela/HSRC Study of HIV/AIDS* was an HIV/AIDS household-based survey using a nationally representative sample of all people in South Africa aged two years and older (Shisana & Simbayi, 2002). One adult (25 years and older), one youth (15–24 years) and one child (2–14 years) were selected to participate from each of the 7 449 households that agreed to participate in the study. Data were elicited regarding many aspects of sexual behaviour, and HIV testing of oral fluid was carried out. Separate reports are available for the youth (Simbayi et al., 2004) and child (Brookes et al., 2004) subsamples. The authors of the study recommend that similar studies be carried out at least biennially.

Suicide

Suicide is addressed separately from mental health and risk behaviour for two reasons. First, it can be regarded as either a mental health issue or a risk behaviour issue. Second, it is the only indicator for which mortality data are directly relevant. However, in South Africa, national epidemiological data on suicide are not collected routinely

since the mechanism of death for fatal injuries is not recorded in the national mortality data set. The most recent cross-sectional national suicide statistics refer to the period 1984–86 (Flisher & Parry, 1994), while the most recent data for trends extend to 1990 (Flisher, Liang et al., 2004). This gap has been partially compensated for by the National Injury Mortality Surveillance System, for which information is collected from an expanding network of existing investigative procedures at mortuaries, state forensic chemistry laboratories and courts (Burrows et al., 2003).

It is certainly necessary to monitor suicide rates, disaggregated by demographic aspects such as age, gender, socio-economic status, geographic region and racially defined social group. If trends are identified, such as an increasing suicide rate for young white males, as documented by Flisher, Liang et al. (2004), this can inform a search for risk factors that can be targeted in prevention efforts. However, case identification as an approach to reduce the suicide rate is not indicated, especially in a country such as South Africa where health services in general and mental health services in particular are underdeveloped. Rather, strategies should be put in place to improve access to health services, especially for those who are exposed to risk factors for suicide such as depression, substance misuse and low self-esteem (Flisher, 1999; Wild, Flisher & Lombard, 2004).

Functional level

In epidemiological and monitoring activities, there is a tendency to operationalise mental disorders as categorical phenomena. However, this contradicts clinical practice, where clinicians make decisions along dimensional lines (Bird & Gould, 1995). For example, clinicians make decisions about whether to implement treatment (and, if treatment is implemented, which treatments are selected) on the basis of the extent of functional impairment that is present. This is consonant with the DSM-IV (APA, 1994), where impairment in one or more areas of functioning is specified both in the general definition of mental disorder and in the criteria for individual disorders. The necessity of addressing impairment in epidemiological and monitoring activities is indicated by the fact that prevalence rates of psychopathology are unreasonably high if diagnosis is based entirely on the satisfaction of symptom-count criteria. Similar considerations apply to risk behaviour. The clinical and public health significance of a certain amount of alcohol use, for example, is dependent on the extent to which functional impairment is associated with such use.

In South Africa, there has been insufficient experience with measures of functional impairment. Internationally, there are two instruments that are brief to administer and which we recommend for investigation with a view to their use in South Africa:

- The Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983) was designed to reflect the lowest level of functioning during a specified time period. Scores range from 1 (most impaired) to 100 (the healthiest level of adaptive functioning). Ranges have been developed for the categories of 'non-case', 'probable case', and 'definite case'. The CGAS has been found to have high inter-rater reliability and both concurrent and discriminant validity, even when administered by lay interviewers (Shaffer et al., 1983). This scale is familiar to many clinicians, since it is similar to the Axis V Global Assessment of Functioning Scale in the DSM-IV (APA, 1994).

- The Columbia Impairment Scale (Bird et al., 1993) is a 13-item scale that taps four major areas of functioning: interpersonal relations, certain broad areas of psychopathology, functioning at school or work, and use of leisure time. Items are scored on a Likert scale ranging from 0 (no problem), through 2 (some problem), to 4 (a very big problem). The score can range from 0 to 52. There are two versions, one for administration directly to a child, and the other to a parent or other caregiver that knows the child well.

Mechanisms level

Mechanisms refer to the cognitive, emotional and social capacities that underpin both the symptomatic, behavioural or diagnostic level and the functional level. They are particularly pertinent for mental health and risk behaviour as interventions are rarely able to target the other two levels directly. Furthermore, an alteration in a single mechanism may have benefits for a range of outcomes. Thus, targeting mechanisms of mental health problems and risk behaviour may be an efficient and cost-effective manner of reducing the extent of psychopathology and risk behaviour. In addition, targeting these mechanisms in unselected populations of children and adolescents contributes to the promotion of development of all young people, whether they are suffering or at risk for problems or not. This is consistent with the national policy guidelines for both child and adolescent mental health and adolescent and youth health (DoH, 2001b, 2003b).

There are a large number of proposed mechanisms for mental health problems and risk behaviour, and any selection of a handful of indicators will be open to criticism. The selection is based on the following criteria:

- Availability of reliability and/or validity data for South African children and/or adolescents;
- Demonstrated associations between the mechanism and more than one outcome of interest;
- The capacity to assess the indicator using inexpensive and convenient questionnaire measures;
- The availability of interventions, which have been tested either nationally or internationally, to address the mechanism.

Based on these criteria, we recommend the following indicators: emotional connection, psychological autonomy, behavioural regulation, self-esteem and leisure boredom.

So far as the first three are concerned, Barber and his colleagues (Barber et al., 1994; Barber, 1996; Barber & Olsen, 1997) have provided evidence from a range of settings (including South Africa) that healthy social and emotional development is associated with experiences of emotional *connection* (warm, nurturant, accepting, loving and supportive relationships with significant others), behavioural *regulation* (supervision, monitoring, rule and limit setting), and psychological *autonomy* (being permitted to experience, value and express one's own thoughts and emotions). These factors can operate in a variety of social contexts, including the family, peers, school and community.

Barber (2000) recommended a number of instruments that can be used to measure these indicators, which were further developed and translated before being applied in a study involving the psychosocial adjustment of adolescents orphaned in the context

of HIV/AIDS (Wild et al., forthcoming). Further details of the instruments, which we recommend for monitoring South African children and adolescents, are provided in the core indicator table for this chapter in Part 2 of the volume. Barber (2000) and Wild et al. (forthcoming) found that experiences of connection, regulation and autonomy in the adolescent's relationship with their carer, and experiences of connection and regulation in the peer and neighbourhood contexts, were all significantly related to one or more discrete aspects of the adolescent's adjustment. The existence of these associations is good evidence of the construct validity of these measures, at least among Xhosa-speaking adolescents in the Eastern Cape.

A further indicator that addresses the mechanism level is *self-esteem*, which refers to one's evaluation of oneself, including feelings of self-worth (Rosenberg, 1979). Self-esteem is a critical determinant of mood disorder and other psychopathology (Beck, 1967) and has inconsistently been found to be associated with risk behaviour (for a review, see Wild, Flisher, Bhana et al., 2004). A possible reason for these inconsistent findings is that they are based on unidimensional measures of self-esteem, as opposed to a more specific, multidimensional measure. One such measure is the Self-Esteem Questionnaire (Du Bois et al., 1996), which has a global self-esteem subscale as well as five specific subscales (peers, school, family, body, and sports). We recommend this measure for monitoring self-esteem in South African children. Psychometric studies involving the use of this instrument among Cape Town adolescents have found satisfactory internal consistency and test–retest reliability, and generally supported the six-factor structure (Wild et al., 2005). Furthermore, Wild and colleagues (Wild, Flisher, Bhana et al., 2004; Wild, Flisher & Lombard, 2004; Wild, Flisher, Lombard et al., 2004) documented associations between each subscale and one or more of the following risk behaviours in each of the two samples of Cape Town adolescents: use of tobacco, alcohol, cannabis, solvents and other substances; bullying; suicidal ideation and attempts; and risky sexual behaviour. There is thus considerable support for the construct validity of this instrument among Cape Town adolescents.

Finally, appropriate use of leisure time and the avoidance of leisure boredom is critical for the optimal development of children and adolescents. In leisure, children and adolescents learn to be self-regulated, develop a sense of identity, develop competence and transitional skills, and experiment with sexual and social roles (Caldwell et al., 2004). Many youngsters are not equipped personally or in terms of their social and physical environment to gain these benefits from their leisure time. In Cape Town, adolescents were found to experience relatively high levels of boredom, with female and black/coloured students being at significantly higher risk than their peers (Wegner et al., 2006). Furthermore, leisure boredom has been found to be associated with risk behaviour such as substance use in South Africa and elsewhere (Iso-Ahola & Crowley, 1991; Caldwell & Smith, 1995; Ziervogel et al., 1997–98; Wegner et al., 2006). We thus recommend that leisure boredom be included as a mechanisms indicator, and that it be assessed using the Leisure Boredom Scale (LBS) (Iso-Ahola & Weissinger, 1990). The LBS consists of 16 items to which participants respond on a 1 to 5-point scale. Total scores can range from 16 to 80, with higher scores indicating greater boredom. The LBS has been found to have satisfactory test–retest reliability and internal consistency among Cape Town adolescents (Wegner et al., 2002).

Type 2: Family and household environment

There are many aspects of the child's primary care setting that will exert an influence on a wide range of domains. For example, poverty, housing quality and access to amenities such as electricity and water will have an influence on mental and physical heath as well as educational outcomes. Some aspects of the primary care setting have been addressed above when considering the mechanisms that underpin mental health and risk behaviour status, for example, connectedness and regulation. Other relevant variables include family management, family discipline, family history of antisocial behaviour, family attitudes favourable to drug use, family attitudes favourable to antisocial behaviour, opportunities for positive involvement and rewards for conventional behaviour. Scales assessing these variables have been found to have satisfactory internal consistency, test–retest reliability and construct validity in Cape Town adolescents (Morojele et al., 2002).

In addition, where children are affected by the presence of caregivers and household members who are ill as a consequence of HIV/AIDS, and where they are caring for the sick people or facing the death of caregivers, this is certainly likely to impact on their mental health (Wild, 2001). Studies of the mental health status of children living in households affected by AIDS are in their infancy. In time, more data will be available to track child mental health outcomes in these contexts.

Type 3: Neighbourhood and surrounding environment

Social indicators such as poverty, exposure to conflict and displacement, as well as levels of community violence impact on mental health status of children and adolescents (Patel et al., in press). A comprehensive set of indicators should thus include measures of these aspects. Child poverty and neighbourhood indicators are covered in chapters 3 and 4 in this volume, and will not be repeated here.

Type 4: Service access

Mental health

In addition to the general challenges addressed above, there are some specific challenges that relate to mental health services for children and adolescents. These are outlined below.

Most children receiving services for mental health problems have multiple needs, involving both mental health in the narrow sense of the term (such as symptoms of depression and anxiety) but also broader aspects such as social needs. Thus, service utilisation and access data ideally need to be comprehensive and longitudinal, and need to indicate frequency, intensity and duration of receipt of services (Fonagy, 2002). However, most systems designed to document access focus on mental health services in the narrow sense, are cross-sectional, and do not include the details of the services that were provided. Consequently, it is difficult to draw any conclusions about the extent to which services were appropriate in nature or sufficient in quantity to be of value. For example, two adolescents with a diagnosis of major depressive disorder may have very different service needs depending on factors such as the existence of family problems.

Services are generally defined in terms of programmes (for example, an outpatient or day programme) as opposed to service items (for example, individual psychotherapy or medication). There are two disadvantages to defining services in terms of programmes (Flisher et al., 1999). First, more specific information is gained by defining services in terms of service items, which is important in light of the large variation in the contents of programmes. Second, defining services in terms of programmes hinders intersectoral comparison. There are many programmes in the health sector that do not exist in other sectors, although the service items may overlap. If services were defined in terms of service items, it would enable access to services in several sectors to be documented.

Both in developed countries such as the US (Flisher et al., 1997) and in South Africa (Dawes, Lund et al., 2004), there is an enormous gap between the need for child and adolescent mental health services and the availability or utilisation thereof. The most obvious reason for this gap is the underdevelopment of services for child and mental health problems, the solution for which is clearly service development (Dawes, Lund et al., 2004). However, even if there were sufficient services to meet the expressed need, there would remain a proportion of people with unmet mental health service needs. Reasons for this would include barriers to service seeking, such as stigma and being unsure as to how to secure services. A comprehensive understanding of access to services should include an assessment of barriers to receiving services (Flisher et al., 1997). One important barrier is that referral is frequently dependent on an adult such as a parent or a teacher identifying the existence of a problem(s), knowing or being able to ascertain what referral steps are indicated, and actually ensuring that the child or adolescent receives the necessary services.

In the case of substance use problems, there may be rapid changes in the prevalence rates of substances over relatively short periods of time. For example, in Cape Town there has been an epidemic of crystal methamphetamine ('tik') use in specific communities in the past two or three years. It is clearly a challenge to provide the appropriate interventions for the sub-populations at risk while the epidemic still represents a public health priority.

There are two major sources of data about access to interventions for mental health services and risk behaviour. First, one can solicit information from children and adolescents themselves or from adult informants. A simple and efficient instrument that can be used for this purpose is the Child School Information and Service Use module of the National Institute for Mental Health Methods for the Epidemiology of Child and Adolescent Mental Disorders Study in the US (Leaf et al., 1996; Flisher et al., 1997). Although this instrument has not been used in South Africa, the fact that it has high face validity suggests that it may be able to be modified and applied without major difficulties. Although this instrument does address barriers, which is an advance on previous instruments, it does not address the other challenges listed above. To do so would require an investment of time and energy in the development of the instruments and also in their administration and interpretation. Both the children and adolescents and the adult informants are asked to identify the mental health and substance abuse services used by the children or adolescents both in the previous year and ever in their lives. The adult informant interview obtains more detailed information than the child interview because of concerns regarding the ability of youths to provide accurate reports about the details of mental health-

related service contacts. In addition, both the child and the adult informant are asked about whether a range of barriers influenced service access. Such barriers can cast light on the reasons for delay in receiving services. Indeed, it can be useful to enquire specifically about the duration of the delay from the appearance of symptoms to receiving appropriate services, which will provide a quantitative indication of ease of service access.

Second, one can solicit information at the service level. An example of an indicator that is relevant for access to a range of mental health services is the staff:population ratio. A key source of service data is the South African Community Epidemiology Network on Drug Use (Parry et al., 2004). This is a network of practitioners, researchers and policy-makers from five sentinel sites who meet biannually to provide community-level public health surveillance information about alcohol, tobacco and other drug-related trends. One data source that is relevant for service access by children and adolescents is specialist alcohol and other drug treatment centres. Data are collected from more than 80 per cent of treatment centres at each site. A standardised one-page form is completed on each person treated in the centre during a particular six-month period. The following information is recorded: source of referral for treatment; biographical information; type of treatment received (inpatient and/or outpatient); the primary and secondary substances of abuse; the mode(s) of use; and whether the person had received treatment prior to the current episode (Parry et al., 2004). The data are available in six-monthly reports, and have informed policy recommendations (Parry et al., 2004). This data source is of good quality and sufficient for monitoring purposes so far as alcohol and other drug use by South African children and adolescents is concerned. Unfortunately, similar data are not available for mental health problems. Indeed, a comprehensive research project to inform the development of norms for child and adolescent mental health services revealed that even basic service utilisation data are not generally available in any of the provinces (Dawes, Lund et al., 2004).

Finally, a major barrier to service access and quality is the provincial budgetary allocation for child and adolescent mental health services. For this reason, the annual provincial health allocations for this purpose should be monitored.

Risk behaviour

There are two aspects of service access which are applicable to risk behaviour. First, there are services for the consequences of risk behaviour, such as injury or post-traumatic stress disorder following exposure to violence, or pregnancy or sexually transmitted infection following unsafe sexual behaviour. These aspects are dealt with in other chapters in this volume (see for example Chapter 7). Second, there are prevention and health promotion programmes, for example, substance use prevention and health promotion programmes based in the school setting (Flisher, Parry et al., 2002).

One can solicit information from children and adolescents about the programmes that they have been exposed to, or one can conduct audits or reviews of existing interventions, as has been done for sexual health promotion programmes (Kaaya et al., 2002). We recommend that this be done on a periodic basis, when a specific need for such information presents itself, as opposed to becoming incorporated into

regular monitoring processes. It would be appropriate to collect mental health service access data from the range of departments that are responsible for addressing the mental health needs of children in their care, including education, justice, social development and health. As such information is not routinely collected, service audits would be appropriate.

Type 5: Service quality

Mental health

The quality of mental healthcare refers to whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice (Institute of Medicine, 2001). This can be assessed using a set of standards, which are normative qualitative statements about what constitutes acceptable and adequate healthcare (Muller & Flisher, 2005a, 2005b, 2006). A wide-ranging consultative process produced a comprehensive set of standards for people in South Africa with severe psychiatric disorders (Muller & Flisher, 2005a, 2005b, 2006). No such process has been undertaken with regard to child and adolescent mental health services. However, a set of key standards have been proposed as part of an effort to develop norms for child and adolescent mental health services in South Africa (Dawes, Lund et al., 2004 – see Addendum B to this chapter). Also, specific attention was given to adolescents in a set of recommendations for substance dependence inpatient centres in South Africa (Muller et al., 2003). These standards can be used to assess the extent to which quality criteria are met in a range of domains. Whether standards are met depends on a range of factors. These include whether staff have received training in child and adolescent mental health, whether staffing norms are met (for example, those proposed by Dawes, Lund et al., 2004), and whether relevant policies have been adopted. Each of these factors can constitute indicators that are relevant for service quality.

The World Health Organization has developed a set of guidelines to inform quality improvement for mental health services (WHO, 2003). The guidelines are organised in the form of seven cyclical steps: align policy for quality improvement; design a standards document; establish accreditation procedures; monitor the mental health service by using the quality mechanisms; integrate quality improvement into the ongoing management and delivery of services; consider systematic reform for the improvement of services; and review the quality mechanisms. A standards document is an essential component of a quality improvement process. However, '[s]uch a process must…be supported by clear legislative and policy guidelines, practical quality assurance tools, and a clear political and managerial commitment to improve the quality of care for all people with severe psychiatric disorders' (Muller & Flisher, 2005b, p. 149).

Risk behaviour

The main quality indicator for prevention and health promotion programmes that target risk behaviour is the effectiveness of the intervention, or whether the programme achieved the desired outcomes (Kaaya et al., 2002). This will depend on whether the programme elements were delivered as intended, for example, whether

life skills sessions took place (outcome evaluation) and whether the intervention was implemented with fidelity (process evaluation). A further issue is whether, if a programme was effective, it was also cost-effective (economic evaluation). Such programme evaluations could be regarded as additional indicators, and would take place when circumstances and funding permit.

Addendum A Items from risk behaviour instrument used by the Adolescent Health Research Institute at the University of Cape Town

In the *past month* have you smoked a whole cigarette?
In the *past month,* did you use alcohol other than a few sips?
In the *past year*, did you smoke dagga on its own?
In the *past year*, did you smoke dagga and Mandrax together?
In the last *12 months*, did you ever travel in the front passenger seat of a motor vehicle?

If yes:

On the *last occasion* you were travelling in the front passenger seat of a motor vehicle, was there a seat belt available?

If yes:

Did you actually wear the seat belt for the whole journey?

In the *past 12 months*, have you ridden on a motorbike or motor scooter as a passenger or a driver?

If yes:

In the *past 12 months*, did you ever ride without a helmet?
In the *past 12 months*, have you driven a motor vehicle (excluding a motorbike) on a public road?

If yes:

In the past *12 months,* have you driven:

- a vehicle that was overcrowded?
- without a licence?
- while affected by alcohol or dagga?

During the past *12 months*, have you ever stolen anything from anybody?
During the past *12 months*, have you caused serious damage to property?
During the past *4 weeks* at school, did you ever carry a knife to be used as a weapon?
During the past *4 weeks*, did you go out at night beyond your neighbourhood and walk home alone?
During the past *12 months*, have you bullied anybody at school?
During the past *12 months*, have you ever been bullied at school?
During the past *12 months*, have you been involved in any physical fights?
During the past *12 months*, did you ever seriously think about harming yourself in a way that may result in your death?
During the past *12 months*, did you ever tell someone that you intend putting an end to your life?
During the past *12 months*, did you actually ever try to put an end to your life?

If yes:

Did any attempt result in injury, poisoning, or overdose that had to be treated by a doctor or nurse?

Have you ever had sexual intercourse? [This means intimate contact with someone of the opposite sex during which the penis enters the vagina (female private parts).]

If yes:

- How old were you when you first had sexual intercourse?
- With how many different partners have you had sexual intercourse in the last 12 months?
- How long ago did you last have sexual intercourse?
- On the *last occasion* that you had sexual intercourse, had you known your partner for more than 7 days?

- On the *last occasion* that you had sexual intercourse, did you or your partner use anything to prevent pregnancy (family planning) or prevent disease?

On the *last occasion* that you had sexual intercourse, **if** you **did** do anything to prevent pregnancy (family planning) or disease, what did you or your partner use? (Indicate more than one if necessary.)

- Condom ('rubber')
- Injection
- Contraceptive pill ('the pill')
- I did not use anything
- Other: please specify: ____

Addendum B Key standards for child and adolescent mental health service planning and provision

Core features of child and adolescent mental healthcare services

- Include mental health in primary healthcare practices.
- Provide a continuum of services.
- Balance prevention, promotion, treatment and rehabilitation.
- Prioritise children most at risk.

Evidence and service planning

- Regularly assess levels of service provision and need.
- Use this information to plan and commission comprehensive services.
- Involve parents/families and communities in service planning.

Range of services, staffing and facilities

- Offer early intervention and mental health promotion in all locations.
- Co-ordinate and integrate services across health, education, social care, youth justice and voluntary sector agencies.
- Use a multidisciplinary team approach.
- Train, supervise and support all staff to provide a full range of interventions.
- Ensure that care is developmentally appropriate.
- Keep children and adolescents' mental healthcare facilities separate from adult facilities.
- Offer services as near to home as possible and in child/adolescent-centred settings, such as schools, youth clubs, the media, and the family.
- Offer 24-hour care services.

Source: Dawes, Lund et al. (2004)

Note

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

CHAPTER 7

Monitoring child unintentional and violence-related morbidity and mortality

Amelia van der Merwe and Andrew Dawes

Introduction: objectives and scope

The focus of this chapter is on childhood injury. Some injuries sustained during childhood are unintentional, while others are sustained through intentional harm inflicted on the child as a result of physical and sexual abuse and exposure to other forms of violence. A range of injuries which could be sustained either intentionally or unintentionally are covered in this chapter, including those which may be the result of child abuse and neglect. However, the primary focus of the chapter is on unintentional or 'accidental' injuries, while injuries which are confirmed as resulting from child abuse and neglect are covered in depth in Chapter 14 in this volume.

Child injury morbidity and mortality are significant problems in South Africa (Matzopoulos, Norman et al., 2004; Stevens, 2004). The purpose of this chapter is to present proposals for core and additional indicators, measures and data sources for monitoring them. Monitoring will provide indications of the extent to which children grow up in safe environments, point to risks to child safety, and show which groups of children are particularly vulnerable.

In the context of child injury, monitoring activities speak directly to the child's right to protection from harm, and the child's right to develop in a safe environment.

Definitions

Risk factors are those events that increase the risk of adverse child outcomes and compromise the child's right to protection and safety.

Protective factors are those factors which interact with risk factors to reduce the likelihood of adverse child outcomes, and enhance child well-being.

Injury is defined as:

> damage to a person caused by an acute transfer of energy [mechanic/kinetic, thermal, electrical, radiation] or by a sudden absence of heat (hypothermia) or oxygen (asphyxiation, drowning). (Berger & Mohan, 1996, p. 38)

For present purposes, unintentional and intentional injuries will be stratified by proximal cause.

Transport-related injuries

Transport-related injuries include road traffic injuries (RTIs) involving motor vehicles, motorcycles and bicycles, and which result in pedestrian, driver, cyclist and/or passenger injury. Other transport-related injuries include railway injuries and fatalities. The vast majority of transport-related injuries are unintentional (Matzopoulos, 2002). For the purposes of this chapter, all transport-related injuries and fatalities will be treated as unintentional, and collapsed into one category.

Other unintentional injuries unrelated to transport

Injuries in this group tend to occur in and around the home, school or neighbourhood and play settings, and include chance burn or thermal injuries, drowning, asphyxiation, falls, poisoning, blunt object injuries, and sharp object injuries.

Violence-related injuries

Violence is defined by the World Health Organisation (WHO) as:

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (WHO, 2002b, p. 5)

This broad definition includes self-directed violence (self-harming, suicide), interpersonal violence (assault, homicide), and collective violence (gang conflict, civil conflict, war).

For the purposes of this chapter, violence-related incidents are those in which the child is injured as a result of a wilful violent act whether or not the child is the intended victim (when a child is injured or killed by a violent act that was not intended to cause harm to him or her, but that targeted another person).

Problems associated with existing injury data sources in South Africa

Despite the substantial contribution of child unintentional injury and violence exposure to the national burden of disease, no provincial or national directorate or policy process is in place to address the problem (Stevens, 2004).

Existing institutions that capture relevant information include the National Injury Mortality Surveillance System (NIMSS), which records fatalities (at some mortuaries only); the Child Accident Prevention Foundation of South Africa (CAPFSA); Statistics South Africa (Stats SA); the Department of Health (DoH) (limited to the Demographic and Health Survey); the Department of Transport (DoT) (transport-related injuries only); Arrive Alive (transport-related injuries only); and the South African Police Services (SAPS) (crimes). Although these are important data sources, only one focuses on children (CAPFSA) and it is not nationally representative, focusing only on physical trauma presenting at Red Cross Children's Hospital in Cape Town.

The existing injury data sets are not necessarily reliable or comparable. For example, data supplied to central registries such as CAPFSA may be incomplete (pers. comm. Nelmarie du Toit, Child Accident Prevention Foundation of South Africa, November 2004). Data sets also vary in the classification of injuries, in their geographical coverage, and in the degree to which data are disaggregated by age, gender and other relevant variables. For example, the NIMSS is not nationally representative and the data are urban-biased. In addition, injury severity scoring can vary from one medical practitioner to another.

Non-fatal injury surveillance systems may be more challenging to develop than injury mortality monitoring systems due to the high volumes of non-fatal injuries presenting at health services, which provides little time for completing the necessary surveillance data capture forms (pers. comm. Richard Matzopoulos; Crime, Violence and Injury Lead Programme, Medical Research Council of South Africa, November 2004).

As a result of the problems with existing data outlined above, it is not possible under present conditions to provide a reliable picture of the national or provincial injury burden. This situation is not particular to South Africa. Quilgars notes that in the United Kingdom:

> While the data available for fatal accidents are fairly robust, information sets on childhood accident morbidity rates are beset with problems of definition and measurement and are unable to capture data reliably over time. (2001, p. 64)

It is essential that South Africa develops an operational national non-fatal and fatal child injury surveillance system, and that government commitment to monitoring injury is accompanied by the dedication of resources to its realisation. Our ability o generate comprehensive, reliable and valid child injury information is dependent on the support of the DoH. As well as the data collection problems due to the volume of non-fatal injuries, scoring consistency and so on, the fundamental issue underlying inadequate child injury data is the absence of an information gathering and dissemination policy which would ensure that data are collected, collated and fed back to policy-makers. Child injury prevention should become a public health priority that leads to the development of a directorate (as exists within the WHO) devoted to fatal and non-fatal unintentional and violence-related injury.

It is recommended that, i) a specific agency be established which is responsible for collating existing child injury data (from data sets such as NIMSS, CAPFSA, Stats SA, DoH, DoT and SAPS), and that ii) a working group is set up which is accountable for implementing the indicators presented in this chapter. The central task of the working group would be to promote the development of a nationally representative, child-centred child injury morbidity and mortality injury surveillance system, which not only draws on existing data sources, but also addresses current informational gaps and the limitations of existing data sets. Existing child injury data at all levels of the health system should be fed into the national child injury morbidity and mortality surveillance system by the agency commissioned to collate data relevant to child injury.

That said, developing and maintaining reliable and valid information and monitoring systems of any kind is challenging. First, the workload of medical

practitioners in the many overburdened clinics and hospitals in South Africa is one of the most significant factors impacting on the feasibility of implementing a child injury surveillance system. A second challenge is to fund and maintain adequate, skilled personnel to manage data collection at individual clinics, hospitals and mortuaries, to facilitate the continuous capturing of good quality data. A priority for collecting child injury data from health services and mortuaries is designing a nationally standard trauma registry form that can capture child injury data. The form should make provision for recording the child's identity number (or another unique identifying number) to control for data duplication at the point of data cleaning prior to analysis. The agency and working group responsible for collecting child injury data for the national non-fatal and fatal child injury surveillance system should decide on the unit of observation (for example, only capturing data pertaining to a child's first injury-related presentation) prior to designing the trauma registry form and capturing data. Finally, ongoing training in the completion of child injury data capturing forms should be provided to medical practitioners and administrative staff to ensure that data capturing forms are accurately completed, despite staff turnover (pers. comm. Richard Matzopoulos, October 2004).

Rationale

A rights-based approach to monitoring child safety

Ennew (1997) suggests that several considerations should be kept in mind when designing a rights monitoring system. Among other points, it is essential to define the phenomenon clearly and to provide an operational definition. Then the data needed to capture the phenomenon must be specified. That which is available must be captured and where there are gaps, information systems need to be set up in order to capture the essential data.

In terms of the protection of children's rights, it is necessary to ask:

- What legal measures exist to ensure children's safety and to ensure that regulations are upheld?
- How well do these provisions work?

In terms of services, it is necessary to ask:

- What is the extent of access to appropriate services in the case of injured children?
- What is the quality of those services, and how effective are they?

Addressing all of these issues is beyond the scope of this chapter. However, these questions inform the discussion which follows.

As a signatory to the United Nations Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3, this volume), South Africa is bound to ensure that the child rights contained in these instruments are protected and advanced.

Although there are a significant number of documents and statements focused on the rights of children more generally, few of these activities reflect specific attention to the prevention and management of child injury as a child protection issue. Most

legislative and policy documents only indirectly address injury prevention and management (for example, children's right to healthcare services), or broadly advocate for prioritising the survival, protection and development of South African children. Rights outlined in the South African Constitution which have direct bearing on child injury include:

- Section 24 – the right to live in an environment that is not harmful to the child's health or well-being;
- Section 26(1) – the right to adequate housing;
- Section 27(1) and (3) – the right to healthcare services and the right not to be refused emergency medical treatment respectively; and
- Section 28(1)(d) – the right of the child to be protected against abuse and neglect.

Even the CRC, considered the most comprehensive document on child rights to date, tends to focus on intentional injury (child maltreatment) largely to the exclusion of childhood unintentional injury, making only cursory explicit reference to the 'prevention of accidents' (Section 24, paragraph e). However, the Committee on the Rights of the Child has recently drawn attention to the importance of strengthening and enforcing child injury prevention legislation and programmes (driving education and examination for adolescents; obligations to have a valid driver's licence; wearing seat belts to improve road safety) as a result of the disproportionately high RTI mortality rate among adolescents (General Comment 4, 2003).

Despite political commitment to monitoring child well-being, there continues to be a dearth of reliable, valid and nationally representative data on the situation of South African children generally, and child injury morbidity and mortality specifically (Stevens, 2004). To date, there is no nationally representative data system for collecting information on unintentional injury morbidity and mortality (for all age groups) in South Africa (Matzopoulos, Norman et al., 2004). This is partially due to lack of legislation making the collection of comprehensive injury morbidity and mortality data for South Africans of all ages mandatory, and insufficient co-ordination across different but related data sources (Stevens, 2004). However, it is encouraging to note that one of the future priority areas described in the DoH's (2004) *Strategic Priorities for the National Health System for 2004–2009* is the development and integration of a non-natural mortality surveillance system. However, when such a surveillance system will be operational, and whether it will include child-centred data, remains to be seen.

As discussed in chapters 1 and 2, in a rights approach to monitoring the situation of children, it is profitable to group the articles of the CRC that apply to the issue in question (Ennew et al., 1996; Ennew, 1997).

Grouping articles of the CRC and the AC

We have grouped articles of the CRC and the AC pertinent to this area. The AC articles are placed after those from the CRC:

Group 1 – Foundation group (as articulated in Chapter 1).

Group 2 – Protection group: CRC articles 19, 36; AC articles 5, 14, 16: Ensuring the protection of children from violence, abuse, neglect.

Group 3 – Treatment group: CRC articles 24, 39; AC articles 4, 14: Actions taken should be in the best interests of the child; the child has the right to treatment and rehabilitation.

South African legal and regulatory provisions

A wide range of regulations exists that are designed to protect both adults and children from injury. They are far too extensive to comprehensively list here but include, for example, building safety regulations, road traffic regulations and regulations pertaining to the safety of children in schools, early childhood development (ECD) facilities and play areas. Other relevant regulations are those relating to gun licensing and storage in the home. Firearm injuries involving children playing with weapons in the home are of increasing concern.

Despite the regulations (and the child injury data presented below), some service providers contacted for this research (for example CAPFSA) suggested that in a number of instances the regulatory environment does not sufficiently protect children. For example, current regulations do not require the mandatory use of safety seats in motor vehicles, or child-resistant containers for packaging poisons and chemicals; there are no compulsory standards for playgrounds, flotation devices, swimming pool enclosures and paraffin stoves. However, children are required by law to wear bicycle helmets.

From a rights perspective, those responsible for upholding the regulations bear the duty to ensure that regulations are enforced. Where children are injured as a result of non-compliance, the relevant duty-bearers have failed to protect the child's right to safety. This may apply, for example, to caregivers or those who run ECD facilities or schools. It also includes authorities who are responsible for ensuring that the regulations are observed.

A full discussion of these deficiencies is beyond the scope of this chapter. However, it is recommended that monitoring tools linked to the relevant regulations be developed by specific authorities, for example, the Department of Social Development in the case of ECD facilities' standards, the DoT in the case of enforcement of the safety belt regulations, and the SAPS in relation to private firearm ownership.

What we know about child injury in South Africa

Transport- and violence-related injuries are the most significant contributors to child mortality (Matzopoulos, Cassim et al., 2004). The leading causes of non-natural death for children of all ages in 2004 were, in descending order, transport-related injuries (pedestrian), violence-related injuries (firearm injuries, sharp and blunt object injuries), drowning, and burns (Matzopoulos, Cassim et al., 2004).

Transport-related injuries

Transport-related injuries have been a leading cause of non-natural death in South African children over time (Knobel et al., 1984; Kibel et al., 1990; Meel, 2003). In

addition, motor vehicle injuries have been found to be one of the most significant determinants of paediatric traumatic brain injury in South African children (Levin, 2004). Pedestrian motor vehicle incidents in particular frequently lead to significant brain injury due to the violent accelerative and decelerative forces to which victims are exposed (Butchart et al., 1991). In addition, the severity of pedestrian injuries among children is also due to the point of impact with the vehicle.

As children grow older, their mobility range increases from the home to the street (for example, walking to school). Consequently, as children grow older, the contribution of transport-related injury fatalities tends to increase (Knobel et al., 1984). Pedestrian injuries remained the leading transport-related cause of death for the five- to nine-year-old group, and other transport-related causes of death (child as passenger, driver, and railway injuries) increased as children grew older (particularly in late adolescence) (Matzopoulos, Cassim et al., 2004).

Most data sources indicate that pedestrian injuries make the largest contribution to road traffic fatalities in young children (CAPFSA, 2006; Matzopoulos, 2002; Sukhai et al., 2004). Pedestrian motor vehicle incidents have been identified as one of the most common causes of head injuries in children presenting at Red Cross Children's Hospital (Semple et al., 1998; Lalloo & Van As, 2004).

Causes of other unintentional injuries

Burns or thermal injuries have been identified as a leading cause of childhood unintentional injury, particularly in infants and toddlers, and children aged up to five years (Van Niekerk, Rode et al., 2004; Van Niekerk, Du Toit et al., 2004).

The incidence of poison/paraffin ingestion similarly mainly affects children under five years (Matzopoulos et al., 2001; Carolissen & Matzopoulos, 2004).

The most recent NIMSS data (based on fatal injuries registered at 37 mortuaries in six provinces) indicated that drowning accounted for the highest proportion of unintentional injury deaths in the 1–14-year-old age group in 2004 (Matzopoulos, Cassim et al., 2004).

Other common, less serious unintentional injuries during childhood include falls and the ingestion of foreign objects, the latter peaking at the age of three years (Van As et al., 2003). These findings indicate the importance of disaggregating data according to child age. It is very important that data be broken down into appropriate age categories in all instances. We recommend the following: <1; 1–5; 6–9; 10–14; 15–17. These bands are consistent with the age stratifications used in most existing databases, and capture particular periods of vulnerability and risk for different types or causes of injury.

Violence-related injuries

South Africa has a long history of socio-politically motivated violence, which has recently been substituted by an alarming rise in criminal violence (Barbarin et al., 1998). Ninety-five per cent of the children comprising a sample drawn from Khayelitsha in the Western Cape reported having witnessed violence, and 57 per cent were survivors of violence (Ensink et al., 1997). In addition, over 70 per cent of a

sample of primary school children living in the Lavender Hill/Steenberg area in the Western Cape reported exposure to a range of violent events, including physical assault (Van der Merwe & Dawes, 2000). It is worth noting that research has established a complex connection between alcohol and other substance use and the perpetration of violence (Marais et al., 2004).

Substantial research evidence demonstrates that violence is a major cause of child injury morbidity and mortality (e.g. Zwi et al., 1995; Bamjee et al., 1996; Hadley & Mars, 1998; Wigton, 1999; Levin, 2004). There was a significant increase in the proportion of homicides for children aged under four years from 1999 (0.7%) to 2001 (1.7%) (Matzopoulos, Norman et al., 2004). This is particularly disturbing because, like transport-related injuries, violence-related injuries, particularly homicide, increase as children grow older (Matzopoulos, 2002). Firearm injuries were the leading cause of violence-related non-natural deaths in children (Matzopoulos, Norman et al., 2004).

The data over many years suggest that the association between (male) gender and unintentional injuries is particularly high for violent injury (e.g. Kibel et al., 1990; Malek et al., 1990; Butchart et al., 1991; Zwi et al., 1995; Brysiewics, 2001; Matzopoulos, 2002; Meel, 2004a). This relationship applies both to other-inflicted violence and suicide, and stresses the importance of disaggregating data by child gender (Matzopoulos, 2002).

Although reliable data on suicidal behaviour in South Africa are lacking, mainly as a result of inadequate and inconsistent reporting, it is estimated that South Africa has very high suicide rates (Schlebusch, 2004). The most recent NIMSS data indicated that suicide dramatically increased during adolescence (15–19 years), and that the most popular method of suicide was hanging (all age groups) (Matzopoulos, Cassim et al., 2004). Suicidal behaviour is more likely to occur in younger age groups (Burrows et al., 2003). Besides age, child gender also constitutes a risk factor for suicidal behaviour. Adult suicide rates reflect more male suicides, while more female South African children commit suicide (Schlebusch, 2004). Family and interpersonal conflict (for example, as a result of a family change such as parental divorce and resultant feelings of loss of support), family violence and abuse are well-established risk factors for child suicidal behaviour (Schlebusch, 2004). Mental health problems such as mood disorders, substance abuse, schizophrenia and substance-induced psychosis have also been associated with non-fatal suicidal behaviour (Schlebusch et al., 2003).

Children have the right to live in primary care settings which are safe, conflict- and violence-free contexts that foster optimal child development. Exposure to aggression and violence in the home and community not only victimises children, but contributes to their socialisation into violent lifestyles (for example, developing aggressive, oppositional/defiant tendencies), which perpetuates violence and the risk of violence-related injury (e.g. Liddell et al., 1994; Jenkins & Bell, 1997; Van der Merwe & Dawes, 2000; Van der Merwe & Dawes, in press). Furthermore, as noted earlier, family conflict and violence has persistently been associated with suicidal behaviour in children and adolescents (Schlebusch, 2004).

Risk and protective factors for childhood injury in the child's environment

Indicators developed for child unintentional injury and violence are outlined below, and are divided into five indicator types according to the indicator typology. The differentiation of indicators for this into five types also reflects an ecological understanding of risks to child well-being. In this approach, the child's environment comprises multiple concentric layers or levels of influence (Bronfenbrenner, 1997). Child development and outcomes (Type 1 indicators) are conceptualised as the product of increasingly complex, reciprocal interactions between individuals and the contexts in which they are embedded (Bronfenbrenner, 1997).

This chapter focuses on a number of contexts that impact on child outcomes (injury status) both directly and indirectly. They include the child's care environment (home, school, day care, recreational settings); the socio-economic environment (household income, employment, condition of housing, neighbourhood); service access (infrastructure, transport, service provision); and service quality (human and financial resources, staff training, sustainability).

To understand and prevent child injury, it is important that risk and protective factors in a range of settings, as demonstrated by existing data and research evidence, are acknowledged and monitored. Indicator Types 2 and 3 are particularly significant in this regard, as many sources of injury to children exist in the home (for example, burns) and the neighbourhood (for example, pedestrian-traffic and violence-related injuries).

Risk and protective factors in the child's primary care settings (Type 2 indicator: Family and household environment)

Supervision of child activities has been shown to impact significantly on the risk of sustaining a number of childhood injuries (Bass et al., 1995; Landen et al., 2003; Morrongiello, Ondejko et al., 2004; Saluja et al., 2004). Child pedestrian injuries specifically have been associated with unsupervised playing in close proximity to heavy traffic, and walking to school and running errands in the neighbourhood while unaccompanied by an adult (Bass et al., 1995; Dowswell & Towner, 2002). This may be why children of school-going age have been identified as particularly at risk of pedestrian injuries (Brysiewics, 2001).

Household structure, the primary caregiver's social connectedness, and the availability of accessible day-care facilities impact on child supervision. Informal (social) support, as well as formal support structures such as day care, increases the number of substitute caregivers and the likelihood that children's activities will be monitored and supervised. Research indicates that caregiver social connectedness and social support affects children indirectly through its effect on important aspects of parenting (Cochran & Niego, 1995; Osofsky & Thompson, 2000). For example, Burchinal et al. (1996) found that mothers with larger support networks receive more caregiving assistance and engaged in more supportive parenting than women who had smaller support networks.

Developing ways of monitoring the quality of child supervision should also be considered, for example, the role of caregiver proximity to the child, and whether

supervision is intermittent or continuous are important variables (Morrongiello & Kiriakou, 2004).

Caregiver alcohol and/or drug use has been identified as an important risk factor for child unintentional injury (Bijur et al., 1992). The use of alcohol and/or drugs interferes with caregivers' capacity to monitor and supervise the activities of children, consequently placing their safety at risk. In addition, alcohol and other substance abuse are major contributors to dangerous driving and the high road traffic trauma rates (Goosen et al., 2003; Marais et al., 2004).

Important focal areas for future transport-related childhood injury research include the use of safety seats and child restraints in motor vehicles, and the use of bicycle helmets by child cyclists. In addition, international literature suggests an association between enclosed play areas that are in close proximity to road traffic and child pedestrian injury (Dowswell & Towner, 2002). Child pedestrian injuries frequently occur close to the child's home and while s/he is at play (Malek et al., 1990). The relationship between safe child play areas and child pedestrian injury is yet to be investigated in South Africa. Furthermore, prevention of RTIs has tended to focus on driver and pedestrian education rather than addressing basic physical requirements for accident prevention, such as well-kerbed pavements and effective traffic law enforcement (Malek et al., 1990; Butchart et al., 1991).

Most existing childhood injury prevention interventions are instructive in nature and aim to reduce or eliminate childhood injury by developing either or both active and/or passive safety promoting behaviours. Passive safety promoting behaviours include environmental modifications (for example, the use of safety plug or stair gates), while active safety promoting behaviours refer to caregiver-based behaviours (for example, prohibiting the child from sitting on high surfaces) (Morrongiello & Hogg, 2004; Morrongiello & Kiriakou, 2004). Interventions aimed at reducing or eliminating childhood unintentional injury alert caregivers to potentially hazardous substances and objects in and around the home, for example sharp objects; hot fluids; machinery; small, inedible objects; poisons (including toxic plants); drawstrings and cords; latex balloons and plastic packets; highly flammable fabrics; and so on.

It is worth noting that although increasing caregiver safety knowledge is important, behaviour change may be facilitated by taking other potentially important variables into account, such as the reasons for caregivers' safety decisions (Morrongiello & Kiriakou, 2004).

Risk and protective factors in the child's neighbourhood: the broader socio-economic context (Type 3 indicator: Neighbourhood and surrounding environment)

Socio-economic disadvantage directly (through the quality of the child's physical environment) and indirectly (through stress placed on the caregiver/household) impacts on children's risk of sustaining a range of unintentional injuries (Carey et al., 1993; Joseph et al., 2002). One example of the direct effects of poverty on child injury is the cost associated with safety devices such as childproof paraffin containers (Carolissen & Matzopoulos, 2004). Furthermore, the high density of

housing in informal settlements, and having no access to electricity or water as a direct result of economic disadvantage are likely to increase the extent and severity of burn injuries in children (Van Niekerk, Rode et al., 2004). The risk of burn or thermal injuries is strongly associated with the type and quality of housing (Roberts & Power, 1996). Significant socio-economic differentials in childhood injury mortality rates have been found in the UK (Roberts & Power, 1996).

Economic disadvantage increases children's risk of sustaining transport-related injuries, particularly pedestrian injuries (Dowswell & Towner, 2002). The reasons for the association between poverty and higher risk of these injuries include exposure to higher traffic volumes and vehicle speeds in deprived areas, and the higher likelihood of children from deprived backgrounds walking to school, unaccompanied by an adult (Dowswell & Towner, 2002). In addition, house and/or neighbourhood design, including houses opening directly onto the street, and a lack of safe areas to play increase the likelihood of childhood transport-related injury (Dowswell & Towner, 2002). Poorer households are also less likely to be able to purchase transport-related safety devices (Dowswell & Towner, 2002).

Economic disadvantage also impacts indirectly on the likelihood of children sustaining injuries through its relationship with the supervision and monitoring of child activities described above. Caregiver availability to monitor and supervise child activities may be compromised by the cumulative stresses associated with poverty (for example, long work hours, inability to meet basic needs) (McLoyd & Wilson, 1991). Low levels of caregiver supervision have previously been associated with the effects of poverty (Huston et al., 1994). At the more extreme end of the continuum, the relationship between material and social impoverishment and child neglect is well established (Garbarino & Sherman, 1980; Coulton et al., 1995; Garbarino & Ganzel, 2000).

Service access and quality (Type 4 and 5 indicators)

It is worth noting that recent research emphasises the importance of rapid access to hospitals, and draws attention to the need for effective emergency vehicle services to prevent the high number of pre-hospital deaths (Meel, 2004b). Preventable pre-hospital deaths often occur as a result of the time taken and vast distances which need to be covered to reach basic trauma care facilities (Goosen et al., 2003). The vast majority of injuries in South Africa arrive at hospitals by private vehicle, and the average time taken from the time of injury to reach the hospital was recently estimated at around 120 minutes, which impacts negatively on the likelihood of survival from serious injuries (Goosen et al., 2003).

For paediatric burns specifically, delays from the time of the burn injury to presentation at a rural district hospital (average time was 42 hours) were associated with longer hospital stays (Chopra et al., 1997). In addition, access to appropriate health services may be compromised because current specialist tertiary services, such as the Red Cross Children's Hospital in Cape Town, are overburdened (Ramphele et al., 1995).

Recommendations for compiling child unintentional and violence-related injury data

It is recommended that the core child injury indicators presented in Part 2 be used to regularly monitor child injury morbidity and mortality at national and provincial levels on an annual basis. Wherever possible, this data should be drawn and collated annually from existing child injury data sets (for example, Stats SA, NIMSS, DoH). Core indicator data should also include information from private and state clinics, general hospitals, regional hospitals, tertiary hospitals, and mortuaries.

From a resource-efficiency point of view, it is recommended that additional indicator data are collected less frequently, and on a purposive basis from a sample of children presenting at private and state health facilities located within selected sites that represent the diverse circumstances of the South African child population. Specifically, wherever feasible, child injury morbidity and mortality data should be collected every three years (over a prescribed period, for example three months) from sites which are typical of particular South African communities, for example, 'typical' rural and urban areas, which differ in terms of resources, population density, and so on. Additional indicator data should be drawn from households, private and state clinics, general hospitals, regional hospitals, tertiary hospitals, and mortuaries located in the selected sites.

The DoH should play a pivotal role in the selection of strategic partners for participation in the working group charged with developing and implementing the national child injury morbidity and mortality surveillance system. The key task of those commissioned with this responsibility would be to facilitate increased co-ordination between existing data sources which capture information that is relevant to childhood injury (for example, CAPFSA, NIMSS, Stats SA, DoT, SAPS data). This process should include advocating for the standardisation of child injury data to increase reliability or comparability across different data sources. As mentioned, in addition to collating existing injury data, strategies for addressing information gaps need to be developed.

The working group should include individuals and organisations which have the necessary resources and skills to select appropriate and feasible sites for the collection of necessary data from clinics, hospitals and mortuaries and feed it into the surveillance system, as well as to facilitate the appropriate training of health service/mortuary personnel.

Child unintentional and violence-related injury morbidity and mortality categories and rates

Child injury morbidity and mortality rates are normally expressed as rates per 100 000 children in a particular age band. Stratifications by gender and other groupings such as social class are essential for the generation of meaningful data. Further stratifications, such as the location (where the injury took place), may also be important to track the risk of injuries of particular kinds in the home, the school, the playground and other spaces occupied by children. In addition, monitoring the time of injury is recommended as certain types of injuries, for example RTIs, peak at certain times of the day.

It is recommended that childhood unintentional injury indicators be categorised into the following types:

Child unintentional injury morbidity

- Non-fatal transport-related injuries.
- Non-fatal unintentional injuries unrelated to transport.

Child unintentional injury morbidity rate refers to the proportion of children in a particular age group recorded as presenting with an unintentional injury during a specific period of measurement.

Child violence-related morbidity

- Non-fatal violence-related injuries.

Child violence-related morbidity rate refers to the proportion of children in an age group recorded as presenting with a violence-related injury during a specific period of measurement.

Child unintentional injury mortality

- Transport-related fatalities.
- Other fatal unintentional injuries which are unrelated to transport.

Child unintentional mortality rate refers to the proportion of unintentional injuries that are recorded as fatal during the same period as used for the calculation of the morbidity rate.

Child violence-related mortality

- Violence-related fatalities.

Child violence-related mortality rate refers to the proportion of violence-related injuries that are recorded as fatal during the same period as used for the calculation of the morbidity rate.

Database stratifications

It is recommended that the child injury surveillance system capture morbidity (non-fatal injuries) and mortality (injury fatalities) data in a manner that enables stratification into the four categories used above.

In addition, all data should be stratified by age and gender. Furthermore, transport-related injuries should be stratified by the type of incident, for example, whether the child was a driver, passenger, pedestrian or cyclist.

Recommended indicators for monitoring child injury and violence exposure

Child injury morbidity and mortality categories and injury causes are presented below, as are key risk and protective factors for childhood injury operating in the child's environments. Indicators, measures and data sources are presented in the Chapter 7 indicator tables in Part 2 of this volume.

Type 1 indicators: Child status

Child injury morbidity

Injury classification: non-fatal transport-related injuries

Injuries should be grouped according to the primary cause of injury (road and other transport-related injuries).

Injury classification: non-fatal injuries unrelated to transport

Injuries should be grouped according to the primary cause of injury (asphyxiation, near drowning, poisoning, burns, falls, insertion/ingestion of foreign object, blunt and sharp object injuries, struck against/caught between objects, injuries from machinery, dog and other animal bites).

Injury classification: non-fatal violence-related injuries

Injuries should be grouped according to the primary cause of injury (firearm injuries, sharp and blunt object injuries, attempted suicide).

Child injury mortality

Injury classification: transport-related fatalities

Fatalities should be grouped according to primary cause of injury (road and other transport-related fatalities).

Injury classification: fatal unintentional injuries that are unrelated to transport

Fatalities should be grouped according to primary cause of injury (asphyxiation; drowning; poisoning; burns; falls; ingestion of foreign objects; sharp and blunt object injuries; struck against/caught between objects; injuries from machinery, dog or other animal bites; Sudden Infant Death Syndrome).

Injury classification: violence-related fatalities

Fatalities should be grouped according to primary cause of injury (homicide, suicide).

In addition to the primary cause of child injuries, other injury outcomes worth monitoring include the severity of the injury/injuries, which indicates the extent of functional impairment.

The degree of impairment, in turn, indicates which types of injuries should be prioritised in primary, secondary and tertiary interventions.

A number of injury severity instruments have been developed, some of which have been widely used (for example, the Injury Severity Score, the Abbreviated Injury Scale, the Revised Trauma Score, the Trauma Score and Injury Severity Score, the Paediatric Trauma Score). The Kampala Trauma Score (KTS) is a promising alternative injury scoring system specifically tailored for use in countries with resource constraints, and has recently demonstrated high validity and reliability in a Ugandan study (highly predictive of need for admission or death) (Kobusingye & Lett, 2000). It is recommended that the rudimentary injury severity categories above be replaced with the KTS once it has been piloted in the South African context.

Another important dimension of childhood injury is the location at which the injury took place, which facilitates the identification of injury risk settings, and could inform injury prevention interventions. In addition, tracking the season, the day on which injuries occur, as well as the time of day, will assist in identifying new injury trends and emerging problem areas.

Type 2 indicators: Family and household environment

A range of risk and protective factors operating in the child's immediate environment are directly relevant to child injury prevention and management.

Transport-related and other unintentional injuries and fatalities

As mentioned, supervision of child activities, caregivers' participation in interventions focusing on active and passive childhood injury prevention strategies, and safety practices have been identified as important protective factors for childhood injury (both transport-related injuries and injuries unrelated to transport).

Priorities for research focusing on safety practices for the prevention and elimination of childhood unintentional injuries (unrelated to transport) occurring in children's primary care settings include the following:

- The use of child-resistant containers for harmful substances (including paraffin);
- The use of paraffin stoves that adhere to the South African Bureau of Standards safety standards for paraffin stoves;
- Electrification, access to water and the incidence and severity of burn or thermal injuries;
- The main wall and floor finishes of shelters and the incidence and severity of burn or thermal injuries;
- The presence of sufficient storage space to safely store dangerous substances and appliances;
- The use of stair gates and safety barriers on bunk beds and infant high chairs;
- The reduction of hot water temperature to a safe preset temperature (e.g. 54°C);
- The presence of appropriate swimming pool fencing.

Violence-related injuries and fatalities

Indicators and future research efforts directed at promoting violence-free primary care settings should reflect attention to the following:

- Children's levels of exposure to self-directed, interpersonal and collective violence in their homes, schools and communities;
- Household safety practices: safe storage of weapons;
- Proportion of children carrying weapons;
- Descriptive studies on the nature and prevalence of child self-harming behaviours, suicidal ideation and/or attempts.

Type 3 indicators: Neighbourhoods and surrounding environment

The poverty level of the child's neighbourhood (defined as census tract) is a risk factor for all unintentional and violence-related injuries both in South Africa and elsewhere (Barbarin & Richter, 2001a).

Road and traffic infrastructure, including the implementation of appropriate road safety laws, and the condition and maintenance of roads and playground/park equipment play a crucial role in the prevention of childhood transport-related injuries. Key areas for future research include:

- The enforcement of speed limits in residential neighbourhoods and school zones (traffic calming measures such as speed humps and road narrowing);
- The separation of motor vehicle traffic from pedestrians and cyclists (pedestrian crossings, bicycle lanes);
- The creation of off-street play areas appropriate for each developmental level;
- The condition of the roads (proportion of tarred roads, and proportion of roads which have evidence of damage);
- The condition and maintenance of playground and park equipment, including the nature and quality of the surfacing.

Overcrowding and large family sizes have been shown both locally and internationally to increase the risk of children sustaining a range of injuries in and around the home (Richter, 1989; Bradbury et al., 1999; Chan et al., 2003; Van Niekerk, Rode et al., 2004). This indicator is specifically relevant to child unintentional injury which is unrelated to transport.

Type 4 and 5 indicators: Service access and service quality

Key service access and quality indicators include the distance to the closest health facility which offers emergency services; the opening hours of the facility; the number of ambulances in relation to the size of the population; the response time of ambulances (the so-called 'golden hour' concept, which refers to the importance of accessing appropriate treatment within one hour of sustaining an injury); waiting times for emergency treatment; the prioritisation of child emergency cases; and the ratio of appropriate, qualified staff members per patient. It is recommended that service access and quality be monitored according to existing emergency care regulations and norms. Where there are no appropriate norms or standards, for example to determine staff:child ratios in healthcare facilities which offer emergency services for children (a key indicator of service quality), steps should be taken to put guidelines in place.

Conclusion

The primary purpose of monitoring child injury is to promote the child's right to protection from harm, and the child's right to develop in a safe environment. Accordingly, the aim of this chapter has been to develop core and additional indicators for monitoring child injury morbidity and mortality (see the Chapter 7 indicator tables in Part 2 of this volume). The key recommendation emerging from this chapter is the importance of developing a national child injury morbidity and mortality surveillance system which incorporates collated data from existing data systems (for example, NIMSS, CAPFSA), as well as new data generated from the implementation of the recommended indicators.

Note

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

SECTION III

Education and development domain

CHAPTER 8

Monitoring children's rights to education

Linda Chisholm

Introduction: objectives and scope

Monitoring the health of the education system assumed great importance with the advent of democracy in South Africa. Such an emphasis also occurred in the international context where educational reform accompanied broader processes of political and economic change. The development of a framework of indicators for South Africa cannot be separated from these international trends which influence it, although the spatial dynamics and goals of local change also have a determinate effect on national processes of indicator development. In the international context, the most significant initiatives include those of the Organisation for Economic Cooperation and Development (OECD); the United Nations Educational, Scientific and Cultural Organisation (UNESCO); and especially the Education For All (EFA) Global Monitoring Initiative. In the local context, there are regional and national initiatives to consider, including those of the Southern and Eastern African Consortium for Monitoring Education Quality (SACMEQ) and the South African Department of Education (DoE).

All processes of indicator development in education make distinctions between contextual inputs, educational processes and outcomes. How these are configured differs. Central to all is the analytical and interpretive framework within which and for the purpose of which indicators are developed. In order to arrive at concrete and practical proposals for the most conceptually sound, practical and cost-efficient way to measure and monitor whether the right to basic education is being met in South Africa using the indicator typology developed for this project (see Chapter 2 in this volume), it is important to examine these approaches to establish what can be learned, adopted and adapted from them. These in turn need to be transformed by the specific requirements of the indicator typology in order to address the need for an adequate indicator framework in South Africa.

This chapter will mainly address school-related indicators (access, quality, outcomes related to child status) as outlined in Chapter 2, as well as indicators related to the home and neighbourhood environment.[1] Early childhood care and education is covered in Chapter 9 in this volume. These early education settings, as well as primary schools, are the platform on which children are prepared for a range of long-term life opportunities and for their ability to participate in social, economic and political life.

The chapter selects key indicators from the international and local Education Management Information Systems (EMIS) frameworks as a proposal for a child rights-based monitoring framework that takes the quality of children's school

environments and child outcomes into account. In so doing, it draws on a longer version of this chapter (Chisholm, 2004b). The chapter starts with a brief consideration of children's rights to education in South Africa. There is consistent evidence that the right to education is not being met. Ensuring that it is requires that we be armed with adequate information so as to be able to act in order to rectify the situation – hence the key role of good monitoring systems.

Children's rights to education in South Africa

In terms of Section 29(1) of the South African Constitution, all (including foreign resident children) have the right to basic education, including adult basic education, and to further education, which the state, through reasonable measures, must make progressively available and accessible. South Africa also subscribes to a number of international conventions that underwrite the right to basic education. These include the United Nations' Declaration of Human Rights, the Convention on the Rights of the Child (see Appendix 1 in this volume), the Convention against Discrimination in Education, and the African Charter on the Rights and Welfare of the Child (see Appendix 3, this volume). This shared global commitment to the right to universal basic education was paired at the 1990 World Conference on Education for All in Jomtien, Thailand, with the provision to explore school fees and user charges as a means of supplementing national, tax-generated resources for education in developing countries. Such fees have, however, been controversial, and so international (and local) pressure has mounted to abolish them, especially at the level of primary education (Fiske & Ladd, 2004).

In South Africa, the scope and meaning of 'basic education' is defined through policy, but policy is inconsistent on this (Seleoane, 2004). The DoE defines it as spanning grades 1–9 and as compulsory from age seven to 15 (or whichever is reached first). The Draft Norms and Standards for Grade R Funding (DoE, 2005) argues that until Grade R is available and accessible to all children (aged six years), enrolment cannot be compulsory for all, but for those who are enrolled it is compulsory. The implication is that once Grade R is rolled out, basic education will include Grade R but Early Childhood Development (ECD) below Grade R is not included (Biersteker & Dawes, in press). There is some debate about whether it should not be extended to Grade 12 instead of being limited to Grade 9 (Seleoane, 2004). Recent Human Rights Commission public hearings on the right to basic education (HRC, 2006) revealed considerable variability of understanding amongst various public constituencies given the legal vagueness.

Enjoyment of the right to basic education in practice creates both positive and negative obligations on the state (for a discussion, see Seleoane, 2004). The negative obligation means that the state should create no impediment to the individual's access to education. The positive obligation requires that the state take active steps to ensure that the individual enjoys these rights. These steps would include enactment of policies and programmes for the provision of adequate infrastructure, as well as resources such as teachers and curricular support materials that would enable the right to be met. The right to basic education is not like that of further education and other socio-economic rights that should be 'progressively realised'; it is an unconditional right and it is the duty of the state to ensure its immediate realisation.

Despite the constitutional guarantees to the right to basic education, as well as the policies and programmes that have been set in place, it is widely acknowledged that the right to basic education has to date not been met (see Seleoane, 2004; HRC, 2006). The most important limitations on the exercise of the right to basic education have been poverty and school-related financial demand for fees and uniforms etc. Despite being a signatory to international conventions that require provision of free basic education, as well as the departmental proviso that no child may be denied access to a public school on the basis of parents being unable to pay fees, and the exemption of poor parents from fees, it is clear that South Africa has not complied with these provisions. Basic education is not free as a matter of right. Parents have been sued for non-payment of fees (Vally, 2001), there is evidence that children have been denied access on the basis of non-payment of fees, and that school principals have not informed parents of their right to exemption (NMF, 2005). The additional financial burdens of transport and uniforms compromise this right severely. Shortfalls in infrastructural provision, including safe schools, the quality of teachers and other learning supports, are also frequently cited as factors that infringe on the realisation of the right.

Government's position on the question of school fees has shifted gradually over the last 13 years. At first, all schools charged fees. Following public pressure, the DoE introduced an exemption policy. In 2006, in the context of the Human Rights Commission's public hearings, and in the light of cumulative evidence of the burden of fees on poor communities despite the exemption policy, it introduced fee-free schools. The National Norms and Standards for School Funding have accordingly been amended and will take effect in 2007. In terms of this, school governing bodies and parents 'may decide to charge no fees at all, even if parents have the right to determine compulsory school fees. In such a case the question of exemptions does not arise. Another parent body may decide to set a small fee, so that no parent needs to be exempted. In most public schools where parents decide to charge fees, parents' ability to pay may vary considerably. In such cases, difficult decisions must be taken about the level of fees, and an equitable threshold should be set for exemption from fee-paying' (DoE, 2006, Section 44). New legislation takes time to take effect and is often implemented in ways contradictory to the intentions. For this reason, strong arguments remain to monitor the implementation and impact of the policy. An indicator system able to monitor such implementation and impact would need to include indicators relevant to this.

In terms of the UNESCO *Education for All Global Monitoring Report* (2004), access and quality are closely linked. Without a quality learning environment, access can be hindered and outcomes are limited. UNESCO (2004) sees two principles as characterising most attempts to define quality in education: the first identifies learners' cognitive development as a major objective. The success with which systems achieve this is one indicator of their quality. The second emphasises education's role in promoting values and attitudes of responsible citizenship and in nurturing creative and emotional development. Quality indicators are thus as important as access indicators for monitoring whether the right to basic education is being achieved or not.

The limitation on the right to basic education is considered to be particularly acute for girls and non-citizens. In South Africa there is poor retention and too high a

dropout rate of both boys and girls through the basic education phase (Perry & Arends, 2003; NMF, 2005). There is very little, if any, information on the access of non-citizens to basic education (Tomasevski, 2002). Outcomes are also poor by international measurements and standards (Reddy, 2005). All these issues would need to be considered in an adequate indicator framework for monitoring rights to basic education in South Africa.

The preceding discussion points to the importance of monitoring compliance with the Constitution and relevant bodies of law and policy. Indicators related to access, equity, quality and outcomes are all relevant. They are central to all international, regional and local indicator frameworks for monitoring education and all form part of international, regional and local indicator frameworks. They differ mainly in terms of the purposes for which they were developed. Before considering them, it is thus necessary to briefly consider the purposes and limitations of indicator frameworks.

Education indicators: purposes and limitations

The purposes of indicator systems are to:

- Monitor the general conditions and contexts of education;
- Identify progress towards specified goals;
- Illuminate or foreshadow problems;
- Diagnose the potential sources of identified problems.

When indicators are not used in a purely descriptive way, they are evaluative judgements that can be used for policy-making and administrative purposes. They are important for policy as good indicators and, when well analysed, can help to identify problems, provide a perspective on performance and achievement, and so enable the development of new strategies and planning to solve the problems.

Given their centrality to policy-making, value judgements are necessarily involved, since 'decisions about educational indicators are determined with reference to the goals of various actors…Changes in a society's views of its educational needs and goals (or in the views of the political party predominating at any given point in time) can and do influence the nature of data collected and the ways in which they are reported and used' (Darling-Hammond, 1992, p. 237).

In addition to this linkage of indicators to international or state goals (that may change), the development of indicators is also complicated by the complexity of the educational environments to be measured, the interrelatedness of issues, and the concerns that reduction of this complexity can result in what might be termed 'management by measurement'. Darling-Hammond (1992), for example, highlights the way achievement tests in the United States became the measure of curriculum goals and as such had far-reaching implications not only for school practices but also for what was taught and learned in schools.

Over the last decade, this approach has come under attack. For example, Ball (2004) has mounted a substantial critique of the performativities and fabrications in the education economy. Performativity is defined as 'a technology, a culture and a mode of regulation, or even a system of "terror" in Lyotard's words, that employs

judgments, comparisons and displays as a means of control, attrition and change. The performances of – individual subjects or organisations – serve as measures of productivity or output, or displays of "quality", or "moments" of promotion or inspection' (2004, p. 143). For Ball and critics of performativity then, the process of development of indicators is infused with a 'discourse of power', and with particular 'rituals' and 'routines'.

For Darling-Hammond, by contrast, performativity forms part of an instrumental use model in which indicators are used in an enlightened rather than a regulatory manner in order to provide data that inform good decisions. As such, there is potential for indicators to change policy and practice – but only if the inferences drawn from them are properly validated, the indicators are appropriately interpreted and the interrelationships among the key variables are understood.

Thus, for example, the continual use of matric scores in South Africa as a measure of change in cohort performance across time indicates an inappropriate use of indicators (in this case the matric score). Such practice is associated with a poor understanding of the meaning and uses of indicators, and an inability to understand the way in which context may change (for example the curriculum) in ways that can seriously undermine the usefulness of a particular measure over time (for example mathematics matric scores).

The limits of the information that indicators provide need to be recognised and understood. Using indicators 'as both change agents and measurement tools' can place burdens on measures that are too heavy for them to bear (Darling-Hammond, 1992, p. 253). Darling-Hammond argues that it is important to recognise that numbers are not enough in helping to understand schooling trends and practices, and that multiple indicators are needed, that they need to be both 'redundant' and constantly revised, and that by themselves they will not solve strategic questions of policy-making.

The dangers of not taking these issues into account include 'inaccurate or misleading answers' and information about causal relationships; behaviour changes that invalidate the indicator, such as using them for punishment and reward incentive systems that backfire; and the neglect of certain kinds of skills and abilities when tests drive curriculum and pedagogy. Genuine accountability will not be achieved only by improving performance measures; it also requires that they be continually evaluated in terms of how well they are meeting their goals. Ensuring such constant revision should apply to all indicator frameworks for monitoring educational access, equity, quality and outcomes.

International indicator frameworks

Environments and outcomes are differently conceptualised in various attempts to monitor the rights and well-being of children in education and primary school (or Grade R–9) contexts. How they are conceptualised also depends on their purpose. For the purposes of this chapter, we need to examine models that address the indicator typology used in this project, including access, quality, outcomes and school environmental factors.

Hua (1998) at the Harvard Institute for International Development provides a useful model of four contextual or 'environmental factors' and their impact on outcomes. The four 'environmental factors' are the social, school, community and family environments. The learner enters school influenced by the social and community environments. Hua's identification of contextual factors influencing education from the child's home and surrounding neighbourhood fits well with Type 2 and 3 indicators (see Chapter 2). Each environment has critical dimensions and indicators that yield information about learning that can be measured through test results, portfolio measures and pass rates. Indicators thus developed can be organised in an 'education production' model of demand–input–process–output–outcome–demand.

The organising OECD (2004) framework for the development of education indicators (understood as ratios) is deeply influenced by a human capital framework that intends to shape policy outcomes. It is more relevant to the school-related indicators. There is a stronger focus within this framework than in Hua's (1998) on the policy circumstances, levers and issues to which the indicators relate. Quality and gender indicators are critical within it.

The framework of indicators developed by UNESCO (2002, 2003, 2004) is similar in its policy orientation and the centrality given to gender, but it is different in its configuration and matrix of indicators. The indicators here are more explicitly located within a capability and rights-based framework and are guided by the six EFA goals identified in the Millennium Declaration and Dakar Framework for Action adopted in 2000. These in turn build on declarations arising from a series of United Nations regional conferences on education in the early 1960s, in the treaties that formed the international Bill of Human Rights in the 1970s, and in the World Declaration on Education for All adopted at the World Conference on Education for All in Jomtien in 1990. There is a core set of 18 EFA indicators (International Consultative Forum on EFA, 2000, p. 7) that are used to describe or measure the main components of basic education. They are grouped according to the six target dimensions linked to this framework. Central to the UNESCO approach is the view that dialogue is essential to defining approaches to monitoring. The framework for indicator development includes a:

- *Learner characteristics dimension:* these can include socio-economic background, health, and place of residence, cultural and religious background and the amount and nature of prior learning. Potential inequalities deriving from gender, disability, race and ethnicity, HIV/AIDS status and situations of emergency require special attention (see Chapter 10 in this volume for comprehensive coverage of disability).
- *Contextual dimension:* these can include national policies for education including goals and standards, curricula and teacher policies, and international aid strategies.
- *Enabling inputs dimension:* these can include material and human resources including, on the one hand, textbooks and other learning materials and the availability of classrooms, libraries, school facilities and other infrastructure and, on the other hand, managers, administrators, support staff, supervisors, inspectors and teachers. Teachers are vital. Useful proxies for teacher quality are pupil to teacher ratio, average teacher salaries and the proportion of education spending allocated to various items. Material and human resources together are

often measured by expenditure indicators, including public expenditure per pupil and the proportion of gross domestic product (GDP) spent on education.

- *Teaching and learning dimension:* here curricula and pedagogies are vital. Actual teaching and learning processes, as they occur in the classroom, include time spent learning, assessment methods for monitoring students' progress, styles of teaching, the language of instruction and classroom organisation strategies.
- *Outcomes dimension:* these are most easily expressed in terms of academic achievement measured by test grades or examination performance, although ways of assessing creative and emotional development also exist. Other proxies include labour market success. It is useful to distinguish between achievement, attainment and other outcomes measures, which can include broader benefits to society.

This comprehensive framework provides a means for organising the different variables to assess access, teaching and learning processes and outcomes influenced by context and the quality of inputs available. This broad structure is proposed as a framework that is most useful for our purposes.

Regional indicator frameworks

SACMEQ is the most important regional body examining educational quality. It works closely with the UNESCO International Institute for Educational Planning. SACMEQ has conducted two major studies, SACMEQ I and SACMEQ II, over the periods 1995–97 and then 2001–03, to monitor educational quality in southern Africa. Indicator development occurred in joint teams to develop a common framework. SACMEQ conducts cognitive achievement tests (including literacy, numeracy and life skills tests) but supplements these with information about learners and their contexts, including household income as well as availability of material and human resources in schools. Important analyses based on SAMEQ results are emerging that will have powerful implications for policy in the region.

Towards a South African national education indicator framework

A comprehensive review of South Africa's indicator movement in education, specifically linked to quality (Motala, 2001), shows that the post-apartheid period was marked by two parallel developments. Within government, the goals of access, equity, quality and redress, combined with a commitment to monitoring and evaluating educational performance, led on the one hand to the creation of information systems and an EMIS and, on the other, to a quality assurance chief directorate.

Outside government, discussion and debate focused on how best to place processes of teaching and learning at the forefront of all educational endeavours for school improvement while paying due regard to context. Whereas the former used quantitative methodologies, the latter used qualitative methodologies: 'the value of this research is that it established an understanding of education quality as concerned

with the processes of teaching and learning and drew deliberately on "insider" perspectives on what happens in schools and classrooms' (Motala, 2001, p. 67).

Motala makes the important point that a major limitation of the use of indicators currently in departments of education is 'the ability of education management to use such information…A key concern of EMIS continues to be how to use information collected, not just to count numbers but to analyse shifts and trends in education, particularly in ways that can be effectively utilised at provincial, district and school levels' (2001, pp. 70–71).

Bearing this important caveat in mind, we can move on to consider the nature of the indicator frameworks developed inside South Africa, examining first those developed outside and then inside the DoE.

Frameworks of indicators developed inside South Africa – whether by the national DoE, public–private initiatives or independent academics – have to date followed 'global trends to increase public sector efficiency and proper resource allocation' (Motala, 2001, p. 70). Significant indicator research and development projects outside the DoE have included the Quality Learning Project (QLP) (Kanjee et al., 2001; Kanjee et al., 2003; Taylor, 2006, forthcoming; see also Mabogoane, 2004). The objectives of these initiatives have informed the manner in which they have developed their indicators. For example, in the case of the QLP, the overall aim was to improve learner performance in mathematics and the languages of instruction in grades 8 to 12 in 500 schools across 18 districts in all nine provinces in South Africa. The main objective was to achieve the effective management of districts and schools, as well as the attainment of appropriate teaching methods. A basic assumption of the project was that 'educational indicators are defined as proxy measures used to provide a general overview of the state of the education system' (Kanjee et al., 2001, p. 31). In order to measure the programme outcomes, a range of indices were developed to measure the functionality of districts, schools, classrooms, learners and learner performance. Achievement outcomes were seen by the research team as the 'final proof of an education system's quality and achievement scores are the most readily available and easily gathered indicators of achievement that we currently have' (Kanjee et al., 2001, p. 31).

Below I examine the EMIS system more closely to see to what extent it includes indicators that monitor the quality of the child's environment and outcomes. More specifically, I examine and compare the extent to which South Africa's EMIS indicators provide for a UNESCO-recommended framework (2004) that specifies monitoring: i) learner characteristics, ii) the contextual dimension, iii) the enabling inputs dimension, iv) the teaching and learning dimension, and v) the outcomes dimension. I conclude with a proposal for a pared down set of indicators drawn from the South African EMIS framework placed within an EFA framework that takes access, quality and outcomes into account.

The EMIS developed by the national DoE

The development of national indicators is guided by national goals and priorities, the most important of which, under Minister Asmal, was the *Implementation Plan for Tirisano* for the period January 2000 to December 2004 (DoE, 2000b). This

programme is still in the process of implementation. Under the programme for organisational effectiveness in national and provincial departments, the various departments established monitoring, evaluation and accountability as a key project. The strategic objective was identified as being to establish monitoring and evaluation mechanisms that enable the assessment of the performance of the education and training system, including the impact of implementation plans and strategies. The activities to flow from this were the development of monitoring and evaluation instruments – and in particular performance indicators – on an annual basis. This would result in regular reports on the performance of the education and training system and annual publication of agreed performance indicators. The DoE's *Education Statistics in South Africa at a Glance* (2002, 2003) is the expression of this goal.

Indicators relevant to this study can be drawn from three different, unlinked national databases: the EMIS system, the School Register of Needs, and the government's Personnel Administration System (the Personnel Salary System – PERSAL). The DoE's EMIS is responsible for systematically collecting and analysing data on learners, educators and resources throughout the education system, including general education and training, further education and training, adult basic education and training, ECD, education for learners with special needs, and higher education. There are two separate surveys, the SNAP Survey conducted on the tenth day of the school year and the Annual Survey of Schools conducted in March of each year. The SNAP Survey provides basic statistics on learners whereas the Annual Survey provides more detailed information on schools, learners and educators.

According to the DoE (2003), there are variations in the definitions and standards that provinces use, with resulting problems about achieving uniform standards across all provinces. The School Register of Needs Survey conducted in 1999 and 2000 provides a substantial database on indicators for school conditions and is currently being updated. PERSAL provides information on educators and the Annual Survey provides information on schools. As Shisana et al. (2005) point out, these databases are not aligned, and it is not possible to link schools across the different sources of information. Processes for indicator development and data collection are unsystematic, instruments are excessively long and analytical capacity in provincial and national departments to analyse the statistics is constrained.

The Annual Survey for Ordinary Schools for 2004 is the most significant instrument for the purposes of this chapter. Close to 80 pages long, it includes indicators across the range identified by the UNESCO EFA framework, but in addition it includes a number of indicators to monitor the impact of new policies. It is clear that the EMIS form has a comprehensive set of indicators for all areas required for a child rights monitoring framework.

Although the Annual School Survey form is extremely comprehensive, it has a range of weaknesses. The form itself can be improved and streamlined. When compared with the indicator framework of the QLP project, it has fewer assessment and outcome measures, but this is largely because the purpose is different. It is an open question whether a national annual survey form can accurately capture questions around pedagogy and the use of resources. Other methodologies and instruments may be more useful in capturing these.

From the point of view of a manageable child rights and well-being monitoring system that takes into account all five of the dimensions, four key indicators need to be selected for each dimension. The framework of indicators used in the EMIS form include general information, learner information, school governing body information, policy, management, administration, curriculum, learner performance, learner support materials, community and parents, safety and security, resources and equipment, finance, provincial support, physical infrastructure, educator information, information on school fees and school uniforms. There are indicators for all of the areas required in the rights-based framework of UNESCO.

Appendix 7 in this volume organises the EMIS indicators into the framework proposed in the UNESCO 2004 *Global Monitoring Report*.

It is clear that the South African EMIS encompasses a vast range of indicators, but not all those that fully cover the different dimensions advocated by UNESCO. Thus, for example, enabling inputs need to include public expenditure per pupil and the proportion of GDP spent on education. These are not included in the EMIS form. If we select key core indicators from the existing UNESCO and EMIS indicators, we arrive at a set that requires some supplementation, especially in terms of home and neighbourhood factors, to meet the needs of the indicator framework developed for this volume. In addition, it is vital to factor in a gender equity index, and the indicators provide for this (Unterhalter, 2005).

Adapting the UNESCO framework

Type 1 indicators (Child Status) relate to scholastic performance (the outcomes dimension within the UNESCO framework). Type 2 and 3 indicators relate to elements in the environmental context (the enabling inputs dimension). Type 4 and 5 indicators focus on elements of access to schooling and the quality and effectiveness of schooling (learner, contextual and teaching and learning dimensions). All types of indicator are seen as essential, that is, core indicators for the purposes of monitoring the relative effectiveness of both prevention and learning support in the cause of promoting the rights and ultimate well-being of learners.

Following the indicator typology outlined in Chapter 2 of this volume, education indicators for child status (Type 1 indicators) would include test results, retention and throughput rates, among others. But education performance does not just depend on the quality of the school and so it is important to include contextual factors operating in the child's home and the surrounding neighbourhood. The former would be Type 2 indicators and the latter Type 3 indicators. These would comprise the learner characteristics dimension of the UNESCO framework.

An obvious example of a Type 2 indicator that would point to the capacity of the child's home background to support the learning process to which the child is exposed, is the educational level of the parents or guardians. Where qualifications are higher, opportunities for stimulation of school-related capacities at home are likely to increase. Other Type 2 indicators would be items in the home, such as the availability of electric light to facilitate study and a quiet area to do homework. For many South African children both these are likely to be absent. Finally, where

poverty is present, inability to pay school fees and meet other financial demands imposed by schooling would be a barrier to schooling. The evidence suggests that children affected by deep long-term poverty and HIV/AIDS are particularly likely to experience the threat of school exclusion or victimisation because they cannot meet the financial demands (Wilson et al., 2002; Giese, Meintjies et al., 2003b; Case & Ardington, 2004).

The presence of a library in the child's community or school would constitute a Type 4 indicator of the child's access to additional supports for learning. Similarly, the educational level of adults in the child's community would constitute a Type 3 indicator. (See Ward, Chapter 4 of this volume for further discussion.)

Some measures of the child's right to education would fall under Type 4 indicators designed to track access and equity. These of course would link to Type 2 indicators which track the caregiver's ability to pay school fees, and to Type 5 indicators such as the efforts made by the state to provide and improve the quality of schooling in areas that were previously disadvantaged under apartheid. Thus small-area analyses of poverty (see Chapter 3 in his volume) would be able to help identify communities in which there is a high risk that the people concerned would be unlikely to be able to afford fees. This data could be validated with information from the local schools. Comparison of teacher to learner ratios (Type 5 indicators) in rural and formerly disadvantaged communities with former model C schools (and with the department's norms) could be made, in order to ascertain the extent to which redress had been achieved.

The quality of the educational environment (inputs) would be measured using a set of Type 5 indicators. In the following section, a range of quality indicators will be discussed. To a greater or lesser extent they draw on the OECD and UNESCO approaches to education indicators. Both the OECD and UNESCO have over the years developed their collection and reporting on comparative statistics and indicators in the field of education. UNESCO and OECD reports may be accessed on the UNESCO website.[2]

Table 8.1 represents the adaptation. It is clear that there is not a neat overlap in the configuration of indicators.

For the purposes of the rights-based child well-being approach to education indicators recommended in this chapter (which are included in the core indicator table for education in Part 2 of the volume), a selection of indicators was made as follows: the first step was to draw on the EFA dimensions in Table 8.1, particularly taking into account the achievement of access, quality and outcomes. South African EMIS indicators were then aligned with the EFA framework and converted into the indicator typology developed in Chapter 2 of this volume (listed in the two left-hand columns of Table 8.1). Finally, relevant indicators drawn from Hua's (1998) model were inserted to provide neighbourhood context indicators (Type 3).

The indicators proposed in Part 2 of this volume therefore provide the basis for a discussion around appropriate indicators to use for the five dimensions specified by the rights-based well-being indicator typology developed for this volume.

Table 8.1 Adapting the UNESCO indicator approach

Type	Indicator typology	UNESCO approach	Recommended indicators
1	Child well-being: scholastic performance	Outcomes dimension	Tests and portfolios, gender, disability.
2	Child's home environment	Learner characteristics dimension	Adult literacy by level of educational attainment of caregivers by gender. Parents alive or deceased; childcare situation; orphanhood; availability of electricity.
3	Immediate social or neighbourhood environment	Learner characteristics dimension	Adult literacy by level of educational attainment of community by gender. Community factor (investment in money, time and other support).
4	Access to school	Learner characteristics dimension	Gross enrolment by race and gender, net enrolment by race and gender – both stratified by poverty level; fees charged; uniforms compulsory; repetition and survival.
5	School quality	Enabling inputs dimension; teaching and learning dimension; contextual dimension	Availability of textbooks and learning support materials; availability and use of physical resources; pupil–teacher ratios; public expenditure on education as % of GDP; time spent learning; language of instruction and home language; educator qualifications, experience, salaries, subjects taught; availability of policies for safety and security, sexual harassment, orphans and vulnerable children; learners' and educators' codes of conduct; educator to pupil ratios.

Conclusion

In conclusion, this chapter has argued that the purpose of the task determines the nature of the framework of indicators, but that there are similarities across international and national sets of indicators. The chapter examined and compared the South African EMIS with international and regional frameworks and argued that although the South African EMIS is extremely comprehensive and enables monitoring the achievement of the right to education, it is too long, and challenges lie primarily in analytical capacities at provincial level.

Note

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 Thanks to the editors of this volume for assistance with preparing the indicator table that corresponds to this chapter.

2 UNESCO website, <http://portal.unesco.org>.

CHAPTER 9

Early childhood development and the home-care environment in the pre-school years

Linda Biersteker and Jane Kvalsvig

Introduction: objectives and scope

The early years of life are a particularly sensitive period for survival, growth and psychosocial development. If the contexts in which young children grow up are not supportive, their later participation and inclusion in society may be severely compromised. This chapter provides indicators, measures and data sources for monitoring the well-being of young children, including the accessibility and quality of service provision for children under school-going age.

Early Childhood Development (ECD) is defined in the *White Paper on Education and Training* as the processes by which children from birth to about nine years grow and thrive – physically, mentally, emotionally, spiritually, morally and socially (DoE, 1995). The *Interim Policy on ECD* stated that the term ECD:

> conveys the importance of a holistic approach to child development and signifies an appreciation of the importance of considering a child's health, nutrition, education, psycho-social and additional environmental factors within the context of the family and the community. (DoE, 1996, Appendix 1, p. 2)

This very broad definition operates across sectors and at national, provincial, district and local levels. It takes in a wide variety of services including health and social services, the school-based reception year, community-based pre-schools and playgroups, home-based childcare (which is usually private), as well as programmes of different kinds targeting primary caregivers, such as child grants, family literacy, home visiting, and health programmes.

ECD service provision therefore falls within the policies and programmes of several departments, the major responsibilities residing with education, social development and health. The health and social development departments focus particularly on children up to five years, while education is concerned with the full 0–9 years. Education policies reflect this, focusing on services for children from five years (Grade R, the reception year).[1] This chapter focuses on 0–5 years (including Grade R) because, although increasing numbers of five year olds are moving into Grade R in the public schooling system, more are in community services and the majority of five year olds are not in any form of ECD service (Biersteker & Dawes, in press).

Indicators of survival, growth and access to preventive health service are so fundamental for young children that they have tended to be the primary focus of monitoring for this age group. As these are discussed in Chapter 5 of this volume, they will only be reflected in this chapter in so far as they relate to the quality of ECD service provision, and in the indicator tables in Part 2 as part of a comprehensive set of indicators for monitoring the well-being of the very young child. Similarly, where young children require interventions from the care and protection system, this is dealt with in chapters 14 and 15 of this volume.

The main goal of this chapter is to draw on findings pertaining to supports for early development in the home environment and ECD facilities to provide indicators that can be utilised for a number of purposes, including:

- Setting standards for government-subsidised provision of alternative care when home and family care is not available;
- Informing government planning by describing the scale, complexity and intensity of problems affecting young children (and where they occur);
- Informing resource planning by determining the availability of existing resources and gaps in service provision;
- Making recommendations for the improvement of ECD indicator systems;
- Providing indicators that can be used by parents and caregivers to track the development of children in the home, while raising awareness of child development and the need for stimulation.

Use of a rights-based approach to monitoring ECD outcomes

The legal and ethical obligations of the state and caregivers to honour children's rights are detailed in the Bill of Rights (see Appendix 2 in this volume) in the South African Constitution, the Convention on the Rights of the Child (CRC – see Appendix 1, this volume) and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3, this volume). These build on the general principles of the best interests of the child, non-discrimination, survival and development and participation. The use of rights as the basis of a monitoring framework for child well-being has high consistency with policy goals and provides for a very broad perspective on children's lives. As noted in Chapter 2, rights-based monitoring requires:[2]

- Specification of the rights to children;
- Provision for delivery of these rights in the form of policies and programmes;
- Measurement of child outcomes.

Article 18 of the CRC states that parents have the primary responsibility for bringing up their children, and that states must provide assistance to parents or guardians in the performance of their child-rearing responsibilities. Section 3 of the Article 18 states that the state should take 'all appropriate measures to ensure that children of working parents have the right to benefit from childcare services and facilities'. The notion of 'appropriate' measures could include a range of options. And following Article 4, the extent and limits of a country's resources would be taken into account. In commentaries, the Committee on the Rights of the Child notes in this regard that this article:

> reflects a realistic acceptance that lack of resources – financial and other resources – can hamper the full implementation of economic, social and cultural rights in some States; this introduces the concept of 'progressive realization' of such rights: States need to be able to demonstrate that they have implemented 'to the maximum extent of their available resources'. (2003, Introduction, Paragraph 7)

The committee has also recognised the importance of providing for the needs of the child and protection from neglect and abuse, particularly in early childhood.

As noted in Chapter 2 of this volume, children's rights are commonly grouped into four domains – survival, protection, development and participation (Ennew, 1999) – as illustrated in Table 9.1 in the case of ECD. These are not legal groupings and of course the boundaries between the domains are not hard – obviously, survival is linked to development. The rights list is not exhaustive.

Table 9.1 Articles of the South African Constitution (SAC), CRC and AC relating to key rights domains

Survival rights	SAC 28(1c); CRC articles 6, 24 & 26; AC articles 5, 14 & 19(2)
Protection rights	SAC 28(1b & d); CRC articles 3(3), 18, 19 & 37; AC articles 18, 19(1) & 20(2c)
Development rights	SAC 28(1b & c) & 29(1a);[3] CRC articles 6, 17, 27, 28, 29 & 31; AC articles 11, 12 & 19(2)
Participation rights	SAC 9(3) & 28(1a); CRC articles 2, 7, 12 & 23; AC articles 3, 6, 7 & 13

The younger the child, the more dependent she or he is on adults to ensure those rights. Yet several monitoring initiatives have excluded younger children in many key areas. So, while World Summit and Millennium Development Goals (MDGs) have a very strong health and survival focus on young children, little attention has been given to the monitoring of development and participation rights in this age group.

South African policies, provisions and delivery challenges

Because early childhood is recognised as a sensitive period for survival, growth and psychosocial development, children in this developmental phase are a target of primary healthcare (PHC), education policy and social development policies.

Education White Paper 5 on ECD (DoE, 2001a) commits government to establishing a reception year (Grade R) for children aged five years and delivering appropriate, inclusive and integrated programmes for children under five years. Improvement of the quality of pre-Grade R programmes, inclusion of health and nutrition aspects and appropriate curricula, as well as practitioner development and career-pathing are aspects of the strategy. Particular targets are 'our poor rural, poor urban and HIV/AIDS infected and affected communities' (DoE, 2001a, p. 49) and four year olds with special needs (DoE, 2001a). The White Paper flags particular areas for attention, including:

- The extent of ECD provision;
- Inequalities in existing ECD provision;
- Inequality in access to ECD services;

- Variable quality of ECD services;
- An incomplete, fragmented legislative and policy framework that results in unco-ordinated service delivery. (DoE, 2001a, p. 3)

Education White Paper 6 on Special Needs Education (DoE, 2001b) flags the importance of inclusion of children with special needs in the education system, something very lacking for younger children with disabilities, when early intervention is optimal. The nationwide ECD audit (DoE, 2001c) found that only 1.36 per cent of enrolments at ECD facilities were children with disabilities and this includes specialist facilities. Further, many of the children who were enrolled were of early school-going age (34 per cent were aged five to six years and 31 per cent were over seven years) suggesting the unreadiness of the public schooling system to enrol them, rather than an early intervention strategy (Biersteker & Dawes, in press).

The Department of Social Development (DoSD) recognises provision of ECD services as a strategy for supporting children who might be at risk. The *White Paper for Social Welfare* (DoSD, 1997) targets poor children under five years for ECD services, prioritising 0–3 year olds and children with disabilities. Departmental policy is to provide a range of services to meet the varied ECD needs of families and to do this through supporting and reinforcing programmes offered by existing role-players, and supporting community development interventions.

Health policies target infants and young children, and pregnant and lactating women for the integrated nutrition strategy (DoH, 1997; see Chapter 5 in this volume). Children under six benefit from the free healthcare policy, the basket of services including immunisation, preventive services, health screening, identification of children with special needs, and basic care and treatment of children with chronic illnesses.

While policies prioritising and supporting ECD services are in place, implementation remains a challenge. Any system of monitoring should therefore include measures of access, the range of services offered, as well as the populations who are accessing services. Education White Paper 5 (DoE, 2001a) indicates that access to services has not been equitable. The nationwide audit (DoE, 2001c) found that approximately 16 per cent of children from 0–5 years were in organised ECD provision. It indicates an urban bias in provision of ECD centres, with the poorer rural provinces least well provisioned. While overall enrolment at centres was consistent with national population figures for both gender and population group, this was not so for all provinces.

Attendance is inversely proportional to age, with the majority attending ECD services aged five to six years; access for children under three years is very limited. However, needs of caregivers and children vary greatly for the ECD age range. The fact that most young children are in the care of family members or informal arrangements is related to low numbers of women in the workforce and the general pattern that it is more common for very young children to be cared for at home. In the case of these very young children, additional indicators of their well-being need to be developed to determine whether public responsibility has been taken to ensure that parents have the necessary knowledge, skills and support to carry out this role effectively and, if not, to provide alternative supports. Access would therefore need to be considered in relation to age.

Quality should also be monitored. The ECD audit showed that a disproportionate number of sites serving African children are of lower quality than those serving the rest of the population.

International ECD indicators

In addition to the CRC, the AC and the Constitution, provisions relating to the monitoring of early childhood care and education occur in a number of international agreements. These include the Education for All Declaration (UNESCO, 1990), the Dakar Framework for Action (UNESCO, 2000), and the MDGs.[4] The New Partnership for Africa's Development initiative also accepts early childhood care and education as an education priority area.

International agreements relating specifically to ECD tend to have an education focus.

The Education for All (EFA) indicators developed under the auspices of the United Nations Educational, Scientific and Cultural Organisation (UNESCO) contain ECD provisions (EFA Global Monitoring Report Team, 2004; see also Chapter 8 in this volume). The World Declaration on Education for All included the ECD period in its commitment to basic education, noting that:

> Learning begins at birth. This calls for early childhood care and initial education. These can be delivered via arrangements that involve parents, the community or institutional programmes as appropriate. (UNESCO, 1990, Article 5)

The Framework for Action set the target of:

> expansion of early childhood care and development [ECCD] activities, including family and community interventions, especially for poor, disadvantaged and disabled children. (1990, Paragraph 8)

The Dakar Framework for Action reinforces the previous ECD commitment, stating the ECD target as follows:

> expanding and improving comprehensive early childhood care and education especially for the most vulnerable and disadvantaged children (Goal i). Provisions regarding the expansion of quality in education, though associated with primary schooling (or above) outcomes, can be read as including ECD and will have reinforced the Department of Education's (DoE's) current focus on quality. (UNESCO, 2000, Paragraph 7)

EFA indicators designed for cross-country comparison have been very limited. For the 1996 mid-decade review these were (UNESCO, 1996):

- Enrolment in pre-primary institutions for children aged three to six years;
- The number of pre-primary institutions and the number of caregivers employed in the field.

EFA Year 2000 Assessment Indicators for ECCD (UNESCO Institute for Statistics, 2000) for country reports focused on comparing current and past enrolments, including:

- The gross enrolment ratio in ECCD programmes (as a measure of the general level of participation of young children in ECCD programmes and the country's capacity to prepare young children for primary education);
- Percentage of new enrolments to Grade 1 who have attended some form of organised ECCD programme during at least one year (helps to assess the proportion of new entrants to Grade 1 who presumably have received some preparation for primary schooling through ECD programmes).

Myers (2001, 2004) has raised as problematic the fact that these indicators did not allow for assessment of the *quality* of inputs to early childhood programmes, the efficiency of programmes, the effects on children or the financial contribution made by nations to this part of the educational system. Further, the focus on children aged three to six years and on institutions (that is, non-parental early childhood care and education [ECCE] arrangements) excludes the vast majority of children under five from the monitoring process.[5]

To assess progress on the 1990 World Summit for Children Goals, the United Nations Children's Fund undertook the first multiple indicator cluster survey (MICS) (there have been three surveys since then). The MICS is a household survey and items for childcare and early education include pre-school enrolment of five year olds, and whether or not three and four year olds are in a programme outside home and, if so, for how many hours per week (UNICEF, 2005a).

In 1999 a resolution was approved at UNESCO's General Conference to improve early childhood indicators. A specific concern was to improve data on non-pre-primary early childhood programmes, including different settings and diverse aims such as components for the child's health and nutritional well-being. The considerable gaps in information were seen as due to a lack of operational guidelines to direct the collection of relevant and meaningful data on non-pre-primary programmes.

In response to dissatisfaction with the EFA indicators and general difficulties of adequately assessing the situation of young children with the existing information and monitoring processes, the Consultative Group on Early Childhood Care and Development[6] formed a working group to identify, develop and undertake some country case studies to pilot country-specific early childhood indicators. The Consultative Group (2001) defined useful indicators in terms of:
- The general status of children during the early years of life;
- Extension and quality of programme initiatives intended to improve that status;
- The quality of contexts that affect child development (Myers, 2001, pp. 3–4).

Myers (2001) offered for discussion 16 possible indicators which might be used for monitoring at a national level, and with policy and planning in mind. These were organised into the following categories: coverage, access and use; programme quality; political will: policy and financing; costs and expenditures; and status of or effects on children and parents.

The reviewing and field-testing of these indicators in different contexts (Namibia, Nepal, Philippines, Jamaica) and by different stakeholders provided the following insights, which are useful for the present initiative:

- The process of arriving at indicators is as important as the indicators created (in the case studies this involved groups of stakeholders and strengthened the lobby for young children);
- Monitoring efforts need to take into account the development level of the country's information systems;
- There was difficulty in arriving at consensus about instruments that purport to measure child development, including environments and risks to children in the assessment;
- A process is needed to help practitioners and advocates arrive at a point where the measurement instruments are validated and mechanisms are in place to assure reliable application;
- The need for systems of indicators to be user-friendly so that those involved in monitoring will be motivated and able to incorporate results into their planning and thinking.

Programme quality

Assessment of ECD programme quality requires a clear statement of the elements that define quality – a construct that is hotly debated. Reviews of the literature on quality indicators and the effectiveness of ECD programmes by Myers (2001), Young (2002) and Coombes (2003) suggest that the following elements should be considered in the assessment of the quality of ECD programmes:

- Effects on children:
  - Measures of child development should cover all dimensions including cognitive and language skills, social competence skills, self-care and life skills, physical co-ordination and dexterity, nutritional and health status;
  - Measures of school readiness are close to measures of child development since development is holistic and integral. In addition, people are interested in assessing how well specific skills are related to readiness for literacy and numeracy;
  - Social well-being – mortality rates, stunting and body wastage rates, literacy rates, delinquency levels;
  - Measures of child development and readiness should be reliable, valid, culture and language sensitive. Repeated measures give a better assessment of children than one single measurement.
- Efficiency (cost per child or parent education participant, number of children/participants completing the cycle).
- Efforts put forth and processes and indicators of quality such as adult–child ratios and programmes. The following inputs are essential ingredients in effectiveness:
  - Definition of aims and objectives by all key stakeholders including children;
  - Curricula that take a holistic view of child development and therefore develop cognitive, social, emotional and physical skills. Experiences should be enjoyable and leave room for play and exploration. These experiences should also help in the acquisition of healthy relations with self, others and the environment. They should be culturally relevant;
  - Education agents including teachers and caregivers who are healthy, sensitive, loving, warm and consistent in the way they interact with children;

- A clean, ventilated, stimulating, healthy, secure physical environment with enough space for learning and interaction;
- Systematic evaluation of methods and services;
- On-the-job training, support and supervision providing for professional and personal growth of teachers/caregivers;
- Programme leadership that provides adequate co-ordination and management but which remains close to children's learning and socialisation. Parent and community participation and involvement in decision-making can support programme implementation.

This chapter builds on these insights. We also draw on work on ECD service access, quality and standards conducted under the auspices of the Human Sciences Research Council (HSRC) in recent years (Dawes, 2003; Dawes et al., 2004a, 2004b; Biersteker & Dawes, in press).

A further and recent initiative that is useful for present purposes is the Learning Cape initiative. As part of policy to strengthen lifelong learning in the Western Cape province, the Directorate Industry Development of the Department of Economic Development commissioned the development of a basket of indicators to guide policy-makers and implementers in developing a Learning Cape. These will include input, output and outcome indicators. The indicators can be used actively to advocate and to mobilise, or more passively to review and take stock.

There are four broad audiences for the Learning Cape indicators – policy-makers, policy implementers (including both government and institutions), local government (through the Integrated Development Plan [IDP]) and the general public, including the media and commentators on public policy.

The Learning Cape approach (and the approach of this chapter) requires that indicators reflect constitutional requirements, provincial and national policy objectives, and provincial strategies, frameworks and targets. Indicators are being developed to cover three categories – the diffuse learning environment, initial learning, and adult learning. The Synopsis Report identified the following ECD-related indicators (DoED, 2005):

- Indicators for which data are available:
  - Bedrock indicators: the proportion of children 0–4 years attending ECD and the proportion of children attending registered Grade R classes;
  - Other indicators: the proportion of children recognised as vulnerable in terms of their weight, cognitive and physical development, HIV/AIDS status or poverty level (initial learning);
- Indicators requiring the collection of new data: establishment and effective functioning of a structured intersectoral body to facilitate more effective provision for all children aged 0–9 years in the Western Cape (initial learning);
- Indicators which would be desirable but have no viable data source: number of parent enrichment groups in existence (diffuse learning).

Articulation of Learning Cape indicators, and those developed for the purposes of this chapter, is essential if the system envisaged here is to be in line with those of the Western Cape province (and probably others that may be informed by the Western Cape process). The Synopsis Report suggests that, 'Different sectors or institutions or

places could be encouraged to expand the indicators in their areas' and is aware that (through this Indicator Project) 'ECD is already doing this' (DoED, 2005, p. 5).

As we experienced in preparing this chapter, the Learning Cape report comments on the poor state of South African statistics. The report notes that, 'Some of the most desirable indicators have no data…Some of the data for the indicators is already neatly captured. Other data will need dedicated data-capturing processes to be set in motion' (DoED, 2005, p. 4).

Apart from data challenges, Walters (2005) raises the challenge of who would be responsible for measurement in a cross-cutting indicator project such as Learning Cape. This applies equally for the ECD sector.

Data sources and challenges for monitoring ECD at home and in public programmes

National surveys

Experience around the world tells us that when developing indicators, particular emphasis should be given to data that are available from administrative data and regular surveys.

Dealing first with households as the environment in which most children are raised, the most convenient sources of information are the Census and regular household surveys such as the General Household Survey (GHS) and the HSRC's South African Social Attitudes Survey (SASAS), currently conducted annually. Apart from these there are specialist surveys such as the Demographic and Health Survey, the Food Consumption Survey, and the National Injury Mortality Surveillance System, which provide health and safety indicators. Government departments dealing with education, health, and social welfare keep administrative data relating to their areas of responsibility.

Unfortunately, with the exception of regular collection of child health data in the PHC system, which itself is subject to several constraints (see Chapter 5 in this volume), and broad socio-economic data – including infrastructure, income, employment and educational status – from the Census and general surveys, data on young children are very limited. Because Census data are collected by 'head of household', determining who the child's parent is presents problems in the case of grandchildren, other relatives and relatives under the age of 18, and variables such as education level cannot easily be matched to the primary caregiver of the child.

There is a need to have more questions aimed at generating monitoring data included in such surveys. This is a challenge though, as enumerators in the Census and interviewers in household surveys are not trained on matters pertaining to children. This was also the case with the national audit of ECD provisioning in 2000.

Administrative data

A major reason for the dearth of information on 0–5 year olds is that the vast majority of this age group are not in regular touch with services. This especially

affects the collection of child status/outcome data but also limits the availability of data on the primary care setting (Type 2 indicators – see Chapter 2 in this volume) to broader quantitative indicators which are easily collected in the context of general surveys. Up until the age of 18 months to two years, most children are reached at least partially by public PHC services, providing an opportunity to gather health data. Then, unless they attend an ECD service or present with problems at a health facility, the next point at which administrative data on young children can be gathered is the school. Household level information would require a general survey or special study of some kind.

Even where children are regularly in contact with services which are responsible for data collection, there are considerable challenges relating to will and capacity. Much would have to be collected at facility level.

The developmental disabilities screening process evaluated in 2003 (Michelson, 2003; Michelson et al., 2004) provides an example of the lack of will and capacity for data collection. Health workers in the Western Cape conduct developmental screening for moderate and severe disability when children visit health facilities for immunisations at 6 weeks, 9 months and 18 months as part of comprehensive PHC service delivery. Each screen should take approximately five minutes and health workers understand that early detection is a strong motivation for this activity. Although developmental screening has been identified as a national priority, it is significant that *none* of the other provinces felt that their PHC services were equipped to introduce the programme. Even in the Western Cape delivery is limited. In Michelson's study (2003) almost a quarter of facilities do not deliver *any* developmental screening, and only 11 per cent conducted screening according to protocol. No register of children who have failed the screening is kept, and as a result a major opportunity to capture the incidence of moderate and severe disability in very young children is lost.

Databases of the departments of education and social services on ECD services focus on facilities receiving subsidisation and do not take advantage of the opportunity to collect and report data on child outcomes and the circumstances of their families. In 2001, 10 per cent of facilities were subsidised by education departments and 15 per cent by social development (Biersteker, 2001, p. 8). If data were collected on child outcomes and the circumstances of their families, it would be of assistance to welfare planning at local level. Furthermore, when monitoring budget allocations, a persistent problem is that ECD service allocations are often not disaggregated from broader line items in provincial and local authority budgets (Biersteker, 2001).

Specialist surveys

Special surveys/evaluations allow for a more textured and composite view. This is valuable information when planning interventions, rather than simply for monitoring overall progress and flagging service gaps. Caregivers and other community members can play an important role in providing data on young children, as is the case with ECD practitioners. These play a vital role in identifying vulnerable children and accessing support. They also provide data on local views of children's development that may be of assistance in developing culturally sensitive developmental standards and indicators (Dawes et al., 2004a, 2004b).

Apart from providing data for monitoring populations of young children, the process of collecting data from caregivers alerts them to the status of their own children and to signs that indicate that the child needs attention. An important added benefit of household environment indicators (Type 2) is therefore to put caregivers in a position to play a more active part in promoting the development of their children in areas where professional help is distant.

The most widely used of these parent participation measures is growth monitoring (Faber et al., 2003). This is particularly important in homes where food is scarce or the nutritional content of the food is poor. Parent ratings of motor, language, social and emotional development have been utilised to good effect for research purposes both in South Africa and Tanzania (Stoltzfus et al., 2001; Kvalsvig et al., 2004; Faber et al., 2005). There are several aspects of the home environment that have been shown to impact strongly on children's emotional and cognitive development, which are not well represented in the measures presently in place. The HOME Inventory (Bradley & Caldwell, 1981; Bradley et al., 1996; Caldwell & Bradley, 2001) is a combination of questions and observations which tackles such important topics as caregiver responsiveness to the child in a series of scales. It has been adapted for use in other developing countries (Austin & Blevins-Knabe, 2003), and has been utilised for research purposes in this country (Richter & Grieve, 1991; Desmond & Kvalsvig, 2005). If robust versions of these scales and others used by researchers in this country were modified further and standardised, they could be utilised by social workers, community health workers and other community care personnel during home visits as individual assessments and as a measure of the level of care available to children in particular neighbourhoods and communities. This is especially important in communities badly affected by the AIDS epidemic, where elderly or very young caregivers may be responsible for more children than they can provide with adequate care, and where the children themselves may be traumatised by the illness and death of their parents, and need specialised attention.

Other indicators which fall into this category of 'available but not well researched for local use', are indices of child problems and caregiver problems which take account of the number of serious life events a caregiver or child has experienced.

Population disaggregation and spatial units for data collection

ECD data are limited unless they are disaggregated by age, poverty levels, disadvantage or disability in order to contextualise provision and to ensure equity. For programme planning purposes it is also extremely important to have data at the lowest possible spatial unit. For example, the Western Cape DoSD is developing a plan for rolling out ECD services. To facilitate development of a contextually appropriate plan, profiles of the ECD context have been developed for each social services region. These include demographic information and indicators drawn from a variety of sources – population by age, access to ECD programmes, economic and poverty indicators, health and nutrition data, HIV prevalence.

This process has presented a number of challenges because different departmental regions are not coterminous, and overlapping boundaries make it difficult to be precise. The increasing use of the ward as a unit of disaggregation and of global positioning system (GPS) mapping will assist in overcoming these obstacles.

However, this may not be the best solution. Electoral wards are political spatial units. They may include areas with heterogeneous populations, for example in terms of poverty. Overrepresentation of more wealthy residents will present a false picture of the poverty situation.

A second challenge is the difficulty in accessing data from different government departments (see Dawes, 2003), and the fact that in many cases key information has not been collected, or not collected in a way that is useful. The reliability of data collected at service sites is also suspect in many cases. Despite these limitations, a district level approach such as described in the case of the Western Cape, has provided a far more textured picture of the service gaps in each district.

Finally, there are many stakeholders who in different ways are capturing data on services and the well-being of young children (for example ECD facility intake forms). There is a critical need to collect this information in central locations where it is accessible. Gauteng province seems to be moving towards a single database of departmental information related to young children. This is planned to include information such as birth registration and grant information as well as information on ECD services.[7]

Indicators of well-being for the ECD phase: an ecological approach

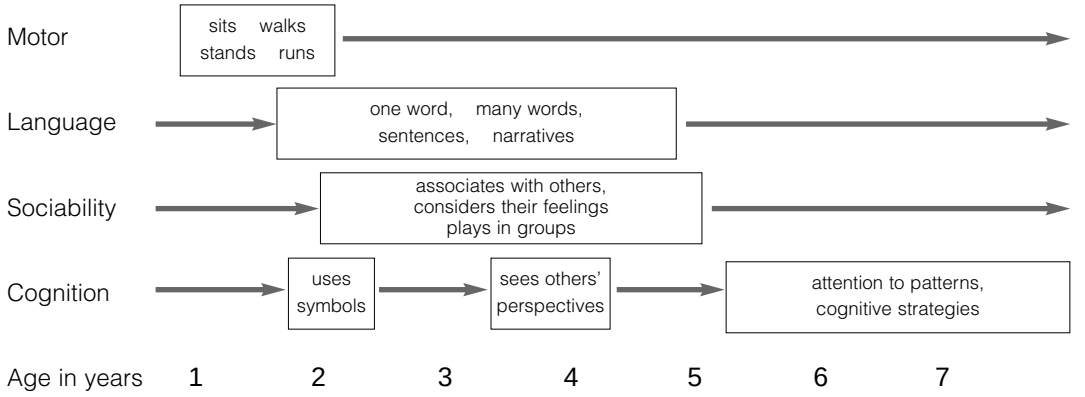
There is wide acceptance that monitoring and assessing child well-being requires an ecological approach that takes account of the child's developmental needs, parent/caregiver capacities to respond appropriately and wider family and environmental factors, including service accessibility and interventions to support those at risk (see for example Woodhead, 1996; Dawes & Donald, 2000; Departments of Health, Education and Employment, & the Home Office, 2000; Dawes et al., 2004a, 2004b; the UNICEF extended model of care). However, challenges relating to appropriate measures and means of data collection have left large gaps in what is monitored.

Monitoring in the ECD sector has focused on neighbourhood/surrounding environment (Type 3) indicators associated with child vulnerability, and service inputs, particularly in terms of access (Type 4) and attempts at assessing some aspects of quality (Type 5). As noted earlier, child outcome data (Type 1) are limited to that routinely collected on health and nutrition in the very early years. For safety and protection information there is little age disaggregated data. Commonly available household environment information collected in surveys focuses on infrastructure and services (for example, water and electricity), employment and levels of education. More qualitative information on care environments and child outcomes is restricted to small-scale research studies.

ECD is holistic and cross-cutting and, as noted above, it is for this reason that it is the responsibility of several sectors, levels of government and agencies. This complexity means that the data environment is not co-ordinated, and there is no mechanism at present to draw information together to inform policy and programming.

It is evident that development proceeds unevenly: individual differences in the timing of growth spurts and the appearance of developmental milestones mitigate against hasty conclusions about developmental delays in individual cases. In general terms, different domains come to the forefront of development at different times and indicators must take account of this.

Figure 9.1 The uneven pace of child development with rapid progress at different times in different domains



For most indicators, particularly community and service-related indicators (Types 3, 4 and 5) and some relating to the care environment (Type 2), it would be important to distinguish two main age ranges:

- Birth to two years – when the child's well-being is extremely dependent on the primary caregiver/s and the supports for development in the home;
- Three to five years – when the child becomes increasingly independent and other influences such as ECD programmes and peers become important mediators of experiences.

Early indicators of child well-being concern the presence of nutritional deficiencies or toxic substances which might affect brain development in utero and in infancy. These give way to concerns about stimulation and emotional well-being. This is not because stimulation and emotional support are unimportant at any age, but because there are few reliable indicators of cognitive and emotional disturbance in infants. These aspects of child development are easier to detect in older children as their behaviour becomes more differentiated and varied. Indicators for development in the three to five age group, for instance, would focus more directly on social and communicative development than on motor development because that is the domain where rapid change is occurring.

Obtaining reliable data on psychosocial outcomes for children is particularly difficult for a number of reasons: the unreliability of outcome measures for very young children (see for example Evans, 2005); the rapid developments of the early years require different indicators and measures both for the changing inputs in the care environment and child outcomes at different ages/stages, making this a large task; and finally, there is the challenge noted by Dawes et al. (2004a) of developing a set of culturally appropriate standards broad enough to capture the capacities that children

require to take advantage of learning opportunities of both their local and wider world (schooling) in the culturally and economically diverse South African context.

Influences in the home are most salient in very young children, and neighbourhood and school influences have more effect later on (see Chapter 4 in this volume). This is an important principle in the construction of indicators for the purpose of designing interventions to alleviate the effects of poverty on children. It has links to the concept of social capital, which emphasises the role of neighbourhood and community as influences on the home environment.

A recent study in Britain (McCulloch & Joshi, 2001) showed that neighbourhood conditions were significant predictors of children's development at around the time they go to school, but both the size and the statistical significance of neighbourhood effects were less than the estimated effects of family level conditions. McCulloch and Joshi conclude that 'families should still be viewed as the key agents in promoting positive development in children' (2001, p. 589).

The relationship between family and community poverty in South Africa functions differently: with the geographic separation of different ethnic communities during the apartheid era, family and neighbourhood poverty still function together in many places because both are based on the purposeful underdevelopment of certain communities. For this reason it is not possible to plot their effects separately. The experience of developed countries can still, however, be a useful reminder of the importance of home circumstances for children's development, and the need to have this reflected in appropriate home-based indicators and interventions, particularly in the birth-to-five age group (Korenman et al., 1995).

Indicator sets for the ECD phase

It is useful to group indicators into sets for particular purposes. Sets may include several indicator types depending on the rationale for their inclusion.

Improvements in conditions for children are usually brought about by the interplay of several interventions and facilitating circumstances (Oyewole, 1984; Kvalsvig, 1998; Romani & Anderson, 2002). This means that although indicator systems should be simple to implement, they should yield sufficient complexity of information to allow analyses which will improve intervention. This necessitates bringing together (grouping) an array of measures so that interventions can be fine-tuned to obtain maximum benefit and coverage.

The outcome of optimal child health (Type 1), for instance, requires at least good hygiene, nutrition and safety in the home (Type 2), combined with access to clean water and sanitation, and a good preventive PHC system (access to an antenatal clinic and a well baby clinic) (Types 4 and 5). This approach permits one to measure outcomes of children living in a particular area (see chapters 3 and 4) in relation to the opportunities and threats to development that exist in the home and community, while also tracking the availability and quality of services.

As a middle-income country, cost is always a factor in South Africa in determining whether an intervention can reach the children who need it, and be sustained. Costs can be contained by analysing the relative contributions of a range of factors.

There are some obvious criteria in determining the most urgent needs for sets of indicators: prevalence of the phenomenon, seriousness of the consequences for the child in later life, and feasibility of intervention.

Top priority for intervention, and therefore for indicators, must always be the conditions which threaten the very survival of children, and although matters have improved, South Africa does not have a good record. A notable exception is the successful control of malaria. Children are especially vulnerable to this parasite infection, and it causes high rates of morbidity and mortality. Ultimately, the funds for an expanded malaria control programme were made available out of concern for economic development, rather than the protection of children's right to health through creating healthy living conditions. Nevertheless, it remains a good example of an intervention based on good geographically referenced indicators, a sound monitoring system and well-researched control principles.

A set of indicators might be devised to detect places which are unsafe as living areas for children, or they might be developed to detect a threat to the care of children in the home.

The following are two examples of sets which can and should be developed and linked to effective action (see also chapters 3 and 4 in this volume).

An aggregated indicator of serious risk to children

In South Africa there are places of concentrated risk where the proportion of children living in poverty, vulnerable to nutritional deficits and frequent infections, and subject to both physical and mental trauma, remains high. Some of these are urban neighbourhoods (often informal settlements) and others are rural enclaves, where children are at risk simply by living in the area. Some areas have high levels of crime and violence and others are exposed to environmental pollutants; toxic substances like asbestos or pesticides make certain areas dangerous for all who live there, particularly children. Aggregated indicators marking unacceptably high levels of risk for children would assist government departments to assess priorities. These areas of high risk should be geographically referenced and given disaster status so that special funding can be assigned to the problems they face.

A set of indicators to support interventions in the AIDS epidemic

The AIDS epidemic is geographically dispersed but presents extremely high risk for large numbers of South African children. Some work has been done but, in view of the scale of the problem, not enough to protect a high proportion of the many thousands of affected children (see Chapter 5 in this volume). A most serious concern from the home-care perspective is mother-to-child transmission of the virus, resulting in a range of risks to child survival, health and well-being. For those children whose parents and caregivers are infected, we require ways of assessing alternative caregiving environments. Institutional living is known to affect the development of children, probably through lack of opportunity and motivational conditions for children to learn new skills (Morison & Ellwood, 2000). What alternative can be offered in overburdened and poverty-stricken community homes, and how are the agencies which support families affected by HIV/AIDS to judge the

extent of assistance needed? These questions do not have simple answers but this should not deter us from seeking out indicators of quality alternative care.

Linking indicator sets to training and action

Primary school educators, pre-school practitioners, community health workers and community ECD workers are all well placed to identify children who are experiencing problems at home, given the right tools and training. Police and welfare agencies, too, have special units for the protection of children. The legislation exists which should encourage reporting of cases of abuse and neglect in the home, but in practice reporting routes are not clear and personnel training is weak in some instances. Practitioners may also be reluctant to report cases because the time lag between reporting and effective police and court action is so great that the child is placed at increased risk by the report.

In ECD sites, follow-up of behaviour problems or absenteeism is needed to identify those pupils whose home circumstances are distressing enough to interfere with their education. Educators themselves could then give advice on accessing grants, so that child-headed households are supported, and education about healthy living with a focus on psychosocial and nutritional support. Much more could be done to train staff in the use of indicators, and to develop school and ECD centre policies for action or referral.

ECD practitioners and other community workers at household level require simple sets of indicators and training in reporting strategies so that statistics can be kept at district level and quickly followed by action when necessary. For community workers who have a basic training in childcare, the foundations have already been laid for more effective action, and their home visits and close ties within the community make them the most valuable resource we have for reaching children in distress. While volunteerism in community work is laudable, good support systems, a reasonable wage, and a planned career path associated with community work would send out a signal that this kind of work is important.

Indicator sets and child rights

Arnold (2004, p. 5) considers that the following aspects of early childhood programmes link to three fundamental areas of a child rights approach:

- Attention to the whole child;
- Working at multiple levels to meet our obligations to children;
- Addressing discrimination and exclusion.

The indicator sets suggested below are based on the child rights categories from the CRC as they were interpreted at a DoE workshop on ECD in Durban in November 2004, where the government's commitment to children's rights was restated with an emphasis on effective service delivery and integration of services.

It is clear that many sets have bearing on more that one category of child rights. Indicators such as income and expenditure refer to poverty, which was characterised by Horowitz (2000) as a set of intensely disadvantaged circumstances that negatively impacts on development (see also chapters 3 and 4 in this volume).

Sets such as the 'Need for stimulation' and the 'Need to play' overlap to a large extent, and the decision to place an indicator in a particular category is largely a matter of emphasis.

In all cases the choice of the sets below has been driven by the need to locate children who are living in suboptimal home circumstances and to understand what the risks are and how these might be changed, in the very practical sense of, 'What is possible? How many children are affected? How serious is this? Who might intervene? What resources would they need?'

Basic needs set

In terms of children's rights, children are entitled to a healthy diet, a safe home, clothing, safe water and sanitation, and healthcare. Compared with adults, children are especially vulnerable to poor provision in these areas: they have energy needs for growth, and are immunologically immature. In South Africa the impact of poor health and nutrition on children's psychosocial development is considerable and needs attention if we are also to move on to consider 'positive well-being' in the way suggested by Ben-Arieh (2000).

In an attempt to build a standards approach to child well-being in South Africa (Dawes et al., 2004a, 2004b), we tried to identify the factors which differ in importance and impact from those in developed countries of the north. The most noticeable of these were health and nutrition. In Africa, the lack of basic services to support health places major constraints on the well-being and psychosocial development of children. Macronutrient and micronutrient deficiencies, chronic parasitic infections and frequent episodes of respiratory and diarrhoeal infections, apart from causing pain and discomfort, impact on the socio-emotional and cognitive development of children in ways that are not fully understood. They act as constraints on children's mood and energy, and consequently on their freedom to diversify their activities. This is discussed in detail in Chapter 5 in this volume. The home environment indicators included in the core indicators table in Part 2 of this volume are directed only at identifying protective factors at household level.

Home environment indicators for nutrition should identify trends in preferential access to food and other resources within the household. There is, for example, a possibility that some orphans may not be accorded the same access to food within their replacement homes as members of the more immediate family. The evidence from other countries for poorer nutritional status among orphans as compared with non-orphans, is mixed, with some studies showing no significant differences in stunting (for example Lindeblade et al., 2003, in Kenya) and others showing increased stunting among orphans (for example Ainsworth & Semali, 2000). Overall, at very low levels of income, it would appear that the AIDS epidemic affects households across a community rather than just the households with infected individuals, because food production and the transfer of agricultural skills are disrupted in the area. This seemed to be the case in a recent study in the Drakensberg mountains (Desmond & Kvalsvig, 2005) where a combination of poverty, winter drought and cold, and ill health or bereavement in many families had affected the nutritional status of children throughout the community. These dynamics need to be understood for intervention purposes.

Care and safety set

In an analysis of the concepts and measurement of care and nutrition, Engle et al. (1999) used the UNICEF definition of care which is the practices of caregivers that affect nutrient intake, health and the cognitive and psychosocial development of the child. Engle et al. mention six types of activities practised by caregivers:

- Care for women during pregnancy (rest and nutrition);
- Breastfeeding and feeding of young children;
- Psychosocial stimulation and support for development;
- Food preparation and storage;
- Hygiene practices;
- Care for children during illness.

For these activities caregivers would require 'appropriate education, knowledge, and beliefs, health and good nutritional status; mental health, lack of stress, and self-confidence; autonomy, control of resources, and control of intrahousehold allocation; reasonable workloads and adequate time available; social support from family members and the community' (Engle et al., 1999, p. 1310). Of particular relevance to the question of measures and indicators in the South African situation for women in the communities hardest hit by AIDS is the issue of caregiver mental health. Some local work on this issue has been done in recent years (for example Cooper et al., 1999; Brandt, 2005a; Swartz et al., 2005; Brandt et al., 2006). Further indicators for child injury and safety can be found in Chapter 7 of this volume.

Set 1: Optimal development

Intuitively, an ordered and calm family environment would seem to be advantageous, and there is evidence that this is so. Petrill et al. (2004) report that results from a study of pairs of twins in England and Wales show that growing up in a calm, well-ordered household was a significant predictor of cognitive skills in three and four year olds, independently of the effects of socio-economic status. They used the short form of an instrument called CHAOS (Confusion, Hubbub and Order Scale) (Matheny et al., 1995). In South Africa, the degree of organisation in the home might be an important source of individual differences in children's cognitive abilities in poverty-stricken communities, and one that can be improved through intervention and support from community health workers and community ECD workers or, in the case of children with disabilities, community rehabilitation workers. Although this will require the testing and validation of the CHAOS instrument in a South African setting, or the compilation of a new locally devised scale, it would appear to be a promising line of investigation because it would link directly to interventions already in existence, and give early warning of families under stress.

'Risk' has different meanings in different cultural groups (Liddell, 2002), as does 'optimal development' (Okagaki & Sternberg, 1991). Ogbu (1982), in his ethnographic accounts of the language development of African American children, showed how conventional research practice using white middle-class standards was not useful in understanding language competencies in minority groups. In formulating indicators of optimal development for South African children, Ogbu's work reminds us to avoid simplistic definitions reflective of only one cultural ideal.

A historically segmented society has given rise to groups that are economically and culturally distinct, and that have only recently been exposed to each other's points of view on child rearing.

Set 2: Child responsibilities

The association between parenting style and cognitive development differs across cultural contexts, and probably concerns different goals in the socialisation process (Darling & Steinberg, 1993). Obedience to authority and respect for elders is frequently cited as an important child-rearing goal in many African communities (see for example LeVine et al., 1994) and family structures vary as a function of both culture and environments (urban and rural), as do attitudes towards corporal punishment. Careful selection of indicators is needed so that blame is not attached to practices which are culturally sanctioned.

Many children in poor communities in South Africa are expected to assist to a greater or lesser degree in running the household (Bray, 2003). In a sample of five-year olds in a rural Zulu community in KwaZulu-Natal, children gathered firewood, ran errands to the local store, fetched water, swept the yard, washed dishes and clothes and herded cattle (Kvalsvig et al., 1991). These activities were regarded as children's work, and the children were expected to perform them efficiently, although allowances were made because they were still very young. In another study exploring age-appropriate behaviours, the nine-year-old participants from a rural area in KwaZulu-Natal related stories of their competence in household chores with some pride (Dawes et al., 2004b). This cultural practice of assigning responsibilities may be viewed positively as part of socialisation, as including children in family activities and making them feel valued, and as practices which allow children to be absorbed into other households when necessary, without placing an intolerable burden on the adult caregivers. In the context of an AIDS epidemic it has clear value in enabling grandmothers, aunts, and older siblings to take over the role of caregivers when infected parents become ill and die.

In other societies, different socialisation skills are valued. In many developing countries throughout the world children are included in activities which are regarded as adult responsibilities in developed countries, and there is often much for the child to gain. As described by Robson (2004), Nigerian children not only acquire commercial skills by helping family members buy and sell, but they also increase their general knowledge of their community through running errands.

The practice does, however, come at a cost in a modern world. Children who spend all their after-school hours working at chores do not have time to develop skills and talents more suited to a modern job market when they come of age. Reading skills in particular may suffer. Indicators of where the positive value ends and exploitation starts will have to be validated against performance on educational tasks and evidence of health and mental health, and seen in the light of the family's needs. If children have no time to look at reading materials, play games and are frequently tired and depressed, this would indicate that they were being burdened with too much work. The evaluation should be sensitive to the cultural value placed on these skills and functions, and the family's needs.

Set 3: The need to play and the need to participate

During play activities children get an opportunity to practise behaviours without serious consequence (as in rough and tumble play), to explore and to exhibit high levels of social, cognitive and linguistic skills (Pelligrini, 2001). Consequently, from a rights point of view, a home environment which allows for and encourages these pleasurable activities is also one in which there are opportunities for the child to learn a wide variety of skills safely and effortlessly.

Set 4: The need for identity

The meaning of identity shifts with the child's age. In the 0–2-year age range, the relationship with caregivers, 'attachment' to constant figures in the infant's environment as explored in the work of Bowlby (1969) and Ainsworth et al. (1978), is a key developmental concept. Disruptions of this process have been noted in the case of autism on the one hand and, on the other, the indiscriminate attachment of institutionalised children who have had a series of transient caregivers. By the pre-school ages (three to five years), children explore gender identity through their fantasy play, constructing the world as they experience it, mainly through family role models. It is a time when caregivers set limits and children test their autonomy by challenging these limits. Parenting style is thought to have an important shaping effect on children's behaviour, and may vary from neglectful to indulgent, and be authoritative (clear and firm) or authoritarian (more punitive) (Baumrind, 1966; Pratt et al., 1988). In the basic education phase (six to nine years) children are learning to function outside the immediate family. They start to explain who they are to others, their family names, where they live, what their family members did and said.

Proposed indicators for ECD

Type 1 indicator: Child status

Research and theory about desirable child outcomes, predisposing conditions and their indicators and measures has been from a predominantly western perspective. Even core features may be expressed differently in different communities and there is the 'lively question about measurements used to evaluate children's cognitive, psychosocial and motor progress and whether these can be used outside their country of origin' (Penn, 2004, p. 9).

Physical well-being is critically important in this period when infants and young children undergo the rapid growth of the first five years. Due to the immaturity of the young child's immune system, they are more at risk for developing infection and disease. The birth to five years period is also a sensitive time for emotional development and trust, and for cognitive and language development. Within these years there appear to be periods of particular sensitivity for particular outcomes, for example emotional control from nine months to two years, peer social skills from three to five years, and so on (Evans, 2005). There is cultural and contextual variation in the age ranges but what is implied is that indicators of child outcomes need to be extremely sensitive to age-related changes.

Indicator domain: physical well-being and motor development

On the basis of an extensive literature review and consensus-building process, Pollard and Davidson (2001) of the Center for Child Well-being[8] identified six critical elements for this domain, of which nutrition, preventive healthcare, physical activity, and safety and security would be most relevant for the birth to five year age range.

Of these, standard health and anthropometric status indicators are covered, as are accident- and violence-related morbidity and mortality in companion chapters (see chapters 5 and 7). Screening for developmental disability (see also Chapter 10) is proposed as a priority, as early identification is key to interventions which will maximise the well-being of children with disabilities.

Indicator domain: social and emotional well-being

Key elements mentioned in the literature include development of emotional regulation; self-control; development of trust and autonomy (related to secure attachments); development of self-system including identity, self-concept, and self-esteem; development of empathy and sympathy; and formation of positive social relationships (Departments of Health, Education and Employment & the Home Office, 2000; Pollard & Davidson, 2001; Rhode Island Kids Count, 2005). Because of the difficulties of reliable measurement for children under three years, measures in this domain will be restricted to children from three to five years:

- Age-appropriate interactions with peers;
- Positive sense of self-confidence, participation;
- Self-regulation appropriate for age.

Indicator domain: cognition and language

This domain includes perceiving, remembering, conceiving, judging and reasoning in order to obtain and use knowledge as well as language skills. As for social and emotional well-being, measures in this domain will be restricted to children from three to five years:

- Curiosity/exploration;
- Approach to learning – motivation, persistence, concentration;
- Problem solving;
- Receptive language;
- Expressive language;
- Literacy and numeracy skills.

The focus for cognitive well-being has been on approaches to learning (which is recommended by Myers [2001] though seldom included in United States standards) and communication skills rather than specific concepts, though these are often the focus of ECD curricula and parent aspirations. However, in view of recent concerns about the poor literacy and numeracy outcomes of children at grades 3 and 6 levels – outcomes which are attributed to the lack of early literacy and numeracy experiences prior to school – these should be an indicator area.

Myers (2001) notes that the focus in standards for child outcomes has been on children aged three to five. This is because for children younger than three,

measurements other than physical assessments tend to be unreliable (Evans, 2005). For younger children the focus in the choice of indicators has therefore been on physical indicators. These include the proportion of children under two years who require referral after developmental screening, and the proportion of children 18 months to three years with age-appropriate gross and fine motor skills and those with age and culturally appropriate self-help skills (for example, feeding/dressing self).

The DoH's Developmental Disability Screen is proposed as a measure of child development outcomes for children under two years. This should be routinely done for all children at the target ages of six weeks, nine months and 18 months. PHC statistics on an annual basis would be the data source. Additional physical and self-help indicators are proposed for children aged 18 months to three years, to be surveyed from time to time.

For children aged three to five years the following indicators are good predictors of child outcomes and indicators of well-being: age-appropriate fine motor skills, appropriate social behaviours with adults and peers, age-appropriate participation, interest in or a positive approach to learning, early numeracy skills and language and literacy development.

Fine motor skill is used as a physical indicator in the 17-state Getting Ready project (Rhode Island Kids Count, 2005). This is more sensitive than indicators of gross motor outcomes and relates to skills needed in the schooling system. Social behaviours and age-appropriate participation, which is linked to socialisation, self-esteem and confidence, and self-regulation are key indicators and relate to the OECD's (OECD, 2004) key competency areas of 'Interact in heterogeneous groups and act autonomously'.[9]

Poor language, literacy and numeracy outcomes for children in South African schooling, which impacts on their ability to succeed both in the schooling system and the globalising economy, are a particular concern. Lack of appropriate early numeracy and literacy experiences is a strongly contributing factor. Indicators to track these have therefore been included. These relate to the OECD (2004) key competence area 'use tools effectively'.

With regard to measures of child outcomes, preliminary work and consensus building for the development of appropriate indicators for South African children aged three to nine years has generated a series of psychosocial indicators (Dawes et al., 2004a, 2004b). These indicators cover several areas in the domains listed above and with further development could be tested as a measure of psychosocial well-being of children aged three to five years. ECD practitioners and caregivers involved in other organised projects could, once trained, routinely assess whether or not children meet these standards. This could assist them in adjusting their interactions with children to focus on developing or extending different capabilities, and be included as part of established reporting to parents on child progress.

Special surveys of children who do not access ECD services should be undertaken from time to time.

An alternative, as an interim measure until more children have access to ECD services, would be to undertake screening on entry to Grade 1. As well as giving an

indication of child outcomes, there could be a comparative study of children who attended ECD centres or programmes (by years of attendance), who attended Grade R only, or who had no access to ECD services. This would be a strategy to track the improving quality of children coming into school. The Western Cape education department is developing an activity programme for Grade R children to be completed in the first three weeks of school which will enable educators to assess developmental status across these areas.

Type 2 indicator: Family and household environment

In the pre-school period, the main influences on the young child are home-based, and family members are the principal mediators of community influences (Dawes & Donald, 2000). Whatever the specific cultural childcare practices, healthy neuro-physiological, physical and psychological development of a child requires nurturant, consistent caregiving by responsive caregivers (Richter, 2004). Inadequate, disrupted and negligent care has adverse consequences for the child's survival, health and development.

Numerous factors can influence the quality of caregiver–child relationships, for example, maternal health (including HIV/AIDS), depression, stress, mood and emotional state (Richter, 1994, 2004; Brandt, 2005a). Household income and the structure of the household will influence the capacity of adults and availability and time to care for young children and provide indications of whether the household may be in need of social support. For example, households with single caregivers with children or child-headed households may be income-poor and vulnerable to stress.

Family environments which lack social support and integration (Dawes & Donald, 2000; Departments of Health, Education and Employment & the Home Office, 2000), are HIV affected, where there is domestic violence and/or substance abuse, or where children are very demanding through illness or disability are especially at risk and in need of targeted interventions (Brandt, 2005a).

Living conditions such as availability of shelter, water, sanitation and a safe, clean power source will have health and safety consequences for the child, and the knowledge and capacity of their caregivers to protect them in adverse environmental conditions is key.

Maternal/primary caregiver education levels are strongly associated with children's survival and development. Children's capacity to learn is supported by families with the necessary interest, knowledge, materials and resources to support emergent literacy (Woodhead, 1996; Willenberg, 1997).

While the same broad development principles apply to children wherever they are, their relative importance differs across and within countries. In addition, in South Africa a particular history, social, economic and political milieu, geography and a terrible epidemic have brought some aspects of the home-care environment for children into sharp relief and have implications for a child rights approach as described in chapters 1 and 2 of this volume. Taking these into account, it is possible to identify groups of children whose family and home circumstances compromise their rights under the CRC and the Constitution. They have been termed 'orphans

and vulnerable children' and usually come from formerly disenfranchised communities where basic services have not been established.

Certain conventions have been observed in constructing the indicators in Part 2 of this volume. Because the home-care environment has its most powerful influence on young children, indicators are discussed for the 0–5 age group. The intention is not to ignore the importance of the home environment for older children – adolescence, for example, is an important transitional period – but the parameters of support for older children are different.

So while there are obvious interconnections with other chapters in this volume, the indicators developed for ECD are concerned with *the home conditions thought to promote child well-being* as opposed to indicators of poor physical and mental health, and developmental delays such as birth defects, infections and child abuse. In this sense they are distal rather than proximal (in the health terminology utilised by Sanders and Chopra, 2004), and strongly concerned with promoting resilience in the tradition of Werner (1989; see also Werner & Smith, 1982) and Rutter (1979).

Nevertheless, it is important to note that most of the individuals living in poverty in this country are children, and that there are more low birth weight babies, children affected by AIDS, and children with disabilities in poverty-stricken homes than there are in more prosperous circumstances. Consequently, rights-based indicators for the home environment must be sensitive to the rights of all these children, and should maintain a cautious watch on risks in the home.

A rights-based approach carries with it the corollary that if a child's rights have not been met, then someone is to blame. The individual or institution can be charged and the court's recommendations can be enforced through the judicial system. This has advantages, particularly in cases of abuse and deliberate exploitation of children. In the context of homes and families in desperate circumstances, however, children's rights are disregarded through a lack of resources or through a poor understanding of how to proceed. Indicators will cease to be effective if parents and caregivers feel threatened and blamed when they are doing the best they can under the circumstances. A fundamental principle in developing and using indicators for the home environment is that caregivers participate in the process and see the benefit.

The mediation of health and nutritional status and safety factors at household level is not considered here as they are covered in other chapters in this volume (see chapters 5 and 7). There is also an overlap on some of the focus issues here, including on caregiver–child relationships and home indicators which optimise development, as well as on vulnerability measures.

Proposed indicators for this section include caregiver warmth and responsiveness to the child; guidance and control; age-appropriate and positive forms of discipline; caregiver education levels; opportunities to play, explore and interact with different objects in the environment; opportunities to participate in simple household tasks with caregivers; exposure to print and writing materials; and verbal interaction with caregivers. Caregiver health and well-being is also a key indicator and is linked to a proposed indicator of household vulnerability.

Measures of caregiver interactions that promote child well-being and opportunities for social and cognitive development in the household could be items included in a

household observation scale and interview. Alternatively, as discussed above, many of these indicators could be measured using an adaptation of Caldwell and Bradley's HOME Inventory.

For measuring household vulnerability, adaptation and use of a vulnerability measure such as that developed by Speak for the Child in the context of AIDS-ravaged western Kenya is suggested (AED, 2002).[10] It comprises a vulnerability scoresheet which helps them target interventions where they are most needed. The interview/observation picks up stress factors such as illness, lack of food security, whether carers of under fives are older or children, as well as whether children have the necessary documents, signs of emotional distress, experience of stigma, and so on. This could be administered in house-to-house surveys in neighbourhoods where there is high vulnerability, and/or as part of the Home and Community Based Care Programme, or by other auxiliary/family workers employed by the public sector or non-governmental organisations (NGOs).

Type 3 indicator: Neighbourhoods and the surrounding environment

As noted in Chapter 4 of this volume, child well-being is affected by a wide range of neighbourhood factors; three in particular are key to their well-being. These are child poverty levels disaggregated by region and local unit, public violence, and crime and accident statistics for the area. These issues will not be dealt with here as they are covered in other chapters in this volume.

Type 4 indicator: Service access

Important service access indicators for children, in addition to health-related and child protection services (see chapters 12, 13, 14 and 16 in this volume), include birth registration, social grant access, access to early childhood services of different kinds, including access to additional support for children with special needs, and budget allocations to ECD services.

Access to ECD services is limited, particularly as a consequence of the lack of funding, especially in poor and rural communities. Budget studies reflect low funding allocations to ECD as a major concern (for example Biersteker, 2001; Nomdo & Mbebetho, 2004; Biersteker & Dawes, in press). Budget allocations for ECD services should therefore be examined in the same set as that which includes access (even though for other purposes they may be used to assess service quality; quality is fundamentally – but not entirely – related to financing).

For children who are able to access ECD centres, the distinction between enrolment and attendance is important. For example, in many areas of South Africa the authors have observed that parents only send children regularly if the facility provides food. Where families are stressed and lack income, children may attend less often or drop out.

The inclusion of an indicator for children who are not in a facility but whose caregivers participate in a programme aimed at supporting their parenting is important. This follows on Myers's (2001) suggestion and is appropriate in South Africa which, like many other countries in the south, is increasingly exploring

programmes which focus on educating and involving parents and other family members. Once implementation of the Social Cluster's Expanded Public Works Programme and the National Integrated Plan for Early Childhood Development is under way, parent programmes are likely to scale up considerably (Biersteker & Dawes, in press). Evidence of positive child outcomes from such programmes is related to regular inputs (Evans, 2005) and it is proposed that programmes only be included where participation had practical as well as theoretical inputs, with regular sessions for at least four months.

To be useful in monitoring non-discrimination in access to services and whether policy targeting to specific groups is rolling out, service access data will need to be disaggregated by several variables. Age is highly relevant as one would not expect many infants to be placed in out-of-home care, unless parents were working or sick, but by the age of five years, high service uptakes would reflect that public policies are being implemented. In view of the increasing needs for household support in the context of HIV and AIDS, the availability and usage of day care by younger children should also be monitored. Increased child support grant uptake with age suggests that there may be a delay with the applications process, possibly due to difficulties in accessing birth registrations (ELRU, 2004).

As Myers (2004) notes in his background paper on ECCE for the 2005 EFA report, part of assessing ECCE provision is determining how well programmes reach the most vulnerable and disadvantaged children. In South Africa it is well documented that services are harder to access by poor, rural and marginalised communities. White Paper 5 on ECD (DoE, 2001a) targets children with disabilities, poor children, and those infected with or affected by HIV. Regional disaggregation of data is recommended to assist with programming and overall monitoring of participation, including social groups likely to be excluded. Data categories should include gender, population group, children with disabilities, refugee children, children living in poverty and those with compromised care circumstances.

For service access, both availability and affordability are important. Service cost is recommended as an access indicator in India (M. S. Swaminathan Research Foundation, 2000). This may mean, in the case of home affairs and health services, that they are located close to communities as transport may make them unaffordable even if the service itself is free. In the case of ECD centres, the majority of them depend on income from fees, which makes them inaccessible to children from poor families (Biersteker, 2003a).

Proposed service access indicators therefore include the proportions of children with birth registration documents; proportion of eligible children (0–5 years) in receipt of social grants; enrolments and attendance at ECD centres and in Grade R classes; proportion of children whose attendance in ECD programmes is subsidised; access to preventive and emergency health services; access for children with additional support needs,[11] who are receiving this (either through health services or Grade R); proportion of children whose parents have participated in parenting/parent support programmes; and budget allocations to ECD services by national, provincial and local government. Most data sources for this information will be regular departmental records.

Type 5 indicator: Service quality

As Myers (2004) points out, assessing the quality of provision in ECCE is more challenging than for schooling. Achievement tests and competency assessments are largely absent at this level. Further, a wider range of outcomes than those related to learning achievement is needed to judge programme quality, especially in developing countries.

While all children have basic needs to be addressed in a service that claims to provide quality, decisions about what constitutes quality are complex and contested. Pence and Moss note that 'quality in early childhood services is a constructed concept, subjective in nature and based on values, beliefs and interest, rather than an objective and universal reality' (1994, p. 172). Woodhead (1996) takes the position that while quality is relative it is not arbitrary and that it is important to make values explicit. Western value-orientated Developmentally Appropriate Practice (DAP) (Bredekamp, 1987), which is criticised for insensitivity to cultural diversity in parenting practices (for example Penn, 2005), has had enormous influence on notions of quality, and therefore on dimensions of quality measured and studied. However, elements commonly found to be associated with quality outcomes in a range of countries and circumstances have been suggested by Myers (2001). Hyde and Kabiru (2004), in their paper on improving the quality of basic education in sub-Saharan Africa, also use these as a reference point. Key elements are listed below together with reference to other studies and monitoring projects that have used them.

Facilities and their surroundings/physical environment

These include infrastructure, access to water and sanitation, safe and secure premises, cleanliness, and space to play. This was also used as a quality index in the nationwide audit of ECD provisioning (DoE, 2001c).

Materials and equipment

This category includes play equipment for inside and outside, learning materials, consumables such as paper, paint, and so on. Recent studies have found this to be associated with positive child outcomes (High/Scope Educational Research Foundation, 2004).

Trained caregivers/education agents

Assumptions are that trained caregivers will be knowledgeable about how children develop, and that they will interact with children in a consistent, respectful, supportive, and unthreatening way. Dlamini et al. (1996) support this as a quality element.

Qualification level is often used as a quality indicator but this is not always associated with better outcomes. Weikart et al. (2003) found better cognitive and language outcomes related to the teacher's educational level. Rhode Island Kids Count (2005) use teacher credentials as a measure, as did the DoE (2001c) in its Educator Index of Quality. The Head Start Family and Child Experiences Survey found that the higher a teacher's educational level, the better the classroom quality (Tarullo, 2002). However, Dlamini et al. (1996) and the DoE's (2001d) reception year

pilot project found that training was important but level of training was no guarantee of a quality service.

Services/curriculum

A curriculum that takes a holistic view of a child's development; provides a variety of relevant, stimulating and enjoyable learning experiences; encourages children to play, explore, and initiate their own learning activities; and adapts to the capacity of individual children is proposed as one which is associated with positive outcomes. To take account of the child's right to participation, the curriculum/service should be responsive to input from the children (Lansdown, 2004). The DoE (2001c) and Dlamini et al. (1996) focus on the holistic nature of development and on the need for a variety of learning experiences.

Integration of education and care

Programmes should attend to children's physical, social, and emotional needs, as well as to their cognitive and intellectual needs. In particular, health and nutrition elements are important for children from poor communities and have been a focus for many initiatives (for example Dlamini et al., 1996; DoE, 2001c; Tarullo, 2002; Dawes et al., 2004a).

Ratio of children to adults

This indicator is less clear. Lower ratios have often been associated with higher quality (for example Tarullo, 2002) and maximum ratios are usually set in national, provincial or local standards. However, international studies (for example Siraj-Blatchford & Wong, 1999) have shown that excellent outcomes can be achieved with far higher numbers of children than are considered acceptable in North America, depending on the curriculum approach. Nevertheless, very poor (i.e. low) adult-to-child ratios tend to reduce the adults' role to group management, limit opportunities for interaction with smaller groups of children and may even compromise safety elements.

Partners/parental and community participation

This includes involvement and participation of families and communities as partners in the programme, helping the programme to set appropriate standards and function well within the context, as well as supporting their children's learning at home. Kagitçbasi's (1996) parent programme and the Home Instruction Programme for Preschool Youngsters (Lombard, 1996) are examples of projects where mothers' involvement has supported positive child outcomes.

Finance/resources/management

A consistent, permanent financial and material resource base, sufficient to support working in an appropriate way with children and to sustain the programme, is necessary. The level of investment in ECD services has to be at a high enough level before child effects become significant (Liddell & Kemp, 1995; Penn, 2004). Rhode Island Kids Count (2005) uses childcare subsidies as an indicator associated with school readiness. The DoE (2001c) Support Index contains financial indicators as well as support and monitoring from the appropriate bodies.

Teaching strategies

This involves learning programmes which include questioning, direct instruction and scaffolding, matching tasks to the children's capabilities, and responsiveness to children's interests, family and community. Many of these strategies require individual and small group learning experiences. Dlamini et al. (1996), High/Scope Educational Research Foundation (2004), Siraj-Blatchford and Wong (1999), Siraj-Blatchford et al. (2002), and Weikart et al. (2003) have all focused on the association of these particular teaching strategies with positive outcomes.

The quality indicators above relate to services targeting children directly rather than those aimed at the primary caregivers. For programmes targeting parents and other primary caregivers evidence of child outcomes is less clear (Evans, 2005), as is what aspects of the programmes support child well-being. Programme experience suggests the following:

Helping families to access resources

This involves helping families to obtain necessary documents such as birth registrations, social grants, nutritional and health support, and so on (Scott-McDonald, 2002; Newman et al., 2003).

Building caregivers' self-esteem and confidence

Supportive programmes which take a strengths-based approach, and which affirm and build on indigenous child-rearing practices have been found to have more value for their participants and positive child outcomes (Kagitçbasi, 1996; Scott-McDonald, 2002; Newman et al., 2003; Evans, 2005).

Knowledge and practices to support children's development

Health and stimulation messages, encouraging caregivers to support early literacy, and other initiatives are another component of services aimed directly at the primary caregiver (Kagitçbasi, 1996; Newman et al., 2003; Rhode Island Kids Count, 2005).

Systemic supports to quality

It is widely recognised (for example DoE, 1996, 2001a, 2001d; Arnold, 2004) that when working at multiple levels, in all the environments that impact on children, one is more likely to meet obligations to children and to address discrimination and exclusion. Indicators of intersectoral servicing are therefore included to cover both access and quality.

Proposed service quality indicators focus on three areas – those relating to ECD services in centres, those relating to services for parents/caregivers and those tracking the quality of and commitment to ECD programmes by the public sector.

For ECD services, the proportion of services complying with departmental registration norms and guidelines and educator qualifications, as well as the proportion of facilities in receipt of a state subsidy for their operational costs, are indicators of programme quality for which data are relatively accessible.

For ECD services through parents/caregivers, quality indicators include assisting caregivers to access grants, registration, health services and nutritional support;

caregiver knowledge and motivation to support their children's development; an assessment by parents/caregivers of the relevance for them of the parent support service; and whether these programmes are monitored and evaluated. Public sector quality indicators include monitoring of public policies in support of ECD against departmental plans, programmes, budgets and service delivery; the proportion of IDPs making specific provision for ECD services per province; and the existence of an efficient intersectoral administrative data system containing information on young children from the departments of health, education and social services.

Potential measures of service quality

There are a number of tools used to measure the quality of settings where young children are cared for, covering different aspects of provisioning and staffing. These include the Early Childhood Environmental Rating Scale (ECERS) (Harms & Clifford, 1980), which has been adapted for Tamil Nadu (Isley, 2000) and a number of middle- to high-income countries;[12] guidelines from the National Association for the Education of Young Children, which reflect the DAP guidelines; High/Scope Program Quality Assessment and the observational instrument for the Improving Educational Attainment Preschool Project. Given the South African context and the lack of resources, a gross but more workable measure would be the extent to which services comply with DoSD guidelines required for registration (or any revision that takes place in view of the planned National Integrated ECD Plan). These cover physical standards, health, parent management, programme, nutrition, and staff training and responsibilities and quality assurance. Dawes et al. (2004a) make the point that these are helpful but too broad for measurement purposes and may need operationalisation. There are two processes which could be used to operationalise the broader areas of the guidelines. Firstly, once the guidelines receive ministerial approval, the DoSD will train provincial staff in their use, which could provide the opportunity to be more specific. Secondly, the use of the guidelines has been proposed as regulations for the Children's Amendment Bill 19 of 2006 (before the National Council of Provinces at the time of writing). Should this be accepted, this would present an opportunity to concretise them.

Educator qualifications based on the ECD unit standards from Levels 4 and 5 require that educators demonstrate competence in all of the process indicators listed above, as well as inputs such as providing resources and materials. If possible, monitoring and support checklists for provincial DoE staff should be adapted to include selected quality indicators.

Access to subsidies from the departments of social development or education would give an indication of the financial sustainability of services, state subsidies being a key factor in creating sustainability (Biersteker, 2001; Unit for Social Research, 2003). This data would be relatively available from departmental sources. These indicators would not take account of finer aspects of teaching strategies or child participation, which might be the subject of smaller research studies.

The success of parent programmes would mostly be measured by changes on family environment measures and service quality factors using small-scale surveys. Data on whether programmes are monitored and evaluated are likely to be difficult to obtain for those run by community groups, faith-based organisations and NGOs. However,

policy developments for ECD, such as the integrated plan for 0–4 year olds and the Expanded Public Works Programme for the Social Cluster, will mean that there is more public funding for this type of programme and that some form of monitoring and evaluation data should become available through departments.

Conclusion

There are many measurement and data challenges for monitoring ECD outcomes, particularly at the child and home environment level. While research has validated many indicators of young child well-being, measures and the capacity to collect data on a large scale remain a huge challenge except for basic health indicators. Indicators of service access are most readily measured through routine departmental data collection processes or national surveys. Certain indicators of service quality, such as the numbers of registered services, are accessible and others could be built into regular departmental monitoring systems. Data on the very many programmes that aim to reach young children through supporting and educating their parents, run by NGOs, faith-based and community organizations, are not readily available or even collected. Here special surveys would need to be undertaken.

The home environment is the place where child development starts and where the foundations are laid for the child's life. Improvements at this level can relieve present suffering, and provide children with the resources, strength and resilience to rise above the vicissitudes of life. They can obviate much of the need for later remediation or rehabilitation. Some rights indicators are already in place in surveys but require collating within systems or sets devised for particular purposes. Others need more research, taking account of local norms and cultural practices so that they may be utilised with confidence by intervention agencies.

There have been several recent local initiatives designed to involve concerned community members in monitoring child well-being in their neighbourhood. This would make it possible for them to refer child-related issues or cases needing attention to local authorities for action. Although these community childcare systems are not yet in general practice, they are an encouraging reminder of what can be achieved at local level.

The least developed indicators are those which relate to household dynamics as they affect young children. These are potentially the most powerful for intervention purposes, and need understanding and support within the communities they are designed to assist. Time, skill and care are needed to develop indicators that are uniquely applicable to the rights issues for South African communities under stress. This means, in many instances, starting from first principles, looking at what children and families are doing, listening to the interpretations they place on their rights, and understanding the information and support they will need to bring about improvements.

ECD as a life stage cross-cuts many of those sectors of child well-being dealt with in other chapters in this volume. To reflect an integrated approach to ECD a limited number of key health, safety and neighbourhood indicators are included in the indicator tables in Part 2. The first table contains the core indicators that are regarded as absolutely essential if we are serious about monitoring the situation of

young children. Some of this data are readily accessible but certain child and household indicator data will require specific studies. Regarding core indicator table entries, data from national surveys such as the Census, the GHS and SASAS are readily available and are collected either annually or at longer intervals; administrative data are collected continuously. Measures in large area surveys such as the KwaZulu-Natal Income Dynamics Study could be extended into national surveys where appropriate or remain as indicators in key areas. They are typically conducted at greater than annual intervals. Local Plan of Action surveys are not yet well developed. They should be continuous.

The second table in Part 2 contains additional indicators which provide more detailed and textured information about the well-being of children. Data are more difficult to collect and would require special research studies conducted from time to time.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 A National Integrated ECD Plan for 0–4 year olds, developed by the departments of education, social services and health, will provide the framework for service delivery to the youngest children and fulfils the undertaking for this age group in White Paper 5 on ECD (DoE, 2001a).

2 We are grateful to Mira Dutschke of the University of Cape Town's Children's Institute for her helpful comments on child rights included in this chapter.

3 The Constitution guarantees the right to basic education. To date there is no clarity that this includes ECD services but in view of the access to education provisions, ECD services have been shown to facilitate access to and progression in schooling and could be seen as an access and equal opportunity issue (see also CRC Article 28 and AC Article 11).

4 MDG goals which affect the ECD period are survival and health-related (reduction of under-five mortality, immunisations, improvement of maternal health, combating HIV/AIDS and other diseases, eradication of extreme poverty and hunger and improving access to basic services) as the education goals refer to universal primary education and provisions for gender equity in primary, secondary and tertiary education.

5 The International Standard Classification of Education (ISCED) defines pre-primary education ISCED level 0 as comprising programmes that offer structured, purposeful learning activities in a school or a centre (as opposed to a home) to children aged at least three years.

6 This group is a consortium of concerned donor agencies, foundations, and international NGOs working with regional ECCD networks.

7 Information shared by Gauteng DoE ECD staff at the DoE conference, Unlocking the Future, Johannesburg 28 February to 2 March 2005.

8 The Center for Child Well-being is a programme of the Task Force for Child Survival and Development, <http://www.taskforce.org/>.

9 The OECD collates and presents a number of indicators on the performance of education systems.

10 See Academy for Educational Development, <www.aed.org>.

11 The DoE uses this term to include all learners who need additional support to benefit from the education system, not only those with disabilities.

12 ECERS was developed at the Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Many research projects in the US, Europe and elsewhere have used ECERS to assess global quality and found significant relationships between ECERS scores and child outcome measures, and ECERS scores and teacher characteristics, behaviours and compensation. See <http://www.fpg.unc.edu/~ecers/>.

CHAPTER 10

Monitoring childhood disability

Marguerite Schneider and Gillian Saloojee

Introduction: objectives and scope

This chapter provides a framework for conceptualising and monitoring disability in childhood (note that psychiatric conditions are covered in Chapter 6 in this volume). The major focus of the indicators proposed is to monitor the prevalence of children with activity limitations and the access these children have to basic services and support to allow them to participate fully in all areas of life, and thus realise their full potential. A disabled child,[1] like any other child, has rights to survival, protection, development and participation in society. What is different about children with disabilities is that they require additional support, services, and technical assistance to maximise their ability to take up opportunities, be fully included in society and realise these rights. Disabled children require this level of support and access to services in addition to, and over and above, that which any child would require. The services and support fill the gap between what the child cannot do and what is required for a particular activity, for example, not being able to walk and being provided with a wheelchair. These additional requirements are the focus of this chapter and the indicators proposed in Part 2.

These additional requirements are preconditions or prerequisites for children with disabilities to be included and to access all opportunities available to children. Without them, children with disabilities experience significant disadvantage and exclusion. The UN Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) states quite clearly that, 'A mentally or physically disabled child should enjoy a full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community' (Article 23, Section 1).

The full inclusion and realisation of the rights of children with disabilities will be monitored in the same manner as for any child (i.e. measures of well-being, educational attainment, and so on). It is proposed that the degree to which the realisation has occurred will be specifically documented for disabled children by disaggregating the data for all children into those for disabled and non-disabled children, and comparing outcomes on aspects such as education, participation in sports and recreation, social inclusion, personal integrity, and so on. In this way, disability becomes a demographic variable for identifying a stratum of children (similar to the use of sex, race, area of residence and socio-economic status as demographic variables) within the data at the point of analysis.

Monitoring at the level of the preconditions provides concrete and easily measurable entities that can indicate to policy-makers possible reasons for increases and/or decreases in the outcomes of general child well-being, levels of inclusion, educational attainment, and so on for children with disabilities.

In order for the disability variable to be used effectively, we need to ensure that the measurement used to identify the presence or absence of disability in children is a valid and reliable measure. Although a number of screening and detailed assessment tools are available, there is no standard and nationally used measure and the debate continues on how to define disability. This chapter will not be prescriptive on this issue except to highlight the importance of understanding what it is we are 'counting' when we use one or other measurement of disability. Since the focus of the chapter is on those indicators that reflect access to services and support, the measurement unit or level of disability proposed is that of activity limitations (person level), and not impairment (body level) or participation restrictions (societal). These aspects are discussed further in the section on defining disability.

The chapter provides a rights-based approach to conceptualising disability, followed by a review on defining disability. This is followed by a proposed framework for developing indicators that monitor disabled children's well-being and development. Existing data sources and their limitations in relation to the proposed framework are presented. National and international data sources are included. The final section of the chapter presents the recommendations for childhood disability indicators and the challenges facing data collection.

Rationale

A rights-based approach to monitoring childhood disability

A rights-based approach ensures that a person enjoys all the human rights accorded in the constitution of the country, the South African Constitution of 1996 in our case. This applies to disabled children as well. A rights-based approach should provide a framework for indicators that ensure that disabled children's rights are upheld.

Traditionally, disability has been conceptualised as a problem of the individual and needing intervention focused on the individual. Experts (mostly medical) took it upon themselves to provide what they thought to be the best interventions for the disabled person. This became known as the individual model (also referred to as the medical model). In the 1980s, the disability rights movement emphasised that 'this medical approach produces definitions of disability which are partial and limited and which fail to take into account wider aspects of disability' (Oliver, 1990, p. 4) as well as the changing nature of disability. Oliver further states that this feature is carried forward into the realm of interventions for disabled people: 'Not only do these definitions medicalise and individualise the problems of disability but they do the same to the solutions (policies) that are applied' (1990, p. 5).

In the early 1980s, disability activists developed the social model which places disability within a social context, and uses a definition of disability that 'locates the causes of disability squarely within society and social organisation'; it is argued that 'the kind of society that one lives in will have a crucial effect on the way the experience of disability is structured' (Oliver, 1990, p. 11).

The South African Human Rights Commission's (SAHRC's) report *Towards a Barrier-Free Society* advocates the adoption of the social model. The report states

that 'society disables people with impairments by failing to take into account their rights and needs, as groups or individuals…A person is disabled if the world at large will not take into account their physical, sensory or mental differences. Most of the day-to-day problems that people with disabilities face are caused by the fact that they live in a hostile, disabling world which is largely designed to suit able-bodied people' (SAHRC, 2002, p. 9).

While the individual model clearly misrepresents the experience of disability, the social model can be criticised for not sufficiently acknowledging the presence and importance of impairments and the role of other personal factors. Thus, a third approach is to acknowledge the importance and role of both the individual and the environment. An example of this approach is the biopsychosocial model put forward in the WHO's *International Classification of Functioning, Disability and Health (ICF)* (WHO, 2001). This is the approach adopted in this chapter to develop the indicators framework.

In summary, the phenomenon of disability requires monitoring at the individual level (individual's health condition and impairment, their age, sex, race, personality, etc.), as well as monitoring of the context in which a person with the health condition and impairment lives, and the services and support that society provides for them.

South African and international constitutional and other legal provisions

Any rights-based approach should be upheld through a system of legislation and regulatory frameworks. South Africa is no exception. A number of pieces of legislation, as well as policy documents, set out the framework for ensuring the realisation of the rights of disabled children. The South African Constitution was passed in 1996 and, as the supreme law of the country, protects the rights of disabled people. Section 9(3) addresses the right to equality, emphasising that the Constitution aims to prevent discriminatory outcomes (covering discrimination based on a range of grounds, including disability). Section 10 is closely linked to Section 9, and addresses the right to dignity. This section suggests that people with disabilities have a right to positive action to enable their equal and equally dignified participation in life. In addition, Article 23 of the CRC states that children with disabilities should enjoy a full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community, and makes reference to the state's duty to provide such children with special care and assistance.

Furthermore, as a member of the UN, South Africa is a signatory to the UN's (1993) Standard Rules on the Equalization of Opportunities for Persons with Disabilities, which provides a framework for action to create societies that provide equal opportunities for all disabled people – children and adults.

Although the Constitution includes a number of sections which are relevant to people with disabilities, it requires further development through other more specific pieces of legislation and policy documents.

In 1997, the *White Paper on an Integrated National Disability Strategy (INDS)* (Office of the Deputy President, 1997) was introduced as 'a framework from which

integrated and current policy can be developed across all spheres of government to address the social, economic and political inequities that marginalise people with disabilities from mainstream society in South Africa' (SAHRC, 2002, p. 20). The limitation of the INDS is that it has remained a White Paper and has not been translated into legislation.

In 2000 the Promotion of Equality and prevention of Unfair Discrimination Act (No. 4 of 2000) was promulgated and it 'gives effect to the letter and spirit of the Constitution, in particular to the principles of equality, fairness, social progress, justice, human dignity and freedom' (SAHRC, 2002, p. 21). This law obligates both state departments and the private sector to implement anti-discrimination policies.

The Constitution emphasises the right to basic education (Section 29), and this right is particularly important to take into account when considering children. The national Department of Education's (DoE's) White Paper 6 on building an inclusive education and training system puts forward a proposal for ensuring that 'those learners who experience or have experienced barriers to learning and development and/or who have dropped out of learning because of the inability of the education and training system to accommodate their learning needs gain access to education' (DoE, 2001b, p. 6). The proposal is based on the human rights principle of 'education for all [in a way] that would enable all learners to participate actively in the education process so that they could develop and extend their potential and participate as equal members of society' (DoE, 2001b, p. 5).

Sections 27 and 28 of the Constitution outline the right to access health and social services. The Department of Health (DoH) provides free healthcare for all children up to the age of six years, and free healthcare services to all disabled people beyond that age who qualify on the basis of the means test applied. The Department of Social Development (DoSD) provides access to both financial grants – Care Dependency Grants[2] (CDG) for disabled children between 1 and 18 years of age and Child Support Grants[3] (CSG) for children in poor households up to the age of 14 years – and a range of social welfare services (for example, food parcels, home-based care, counselling services) for all families and individuals in need, including for disabled children and their families.

In summary, the rights-based approach to monitoring childhood disability highlights the need to consider aspects of disability in a holistic manner that includes but also goes beyond a medical condition and impairments approach, and beyond the individual. Thus, the indicators developed must reflect this holistic framework.

Defining disability

Disability is a multidimensional and complex phenomenon that is determined by both the inherent features of the individual concerned as well as by the environment in which the individual lives (WHO, 2001). When either the individual's inherent features or the environment change, so the experience of disability changes. Hence, the experience of disability for an individual is not static, but dynamic. The implications are that data collected for one individual should look different after the necessary services and support are provided and an inclusive society is created. In

addition, while the incidence and prevalence of certain health conditions might remain the same, the outcomes in terms of disability might change significantly because of one or more interventions.

To understand disability, we need to 'unpack' the different components or aspects that make up this experience. The ICF developed by the WHO (WHO, 2001; Schneider et al., 2003) understands disability to have as one of its necessary components a medical or health condition and one or more related impairments. This necessary component of a health condition is often diagnosable but probably, as often, not. Examples of a diagnosable condition include epilepsy, brain damage (causing impairments such as cerebral palsy, intellectual impairments, and so on), physical abnormalities such as underdeveloped or missing limbs, malformations of various body organs, genetic syndromes such as Down's syndrome, various conditions affecting hearing and vision, chronic illnesses such as juvenile diabetes, HIV/AIDS, and so on.

In other instances, the health condition is assumed although it cannot be directly 'tested'. For example, autism, childhood depression and intellectual impairment are generally diagnosed on the basis of observed behaviours and not from a direct test for the health condition (child and adolescent mental health conditions are covered in Chapter 6 of this volume). These observable behaviours provide an indication of the child's impairments. This level of measurement involves the function and structure of individual body parts, organs or body systems. Thus, when there is a problem at this level, it is referred to as an impairment of body function or structure. Body function and structure are inherent features of an individual.

The person level is concerned with activities such as walking, communicating, learning, playing, interacting with others, or some similar type of activity. When a child is doing a task or activity, she is using her whole being in a complex set of actions that make up that activity. The person level of human functioning is also an inherent feature of the individual. If the child has difficulty doing one or more activities (as determined by an assessment process, by observation or by report from the caregiver), this is called an activity limitation and is what is usually referred to when using the term 'with disabilities'. For example, a child with cerebral palsy could have a range of difficulties in the domains of mobility and communication because of the impairments in muscle function, and a child with HIV/AIDS might have similar areas of difficulty because of impairments in a range of body functions and general weakness.

A child with one or more activity limitations is at risk of being excluded from participating in a range of activities because of the impact of environmental factors. The extent to which a child does or does not participate in learning, recreation, socialisation, mobility, communication and so on, will contribute to the type and extent of disadvantage experienced by that child. For example, a child who does not participate in learning will experience disadvantage at the level of educational attainment, while a child who does not participate in communication and socialisation will experience the disadvantage of social exclusion.

At the societal level of functioning, the impact of environmental factors (physical, social, attitudinal) is crucial. If the environment is facilitating, the child may have significant activity limitations but still participate in a range of tasks and activities.

For example, a child in a wheelchair who cannot walk is able to be mobile if the physical environment is accessible for wheelchair users. Another child may have difficulty communicating, but if family members, schoolteachers and peers are supportive and allow the child space to communicate, and provide a system for augmentative communication, she will experience little disadvantage.

If the environment has many barriers, the same children could face significant disadvantage because of an inaccessible physical environment or a stressful and non-supportive social network.

Environmental factors that are important for childhood disability include:

- Access to early diagnostic and intervention services;
- Support services for family and school (see chapters 8, 9 and 11 in this volume for further discussion of the education system);
- Social security to ensure adequate access to basic requirements such as food, clothing and care;
- Adequate and accessible transport;
- An accessible physical environment;
- Adequate access to health, educational and recreational services to ensure that they develop and maintain a sense of well-being; and
- Positive and inclusive attitudes of families, health and educational professionals, as well as general society towards disability.

These factors are crucial to monitor as preconditions to a disabled child developing to their potential and maintaining their well-being. They contribute to creating barriers to learning but also to development generally.

In summary, the definition of a child with disabilities used in this chapter is a child who has a health condition and related impairments together with activity limitations in one or more domains of functioning. The assumption is that the presence of activity limitations puts the child at risk for experiencing the disadvantages of disability, such as low educational attainment, social exclusion, limited development of their potential and so on. This disadvantage is the outcome of the interaction of the child and their health condition with their environment. The indicators presented in this chapter focus on determining the prevalence of children with activity limitations and monitoring a range of services and support systems (preconditions) that will have an impact on the outcome of development or disadvantage for the child. The components that are targeted are the presence or absence of one or more activity limitations (degree of severity not specified), the level of participation in different domains or areas of functioning as outcomes (for example, school attendance and educational attainment), and the environmental factors (physical, social/attitudinal and policy/legislation) that create the experience of disability or prevent it, with an emphasis on service provision.

A framework for childhood disability indicators

The conceptualisation presented above highlights the complex and multi-dimensional nature of disability. A child with a health condition and associated impairments[4] could be managed through provision of healthcare services and have no further consequences. However, many children do experience the consequences

of these impairments, and have activity limitations. If a child with disabilities has the necessary services providing personal support, rehabilitation, assistive technology and products, an accessible physical environment and transport, as well as access to social security, these activity limitations should not pose serious restrictions for the child. This child will progress through the stages of development without much difficulty and realise their potential as a human being. This realisation can be monitored through the level of education attained, the integration within the family and society generally, as well as participation in other aspects of life such as recreation, culture, religion, sport, and so on – that is, general well-being indicators.

This section reviews the conceptual aspects of disability which need to be considered in developing indicators. The section on recommendations for indicators develops these into more specific indicators that are concrete and measurable.

Health conditions and impairments

Children with activity limitations are assumed to have a health condition or impairment as the basis for the activity limitation. The collection of data on health conditions and impairments requires access to health and rehabilitation services (physiotherapy, occupational therapy, speech therapy, audiology and/or psychological services) for diagnosis and intervention, and a functioning health information system.

A health condition is 'an umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO, 2001, p. 189 [short version]). Health conditions may be visible or invisible, consistent or intermittent, and stable or progressive.

Impairments and health conditions are closely related, as often impairments are the manifestations of an underlying health condition which cannot be diagnosed by any means other than through observation of the impairments. An example is an emotional impairment (emotional disturbances), which could be a manifestation of an underlying psychological illness. The ICF defines impairment as 'a loss or abnormality in body structure or physiological function (including mental functions)' (WHO, 2001, p. 213). It is important to collect information on impairments and health conditions as indicators of the health status of children, but this should not be assumed to be equated to disability.

Activity limitation

Activity limitations are difficulties a child may have in executing activities in one or more domains of functioning (WHO, 2001). The domains of functioning relevant for children up to adolescence include (as set out in the ICF [WHO, 2001]):

- Learning and applying knowledge (for example, watching, listening, basic learning, solving problems, making decisions);
- General tasks and demands (for example, undertaking simple and complex tasks, handling stress, carrying out a daily routine);
- Communication covering any modality (written, spoken or signed) as well as reception and expression of language and conversation;
- Mobility (for example, changing body positions, carrying objects, walking and moving around);

- Self-care (for example, washing, toileting, dressing, eating and drinking);
- Domestic life (for example, caring for household objects and assisting others);
- Interpersonal interactions and relationships (for example, interacting in a contextually and socially appropriate manner; relating to family, friends, strangers in formal or informal relationships);
- Tasks and actions required for engaging in education or vocational training;
- Community, social and civic life (for example, engaging in community groups, recreation and leisure, religion and spirituality).

These domains would need to be covered in the assessment of the presence or absence of an activity limitation, although some might be more crucial than others, for example, learning, mobility, communication and self-care, as these are prerequisites for engaging in education tasks and actions.

Preconditions for accessing equal opportunities or environmental factors

The role of these preconditions is to ensure that children with activity limitations do have the necessary technological, personal, attitudinal, as well as policy and legislative support to manage their activity limitation in a way that allows for their full participation in all aspects of life. This would ensure their well-being, and development to their full potential.

The main factors to be monitored as preconditions are services – health, rehabilitation, assistive technology, education, social security, social welfare services such as respite or home-based care, and so on. However, support from family and beyond, the availability of assistive devices, and physical accessibility of the natural and built environment are also important preconditions to be monitored. The availability and effectiveness of implementation plans linked to national and provincial policies should be monitored. Specifically, the goals and objectives of the departments of social development, health and education should be translated into implementation plans at provincial and district levels. The initial stages of monitoring would be to establish whether implementation plans related to all the legislation and regulatory frameworks discussed above are in fact being implemented. The next stage would be to look at individual services and/or programmes and interventions and to monitor utilisation of these services or participation in programmes.

Exclusion and participation as outcomes

The disadvantage associated with disability is determined by the level of participation a child has in life activities. This can be assessed through indicators such as youth membership to community organisations, participation in recreation and sport, religious or related activities, as well as through school attendance and educational attainment. The level of satisfaction of both parents or caregivers and the child would be additional indicators of overall well-being.

The impact of a health condition, and related impairment(s) and activity limitation(s), is highly dependent on the age of onset of the health condition. Early onset (before the start of formal education) will have a significant impact on the education level the child can reach, while onset towards the end of school will have a very different

impact. A national survey on disability done in 1998 in South Africa clearly shows the differential impact of age of onset on the experience of disability (Schneider et al., 1999). Early onset was associated with lower levels of educational achievement.

The same survey also showed a correlation between age of onset, number of activity limitations, level of integration within the family and ability to make decisions about one's own life. The results show that age of onset and the number of activity limitations are the major explanatory variables for determining the level of integration of a disabled child or adult in their family. The earlier the onset and the more activity limitations a person had, the more likely they were to experience exclusion within the family. This trend is likely to be exaggerated in relation to inclusion within society beyond the family.

Assessment instruments and indicator measurements

This chapter does not discuss the nature of the tools or the issue of standardisation required to ensure accurate measurement of activity limitations and impairments. It merely sets out the framework for understanding childhood disability and the parameters to be included as indicators. Further work is required to develop the actual measurement tools. However, there are currently a number of assessment tools used by professionals such as occupational, physio-, remedial and speech and language therapists which assess children's ability to carry out activities. The task at hand is to link these existing assessment tools to the ICF framework. The additional work still to be undertaken is to decide where the cut-off point for having an activity limitation should be. For example, would a child need to have an activity limitation that is at least moderate in severity or would even children with mild limitations be included when determining the prevalence of activity limitations? Would a child need to have an activity limitation in more than one domain of functioning or not? We propose that prevalence data be collected on children who have a moderate to severe limitation in one or more domains of activity.

It should be noted that any instrument used or indicator developed must take into account developmental stages of children and adolescents and use instruments and norms that are age appropriate.

Existing data sources and their limitations

Currently there are relatively good data on the prevalence of different health conditions and impairments, usually measured at local level. Examples of these are cited in McLaren et al. (2004) and include prevalence rates for childhood disability in a rural area of KwaZulu-Natal, causes of childhood blindness, and diagnosis and treatment of ear disease in children. For activity limitations and overall disability, there are data available for children, although again mostly at the local level and often included as part of adult data. Examples cited in McLaren et al. (2004) include motor impairment and disability in a rural community, childhood disability in rural KwaZulu-Natal, and early school failure in Zulu children. Little data exist looking at the outcomes of the disability in terms of disadvantage and exclusion, although the national disability survey of 1998 (Schneider et al., 1999) provides some information of this nature. The analysis of child level data for participation and family

integration was, however, limited, although this is covered to some extent in the report on Gauteng's disabled children (Saloojee, Phohole et al., 2003).

Because of the complexity of the conceptualisation, definition and measurement of disability, there are no data that provide one clear figure of the prevalence of disability. Depending on which components of disability are measured, the results provide different prevalence rates. The aim is not to have a single or 'true' measure of disability but rather to be clear on what is being measured and the policy implications of each measure. In other words, we must understand who is included and excluded by a particular measure, and what the policy implications are.

While prevalence rates for disability in general are notorious for their variation (Me & Mbogoni, 2001),[5] this is even more so for childhood disability prevalence rates. Childhood disability rates in developing countries vary from country to country and from survey to survey. Couper (2002) reports rates of 8.2 per cent in Bangladesh through to 15.2 per cent in Jamaica, while in South Africa the rates are reported to vary between 3.3 per cent and 6.4 per cent across surveys using different measurement tools and methodologies, and incorporating different age groups. In her own survey done in a small area within rural KwaZulu-Natal, Couper (2002) found a prevalence rate of 8.3 per cent for children under ten years of age.

While the above discussion provides some indication of the possible range of disability prevalence rates likely to be relevant for South Africa, we do not have a standard and nationally accepted tool for assessing disability. This chapter recommends that prevalence rates be measured using an assessment of activity limitations, and not just a medical and/or impairment assessment. A prevalence rate indicating the number of children within a certain age range who have one or more activity limitations, which are moderate or severe in nature, would be the information required to establish the stratum for analysis of all other variables related to child well-being.[6] This approach of using activity limitations as the defining characteristic of the population of children with disabilities is reflected in international efforts to measure disability as discussed by Simeonsson et al. (2003). The trend has been to develop categories of impairments with diagnostic labels rather than looking beyond these categories to the functioning profiles of children using a tool such as the ICF (WHO, 2001). Simeonsson et al. state that 'this approach is especially important in education, where categorical identification of students becomes barriers to intervention' (2003, p. 607).

Numerous documents, both national and international, refer to the need to develop indicators and collect data on disability.[7] Kohler and Rigby (2003) refer to the trend of reporting negative aspects of child development and the difficulty in finding suitable indicators for monitoring children's general development, and propose the use of educational indicators as a proxy for social development. However, they caution that these education indicators reflect the resources and priorities of the country, and are thus input factors that determine, in part, children's development, and are not outcome measures of child development. This cautionary note supports the need to measure not only educational performance but also the factors external to the child that also have an impact on the child's functioning.

The DoH's (2001a) document outlining health goals, objectives and indicators lists only three indicators that refer to disability directly, and only one of these has direct

relevance for monitoring childhood disability. This is the indicator that monitors improvement in the quality of life of people with disabilities as determined by and measured through increased access to basic rehabilitation services and assistive devices (see Chapter 5 of this volume for indicators for monitoring the health of children).

This limited monitoring of disability indicators within the health information system (for both children and adults) reflects the lack of clear methods and approaches to childhood disability. The Health Systems Trust (McLaren et al., 2004) reports there is a lack of development of disability indicators at district and provincial levels. Furthermore, these authors report that, where data were collected in a disability information project in two districts in KwaZulu-Natal, these data were not used and, even when compiled and sent through to provincial level, they were not used to plan effective actions.

Data on provision of the necessary services and support do exist to some extent but remain limited. These data include school attendance (routinely collected by the DoE), utilisation of health and other services (collected by the DoH), number of children who are beneficiaries of the care dependency grants (collected by the DoSD), and the gaps between services needed and received (Schneider et al., 1999; Saloojee, Phohole et al., 2003).

The Education Management Information System (EMIS) is described in Chapter 8 in this volume. EMIS appears to collect disability-related information on a systematic basis. The DoE's (2001b) White Paper 6 provides analyses of these data to show disparities in the provision of education for learners with disabilities. For example, the Eastern Cape has 17 per cent of the disabled child population but only 11 per cent of the total number of special schools; and Gauteng has a similar proportion of disabled children, with 25 per cent of the total number of special schools. Furthermore, the Western Cape has 5 per cent of the disabled child population but 22 per cent of the total number of special schools. The exact nature of the data on disability collected by EMIS would need to be reviewed to determine how it relates to the framework presented here, but could be a very useful source of information on disabled children attending school. However, information on out-of-school disabled children will not be captured by EMIS.

The budget allocations for services for disabled children within the departments of health, education and social development provide useful information on changes in the proportions allocated to each of the services (Philpott, 2004). The information provided also covers the number of personnel, and each department responsible for providing these services.

Reported service provision from the consumer end is a good way to determine the impact of budget allocations in relation to the target users. When disabled adults and caregivers of disabled children were asked whether they had received services they needed, the response showed that healthcare, medical rehabilitation and assistive devices were reported to be the most frequently needed services (Schneider et al., 1999). Healthcare was received by three-quarters of those needing it. This reflects the relatively good spread of healthcare services across all areas. However, of those who reported needing medical rehabilitation, assistive devices, educational or welfare services, only between one and two out of every five people received these

services. This indicates a large gap in service provision. White and Indian respondents were the most likely to have received services, highlighting the racial differences arising from the legacy of apartheid in South Africa.

A study on childhood disability in a peri-urban township in Gauteng reports that 'more than half of disabled children of school going age included in the study are not attending school whilst less than half of the disabled children eligible for CDGs are actually receiving them. Only 40% of disabled children who require rehabilitation actually receive it' (Saloojee et al., 2006).

Internationally, the picture is not dissimilar to that in South Africa. Epidemiological data on the prevalence and incidence of health conditions and impairments are relatively easily available while the growing emphasis on the need for functional profiles (Simeonsson et al., 2003) has not translated into concomitant data collection methods. Kozinetz et al. (1999) reviewed instruments used in measuring health status for children with special healthcare needs, and conclude that the majority of instruments for measuring a child's health status have not been developed for clinical use but rather for research. In addition, these authors report that there is a dearth of instruments for measuring aspects such as functional status, and parent- and child-reported satisfaction with healthcare as well as health status.

Recommended indicators for monitoring childhood disability

The full set of indicators relevant to childhood disability are presented below, with a brief rationale for their inclusion based on the framework presented above, as well as the data sources available for their measurement.

The measurement of childhood disability indicators can and should be measured at local, regional, provincial and national levels. Each level will have different applications. At the local level, the measurement is to inform management of children's specific needs within that locality and outcomes of intervention, while at the provincial or national level the information is used for policy development and service provision. Furthermore, the data on childhood disability must be analysed in terms of sex, race and geographical location to provide a clear, disaggregated picture for the whole country.

In accordance with the indicator typology presented in Chapter 2 of this volume, core and additional indicators are summarised in the Chapter 10 indicator tables in Part 2. Not all indicators listed below are categorised as core or additional indicators and included in Part 2. This is because, irrespective of the appropriateness or desirability of particular indicators, it may be unfeasible to implement them given current resources and constraints (for example, the likelihood of reliable data collection systems being developed in the foreseeable future). Indicators marked with an asterisk (*) in the text below are those excluded from the Part 2 tables, and these should be considered 'wish list' indicators, which should be implemented once resources allow.

Indicators for childhood disability cover the following categories (with the associated indicator type included in brackets):

- Indicators which measure the extent or prevalence of activity limitations, that is, prevalence rates. These indicators would include age-specific and cause-specific rates (Type 1 indicators: Child status).

- Indicators which measure aspects of prevention of disability. Existing information systems such as the DoH's Notification System and the Acute Flaccid Paralysis (AFP) Surveillance System could be used to develop indicators to monitor aspects of prevention (for example, monitoring incidence rates of haemophilus, influenza B, meningitis, meningococcal meningitis, TB meningitis, TB spine, and the non-polio AFP rate). Related to these indicators are the immunisation rates for children as per the recommended schedule of immunisations (see Chapter 5 in this volume). In addition, the indicators relating to childhood injury morbidity due to transport accidents, non-transport accidents and violence would also be useful in monitoring the prevention of disability (see Chapter 7). Monitoring the provision of developmental screening services and early intervention also forms part of the preventative aspects of disability (Type 4 indicators: Service access).
- Indicators which measure aspects of the child's environment both at the micro level (family, dwelling – Type 2 indicators: Family and household environment), as well as the broader environment including community level security and poverty levels (Type 3 indicators: Neighbourhood and surrounding environment), access to services (health, education, social security – Type 4 indicators: Service access) and quality of services (Type 5 indicators: Service quality).
- Indicators which measure aspects of inclusion and participation as an outcome at the level of the child (Type 1 indicators: Child status).

Type 1 indicators: Child status

Type 1 indicators measure outcomes at the level of the child. With regard to childhood disability they would include prevalence rates, as well as a range of indicators relating to the child's participation in family, educational, recreational and other activities.

Prevalence rates for activity limitations

Core indicator 1

Age-specific prevalence rates of children with one or more activity limitations.

This would include all children who have one or more activity limitations as a result of a health condition. Suggested age categories for data collection are 0–4 years, 5–9 years and 10–14 years. The duration of the health condition should have lasted, or be expected to last, for six or more months.

Limitation of this indicator: It is difficult to capture this data on children under the age of two years, as screening tools for assessing activity limitations in this age group are not well developed.

Core indicator 2

Cause-specific prevalence rates of children with disabilities.

Data on the underlying reason for the chronic health condition giving rise to the activity limitation/s will assist in monitoring the outcome of preventative strategies and programmes. These data would be collected by the DoH.

Limitation of this indicator: The cause may not be immediately evident or easy to establish, especially in a primary healthcare setting.

Participation in social and recreation activities

These indicators would measure levels of participation as well as the attitudinal context of various social and recreational groups. This measure could be obtained through reviewing membership and calculating the proportion of disabled members relative to the total membership. This assumes the possibility of identifying members' disability status in terms of presence or absence of activity limitations. While this is simple for the more visible activity limitations, the less visible ones (for example, ones resulting from cognitive, neurological, or mental health impairments) are more difficult to identify and often require self-identification by the person concerned.

Additional indicator 1

Social inclusion of disabled children.

Children with disabilities are less likely to be involved in social activities and sport compared to non-disabled children. Social activities include going to the movies, going on outings with a group of people, attending sports events, involvement with a youth club, and so on. These data could be captured via self-report survey instruments applied in school, or as a population-based sample. Although the social inclusion of disabled children has been categorised as a Type 1 (child status) indicator here, it overlaps considerably with Type 4 indicators, which relate to opportunities to access social activities which are inclusive of disabled children.

Additional indicator 2

Mental health status of disabled children.

Information on the emotional status of disabled children could be collected in a self-report format through survey instruments applied in school, or as a population-based sample of children with disabilities. While the prevalence of reported emotional distress and psychological problems can provide indications of exclusion and isolation, they could also be indications of the actual impairments themselves. Measurement of this indicator would need to be interpreted with this caution in mind.

Mortality rates of disabled children

*Indicator 1**

Number of disabled children dying annually.

Sub-indicators: These would include age-specific mortality rates, cause of death, and severity of the disability.

Presently, there is no information on the mortality rates or causes of death in children with disabilities in South Africa. This information could be captured annually at the mortuaries. This would provide a measure of the impact of lack of services on survival rates, or abuse as a cause of death, and of general health problems affecting disabled children and contributing towards the mortality rate.

However, this analytical stratification assumes that the registration of cause of death would include information on the disability status of the child before death, which does not currently occur. Ideally, the disability status of a person (child or adult) should be recorded on the death certificate to allow for this stratified analysis to take place.

This information could also be obtained from a longitudinal follow-up study of a cohort of disabled children at a community or district level.

Limitation of this indicator: The accuracy of the data collected at mortuaries is dependent on the adoption of a standardised definition of disability.

Type 2 indicators: Family and household environment

These indicators relate to risk and protective factors in the child's primary care settings, such as the resources in the home environment and quality and type of childcare support. They include indicators of maternal education as well as factors relating to child injury prevention. These indicators would be no different to the development of indicators for non-disabled children.

In addition, disability-specific indicators would be the child's home environment and the accessibility of the entrance, corridors, and rooms within the dwelling, as well as the availability of assistive devices required by the child and personal support from household members. These are examples of the preconditions or necessary supports specifically required by children with disabilities, and make up part of the environmental factors that have an impact on the child's experience.

*Indicator 1**

Availability of positive personal support from household members to the child as reported by the child and caregiver on population-based sample surveys, as well as clinical records by rehabilitation service providers.

*Indicator 2**

Availability of positive personal support from household members to the child's caregiver as reported by the caregiver on population-based sample surveys, as well as clinical records by rehabilitation service providers.

Type 3 indicators: Neighbourhood and surrounding environment

Type 3 indicators would primarily relate to the child's socio-economic context. Because of the necessary assistive devices, services, and specific requirements of disabled children (for example, special food, nappies, big pushchairs), a household with a disabled child will experience additional costs related to the child's needs. In addition, a poor household can often not afford the necessary healthcare at times of ill health. Lack of healthcare will aggravate a treatable condition, possibly resulting in a permanent impairment for the child. Thus, poverty is a risk factor for disability. For example, a child with frequent middle-ear infections which are not treated may eventually develop permanent hearing loss. Similarly, a child with a lower limb amputation who cannot afford transport

in order to access orthotic-prosthetic services will experience significant activity limitations and participation restrictions because of not being able to move around.

Indicators measuring poverty levels at both a household and a community level have been covered elsewhere in this volume (see chapters 3 and 4) and will not be repeated here, except to highlight the importance of the disability demographic variable during routine data collection. The only indicator covered here would be the additional costs of the child's specific needs directly related to the impairment.

Type 3 indicators also include measures of the built environment, such as the state of pavements and roads, ramps, accessible playgrounds, and so on, as these are all conditions external to the home which have an impact on the participation and inclusion of children with disabilities in all aspects of community life. Again, this is an area where further work is needed.

Type 3 indicators relate to the broader context of the child, which stretches beyond the immediate/primary care setting and household members to the community or neighbourhood in which the child lives.

Measures of the built environment

Core indicator 1

Accessibility of the local authority facilities to disabled children (including playgrounds and other recreational facilities) in the form of pathways, roads, entrances and exits to buildings, signage and lighting.

Data collected would be caregiver and child reports during population-based sample surveys, as well as environmental accessibility audits, where these are carried out.

Core indicator 2

Physical accessibility of the disabled child's local school (in terms of entrances, exits, inside corridors, doors, lifts/stairs, toilets).

These data could be collected via school accessibility audits, where these are conducted.

Community attitudes towards disability

*Indicator 1**

Attitudes held by the local community to disability.

The nature of the attitudes held by community members is an important determinant of the extent to which disabled children and adults are included in community life, as well as supported when requiring personal assistance.

The data collected would be provided by caregivers and children during population-based sample surveys. Further data could be collected by conducting a review of attitudes held by communities, as reported by local organisations, especially those including disabled people or parents of disabled children.

Type 4 indicators: Service access

The focus of Type 4 indicators is to measure children's access to services. This group of indicators is a critical part of monitoring the status of disabled children, as rehabilitation therapy, specialised educational services and social support are needs which children with disabilities have over and above the needs of non-disabled children. In addition, the majority of disabled children in South Africa are denied access to their basic rights listed in the South African Constitution (Schneider et al., 1999; Saloojee, Phohole et al., 2003; Saloojee et al., 2006). Type 4 indicators are further examples of the environmental factors that determine the child and her family's experience of disability.

Ideally, the data collected for these indicators should be the proportion of children accessing the service who need that service. However, the reality is that until we have clearer data on prevalence rates for activity limitations, the denominator of the children needing a service will remain unknown. Therefore, the starting point is to use self-reported or caregiver reported needs for services together with utilisation rates by these same respondents for different services (health, education and social development).

Philpott (2004) outlines the health, education, and social development services that are provided by the three government departments. These services are generally provided at the local level, but also include secondary and tertiary levels of service provision, with the primary level providing the more basic, general level of service, and the secondary and tertiary levels being the more specialised levels of service provision. Philpott describes the budget allocations for each service, and these allocations can be monitored at national and provincial level to determine the extent to which the services are being developed.

Disabled children's access to rehabilitation services, support services and grants

Core indicator 1

Disabled children in receipt of rehabilitation services, including community-based rehabilitation services.

These data should be collected in population-based sample surveys, and routine health service utilisation data to determine what proportion of children requiring rehabilitation services receive such services.

Core indicator 2

Disabled children's access to assistive devices.

Disabled children's access to assistive devices which address the needs of the child should be collected via population-based sample surveys, as well as through the use of clinical records of service utilisation by rehabilitation service providers.

The devices need to be maintained in good working order, and consequently require maintenance and repair services. The collection of this additional information is important to consider.

Core indicator 3

Disabled children requiring specialised educational support who currently receive it.

These data can be collected in population-based sample surveys and using routine school attendance data undertaken by the DoE. Information should be collected on services in both formal and informal educational or care contexts.

Core indicator 4

CDG uptake for eligible disabled children.

CDGs are available for any child and their caregiver if the child has a severe disability (measured in terms of an activity limitation) and requires full-time care. This indicator should be measured in terms of the absolute numbers, and the rate of increase and access disaggregated by, for example, rural and urban areas. In addition, it should be measured as a proportion of the estimated number who are eligible on both financial and disability criteria. Absolute number of beneficiaries is not sufficient to measure the rate of correct targeting of this form of social security. Much of these data could be drawn from the DoSD's Social Pension Database (SOCPEN).

Additional indicator 1

CSG uptake for disabled children who are not eligible for CDG.

Children with mild disability are not likely to be eligible for the CDG, but are entitled to receive the more generally targeted CSG. The data collection for this indicator is likely to be problematic as the SOCPEN for the CSG does not collect any information on the disability status of the applicant.

Educational status of disabled children as a measure of access to appropriate education

Core indicator 5

Disabled children attending primary and secondary school.

Sub-indicators here would stratify children according to the type of education facility, for example mainstream school, full-service school, special needs school, training centre, stimulation centre, and so on. These data would be collected by the DoE as part of their routinely collected information on school attendance, and stratified by disability status. Disability status is a category in the DoE EMIS, but data are not collected on a routine basis (see Chapter 8). Data should be analysed by education level (primary vs. secondary) as a proxy indicator of the quality of education, since the progression of disabled children from primary to secondary school presupposes an education system that is able to facilitate disabled children moving through school.

Additional indicator 2

Disabled children's attendance of Early Childhood Development facilities.

As early diagnosis and intervention are important features of high-quality services for disabled children, attendance at pre-school would provide a useful indicator of

the extent to which disabled children have access to these services, as well as the level of inclusion of disabled children.

Additional indicator 3

Placement of disabled children of school-going age outside of the formal education system or in an informal education facility.

As for the previous two indicators, while the placement of disabled children outside the formal education system has been categorised as a Type 4 indicator, it can also be used as a proxy indicator for the quality of educational services. Quality educational services ensure that disabled children progress through school and reach Grade 12 successfully. Thus, they also provide information on Type 5 indicators.

Type 5 indicators: Service quality

This group of indicators measures the quality of services for disabled children. Only indicators specific to children with disabilities are discussed, including indicators pertaining to early identification and referral of children with developmental problems.

The data for most of these indicators can be collected at a local level, either at the district office, or at hospital or clinic level, or through nationally or provincially collected data systems.

Type 5 indicators are further divided into those providing information on waiting time, caregivers' perceptions on service, number of personnel and their training levels, as well as those relating to early diagnosis and intervention programmes.

Educational attainment of disabled children as a measure of quality of educational services

Core indicator 1

Pass rates for disabled children.

Since disabled people generally have a lower level of educational attainment than the general population (Schneider et al., 1999), the number of disabled children reaching and passing grades 7 (end of primary school), 9 (end of compulsory school age) or 12 (university entrance level), as well as the proportion of these in relation to the general adolescent population, would provide a measure of the provision of services, and the quality of these services in providing an appropriate education which allows disabled children to progress through school. Information on learner pass rates is routinely collected by the DoE, but would have to be stratified by child disability status. This indicator overlaps with Type 1 indicators, which cover child status measures.

Waiting time and caregiver perceptions of services as a measure of quality of health and social services

Additional indicator 1

CDGs processed on time.

Additional indicator 2

Waiting time for first appointment for rehabilitation therapy as collected through hospital and clinic records.

Additional indicator 3

The degree of family-centredness of rehabilitation services as collected in surveys or evaluations of services undertaken at clinical level.

*Indicator 1**

Number and location or distribution of repair workshops for assistive devices at district level as reported by the DoH, and time taken for repairs to be completed.

Staff to child ratios and training as a measure of quality of services

Additional indicator 4

Number of special educational units having the required resources and training of staff to meet the needs of disabled children. These resources include aspects such as computers in the classroom for children who cannot write, Braille printing of materials, access to sign language interpreters, and so on.

Additional indicator 5

Ratio of paediatric rehabilitation staff per 100 000 children and their knowledge and skills in the field.

*Indicator 2**

Average waiting time for an assistive device as noted in assistive devices service centres. Sub-indicators could include a breakdown of the types of assistive devices.

*Indicator 3**

Ratio of paediatric social workers with appropriate training per 100 000 disabled children.

*Indicator 4**

Ratio of educators with appropriate training per 100 000 disabled children and their knowledge and skills in the field.

Developmental screening and early intervention programmes

*Indicator 5**

Primary healthcare personnel trained to do developmental screenings in children aged 0–3 years.

*Indicator 6**

Primary healthcare clinics providing developmental screening for all children under three years.

*Indicator 7**

Number and location of healthcare institutions providing early intervention services.

*Indicator 8**

Children under three years of age identified as having developmental delay or special needs who access early intervention services.

Conclusion

The monitoring of childhood disability requires a clear conceptualisation of the phenomenon, making a decision about which component should be focused on, and developing reliable, valid and tested measures. This chapter proposes that activity limitations at the person level be used as the basis for any measurement. The participation and realisation of full well-being should then be monitored through disaggregated analysis of existing data sets that make use of the activity limitation measure to determine disability status.

As highlighted above, the main issue facing the monitoring of well-being of disabled children is the fact that very little data has been collected using a variable on the disability status of children that allows for stratification of data in analysis. Until such time as we have a tested and understood measure of disability, childhood disability cannot be adequately monitored.

The use of a demographic variable indicating disability status (either a categorisation into a dichotomous variable of yes/no or into a scale reflecting degree of disability) will open the door to a range of data collection tools for adequate monitoring.

In addition to the use of national and provincial survey or Census data collected, there is a need to do more specific reviews of policies, programmes and processes to determine the disability-friendly nature of these. Many of the proposed data collection strategies still need to be developed. The indicators proposed are, by and large, those that have current data collection procedures in place.

This chapter provides a framework for understanding the monitoring of childhood disability, but much more work is required to refine these concepts and to develop appropriate measures.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 The terms 'disabled child' and 'children with disabilities' are used interchangeably as there are arguments for and against using each term, but this debate is beyond the scope of this chapter.

2 The criteria for eligibility for a CDG in July 2005 were that the child must be between 1 and 18 years of age, the caregiver (applicant) must have an income below the stipulated means test amount and the child must need full-time care because of a severe physical and/or intellectual disability.

3 The criteria for eligibility for a CSG in 2005 were that the child must be under the age of 14 years, and the primary caregiver (applicant) must have an income below the stipulated means test amount.

4 For example, brain injury would be the health condition and loss of muscle power and tone would be the impairment. Similarly, meningitis would be the health condition and hearing loss the associated impairment.

5 See also <http://esa.un.org/unsd/disability>.

6 The severity criterion is something that can be decided at different points in time with a more severe criterion being used initially in the spirit of progressive realisation of rights.

7 The Committee on the Rights of the Child has specifically requested information on the measures taken to ensure an effective evaluation of the situation of disabled children; the measures taken to ensure adequate training, including specialised training, for those responsible for the care of disabled children; the measures taken to promote the exchange of appropriate information on the prevention and treatment of disability; and the extent to which there is co-ordination and collaboration between the relevant government departments and agencies.

CHAPTER 11

Monitoring specific difficulties of learning

David Donald

Introduction: objectives and scope

Specific difficulties of learning (SDLs) have a notoriously confusing record of nomenclature and identification. Over time and across different countries, terms such as 'minimal brain dysfunction', 'dyslexia', 'specific learning disability' or 'learning disability'[1] have been used interchangeably in practice and in the literature. In particular, many of these terms have carried connotations of neurological and/or genetic deficit that are, in many cases, questionable: positive identification of the condition – even in the most sophisticated and well-resourced of situations – is, and always has been, problematic (Kriegler & Skuy, 1996). To make this clear, the relevant criteria for making a clinical or categorical diagnosis of this condition have, in summary form, generally involved the following elements (Kirk et al., 1993; Hallahan & Kauffman, 1994):

- All, or some, cognitive deficits that may include attention, perception, memory, and/or language. (These usually require specialised assessment to identify.)
- Variable patterns of specific scholastic adequacies and weaknesses – for example adequate oral language skills but poor reading and spelling – that result in a discrepancy between general intellectual ability and scholastic performance. (To establish the discrepancy, specialised individual intelligence assessment is usually required.)
- A presumed minor underlying neurological dysfunction. (This requires a neurological examination, but in few cases is a positive neurological diagnosis possible. It may, however, be suggested in specific problems of hyperactivity and/or attention – Attention Deficit Hyperactive Disorder or Attention Deficit Disorder [APA, 1994]).
- The condition is not primarily due to sensory or motor disability, not primarily due to intellectual disability, not primarily due to emotional disorder, and not primarily due to environmental factors.

Conceptually, perhaps the most important difficulty with the clinical definition is the notion that intrinsic (deficit-related) and extrinsic (environmentally-related) factors are in fact distinct and separable. This is seldom the case. Such factors invariably interact to create exacerbating cycles and developmental trajectories that are subtly interwoven (Dawes & Donald, 2000). As an example, a child with specific cognitive deficits growing up under conditions of environmental disadvantage will inevitably experience a complex interplay of these factors which is likely to result in an entirely different developmental trajectory (and set of scholastic needs) to that of

a child growing up under different environmental circumstances. Attempting to determine what is primary and what is not, in this sort of situation, is essentially non-productive – it relates to a linear model of causality and is ultimately less helpful to the child concerned than conceptualising the interactive and functional nature of the learning difficulty, and intervening accordingly.

In a context like South Africa – and for that matter in any but the most developed of countries – the clinical definition also poses considerable practical difficulties. As pointed out above, for all criteria, specialised assessment to establish a differential diagnosis is required. Such services are expensive, scarce and almost totally unavailable for the vast majority of South Africans.

Precisely because of such scarce resources, it has been impossible to gather meaningful and representative prevalence data in countries such as South Africa. Even in developed countries, the prevalence of SDLs is uncertain. The US Department of Education statistics show an increase from 3 per cent to almost 5 per cent of school-age children identified with 'learning disability' in the public school system from 1975 to 1992 (Hallahan & Kauffman, 1994). In large measure this very substantial increase has been attributed to problems of definition (Lewit & Baker, 1996) and to this category increasingly being used as a catch-all for a wide range of difficulties of learning (Kirk et al., 1993) – including, most probably, those with extrinsic involvements. There are likely to be many more children who experience difficulties of learning through gaps in their schooling or through being badly taught than there are children with genuine 'learning disabilities'. How much more so would these, as well as other poverty-related environmental factors, operate in a country like South Africa?

This then creates an ethical issue. In most developed countries, children whose needs are seen to be environmentally-related (that is, not intrinsic, deficit-related 'exceptionalities') are generally *not* seen to be in need of special educational services (Hallahan & Kaufmann, 1994). But where the overwhelming need is to identify and provide learning support to all such children – for a complex of reasons around poverty and adequacy of schooling (see under 'The evolution of current policy' below) – it is neither ethical, nor practicable, to divert scarce resources into diagnostically differentiating out environmental from cognitively-based SDLs.

Apart from this, if identification is based on *functional* criteria – what children are and are not able to do in scholastic terms – it does not require such a categorical differentiation. Indicators based on *operationalised*, functional assessments are now being recognised as not only more definitive (Benedict & Farel, 2003), but also as more useful in pointing to the specific kinds of services and help that such children require.

Although still in draft form, such indicators are, in fact, currently being developed by the Directorate of Inclusive Education (DoE, 2004a). For example, indicators over five progressive levels that represent the relative intensity of learning support (and the degree of specialised intervention) required by any one learner have been suggested (DoE, 2004a). While this is an important step in a process of developing functional indicators, operationalisation of the criteria that differentiate the progressive levels still requires considerable refinement. It is hoped that the current project, particularly in its integration of 'extrinsic' indicators, may be of some assistance in this.

Finally, in accordance with the aims of this volume, this chapter is explicitly focused on developing a practical and cost-efficient way to measure and monitor the situation of children with SDLs. Under these circumstances, it would be fatuous to develop an inevitably complex set of categorically differentiating indicators and measures that, in terms of resources and available expertise, would be impossible to apply.

Thus, in the context of this chapter, the term 'specific difficulties of learning' has an intentionally broad definition, including those with specific cognitive as well as environmental associations. As argued, the reasons why this position has been adopted are in the author's view important, conceptually, practically and ethically.

Rationale

A rights-based approach to the monitoring of child SDLs

Article 23 of the Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) states that State Parties must ensure that children with disabilities, including those with SDLs, enjoy a full and decent life; should promote self-reliance; and facilitate active participation of the community. The right of children with disabilities to special care is spelled out in this section, and it is recommended that both the child and their caregiver/s be provided with appropriate and affordable (preferably free of charge) assistance (special needs education would fall under such assistance). Assistance must be aimed at ensuring that children with SDLs have access to education which promotes independence and prepares them for employment.

Article 6 of the CRC as well as General Comment 1 of the Aims of Education (Committee on the Rights of the Child, 2001) emphasise that the right to development, including cognitive development, should be ensured 'to the maximum extent possible' (Article 6), and that the state is responsible for providing children with an education that is child-centred and empowering, and reflects attention to special developmental needs.[2] In addition, with its focus on education quality, Section 29 of the South African Constitution states that the education of the child should be directed towards developing them to their fullest potential.

The CRC (Articles 9, 28 & 29) and the Bill of Rights (Appendix 2 in this volume – Section 29) focus on equality and recognition of the right to basic and further education for all, and the Ministry of Education's commitment 'to the provision of educational opportunities in particular for those learners who experience or have experienced barriers to learning and development…' (DoE, 2001b, p. 6), taken together, constitute a clear undertaking to meet the needs of children with SDLs.

Existing provisions relevant to the rights of children with SDLs frequently focus on addressing non-discrimination and equality, specifically making reference to the notion of 'barriers to learning' and 'particular life experiences or socio-economic deprivation' (DoE, 2001b, p. 7) – that is, the cognitive and environmental dimensions of SDLs referred to previously. Article 9(3) of the CRC states clearly that children with SDLs are to be afforded the same learning opportunities as children who do not share these difficulties. Article 28 of the CRC also addresses equality, requiring the provision of compulsory primary school education which is free for

all, and the development of different forms of secondary education, which take into account the financial limitations of many families of children with specific difficulties of learning. Thus, with the ratification of the CRC and the adoption of the 1996 Constitution and the Bill of Rights, South Africa committed itself to creating access to, and provision of, a non-discriminative process of education which is appropriate to the needs of all children. Within this was a commitment to develop a policy of inclusive education for learners with special educational needs.

In essence, policies of inclusive education require that all children receive an *appropriate* education in the *least restrictive environment* that is consistent with their needs (Green, 1991). Thus, such policies may be seen as enshrining not only the right of all children to participate in schooling and relationships that are integral to their home and neighbourhood communities, but also the right to an education that is appropriate to their needs. Assessing and implementing what is appropriate to children's needs has to include an understanding of an *interaction* of factors. As well as the performance status of the child, these factors necessarily include taking into account elements of the primary care setting, the immediate social environment, relative access to schooling and learning support within that, and the quality of tuition and of learning support. Only with an integrated, holistic assessment and understanding of such interactions can educational resources be applied for the optimal benefit of all learners (Sands et al., 2001).

Current policy and provision

The evolution of current policy

Based on a rights perspective, policies of inclusive education have been widely adopted in almost all developed countries as well as some developing countries. In South Africa, what was inherited from the past, however, was a totally inadequate and divided system of meeting the needs of learners with disabilities and SDLs.

On the one hand, support services and special educational facilities were quite widely developed in those departments which had previously served the privileged minority. But the main focus of these services was to separate those with special educational needs from the mainstream and educate them in 'special schools' or 'special classes'. This was counter to the very philosophy of inclusive education (Mittler, 2000).

On the other hand, services in those departments which had served the majority were minimally developed (NEPI, 1992). In this sector, there were two main results. For many with special educational needs, attending school was just not possible. For example, a significant proportion of those with disabilities were excluded (Ministry in the Office of the President, 1996). For those who were able to attend, there was a perverse form of 'inclusion': it existed without choice and without the facilities, resources, and support needed to make it work. Thus, special educational needs were often unrecognised and neglected, resulting most commonly in repeated failure and eventual drop out (Donald et al., 2002).

The duality of this system posed a particular problem in South Africa. In terms of the rights perspective, constitutionally, and in terms of international practice,

inclusive education was not an option – it was a necessity (Lomofsky & Lazarus, 2001). However, in developed counties, inclusion has been focused on providing sufficient specialised support services to the mainstream in order to meet individual special educational needs as far as possible in that context. This has been appropriate and feasible, given two important realities. The first is that children with special educational needs in such contexts are understood to be a relatively small minority – for example, approximately 10 per cent of the school-age population in the US (Benedict & Farel, 2003; Hallahan & Kauffman, 1994). The second is that the mainstream education system itself has generally been sufficiently developed (physical resources, human resources, curriculum flexibility, and so on) to make the accommodation of these needs possible. In South Africa these two realities have been very different.

First, the number of children with special educational needs in most developing countries has long been estimated to be considerably greater than 10 per cent (Wiesenger-Ferris, 1989), South Africa being no exception. There are several reasons for this. Under conditions of poverty and social disadvantage, a number of research studies have shown how health and safety factors create substantially greater risks for physical, sensory, neurological and cognitive deficits than in developed contexts (Donald, 1994). In addition, widespread conditions of poverty and social disadvantage create a range of special educational needs which are not deficit-related, but are nevertheless extremely common (Donald, 1994). Then, as pointed out in the previous section, there is an *interactive* effect between deficits and environmental disadvantage. Taken together, these factors undoubtedly have a substantial impact on the prevalence of special educational need.

Second, the resources of mainstream schools (physical and human), the curriculum, the teaching and learning processes that happen in schools, and the poverty and disadvantaged social conditions which surround it, have, in South Africa, been far from optimally facilitative of the developmental needs of the majority of children – let alone of those with special educational needs (Donald, 1994). The introduction of a more learner-centred approach in mainstream teaching through outcomes-based education (OBE) and the new curriculum (DoE, 1997a) has undoubtedly been an important step in modifying this situation. The reality, however, still remains far from the ideal.

Such reality differences must influence priorities. These are hard lessons that are still being learned elsewhere in the world (Csapo, 1993), and particularly in other developing countries (Zimba, 1992). What is clear is that with such numbers of learners with special educational needs, and fiscal resources that are inevitably more limited, it is not feasible, *as the priority*, to attempt to provide the expensive, specialised, individual services required to meet all such needs in the mainstream.

A possible solution, originally suggested in the NEPI (1992) report, is to adopt a model of 'progressive mainstreaming'. Basically, this would involve a gradual move towards inclusive education. Learners with special needs would become progressively absorbed into the mainstream as, where, and when it developed the capacity to meet their needs. At the same time the existing system of separate special education would have to cater for more children with severe special needs from all communities. In the process, all specialised facilities would need to adapt their functions to offer a more supportive and consultative service to the mainstream.

Following the report of the National Commission (DoE, 1997b) and public discussion on the release of the Green Paper (DoE, 1999), this basic model, with a number of important conceptual and practical refinements, was ultimately recommended in the Department of Education's (DoE's) White Paper (2001b). Details of this final process are reported by Lomofsky and Lazarus (2001).

Current policy and its implementation

Flowing from the process of evolution, investigation and dialogue outlined above, and culminating in the DoE's (2001b) White Paper, the following principles may be seen as at the core of the current inclusive education policy in South Africa:

- To develop a programme of advocacy at all levels so as to facilitate a positive attitudinal shift towards inclusive education, including a conceptual shift to a systemic rather than an individual deficit focus;
- To build capacity and intersectoral collaboration at all levels, pre- and in-service training of relevant personnel being an important element of this;
- To strengthen education support services through the development of school-based[3] and district-based support teams (attached to nationally distributed Education Management Development Centres). Special schools to be strengthened and enabled to function as local resource centres;
- To develop selected primary schools as full-service schools – that is, fully inclusive and with maximum district level support – as an initial development, to be taken further as resources and readiness mature;
- To promote whole-school development and flexibility in the application of the curriculum so as to optimise the accommodation of diversity in all schools;
- As a priority, to provide appropriate funding to support the needs of the most vulnerable institutions and learners, including disabled out-of-school youth.

Implementation

While the long-term goal for full implementation is 20 years, a number of concrete steps have already been achieved in relation to each of these principles (pers. comm. Dr S. Naiker, Director: Inclusive Education Directorate, DoE, October 2004):

- Three phases of advocacy have been completed in provinces with provincial officials, district officials, school educators, the higher education sector, the disability sector and parents. A national co-ordinating structure involving provincial directors, educator unions and the disability desk in the Presidency has been set up. Conceptual and operational guidelines on full-service schools and special schools/resource centres have been set up in consultation with the mainstream and the special education sector. All Foundation and Intermediate Phase educators have been exposed to the White Paper and its implications.
- Substantial interdepartmental dialogue has taken place with the departments of justice, correctional services, health, and social development around intersectoral collaboration. The majority of institutions involved in pre-service education now include modules on inclusive education.
- An audit of all special schools has been conducted. Thirty special schools that, initially, will be converted to special schools/resource centres, and 30 districts for the establishment of district-based support teams, have been identified to constitute a pilot study of the system (see below).

- Likewise, 30 primary schools have been selected for conversion to full-service schools. Funding has been approved for the resourcing of these schools (as well as for the special schools/resource centres and district-based support teams mentioned above).
- Two national working groups have completed guidelines on curriculum adaptation, as well as screening, identification and assessment. All National Curriculum Statement Grade R to 9 documents have been Brailled and developed for low vision.
- An interdepartmental protocol to deal with youth at risk has been developed with the departments of justice and social development. Three working groups have been established to look at strengthening special schools, particularly in under-resourced provinces (disability desk in the Presidency, provincial departments of education and disability movement).

The above represents substantial progress on all the key areas of policy. Beyond this point, between 2004 and 2009, the intention is to field-test or pilot the model through the functioning of the selected full-service schools, special schools/resource centres and district-based support teams. Based on a full evaluation, the strengths and limitations of the assumptions made in the White Paper (DoE, 2001b) will then be reassessed and best practices within the initial target areas will be disseminated for wider system use (pers. comm. Dr S. Naiker, October 2004).

Focusing on SDLs in particular, positive outcomes will depend on the efficacy with which schools and classroom educators can make and implement holistic assessments such as have been referred to earlier. In turn, classroom educators will depend on the availability and efficacy of both school-based and district-based support teams in assisting them. As yet, in terms of implementation, these elements of efficacy cannot be judged.

As is true for all provisioning, there are still wide discrepancies between provinces, between rural and urban areas, and between race/class divisions in the provisioning that has been inherited from the past. Indicators that can contribute to clarifying those discrepancies will undoubtedly be valuable in the unfolding and monitoring of implementation as described above.

Well-being outcomes

As a useful shorthand, Lerner et al. (2000) have listed five key competencies (their five Cs) that are associated with positive child development. They include *competence* (intellectual ability and social and behavioural skills), *connection* (positive bonds with people and institutions), *character* (integrity and moral centredness), *confidence* (positive self-regard, a sense of self-efficacy and courage), and finally *caring or compassion* (humane values, empathy, and a sense of social justice).

For children with SDLs, the three Cs that are usually under the most risk in terms of their well-being are *competence, confidence* and *connection*.

Competence

Although intellectual ability is by definition adequate in such children, it is their scholastic competence that is compromised. In particular, it is characteristic that, because of performance weaknesses in specific scholastic skills (for example reading), achievement *in other scholastic areas* often also becomes affected (Donald et al., 2002).

In terms of well-being, therefore, the development of optimal scholastic competence becomes a primary outcome. It has a roll-on effect on both confidence and connection.

Confidence

Children with SDLs inevitably have daily experiences of inadequacy and failure; of feeling that they are not coping with what caregivers, educators, or peers might be expecting of them in terms of their age and performance. Unlike those who have disabilities which are apparent to themselves or to others, these feelings are exacerbated by a sense that they *should* be able to cope. Under these circumstances, a vicious cycle of failure is almost always set up. As performance deteriorates, these children's confidence is undermined; they begin to feel that they have no control over their performance (that is, erosion of internal locus of control); they therefore tend to give up or stop trying; the performance gets worse; confidence is further undermined; and the vicious cycle becomes progressively more entrenched (Donald et al., 2002).

Thus, in terms of well-being, children should be assisted to develop sufficient confidence in their scholastic competence to overcome setbacks and to accept challenges in daily school work so as to avoid or arrest the vicious cycle of failure.

Connection

Erosion of scholastic competence and confidence frequently has, in turn, a negative effect on social relationships. This is especially true in terms of perceived or real peer expectations and consequent feelings of social rejection or unworthiness (again, perceived or real). Children may then withdraw from social relationships or act out in aggressive or disruptive ways, which then lead to more rejection. Others may be drawn to deviant, anti-school subcultures (Dawes & Donald, 2000) – a situation that may, in turn, lead to dropping out of school. A minority of these children may be acting inappropriately in social relationships through genuine (cognitive) impairments in their ability to make social judgements (Hallahan & Kauffman, 1994). However, erosion of scholastic competence and confidence and its social effects would be as common to these children as to others.

The circular and self-reinforcing relationship of this area to confidence, and ultimately to competence, again emphasises the centrality of developing optimal scholastic competence as a primary well-being outcome.

Recommended indicators for monitoring child SDLs

At the outset in this section, it is important to distinguish between assessment for the purpose of generating indicators on the one hand, and holistic assessments for the purposes of particular school or classroom application on the other. Both require taking an interaction of factors into account. However, while assessments in a particular school or classroom context require a detailed, fine-grained analysis of situational specifics for the purpose of individual or group educational programming, indicators are designed to represent key, measurable variables that may be aggregated or disaggregated across a range of situations for the purpose of educational monitoring. Thus, while the focus of assessment in the former needs to be more exhaustive, the focus of assessment in the latter needs to be more selective – including, if necessary, proxy measures that capture the essential variability in more complex phenomena.

Within the policy of inclusive education, it is important to stress this point to avoid misunderstanding. The indicators and measures discussed below should be seen as intentionally selective; as specifically appropriate for *baseline* and *monitoring* purposes. However, the process is *not* intended to model the sort of detailed, holistic assessment of individual learner's strengths and weaknesses which should occur in any one classroom.

Because early identification is critical in cases of SDLs, it is suggested that data gathering be focused on the end of the Foundation Phase (that is, Grade 3) for Type 1 (Child status), Type 2 (Family and household environment) and Type 3 (Neighbourhood and surrounding environment) indicators. However, because intervention in the form of learning support for SDLs is most appropriate and realistic throughout the Foundation and Intermediate phases, it is suggested that data gathering for Type 4 (Service access) and Type 5 (Service quality) indicators covers these phases fully (that is, grades 1–6).

For the purposes of the different types of indicator (Types 1 to 5), data would be needed on the scholastic status of the child, as well as supports for learning in the primary care setting, the school, and the district. This data would then be aggregated to provincial and national levels. Disaggregation would be necessary in terms of age, gender, poverty level, and population group (for purposes of redress).

Type 1: Child status – identification of learners with specific difficulties of learning

Core (screening) indicator: reading performance delay (proxy for scholastic performance delay)

Reason for use

As an absolute indicator, scholastic performance delay is more problematic than it may superficially appear. Results drawn from internal school assessments are notoriously variable so that, traditionally, for the purposes of determining absolute levels of scholastic performance, standardised tests have been used. A good example which extends across international boundaries is the Third International

Mathematics and Science Study (Howie et al., 2000). However, where language performance is concerned – which is much more context-bound – the use of standardised tests is more problematic. Because the content and form of such tests do not necessarily relate to children's contexts and experience of learning (especially in relation to the curriculum to which they are exposed), the validity of this form of measurement has been questioned. This is especially true in relation to those with learning difficulties (Hallahan & Kauffman, 1994).

Thus, due to its greater validity, curriculum-based measurement[4] (Deno, 1985) has for some time been seen as a more favoured means of assessing the scholastic performance of children experiencing any form of learning difficulty (Shinn, 1989). In essence, the process involves educators recording the level at which specific curriculum-based learning outcomes are being achieved by their students and designing appropriate learning tasks and objectives in relation to their observations. Mainly, the process has been used for individual diagnostic and programming purposes. However, because it uses operationalised, functional observations based on an established curriculum structure, it also has the potential merit of meeting current trends in broad-based prevalence data gathering (Benedict & Farel, 2003). Finally, in the South African context, curriculum-based measurement is not only in line with OBE assessment methods, but it has the important advantage of being applicable across languages within the same curriculum structure.

Where SDLs are concerned, it is not necessary to gather performance data over all scholastic learning areas. Reading competence has long been recognised as a critical tool for performance in other learning areas (Bond et al., 1979). Reading competence is also especially vulnerable to SDLs associated with both cognitive factors (for example language, perceptual, attentional) and environmental factors (for example insufficient home support, missing school, poor teaching) (Donald et al., 2002). Both are areas of difficulty which it is important to capture.

Reading performance, therefore, may be taken as a useful *proxy* indicator of scholastic performance. In particular, it is those learners whose scholastic performance is significantly *delayed* – to the extent that they need education support – who need to be identified. A reading delay in the region of two years has, for practical purposes, generally been accepted as indicating the need for such support (Hallahan & Kauffman, 1994).

Measurement

To meet the requirements of curriculum-based measurement in the South African context, a test of reading performance must relate in terms of *content, task(s)* and *language* to what learners have been exposed to in the classroom, and to the learning *outcomes* and *skills* that are expected within the curriculum structure. To meet the requirements of this indicator, it must also be specifically applicable at the Grade 3 level (and taking lower than Grade 3 levels of performance into account).

Such a test has been designed and applied at the Grade 3 level to a substantial sample by the Western Cape Education Department (WCED, 2005). Because it may be applied again by the department in its learner assessment surveys, the test itself has not been released into the public domain. However, information about the structure of the test and its basis of scoring and analysis is given in Addendum A to this chapter.

As a screening instrument, applied on a national basis to determine the proportion of Grade 3 learners whose reading performance is significantly delayed, a test of a similar design would have a number of advantages. Most important, the design meets the requirements of curriculum-based measurement in the South African context. In addition, since the design uses a group-test format, it could be economically applied to large samples. The disadvantages are that considerable work would have to go into constructing and pre-testing new content (text and illustrations), translating it into all appropriate South African languages (and pre-testing these translations for equivalence), and then establishing norms for an appropriate performance cut-off representing a two-year reading delay. The fact that, at this early stage of reading development, the test measures only silent reading skills on a group-test basis – which is also a relatively unfamiliar task for these learners – could also be seen as a drawback.

An alternative to this measure, having different advantages and disadvantages, would be to make use of the Informal Reading Inventory (IRI) technique (Bond et al., 1979; Hallahan & Kauffman, 1994) to determine a two-year reading performance delay. The IRI, a curriculum-based technique, was developed mainly for educators to apply for individual programming purposes in the classroom. It is founded on the notion of three simple but basic levels of early reading performance: frustration, instructional, and independent levels. Instructional level is defined as that marginal level of reading performance above which the learner can read independently, and below which frustration sets in. In operational terms, instructional level has been taken as learners reading (word recognition and comprehension) at no more than a given error rate. In the classroom, this has conventionally been used to adjust the difficulty level of reading material that is optimal for an individual learner to work with. However, it can equally be used as a measure of reading performance delay (see Addendum B to this chapter).

There are several advantages of this measure to be used as a screening instrument for the present purposes. Performance is measured against reading material that, in terms of difficulty, language and content, is drawn from text which is at a standard level of expectation for the grades concerned within the South African curriculum. The form of the task expected of the learners is familiar in normal classroom practice. It is appropriate for assessing early reading development in that oral word recognition as well as comprehension are measured on an individual basis – as opposed to measuring only silent reading skills on a group-test basis. And it is a valuable technique for general classroom application that, without prejudicing its future use as a screening instrument, could be demonstrated to educators in the course of data gathering. Its disadvantages are that, being an individually applied instrument, it would take longer to apply than a group test and it would be more difficult to control the reliability of its application over a large-scale sample.

The choice between these two instruments for the purposes of screening is difficult. Both have somewhat different advantages and disadvantages. Since no new materials or norms for the IRI technique need to be developed, perhaps the most pragmatic route would be first to trial the use of the IRI as a measure of reading performance delay. Its reliability, especially, has not been established for this purpose. And reliability will depend, amongst other things, on the consistency and accuracy with

which the instructions for the application of the IRI, and calculation of the Reading Performance Index, are carried out (see Addendum B below). Such a trial could then establish whether it is worth pursuing this option, or whether the alternative group test should be developed – with all that that implies.

Type 2: Family and household environment – supports for learning in the home/primary care setting

A number of Type 2 indicators are relevant to the area of SDLs, but are either available in existing data, or would apply more broadly to areas such as the general learning environment. To avoid repetition, these indicators are not elaborated in this chapter (see chapters 8 and 9 in this volume). However, here is a list – with brief reasons – of those that should, nevertheless, be seen as having particular application to the area of SDLs:

- *Household structure: number of children <18 years:* the number of children cared for by the primary caregiver is likely to affect the time and quality of supervision for the extra learning requirements of children with SDLs.
- *Level of education of primary caregiver:* level of education relates to level of support (especially literacy) available to address the learning requirements of children with SDLs.
- *Employment status of primary caregiver:* unemployment creates survival stresses affecting the provision of the extra emotional and learning support required by children with SDLs.

Type 3: Neighbourhood and surrounding environment

The relevant indicators for this area are covered in chapters 3 and 4 in this volume and will not be repeated here.

Type 4: Service access

Core indicator: educator access to school-based support

Reason for use

The school-based support team is the first level of resource for educators to get help and support in devising and carrying out programmes of assistance for those with SDLs (DoE, 2004a).

Measure

Data to be gathered from school records at district level by the DoE:

- Number of schools in each district with a functioning school-based support team (WCED, 2003);
- Number of classroom educators (grades 1–6) in each district who have received individual help in relation to SDLs through the school-based support team in the past year.

Core indicator: educator access to district-based support

Reason for use

The district-based support team is the second level of resource for educators to get more specialised assessment and support in assisting those with SDLs (DoE, 2004a, 2004b). Educator access to both systemic and individual support, including access to specialists, is critical to their intervention with children with SDLs.

Measure

Data to be gathered at national level by the DoE:

- The number of functioning district-based support teams that have been established (DoE, 2004b).

Data to be gathered from school records at district level by the DoE:

- The number of schools that have received systemic help (for example in-service courses/workshops relating to SDLs) through the district-based support team in the past year;
- The number of classroom educators (grades 1–6) that have received individual help through the district-based support team in relation to SDLs in the past year.

A number of additional Type 4 indicators are relevant to the area of SDLs, but are either available in existing data, or would apply more broadly to areas such as the general learning environment. To avoid repetition, these indicators are not elaborated in this chapter. However, here is a list – with brief reasons – of those that should, nevertheless, be seen as having particular application to the area of SDLs:

- *Access to health services:* lack of access to health services creates greater risks for the development of cognitive deficits (sequelae of particular diseases and untreated medical conditions) and exacerbates existing SDLs.
- *Access to school (School enrolment):* for children with SDLs, difficulties with school enrolment – related to factors such as school registration, transfer, or costs (fees, uniforms, travel, etc.) – will have exacerbating effects on already delayed scholastic performance.
- *Access to school (School attendance):* for children with SDLs, difficulties with school attendance – related to factors such as distance from school, or safety – will have exacerbating effects on already delayed scholastic performance.

Type 5: Service quality

Core indicator: the quality of learning support available at the classroom level

Reason for use

The quality of support to learners with SDLs provided in the classroom on a daily basis by the classroom educator is the primary level of appropriate service delivery. A useful proxy for this complex variable (which would be difficult to measure practically and on a reliable basis) would be the extent to which classroom educators have had specialised post-basic training in the principles and practice of inclusive education for learners with special educational needs (LSEN), for example, a fourth year Advanced Certificate of Education or a B.Ed specialisation.

Measure

Data to be gathered from DoE records: the number of foundation and intermediate phase educators with post-basic training in the principles and practice of inclusive education for LSEN.

Both quantitative and qualitative data on both indicators below would best be gathered through a *dedicated research study* conducted by the DoE at district level (qualitative data could also be used in the department's 'best-practice' scenarios).

Core indicator: the perceived usefulness of educator guidance received from school-based and district-based support teams

Reason for use

Whether classroom educators have received what they perceive to be useful guidance in relation to those with SDLs from the school-based and/or the district-based support teams is an indication of the effectiveness of the respective support structures.

Measure

The number of grade 1–6 educators who report receiving what they perceive to be useful guidance – that is, guidance that made a difference to the scholastic performance of those with SDLs in their classes – over the past year from:

- Their school-based support team;
- Their district-based support team.

Core indicator: process of educator-based support for SDLs

Reason for use

In order to lend effective support to those with SDLs, classroom educators need to be involved in a continuous process of identification, definition of learning objectives, intervening with appropriate programmes of learning support, and evaluation; a continuously evolving process (Donald et al., 2002). Central to this is the principle of *continuous re-evaluation and programme adaptation* (DoE, 2004a). Whether educators are making use of this process, especially the central principle, is an indication of educator competence in offering effective learning support to those with SDLs at the classroom level.

Measure

The numbers of grades 1–6 educators who are able to describe and demonstrate (through classroom practice and records) the principle of continuous re-evaluation and programme adaptation in their own process of supporting those with SDLs.

A number of additional Type 4 indicators are relevant to the area of SDLs, but are either available in existing data, or would apply more broadly to areas such as the general learning environment. To avoid repetition, these indicators are not elaborated in this chapter (and are not included in the Chapter 11 indicator table in Part 2 of this volume). However, here is a list – with brief reasons – of those that should, nevertheless, be seen as having particular application to the area of SDLs:

- *Educator/learner ratio in grades 1–6:* the size of the class determines, in large measure, the time and freedom the educator has to attend to the extra learning requirements of those with SDLs.
- *Level of educator education in grades 1–6:* the level of educator education reflects the depth to which educators have been exposed to theory and practice in relation to supporting those with SDLs.

Both forms of data would need to be compared to DoE norms for these grade levels.

Core indicators and relevant data parameters are included in Part 2.

Conclusion

In conclusion, for all the reasons given in this chapter, it is critically important to develop indicators that not only clarify the *numbers* of learners who experience SDLs (whether intrinsically, extrinsically or interactionally generated), but that also indicate the *circumstances* in which SDLs are generated and maintained, the degree of *access* to learning support services for those affected, and the *quality* and effectiveness of those services that are accessed.

Without continuous data provided by such indicators, there is little hope of directly addressing the needs of what is likely to emerge as a substantial proportion of school-age children in South Africa, of attempting to prevent such needs from arising in the first place through identifying relevant contextual causes and exacerbating factors, or of monitoring the effectiveness of services and interventions.

This project is of the utmost importance for thousands of South African children, now and in the future.

Addendum A Structure of the Western Cape Education Department Grade 3 literacy test[5]

Learner tasks (Group application to Grade 3 learners)

The literacy test consisted of five sections.

- Section 1 (Grade 1 level): Reading single words. (Choose one of four pictures to match a given word.)
- Section 2 (Grade 2 level): Reading single sentences with visual cues. (Short sentences with missing word, and a choice of four words to complete the sentence.)
- Section 3 (Grade 2 level): Reading single sentences without visual cues. (Short sentences with a choice of four words to correctly complete the sentence.)
- Section 4 (Grade 3 level): Comprehension based on 'mind map' text. (Textual mind map with pictures for visual cues on which questions were based.)
- Section 5 (Grade 3 level): Comprehension based on extended passage. (Paragraph in narrative style, with photographic cues. Three short paragraphs and 12 sentences in all.)

All items, classified in terms of grade level, tested various learning outcomes (namely, learning outcomes 3, 5 and 6) and appropriate skills.

Scoring and analysis

Learner responses were scored 1/0. A less than 50 per cent score for the tasks at each grade level was taken as indicating that that learner had not achieved reading competency at that grade level. The data were then aggregated over individual schools as well as over the whole sample to indicate the proportion of Grade 3 learners who had/had not achieved reading competency at the Grade 1, the Grade 2 and the

Grade 3 levels. In addition, the sum of individual learner scores over the whole test (all grade level scores) was calculated to produce percentage performance and average data over individual schools and the whole sample.

Language

The test was constructed in English and then translated into Afrikaans and Xhosa. Learners were tested in the medium of instruction of their schools.

Content

The text and pictures in the test were based on content relevant to the South African context.

Addendum B Application of the informal reading inventory as a measure of reading performance delay

A reading performance delay in the region of two years has, for practical purposes, generally been accepted as indicating the need for learning support (Hallahan & Kauffman, 1994). However, any delay is relative to the chronological age and grade level of the child concerned. In order to define delay in more absolute terms, therefore, a ratio of reading performance age divided by chronological age for this measure is suggested as a reading performance index (RPI).

Application of the informal reading inventory

The measure should be applied at the *end* of Grade 3. It would require support-service personnel (or other trained testers) to:

1. Select three illustrated, narrative passages from standard curriculum reading material (in the appropriate language of instruction) typically used at the *end* of Grade 1, Grade 2, and Grade 3. (Passages should be close to 100 words long.)
2. Devise four content-based (literal level) comprehension questions for each passage, appropriate to each grade level.
3. Individually test each Grade 3 learner, starting with passage 1 (Grade 1) and moving upwards through passages 2 and 3. (This *must* be done out of hearing of other learners.)
4. Normal encouragement should be given, but *without* specifically helping or prompting the learner. Record the number of word recognition errors (ignoring self-corrected errors) over each passage.
5. After each passage has been read, ask the four comprehension questions. Record the number of wrong/don't know answers.

Note: Testing should stop when a learner reaches *ten or more word recognition errors* OR *two or more wrong/don't know comprehension answers* (that is, instructional level[6]).

Calculation of the RPI

The RPI should be calculated for those learners who reach instructional level on any of passages 1, 2, or 3:

1. Note the grade level of the passage at which a learner reaches instructional level.
2. Convert this grade level to the equivalent performance age (7 years at the end of Grade 1; 8 years at the end of Grade 2; 9 years at the end of Grade 3).
3. Calculate the RPI by dividing the performance age in months (for example, 7 years = 84 months) by the learner's chronological age in months (for example, 9 years 6 months = 114 months).

Those learners whose RPI = 0.80 or less may be taken as having a significant reading performance delay. For example, a nine-year-old Grade 3 learner with a performance age of seven years – that is, with an end Grade 1 reading instructional level – would have an RPI of 0.74.

Since some learners, despite current age-based promotion policy, may still be over age for Grade 3, it is possible, for example, for a Grade 3 learner who is 11 years and 4 months old to perform at Grade 3 instructional level and yet still have a significantly delayed RPI. For this reason, all learners who are more than 11 years old in Grade 3 and do not reach instructional level by the Grade 3 passage, should be tested

on a Grade 4 passage, or beyond, until they reach their instructional level. For example, a Grade 3 13-year-old who reaches instructional level on a Grade 4 passage would have a significantly delayed RPI of 0.77.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 In the UK, for instance, 'learning disability' refers not to this condition at all, but to intellectual disability.

2 Child Rights Information Network, <www.crin.org>.

3 While this summary has intentionally focused on schools, it should be noted that the White Paper refers to educational institutions at all levels.

4 This is a process that emerges from the principles of criterion-referenced testing, but goes further in its specific links to curricular structures (Hallahan & Kauffman, 1994).

5 Supplied through personal communication, WCED, June 2005.

6 In order to limit false identifications of reading performance delay, these error rates are defined conservatively (that is, at the lower limit of instructional level).

SECTION IV

Child protection domain

CHAPTER 12

Monitoring the well-being of street children from a rights perspective

Catherine L. Ward

Introduction

Identifying street children is more problematic than may appear at first, for several reasons (Panter-Brick, 2002): i) the generic term 'street children' obscures the heterogeneity in children's actual circumstances; ii) the term is not a good reflection of children's own descriptions of their lives, nor does it reflect the fluidity of the ways in which they move on and off the streets; iii) it has pejorative and/or pitying connotations; and iv) it deflects attention from the broader population of children who are poor and socially excluded. One of the most enduring definitions, which comes from the United Nations Children's Fund (UNICEF), distinguishes between children 'on the street' and children 'of the street' – respectively, children who are visible and working on the streets, but who continue to live with their families; and children who no longer live with their families and who are homeless (Ennew, 1996). However, in practice it has been found that children do not fit neatly into such categorisations (Panter-Brick, 2002).[1]

South African studies echo these difficulties. For instance, in a study of eight boys in a shelter, the time they had spent on the street varied from a few days to over a year (Donald et al., 1997), and even this recognition of variation may obscure more fluidity in children's experience with the street. Children may start by working or begging on the street but end up living there; they may have regular, even frequent contact with their families and may often sleep at home; they may have no contact with family after leaving (Baker, 1999); or they may migrate into a life on the streets via informal foster placements with other families (Motala & Smith, 2003) or institutions such as children's homes (Swart-Kruger & Donald, 1994). Children thus have, amongst themselves and over time, varying experiences of street and family life that make it difficult to differentiate street children from other children in need.

Another UNICEF term that is also often used is 'Children in Exceptionally Difficult Circumstances', or CEDC. This term was originally intended to encompass far more than street children – it was intended to include refugees, children with disabilities, children affected by organised violence, working children, children unaccompanied in disaster situations, as well as street children – but has often been used synonymously with the term 'street children' (Ennew, 1996). This broader term, however, has been criticised for including poverty and food insecurity as causes of difficult circumstances rather than as difficult circumstances in themselves (Ennew, 1996).

What underlies the recognition of the shortcomings of these terms is the recognition that poverty is what puts children at risk of becoming 'street children' (Ennew, 1996). Use of the term 'street children' can appear to delineate a distinct group of children and, in so doing, deflect attention towards the most visible tip of a large iceberg and away from the main body of that iceberg: children living in poverty (Panter-Brick, 2002). Strengthening this argument is the finding that, while street children do experience emotional, cognitive, social and physical problems, there is very little evidence that is able to distinguish risks associated with street life from risks associated with poverty, as most studies compare street children with middle-class children, rather than with the more realistic comparison group of home-based poor children (Panter-Brick, 2002, 2004). For instance, in terms of health, it is far more likely to be growing up in poverty that is the most salient risk factor for children, rather than homelessness (Panter-Brick, 2004). In fact, most studies that do include both a sufficiently large sample of children and a suitable comparison group, find no differences in physical and mental health between poor children living at home and street children, and in some cases find street children to be in better health than their counterparts at home (Panter-Brick, 2004). A possible explanation for the latter finding is that street children on their own may have a better source of income than their families as a whole. For instance, one child begging may well receive sufficient funds to buy some food for the day, while an adult begging may not receive enough to feed his or her whole family. The one area of exception to this may be in the area of sexual health, and in exposure to violence (Panter-Brick, 2004): street children may be more at risk for sexual health problems, violence and injury. However, accurate figures of experience of sexual and other violence and of sexually transmitted infections are hard to obtain. Certainly, one Cape Town programme for girls finds that they are raped as often in their home communities as on the streets, and that this has become a reason to take to the streets (pers. comm. Pam Jackson, Director, Ons Plek, 20 July 2005).

In essence, the inclusion of street children, under the Children's Act (No. 38 of 2005), with other 'children in need of care and protection' (Chapter 9), captures this notion that children may face a wide range of difficulties, and that some children in these circumstances may live, work or beg on the street. Chapter 1 gives the following definition of the term 'street child' – 'a child who:

(a) because of abuse, neglect, poverty, community upheaval or any other reason, has left his or her home, family or community and lives, begs or works on the streets; or
(b) because of inadequate care, begs or works on the streets but returns home at night.'

Clearly, the Act identifies the overlap between street children and other categories of children in need of care. However, the needs of street children are distinct in some ways from other groups of children in need of care. They have lived independently of adult care and often resist formal service provision. The most successful way to work with street children is to offer them a range of services and to allow them to refer themselves (National Alliance for Street Children, 2005; National Association of Child Care Workers, 2005).

Aside from intervening with children who are already street children, preventing children from reaching the streets is increasingly recognised as a key area (Swart,

1990; the National Alliance for Street Children, 2005). This recognises the importance of protecting poor children's rights before their situations become so dire that they begin to beg, work or live on the streets, a task that is facilitated by the fact that street children often come from the same small areas – the same street or even the same block of flats (Cockburn, 1991). This is being recognised by the introduction of a third categorisation of street children, in addition to UNICEF's notions of 'children of the street' and 'children on the street': 'children for the street' – children who live in poverty, suffer difficult family circumstances such as family break up and abuse, who do not go to school, and who are at risk of begging, working or living on the street (Baker, 1999).

The Children's Amendment Bill (No. 19 of 2006) had not been passed into law at the time of writing, but was before the National Council of Provinces as a 'Section 76 Bill'. Under Chapter 14, the Bill deals with shelters and drop-in centres for children living on the streets. Under Section 213(1), the following definition of a shelter is provided:

> A shelter is a facility located at a specific place which is managed for the purpose of providing basic services, including overnight accommodation and food, to children, including street children, who voluntarily attend the facility but who are free to leave.

Under Section 213(2), a drop-in centre is described as:

> a facility located at a specific place which is managed for the purpose of providing basic services, excluding overnight accommodation, to children, including street children, who voluntarily attend the facility but who are free to leave.

These facilities qualify for provincial government subsidies if they comply with minimum standards (Section 220) and are registered with the relevant department. Such facilities must be regularly inspected by the department.

South African street children

As with the literature on street children in general (Panter-Brick, 2004), the literature in South Africa is sparse and not always of good quality. This section provides a brief review of the available literature to set the context for the indicators in Part 2 of this volume.

The extent of the problem

One of the first questions about street children is how many there are. This figure can itself be regarded as an indicator of the state of South Africa's children, in that it represents the tip of the poverty iceberg. However, because of the fluid nature of children's lives on the street and their reticence to engage with authority, they are very difficult to count. National estimates currently available date from the early 1990s and include children working on farms. These estimates were in the region of 9 000–10 000 nationally, with less than 10 per cent of these being 'of the street' (Richter, 1991; Swart-Kruger & Donald, 1994). One of the only recent studies

available found 782 children aged 0–18 living on the streets of greater Cape Town (CMC, 2000). Consistent with the structured poverty entrenched by the apartheid system (Swart-Kruger & Donald, 1994), older studies identified street children as black and coloured, and found no white children in their samples (Richter, 1991; Le Roux, 1996; Motala & Smith, 2003). More recently, however, service providers report that although white children remain in the minority, white children are now amongst those they serve (pers. comm. Pam Jackson, 24 November 2005; and Annette Cockburn, former director of The Homestead, and private consultant on street children matters, 29 November 2005).

Most street children are male and aged between 7 and 18, although the majority are likely to be between 13 and 16 (Richter, 1991). Some authors suggest that girls are less likely to take to the streets as neighbours and extended family are more likely to take them in because they are perceived as able to contribute to households by participating in chores and childcare (Swart-Kruger & Donald, 1994). However, the gender estimates may be inaccurate, as some female street children may be 'hidden' in that they may be working as commercial sex workers (Richter, 1991), although this is not true of all female street children (Motala & Smith, 2003).

Clearly, the implementation of an indicator system will assist greatly in estimating the number and demographics of children presently living on the streets in South Africa.

Reasons for leaving home

The event that leads to children beginning to beg, work or live on the street occurs against a backdrop of poverty. Parents' inability to provide food for their children and/or to pay school fees often plays a role in children playing truant from school and ultimately leaving home, or being needed to bring an income into the family (Swart-Kruger & Donald, 1994). In many cases, the streets offer children a better survival prospect than their homes (Baker, 1999). Rapid industrialisation, urbanisation and westernisation have led to weakening of extended family systems, so that the family is less able to provide a safety net to children (Swart-Kruger & Donald, 1994). In addition, there were fewer and less adequate support structures (such as places of safety and children's homes) for children of colour under the apartheid regime, and studies of this era indicate that a large proportion of street children – some suggest as much as half – are secondary runaways from such institutions (Richter, 1991). In addition, the Group Areas Act (No. 41 of 1950), the migrant labour system and influx control together prevented families from moving intact to the cities, and so contributed to the breakdown of families (Swart-Kruger & Donald, 1994; Baker, 1999).

Against this backdrop, reasons for leaving may be categorised both as 'push' and as 'pull' factors: children leave home in order to escape what they view as an intolerable situation, and in the hope of finding something better. Amongst the push factors, they number discord between themselves and family members and family violence (sometimes fuelled by substance abuse); discord with neighbours; fear of punishment; a lack of safety in their neighbourhoods; school difficulties (both with the work and with paying fees); and household homelessness (Schärf et al., 1986; Richter, 1991; Swart-Kruger & Donald, 1994; Baker, 1999). Amongst the pull factors

they list the influence of friends or family members who are already on the streets, the freedom of the street lifestyle, and the need to find an income (Schärf et al., 1986; Richter, 1991; Baker, 1999). Some, more neutrally, are accidentally separated from their families and/or lack the money to return home (Richter, 1991; Baker, 1999). Despite having left home, often because they were being abused, many children demonstrate a longing to return or to find a substitute family (Richter, 1996).

In addition, most recently, some authors suggest that the HIV/AIDS pandemic may increase children's homelessness (Baker, 1999). Anecdotal evidence suggests that a number of street children in Cape Town are AIDS orphans.

Educational needs

Among street children, the frequency of reports of experiences of school failure, and of harsh punishment, is startling (Swart-Kruger & Donald, 1994). Not only are they failed by their families, but they are also failed by the school system (Schärf et al., 1986). Many children find themselves unable to attend school because their parents cannot afford the fees, or pay for the uniform or books (Schärf et al., 1986; Richter, 1991; Swart-Kruger & Donald, 1994). Most street children, therefore, are functionally illiterate, and while most say they want to return to school, only about a third will find this relatively unproblematic – others are likely to be handicapped by being too old for the grade, or by learning and other disabilities (Richter, 1991). Children may also be reluctant to return to an institution which has painful associations. Several programmes have been developed that creatively attempt to provide ways to address children's educational needs. For instance, one programme creates opportunities for students training as teachers to coach children individually (Smith, 2000); another uses an outreach programme to draw children into services[2] where, amongst other programmes, they can be helped to achieve functional literacy, vocational skills or even be reintegrated into the formal school system (Le Roux, 1994).

Experiences on the street

According to Richter (1991), about half of street children leave home with a friend or family member. Once on the street, they are quickly absorbed into established networks. These groups of children provide routines for the day (including where to sleep and where to obtain food), and safety and companionship. In most cases, these networks are supportive, although fights and betrayal do occur. They obtain money and/or food through begging or through working, with work consisting of carrying parcels, guarding cars, or selling for hawkers. Children may also 'carry' drugs for drug dealers, or trade sex for money or protection. They are often the victims of theft, and face harassment from the police. Most have been arrested at least once, and many report abuse at the hands of the police (Schärf et al., 1986).

Physical development and health problems

The chief risks to the health of street children lie in their lack of shelter and concomitant exposure to cold and damp; their vulnerability to traffic accidents (often when intoxicated from sniffing glue, paint or thinners); the high levels of

violence and abuse they suffer from other street dwellers, gangs, and the police; lack of adequate nutrition; substance use; and the high risk of contracting sexually transmitted infections, especially HIV (Swart-Kruger & Donald, 1994). To these may also be added illness and infections associated with lack of adequate ablution facilities, such as dental caries, sores, rashes, scabies, and urinary tract infections (Nzimakwe & Brookes, 1994). While children do report that they can access healthcare, they do not always do this, and some injuries and conditions go untreated and can result in deformities (Nzimakwe & Brookes, 1994). In addition, children are unlikely to receive immunisations (Nzimakwe & Brookes, 1994). In one study, about one-third of children had some kind of physical deformity, perceptual problem or manifest psychological disorder, and about one-third had received a blow to the head. In addition, about one-third showed signs of anxiety and/or depression (Richter, 1991).

Many children on the street abuse substances, most commonly solvents such as glue and thinners, but also alcohol, marijuana and other drugs (Richter, 1991). They report that use is primarily to block out their experiences of fear, cold and hunger. Studies of the effects of glue sniffing are equivocal. One study, which examined children with a long history of solvent use who were no longer using, found multiple deficits including visual-spatial difficulties, visual scanning problems, language problems, motor incoordination, memory deficits, attention and concentration problems, and cerebellar signs (Jansen et al., 1990). However, a later study which compared street children who had sniffed glue with those who had not, found that both groups displayed visuo-motor and problem-solving difficulties, poor judgement, weak logical thinking strategies and slow performance on speeded tasks. Shelter staff rated the group who had used glue to be more behaviourally disturbed than those who had not, but this finding is not robust as the staff were not blind to the aims of the study (Jansen et al., 1992). It is most likely, therefore, that children who end up on the street have a range of problems that act as barriers to success in school, and that these problems both pre-date and play a role in their taking to the streets. While the long-term effects of their substance use may not be clear, it is clear, however, that sniffing glue places them at high risk for injury in pedestrian traffic accidents.

In terms of their risk for HIV infection, street children are judged to be at high risk because they tend to become sexually active at a young age, have more partners, are less likely to use condoms, use alcohol and drugs more frequently than other youth, and are vulnerable to rape and various forms of 'survival sex' (Richter, 1997). In one study of boys, their AIDS knowledge was comparable to that of other 'hard-to-reach' groups, but it was equally clear that fear of infection was not a concern in their list of day-to-day priorities, which focused on their immediate needs for food, clothing and shelter (Swart-Kruger & Richter, 1997).

Emotional, social and cognitive development

In an excellent review of the literature on street children, David Donald and Jill Swart-Kruger (1994) recognise that street children evidence risk and vulnerability in the areas of emotional, social and cognitive development, as well as physical development.

In terms of emotional development, the primary loss is that of an adult caregiver relationship. Although children may retain some contact with their homes, they usually have experienced their homes as hostile, rejecting and/or abusive. This particular loss has profound implications for children's development, in that it affects basic emotional security and trust. In addition, many street children are reported to suffer from anxiety and depression, or to show regressed behaviours such as enuresis (Richter, 1991).

Socially, children may have developed identities as social rejects, or have incorporated criminal, amoral or opportunist notions into their identities. Richter (1991) also notes that the children tend to have a strong fear of being left alone and unloved. Their peer relationships are erratic and unstable. In the cognitive domain, as described above, children may have many deficits in cognitive and neuro-psychological functions such as attention, concentration and memory. These problems will both lead to, and be compounded by, loss of schooling.

However, it should never be overlooked that street children show considerable signs of resilience (Donald & Swart-Kruger, 1994). They are ingenious in finding shelter, and often in engaging adults to assist them with getting food or keeping their belongings. The literature is replete with such stories as children using local church offices to store their belongings during the day (Stavrou, 2001), or enlisting the aid of shopkeepers when one of their number has been injured in a pedestrian accident (Schärf et al., 1986). Although their peer relations are erratic, they do provide an experience of peer support and bonding. They maintain notions of morality and hold their peers to these. In terms of their identities, they place a great deal of value on 'freedom' and are able to act with autonomy. They may also identify themselves as survivors. Although they may experience cognitive deficits, they may also show great skill at problem solving, and are highly likely to have developed informal mathematical skills. For instance, both buying and selling and the game 'tiekie-dice' (frequently played among street children) require quick computations (Kruger, 1997).

Intervention with street children

Street children are in need of unique interventions, distinct from other children in need of care. Their strong drive towards autonomy and their tendency to run from problems (Richter, 1991) mean that traditional children's homes are inappropriate placements (Keen, 1991). Amongst the possible strategies are outreach work on the streets (going to where children are, befriending them and acting as a resource); soup kitchens; drop-in centres (non-residential centres that provide food, washing and other services); skills training and alternative education programmes; intake shelters; interventions via the Children's Court; and children's homes that can cater for the specific needs of ex-street children (Keen, 1991). In offering this range of services, children can begin to build trust with the staff of the interventions, and this improves the chances that children will increasingly use these services and ultimately either be returned to their communities of origin or, if this is not possible, be able to make a commitment to an alternative placement such as a children's home.

Although returning children to their communities is the gold standard as an outcome for work with street children, it is crucial that if the child is returned to his

or her family, the reasons the child left home are addressed before reintegration takes place. Children who are simply returned home face the same situation they left, and may be punished for bringing disgrace on the family through involving the police or social workers. In fact, fear of precisely this may well lead children to lie about where they come from (Swart, 1990).

Preventive services, services that can recognise early warning signs that a child may be moving towards leaving home (such as a child out of school), should also be established (Keen, 1991).

In addition to this range of services, children may well need services that assist them to make the transition back into the formal education system, or that assist them with gaining sufficient vocational skills if reintegration into formal education is not necessary (Keen, 1991).

Monitoring the well-being of street children

Since street children represent the tip of the iceberg that is children living in poverty, one of the first indicators should be the proportion of children who are 'street children'. This may give an overall indication of the effects of poverty on South African families. Given the difficulties inherent both in the lack of precision in the term itself, and the difficulties in counting children who live on the streets, the most feasible indicator is to monitor the number of children who access services each year. Although even this will not provide a clear, distinct total, as some children will access more than one type of service (for instance, a child may use a soup kitchen and a drop-in centre), these numbers will provide at least a rough indication of the extent of children who identify themselves as being in need of such services. Some children may also access only alternative learning centres, so these should be included in monitoring mechanisms.

Beyond this, there are other areas in which the rights of this specific group of children need to be monitored. These should be monitored via service providers, because this is the only feasible way to collect the data. Because there is a considerable overlap in the needs and experiences of street children and other special groups of children, rather than duplicating indicators, readers are referred to other chapters where indicators already exist. However, precisely because these children access a unique set of services, it is important to monitor their well-being as a group, rather than merging their data with other groups. For instance, although they are recognised by the Children's Act as 'children in need of care', collecting data via service providers specifically serving this group of children ensures that any special needs of this group of children are not lost in the data of the much broader group of children in need of care.

Below, therefore, is some discussion of indicators that should be used by service providers to monitor the well-being of street children, together with discussion of the relationship of these indicators to the Convention on the Rights of the Child (CRC – see Appendix 1 in this volume), the Bill of Rights (see Appendix 2, this volume) in the South African Constitution, and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3, this volume). All of the indicators should be disaggregated by race, by gender and by age group (7–11, 12–15, 16 and

over), as this disaggregation will make it possible to assess whether there are specific subgroups whose rights are not being fulfilled.

Type 3 indicators: Neighbourhood and surrounding environment

The mere existence of street children indicates a failure of the social system to support families in raising their children. Several indicators are thus proposed so that, via street children, the wider context of children's rights can be monitored.

First, data on the proportion of children who are street children will – especially through monitoring changes in this figure over time – provide a rough assessment of whether families are adequately supported in raising their children. Increases in this figure would indicate, in very general terms, increases in pressures on families that undermine their ability to care for their children, and failures in social security to compensate for these pressures. Likewise, decreases in this proportion will indicate successes in these areas. Assessing this, however, requires an on-the-street census with highly trained fieldworkers who are familiar both to street children and with the places where street children are likely to be found. Because of the practical difficulties of such a census, this is rated as an additional indicator. A rougher but still useful indication can be obtained by examining the number of children attempting to access services (see Type 4 indicators below).

More specifics of the failure of the social safety net can be obtained during early intervention programmes for families at risk (what factors are jeopardising their ability to care for their children?), and by examining reasons children left home and reasons placements of children break down. This will make it possible to assess, even if approximately, any gap between the ability of families and the support of the state in meeting children's right to access to social security (section 27(1)(c) of the Bill of Rights), their right to have access to sufficient food and water, and to adequate nutrition (sections 27(1)(b) and (1)(c) of the Bill of Rights). If, for instance, the majority of children using services for street children indicate that they left home because of a lack of food at home and that the family had not been able to access a Child Support Grant (CSG), this indicates a clear intervention point for prevention.

Type 4 and 5 indicators: Service access and Service quality

Several types of services are necessary in order to ensure that the well-being of children on the street is promoted. Children who end up on the street often have, aside from their basic need for shelter and nutrition, complex mental and physical health problems that must be addressed if they are to achieve more stable lifestyles off the street.

The existence of quality, accessible services

Manifestly, children living on the street are not under the protection of a family unit. Under Article 20 of the CRC, such children are entitled to 'special protection and assistance provided by the State'. The AC (Article 25) and the Bill of Rights (Article 28) make similar statements. In addition, Section 26 of the Bill of Rights states that everyone (including children) has the right to access to adequate housing, and under

Section 28(1)(c) children have the additional right to shelter. It is also clear from these documents that the duty-bearer in this case is the state.

Thus the first indicator is that there are sufficient services to meet the demand for services – that the number of children trying to access services does not outstrip the ability of services to meet the needs. In addition, a range of facilities (from drop-in centres to residential services) should be available, and should be registered to provide the services they actually provide. For instance, drop-in centres should be registered as drop-in facilities and not as residential facilities. Facilities that are providing services in a category in which they are not registered may not be appropriately regulated, and this may mean that children are placed at risk through receiving inappropriate or under-resourced services.

There is, however, an additional aspect of access to shelter services: children often begin their lives on the street close to home, but drift towards the city centres, where they may be more likely to find opportunities to work or to gain food. In order to intervene as early as possible (and hence to maximise the possibility of successfully reintegrating the child into family life), it is critical that facilities be established in the areas from which street children tend to originate. If this is not monitored, cities run the risk of over-providing services in the central business district (CBD), in response to business and political pressure to clean up the city, and thus of creating unnecessary duplication of services at the expense of children living in poverty elsewhere (*Cape Times* 8 November 2004). At a city level, therefore, the position of services should be monitored, and while there should be some services in the CBD, prevention and other services should also be strategically placed near or in the areas from which street children disproportionately come.

Finally, service providers report difficulty in accessing services for street children who do not have birth certificates or (where they are old enough) identity documents, and they report difficulty in obtaining such documents for the children.

In addition to accessible services, these should also be quality services. Article 3 of the CRC explicitly states that, 'States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.' Other articles that bear on service quality include Article 27 of the CRC, which emphasises the 'right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development', and Article 25 (the right to a periodic review of treatment), which could also be understood to apply to services for street children in that they need to provide more than simply shelter: they also need to provide services that promote development. Article 39 of the CRC states that, 'States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.' This article provides the benchmark against which all services to street children should be measured. Enshrined in all these documents is also the right to protection, a right that must be made a part of how the service

operates (for example, the right to protection from child abuse). Providing shelter, however, goes beyond protection – it must also enable the child's recovery from the experiences that drove them onto the street, and their future development. The indicators for monitoring the quality of services can be found in Chapter 15 in this volume. However, care should be taken to examine services for street children separately from other services for children in need of care, as shelters have tended to receive lower state subsidies than children's homes, and these lower levels of funding have the potential to result in lower standards of care for street children.

Existence of quality education services

Some street children do not access any services but instead come to alternative education centres such as Learn to Live and StreetWise. These alternative education centres usually assess the children and attempt to integrate them back into mainstream schooling, but also provide adult basic education services. Learning centres should, as a mark of their service quality, be registered as private schools and provide training that meets the standards of the South African Qualifications Authority for adult basic education.

Access to services through law enforcement

Street children frequently report abusive encounters with police (Schärf et al., 1986; Swart, 1990) and with the private security companies that have recently been installed in many city areas (pers. comm. Directors of Ons Plek Projects, the Hostel at the Salesian Institute, The Homestead, and No Limits, 20 July 2005). Practices such as detaining children without charging them, and removing them from central city areas and dumping them on the outskirts of town infringe Section 12 of the Bill of Rights, the right of every person to freedom and security of person. Section 12 applies to all people, and children have additional protection under Section 28(1)(d), the right to protection from abuse. Since the police and security officers do encounter street children, they could – and sometimes do (Swart, 1990) – provide a point through which children could access services. However, the fact that this does not appear to be happening consistently in the case of street children indicates that police and private security companies need a protocol for dealing with street children. This protocol must include referral to services, as well as a ban on abuse. Having a protocol is not sufficient, however – officers also need to be trained so that they are aware of the protocol and are able to implement it. In addition to giving practical form to the rights mentioned earlier, such a protocol would also meet the directives of Section 10 of the Bill of Rights, the right to have one's dignity respected and protected.

Type 1 indicators: Child status

The first five sets of indicators described below (birth certificates and identity documents, health, disability services, education, and encounters with police) must be monitored at the level of the individual child, for they encompass important child outcomes. However, they can also be used as Type 4 and 5 indicators when the data are reviewed for groups of street children – they can be used to assess the extent to which these services are meeting the needs and fulfilling the rights of this particular group of children, which has a specific set of needs and difficulties for service

provision. The indicators should be read against the backdrop of indicators in other areas. For instance, data revealing that no street child who has a substance abuse problem has received treatment, may indicate that no age-appropriate services are available (i.e., that no children, regardless of whether they are street children or not, are not receiving services), or that substance abuse services are presenting particular barriers to this group of children (for instance, services are specifically refused to street children). Thus these indicators can be used, in concert with indicators described in other chapters in this volume, to investigate service access and quality, as well as child outcomes, for this particular group of children.

The possession of birth certificates and identity documents

The CRC (Article 7), the Bill of Rights (Article 28(1)(a)), and the AC (Article 6) all address the right of the child to have a name and a nationality. While these documents intend to address the right to have an identity per se, the possession of a birth certificate and an identity document are also essential prerequisites for accessing services (such as a CSG or a disability grant). It is therefore essential to monitor whether a child has a birth certificate and, if old enough, an identity document.

A small proportion of street children in South African are foreign nationals. While they may possess identity documents, these are often falsified and services find it very difficult to identify their country of origin. The rights of these children are not less than the rights of South African nationals, and are addressed in Article 22 of the CRC and Article 23 of the AC (such children should 'receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties'). The AC explicitly says that, 'Where no parents, legal guardians or close relatives can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his family environment for any reason.'

Healthcare

All three rights documents emphasise the right 'to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' (CRC Article 24). Article 14 of the AC and sections 27(1) and 28(1)(c) of the Bill of Rights also enshrine the right to healthcare and access to social security. Substance abuse treatment is also addressed in Article 33 of the CRC and Article 28 of the AC: 'States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances.' For a child who is regularly using substances and who may be addicted to them, the only way to fulfil this right is to provide age-appropriate treatment. Physical and mental health problems are prevalent amongst the population of street children, and a particular problem is accessing mental health and substance abuse treatment services for this population. While details of quality health services can be found in chapters 5 and 6 in this volume, it is critical that attention be paid to this population in particular. The indicator thus is whether the care staff has been able to access services for each health problem of each child.

Disability services

The rights of children with disabilities are enshrined in Article 23 of the CRC ('a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community') and similarly in Article 13 of the AC. Both also emphasise the duty of the state to provide appropriate resources so that these rights may be fulfilled. Again, while the rights of children with disabilities are covered in detail in Chapter 10 in this volume, specific attention should be paid to street children. The indicator is thus similar to that with regard to access to health services: whether shelters have been able to access services for these disabilities and, where necessary, access a disability grant.

Education

As with access to health, all three rights documents explicitly mention the right to education – CRC Article 28, AC Article 11 and Section 29 in the Bill of Rights. Access to education for street children, however, may be compromised by the difficulties attendant on getting children into school at different points in the school year (rather than more traditional points, such as the beginning of the year) and with inadequate records, and by the range of learning and other disabilities that may compromise children's education. Anecdotal evidence suggests that children are often placed with their age peers, rather than being assessed for their ability and placed in grades where they may have the opportunity to make up work they have missed. Children placed with their age group may not be able to catch up what they have missed, and they then fare poorly, increasing the risk of dropout and a return to the streets. Of course, placing children with an ability group that is very much younger than they are carries its own set of problems. Children may thus need remedial help or other appropriate educational assessment. The key indicators here, therefore, are: i) whether the child has been appropriately assessed and placed with an appropriate ability group; and ii) whether the child is in school. This latter should be monitored monthly while the child is receiving services (such as living in an intake shelter or children's home), and for at least six months after a return to the community. In addition, an indicator should also be used to assess whether children who have special educational needs are receiving the appropriate support services.

Often, the assessment and reintegration of children into mainstream education is managed through an alternative learning centre. However, for some children reintegration is not a realistic option, and in these cases the children receive adult basic education training that aims to assist them to achieve functional literacy. For those children who are not reintegrated into mainstream schooling one educational indicator should therefore track whether children achieve functional literacy.

Encounters with law enforcement

While children's rights with regard to the law have been dealt with more comprehensively in Chapter 16 in this volume, service providers can also monitor children's encounters with the police, and whether they receive appropriate treatment from police officers and those working for private security companies. This is key in terms of Section 9(1) of the South African Bill of Rights, which provides that 'everyone is equal before the law and has the right to equal protection

and benefit of the law'. In addition, this would monitor the right to human dignity that is entrenched in Section 10 of the Bill of Rights.

Placement of children

The goal of service providers working with street children is to reintegrate them into their communities of origin – either into their original family or, if that is not possible, into extended family or a host family. This is in line with the child's rights to family care or parental care (Bill of Rights Section 28(1)(b)); the child's rights to maintain personal relations and direct contact with both parents (AC Article 19; CRC Article 9); and the right of the family to be protected and supported (AC Article 18). While of course the rights of the child to protection from abuse, neglect and exploitation must be paramount in making decisions about reuniting a child with their family, ultimately this achieves the fulfilment of children's rights, and their rehabilitation, far more effectively than keeping them in a residential care facility (although there will be a minority of children who will need long-term care because reunification with families is impossible). Indicators for reunification of children with their families, and for other placement alternatives, can be found in Chapter 15 in this volume.

Conclusion

An indicator system that uniquely focuses on street children will achieve two key functions: it will provide some indication of children living in poverty, and it will play a role in ensuring that the most vulnerable of our poor children have their rights fulfilled and opportunities for well-being maximised. At present, the only good data available on the numbers of children living on the streets date from 1999 and are available only for the metropolitan area of Cape Town (CMC, 2000). Nor is good data available from shelters and, in fact, it is likely that there are many organisations providing services to street children which are not registered with the Department of Social Development, at least in the Western Cape (Dawes, Long et al., 2006). The Children's Amendment Bill (19 of 2006), which explicitly requires registration of shelters and drop-in centres, should facilitate improvements in the data available about the situation of street children, as well as ensuring that such facilities meet minimum standards. This attention to one of the most socially excluded groups of children is long overdue.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 I am grateful to Reneé Rossouw and Pam Jackson from Ons Plek, Mariette Swart from No Limits, Greg Berry from The Salesian Institute, Sandra Morreira from The Homestead, and Paula Proudlock of The Children's Institute, for their expert advice. Pam Jackson, Annette Cockburn, Greg Berry and Paula Proudlock in particular provided very helpful reviews of earlier drafts of this chapter – thank you.

2 The term 'services' is used throughout this chapter to refer to the full range of services that may be offered to street children, from soup kitchens to children's homes. Similarly, 'service providers' is the term used here for those who staff these services. Where other services (such as health or education services) are intended, the context should make this clear.

CHAPTER 13

Monitoring the worst forms of child labour, trafficking and child commercial sexual exploitation

Lucie Cluver, Rachel Bray and Andrew Dawes

Introduction

South Africa has one of the world's most comprehensive pieces of legislation that addresses the interlinked problems of harmful child labour (including use of children in the drug trade), trafficking of children (including organ trafficking and illegal adoption), and child commercial sexual exploitation (CCSE) (including involvement in the production of child pornography). The Children's Act (No. 38 of 2005), and the Children's Amendment Bill (No. 19 of 2006) create an unprecedented opportunity to develop systems both for monitoring these problems, and for the provision of relevant services.

The task is a daunting one, not least because these abusive practices are distinguished by their illegality and taboo nature. Victims and perpetrators are detached from the administrative, community and research frameworks which facilitate effective data collection.

Similarly, and because of their illicit nature, counting the numbers of children involved in these activities has proven to be extraordinarily difficult. As Ennew et al. (1996) have noted, claims as to the numbers of children in the industry are more often than not 'guestimates'. The situation is no less true in South Africa where there is no reliable prevalence information on children exposed to the activities that are the subject of this chapter.

In spite of the challenges, if we are to develop interventions for prevention and rehabilitation of affected children, nationally accepted systems are required that can provide reasonable estimates of the numbers of children involved in these practices, where the problems are most acute and the conditions that place children most at risk. Optimally, for planning services, data are necessary at a small-area level (this may be particularly relevant in, for example, identifying urban concentrations of child prostitution or begging). Furthermore, as a signatory to the Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) (UNICEF, 1989) and International Labour Organisation (ILO) Convention 182, the South African government has an obligation to collect and report the most accurate data possible on these forms of child exploitation.

That said, international experience tells us that given the nature of these problems, it will simply not be possible to generate accurate figures on the numbers of children

involved. Efforts will probably be better spent in understanding the social conditions that generate the problems and taking steps to reduce them, while being vigilant to the situation of children in such high-risk conditions.

The purpose of this chapter is to propose a set of indicators and sources of data for monitoring patterns of harmful labour, trafficking and commercial sexual exploitation of children. Clearly, these areas must also be understood as existing within the broader framework of child abuse (see Chapter 14 in this volume). Of related relevance are also chapters 3, 4, 12 and 16.

In developing indicators, we have attempted to incorporate those recommended by a range of relevant international organisations, such as the ILO, the United Nations Children's Fund (UNICEF), and Save the Children, in addition to South African organisations promoting children's rights. We have also drawn on lessons learned in other countries with experience in monitoring these problems, such as Thailand and the UK (Ennew et al., 1996). We have prioritised indicators for which data are currently available in existing administrative systems and national surveys, or that can be disaggregated from available data.

We begin with an outline of the definitions of harmful child labour, child trafficking, and child commercial exploitation, in line with the Children's Act (No. 38 of 2005), and the Children's Amendment Bill (No. 19 of 2006). We briefly explore the distinctions and commonalities between the problems grouped together in this chapter with reference to a conceptual framework. The subsequent sections outline current knowledge of the South African situation, underlying risk factors and existing service responses, all of which inform the design of a monitoring system specific to the nature of these problems in South Africa. The chapter continues by discussing international attempts to monitor incidence and patterns, and the challenges that lie therein. Thereafter we examine the relevant legislation (both international and national) within a child rights framework, focusing especially on the new provisions found in the Children's Act and the associated Bill. Finally, we recommend a set of indicators that are aligned with the CRC, the South African Constitution, the Children's Act and Bill and other relevant legislation.

Definitions

For the purposes of the problems described in this chapter, a child is defined as a person under the age of 18 in accordance with the relevant international conventions, the South African Bill of Rights (Section 28(3) – see Appendix 2 in this volume), the Children's Act and the Children's Amendment Bill.

Where commercial sexual exploitation of children is concerned, we follow both the international and national legislation which defines all forms of such exploitation as a form of child abuse, and maintains the under-18 definition of childhood regardless of whether homosexual or heterosexual practices are involved.

There are a number of available definitions of child exposure to hazardous labour, commercial sexual exploitation of children, and child trafficking. Examples include the ILO, UNICEF and Human Rights Watch definitions. However, the primary

source for South Africa regarding definitions must be the Children's Act and relevant provisions in the Bill. For the purposes of this chapter we shall be using the Act and the latest draft of the Children's Amendment Bill, with the presumption that the Bill will be passed into law within the next two years.

Child labour

Following a recent consultative process towards forming the state's Child Labour Action Programme (CLAP), the following definition of child labour has been agreed on by government and other stakeholders:

> Work by children under 18 which is exploitative, hazardous or otherwise inappropriate for their age, detrimental to their schooling, or their social, physical, mental, spiritual or moral development. The term 'work' is not limited to work for gain but includes chores or household activities in the child's household, where such work is exploitative, hazardous or otherwise inappropriate for their age or detrimental to their development. (DoL, 2003, p. 5)

Chapter 1 of the Children's Act defines 'child labour' as work by a child that:
(a) is exploitative, hazardous or otherwise inappropriate for a person of that age; and
(b) places at risk the child's well-being, education, physical or mental health, or spiritual, moral, emotional or social development.

For the purposes of this chapter, and in order to distinguish these types of child labour from the wider category of non-harmful child labour, we shall use the terms 'harmful', 'hazardous' or 'exploitative' in addition to 'child labour'.

The wider definition of 'child exploitation' in the Act includes various labour practices, as well as the removal of body parts for sale (or 'organ trafficking'). 'Exploitation' in relation to a child includes:
(a) All forms of slavery or practices similar to slavery, including debt bondage or forced marriage;
(b) sexual exploitation;
(c) servitude;
(d) forced labour or services;
(e) child labour prohibited in terms of section 141; and
(f) the removal of body parts.

Distinctions as to what constitutes unacceptable child labour are normally based on judgements as to the age appropriateness of the activity, and are therefore open to qualification.

ILO protocols state that each country should determine age cut-offs for particular work activities. At present, South Africa's Basic Conditions of Employment Act (BCEA) (No. 75 of 1997) and the BCEA Amendment Act (No. 11 of 2002) prohibit the employment of anyone under 15 years (the minimum school-leaving age). An employee is defined as someone who works for another person and is remunerated, or who assists in carrying on or conducting the business of an employer. Interestingly, the scope of this Act is widened by the fact that it gives the Minister of Labour the power to deem any category of persons to be employees for the purposes of the Act.

The BCEA further prohibits the employment of anyone over 15 years but under 18 years of age if the employment is either inappropriate for the age of the child, or if the work places the child's well-being and development at risk, or if it has been prohibited by the Minister of Labour through regulations.

The Department of Labour (DoL) has identified the definition of acceptable working hours and conditions for children aged 15–17 years as a key priority within the CLAP (DoL, 2003). As far as we were able to establish at the time of writing, South Africa has not yet made this determination.

Child commercial sexual exploitation (including involvement in pornography)

The Children's Act includes in the definition of commercial sexual exploitation both the procurement of children for use in pornography, and trafficking of children for use in sexual activities. This recognises that, for some children, these experiences will overlap (and this will be reflected in the indicators presented in Part 2 of this volume). In Article 1(1), 'commercial sexual exploitation' in relation to a child means:

(a) the procurement of a child to perform sexual activities for financial or other reward, including acts of prostitution or pornography, irrespective of whether that reward is claimed by, payable to or shared with the procurer, the child, the parent or caregiver of the child, or any other person; or
(b) trafficking in a child for use in sexual activities, including prostitution or pornography.

Notably, the definition of commercial sexual exploitation does not include commercial sex work by children who have not been 'procured'. This is addressed under the broader category of 'sexual abuse' in Article 1(1), where 'sexual abuse' is defined as:

(a) sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted;
(b) encouraging, inducing or forcing a child to be used for the sexual gratification of another person;
(c) using a child in or deliberately exposing a child to sexual activities or pornography; or
(d) procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.

Child trafficking

Trafficking is a practice and a process and, crucially, the Children's Act definition of child trafficking includes all stages in the trafficking process. The definition also includes trafficking through the more subtle means of deceit, and the more commonly known process of abduction (abduction is addressed through the ratification of the Hague Convention on abduction). The Act is aligned with the UN Protocol to Prevent Trafficking in Persons and the UN Convention against Transnational Organised Crime (UN, 2001a, 2001b).

In Chapter 1 of the Children's Act, 'trafficking':

(a) means the recruitment, sale, supply, transportation, transfer, harbouring or receipt of children, within or across the borders of the Republic –
    (i) by any means, including the use of threat, force or other forms of coercion, abduction, fraud, deception, abuse of power or the giving or receiving of payments or benefits to achieve the consent of a person having control of a child; or
    (ii) due to a position of vulnerability, for the purpose of exploitation; and
(b) includes the adoption of a child facilitated or secured through illegal means.

Trafficking includes illegal adoption, which is further defined in Section 249 as follows. No person may:

(a) give or receive, or agree to give or receive, any consideration, in cash or in kind, for the adoption of a child in terms of Chapter 15 or Chapter 16; or
(b) induce a person to give up a child for adoption in terms of Chapter 15 or Chapter 16.

Conceptual framework

How are child labour, trafficking, and commercial sexual exploitation linked and how are they different?

The South African government and the ILO make a careful distinction between problematic child labour and the forms of child work that most South African children engage in. The latter include assisting with domestic tasks and care in the home environment, fetching fuel and water, and cleaning schools (further details are given later in the chapter). When undertaken in moderation and under the right conditions, these activities are found to be non-harmful and even beneficial in terms of social responsibility and inclusion (Cigno et al., 2003). Children often consider them an important part of their role in, and contribution to, the household and community (Bray, 2003a; Clacherty & Budlender, 2003).

This chapter does not address the majority of child work (both domestic and non-domestic) which is within the ILO definitions of unproblematic labour. The focus is on harmful and exploitative child labour only. This includes both excessive domestic or school-based labour, and labour for economic gain. Essentially, child work is perceived as problematic when it:

- Begins to erode time available for children to develop their skills and capacities, for example through attending school and completing homework tasks (Dachi & Garrett, 2003);
- Involves hazardous conditions (such as carrying very heavy loads over long distances, working at night, operating heavy machinery or being exposed to pesticides);
- Is one of the ILO Convention 182-defined worst forms of child labour (given above, and including CCSE, trafficking, slavery and harmful labour). These are considered unacceptable forms of labour, regardless of hours or working conditions involved.

An area that we have not considered up to this point is the use of children by adults or other children to commit crime. For children living in extreme situations, such as

on the streets, this may be one way of surviving. It is not a new practice in South Africa or elsewhere (as those familiar with Dickens's *Oliver Twist* will know).

However, the use of children in the drug trade is a particularly harmful form of labour. We address it specifically due to growing concerns about the practice in South Africa. Notably, this is both another form of exploitative labour, and a method used by those exploiting children to maintain their co-operation in other forms of exploitation (such as sexual exploitation).

It is important to understand how this set of problems is interlinked and where they diverge. The definitions given in the Children's Act recognise both the conceptual overlap (for example, sexual exploitation is a form of harmful child labour and can also be an outcome of trafficking), and the unique attributes of these practices (for example, illegal adoption is part of trafficking, but not part of harmful labour).

There is also overlap and distinction between these problems in the experiences of individual children. For example, some children are trafficked for use in CCSE and some for domestic labour. They share the experience of being unwillingly removed to a new environment for the commercial gain of adults, yet their experiences will differ markedly in terms of the nature of the abuse.

Trafficking must also be understood as both an abuse in itself (through the exploitative action of removing and commodifying a child) and as a vector for recruiting and maintaining children in exploitative labour practices such as CCSE, domestic labour and the drug trade. The ILO highlights the necessity for a nuanced understanding and measurement of 'trafficking':

> Trafficking as a distinct, discrete act does not really exist. It is, in fact, a combination or series of events that occur at places of origin, transit points and destinations, involving potentially both legal and illegal acts. (ILO & IPEC, 2004, p. 11)

Trafficking of children should not be confused with migration of children. It must be accepted that children do migrate without adult supervision and without being trafficked, both within and across borders. Such migration is always due to the dire circumstances in which they find themselves, for example poverty and political conflict. In southern Africa children migrate from their homes to the streets for a number of reasons (see Chapter 12 in this volume). In the context of the HIV/AIDS pandemic, children whose caregivers have died and who have no source of economic support are also at risk for migration to places where they believe their chances of support and survival will be greater.

Child trafficking, on the other hand, is the act of removing a child for the purpose of exploitation, and this can be for a range of purposes including domestic slavery, economic labour, CCSE, pornography, illegal adoption and the organ trade. Some of these purposes fall under the remit of 'harmful labour', whilst others (such as illegal adoption) do not.[1]

Potential risk factors

Certain high-risk conditions can result in trafficking children into exploitive and harmful activities. However, while these conditions increase the risk of trafficking,

the practice is driven by much more than the unfortunate consequences of household poverty. The vast majority of very poor and vulnerable children are of course not trafficked. Trafficking is the result of the purposive actions of adults bolstered by entrenched power relations that include male authority over women and adult command of children's lives, all of which operate at local, regional and, at times, international, levels.

As we have already mentioned, the embedded, illicit and often illegal nature of these relations makes tracking and policing very difficult. It also poses challenges in knowing how best to support children who have been drawn into harmful work and/or illegal activities. There is a real risk of doubly exploiting children through inappropriate responses that further isolate or stigmatise them, or place them in economic positions where they are forced to earn by whatever means possible.

But what do we know about the risk factors? There is in fact little reliable research on pathways to victimisation in harmful labour, commercial sexual exploitation and especially trafficking. However, certain groups of children are more likely to be at risk of these abuses, and some groups of children may face increased risks in the future.

Chronic poverty

Research suggests that chronic poverty in the form of lack of basic income underlies a large proportion of harmful work done by South African children (Edmonds, 2006). Survey data show that most children engaged in these forms of work live in deep rural areas where historical and structural factors have led to very limited access to land, employment, education, credit and grants (Dachi & Garrett, 2003).

The very limited evidence on patterns of child trafficking into work suggests the recruitment of children from rural areas with low levels of education, both in South Africa and in neighbouring states (UNICEF, 2003b). Poverty that stimulates harmful child work may also be due to shorter-term factors such as loss of an adult job in the household or HIV-related illness or death (see below). A more detailed explanation of the ways in which economic and social inequalities contribute to child poverty and vulnerability is found in Chapter 3 in this volume.

In light of the links between chronic rural poverty and exploitive child labour, the South African government puts the reduction of poverty at the forefront of its strategy to address child labour (DoL, 2003). Components of this strategy that stand to impact on child work include the elimination of illiteracy through free access to quality education and employment creation through public works programmes and national economic policies.

Acute vulnerability

A proportion of children who are growing up facing aspects of structural poverty also have to contend with circumstances that make them even more vulnerable. These include living and working in isolation from families or supportive community members (as street children do), or in conditions of family or community violence.

The work that children do in these circumstances is likely to remain hidden because children are not in close contact with supportive adult spokespersons and the nature of their work may be illicit or illegal (such as CCSE). For example, extreme household poverty alongside a lack of other money-earning opportunities for children can result in children selling sex in order to ensure survival (Barnes-September et al., 2000).

International evidence shows that children who have been sexually abused, or who have run away from sexually abusive home circumstances, may be at particular risk of engaging in CCSE, as are children who have left institutional care and who may also have been connected with abusive circumstances prior to entering care (Donovan, 1994; Bundle, 2001). Small-scale studies and pilot projects in South Africa suggest triggers to children's movement into CCSE, including acute poverty, domestic violence, substance abuse and more general child abuse and neglect (Barnes-September et al., 2000; Molo Songololo, 2005). Child advocacy groups suggest that children who have learning difficulties or those who have been sexually abused might be at greater risk of being trafficked. These children are also at heightened risk for contracting sexually transmitted infections, including HIV/AIDS.

Particular attention to the intensification of poverty characterised by these risk factors is therefore appropriate within a child labour monitoring framework.

HIV/AIDS as an intensifier of risk

The HIV/AIDS epidemic can be seen as an intensifier of risk in many of these areas (Richter, 2004). Risk factors include evidence of greater poverty amongst affected families and communities (Booysen & Bachman, 2002), increased dependency ratios, and children with limited or no parental protection (International Labour Office, 2002).

It is also important to be aware of the increased risk of excessive domestic work for children in households where guardians are unwell or deceased, whether through HIV-related or other forms of illness (Richter, Manegold et al., 2004).

There is also emerging evidence of increased domestic and economic workloads on orphaned children in foster homes (Giese et al., 2001; ACESS, 2002). Children in child-headed households are likely to be undertaking much of the domestic and economic labour which would otherwise be done by adults in the household (Foster, 1997). Furthermore, children acting as young carers to HIV-affected and other unwell household members are at risk of both reduced time available for education (Ansell & Young, 2004), and potentially to hazards associated with opportunistic infections (Van Dyd, 2001).

For some children, orphanhood results in living or working on the streets or in institutions, where children are at higher risk of CCSE, involvement in the drug trade and harmful labour. It is plausible that the movement of children between relatives as a response to the HIV/AIDS epidemic may place some at risk for trafficking, but we have no supporting evidence. Although numbers are small at this point,[2] it is worth noting that children living in child-headed households may be at increased risk as victims of trafficking and CCSE (Fitzgibbon, 2003). The proportion of South African children affected by and orphaned by AIDS is rising (Bradshaw

et al., 2002; ASSA, 2005), indicating a potential future increase in the forms of exploitation addressed in this chapter.

As will be evident, it is important to track these risks as early warning indicators. This form of indicator points to the probability of a growing risk to children in the future, and suggests steps to be taken in the short term in order to avert a major problem later.

Risk indicators in regard to child labour, CCSE, trafficking and involvement in drug-related crime are dealt with in some detail in chapters 3, 4 and 12 in this volume.

Suffice to say at this point that a monitoring system for the problems that are the focus of this chapter should include geographic areas in which children are living in long-term (chronic) poverty (both rural and urban).

Rural areas are likely to include children at risk for agricultural labour and trafficking; urban areas are likely sources of children being involved in crime by adults and also commercial sexual exploitation.

Areas within which both chronic, deep poverty and high levels of adult HIV/AIDS infection and illness-related mortality prevail, present risks for children: having to undertake excessive domestic tasks, including caring for infected adults, being orphaned and having to fend for siblings (see also chapters 3, 4 and 17 in this volume).

Current knowledge, service responses and their implications for monitoring

The purpose of this section is to provide a brief overview of what is currently known about the nature of these problems in South Africa and to draw attention to the main features of current or proposed government responses in terms of tracking the problem and service provision. These specificities inform the design of a monitoring system appropriate to the national context, as do the underlying factors that make children vulnerable to these forms of work and abuse (described above).

The nature and extent of child work in South Africa

The 1999 Survey of Activities of Young People (SAYP) provides information on the types of work activities that children perform and the age, gender and residential profiles of children most heavily engaged in these. Importantly, the SAYP data show that the vast majority of child work takes place in the family and community context (domestic chores in the home, cleaning schools, helping run family farms or businesses), rather than for external employers. For example, only 12 per cent of children working in agriculture were in commercial farming areas whereas 77 per cent live in deep rural areas.

It is also important to recognise that work is but one part of most South African children's everyday lives, and is therefore usually compatible with attending school. Just over one-third (36%) of South Africa's children are engaged in work activities for less than an hour a day, whereas only 12.5 per cent are doing more than 12 hours of economic activities per week (DoL, 2003, p. 12).

It is both sobering and instructive to note that of those children who engage in economic activities (and whose work therefore has the potential to impinge on their well-being), the majority live in deep rural areas defined as 'homelands' under the apartheid government. Amongst the smaller number of children working in urban areas, black and coloured children tend to work longer hours than their white counterparts. These findings point clearly to the major underlying cause of child work (of both an unproblematic and a harmful nature), namely high levels of chronic, structural poverty.

Older children are more likely than younger ones to engage in economic activities, and boys more likely to do so than girls (DoL, 2003). At the same time, because the definition of 'economic activity' does not encompass household work when core family members are present, there is a risk of overlooking the long hours girls spend on unpaid domestic work in their family homes and its implications for well-being (Bray, 2003a; Budlender & Bosch, 2002). The fact that most child work is orientated around the needs of the household means that the particular composition and financial position of the household will influence what children are expected to do at a certain point in time. For example, the SAYP found that of the children who regularly collect fuel, 70 per cent live with their mother only or neither parent, as compared to 25 per cent who live with both parents (DoL, 2003, p. 13).

Work defined as exploitative or harmful child labour

The South African DoL, in conjunction with the ILO, has recently completed a consultation process to identify priorities for action based on a consensus around which forms of child work are currently or potentially harmful to children (see DoL, 2003). This is reasonably straightforward where child work clearly involves exploitation (as laid out in the ILO definition of the worst forms of child labour [WFCL]), but becomes more complex when one tries to include work that compromises the safety, health, development and morals of children. Factors that cause or increase the risk of harm fall into three broad categories, namely:

- Those that endanger children physically;
- Those that threaten educational opportunity; and
- Those in which a child is at risk of being exploited.

With the exception of work activities that fall under the 'worst forms of child labour' and/or that are illegal (such as children's involvement in the drug trade, described below), it is both pointless and misleading to present a list of children's work activities that deserve monitoring, owing to the fact that it is the conditions under which children work, rather than the type of work per se, that determine their status as 'harmful' and therefore deserving of government action. Nonetheless, it is helpful to draw attention to features of the most prevalent forms of harmful or potentially harmful child work in South Africa that have a bearing on the task of monitoring.

Data gathered in 1999 and 2000 show that a small proportion of South Africa's children (less than 10 000) engage in paid domestic work in which working conditions put their health or development at risk, whereas many more (85 000) do unpaid domestic work under similar conditions (Budlender & Bosch, 2002, p. ix).

The harmful conditions include night work, long hours, the presence of people whom children fear may hurt them and an increased likelihood of injuries at work.

If the definition of 'domestic work' is expanded to include the collection of fuel and water (an activity that many rural children are engaged in), then the numbers increase substantially to 605 000. Reasons to do so include the physical harm to children who have to carry heavy loads over long distances and interference with school or homework time.

The potential for the intensity of children's work to move from benign to harmful levels in response to broader social and economic trends requires that patterns of work be tracked over time. Current opportunities for doing so, and the challenges therein, are outlined at a later point.

In conjunction with the ILO and a range of government stakeholders, the DoL has identified an action programme to address child labour, termed the CLAP. The monitoring and evaluation component of the programme relating to harmful labour specifies three actions:

- Continued tracking of changes in the situation of children's work (through the SAYP or other sources);
- The development of indicators of success; and
- The amendment of existing departmental management information systems.

The purpose of all three is to allow the DoL to monitor progress in identifying areas of concern and targeted actions to address these, as well as to track children removed from child labour (DoL, 2003).

In terms of responses to address specific types of harmful work, the DoL identifies a comprehensive range of actions, many of which relate to broader development and poverty reduction. These include:

- Regular inspection of domestic employment agencies;
- Improved physical infrastructure and increased land redistribution in deep rural areas (where children carry water and fuel over long distances);
- Improving access to schools through more flexible hours; and
- Enforcing minimum wages for adults.

While we recognise the importance of an integrated response to the problem of child labour, the purpose of our proposed monitoring framework is to identify core indicators of incidence and response, rather than attempt a comprehensive overview (which is, in any case, well documented in the department's CLAP document).

Use of children in the drug trade

We briefly draw attention to child work in the drug trade because qualitative research has identified the targeting of children by drug traders as both sellers and carriers, partly due to a perception of greater legal leniency towards children (Clacherty & Budlender, 2003). Yet, as is the case for other criminal involvements of children,[3] we have little reliable evidence regarding the extent of this problem.

Research with children living and working on the streets has found that they are at increased risk of being used in the drug trade. Small-scale studies and anecdotal evidence in South Africa have found that addiction is used to ensure compliance by

children involved in CCSE (Molo Songololo, 2005). Consequently, services addressing the problem of children used in the drug trade must in many cases also address accompanying problems of addiction.

Research conducted elsewhere suggests strong links between the narcotics industry, trafficking and commercial sexual exploitation (UNICEF Innocenti Research Centre, 2003).

Child commercial sexual exploitation, including pornography

Ennew et al. (1996) highlight the poor evidence base for much numerical data regarding CCSE, as well as the frequent confusion in data between CCSE and adult commercial sexual exploitation, and between child prostitution and CCSE.[4]

One estimate given for numbers of children working as prostitutes in South Africa has been around 28 000. This figure appears often in media (including the ECPAT – End Child Prostitution in Asian Tourism – website). There is no way of knowing the validity of this claim. The source is never stated and it cannot be considered reliable. Similarly, there are no data on sex tourism to South Africa for which children are procured.

There is no systematic research on the use of children in pornography in South Africa. The rise in Internet-based pornography has further complicated the identification of perpetrators and sites, and is facilitated by advanced encryption methods to limit detection (Carr, 2002). However, international evidence and anecdotal South African evidence suggest strong links between child commercial sex work and child pornography (Petit, 2005).

In spite of the challenges, indicators for CCSE must attempt to provide data on how many children are involved and where they are located (Ennew, 2004). This is important if we are to attempt to respond to this form of abuse. Whereas we can hope to capture information on the broader area of child labour through survey data (see above), the illicit and taboo nature of CCSE renders this unrealistic. We will propose a set of interlinking indicators – including the use of the Child Protection Register (CPR) as a monitoring tool, police and child helpline data – in order to attempt to capture its extent (see the indicator tables for this chapter in Part 2 of the volume).

It is also important to monitor responses to CCSE as detailed in the Children's Amendment Bill which, in Section 141(3), outlines the state's responsibility to enforce prohibition of the worst forms of child labour, including CCSE. Thus, a set of indicators focusing on the prosecution of child pornographers, pimps and users of exploited children is needed. This is an attempt to dissuade and thus reduce the 'demand' side of the business of CCSE.

Finally, indicators are needed to measure service access and quality for those children already involved in CCSE. This ranges from the inclusion of CCSE as a category on the CPR, to access to mainstream services such as health and contraceptive care, through to a limited but vital tier of intensive, specialised and integrated rehabilitative services. Education of staff in key services – such as police, health and social services – and the provision of helplines are indicators reflecting the need for improvement in the response of current services.

Service provision for children experiencing CCSE in South Africa is reported by child advocacy agencies to be poor (Barnes-September et al., 2000). A current[5] situation analysis by the Community Agency for Social Enquiry and the ILO focuses on future areas of service provision. International evidence regarding the combating of CCSE focuses on the three key areas of:

- Reducing the supply of children;
- Deterring perpetrators through legal processes; and
- Providing rehabilitation services to children experiencing CCSE.

We further recommend the development of resources and expertise amongst law enforcement agencies (Petit, 2005) and partnerships with the private sector regarding child pornography, especially internet service providers (ISPs) and credit card companies (Carr, 2002). Given that pornography is now downloadable to videophones, other productive linkages would include those with cellular phone companies (pers. comm. Film and Publications Board of South Africa, 16 November 2005).

Further recommendations include provision of specialised services aimed at rehabilitating victims of CCSE. These should address the multiple interlinked needs of victims, such as accommodation, psychosocial support, education, vocational training, legal services and drug rehabilitation services (Barnes-September et al., 2000; Molo Songololo, 2005).

Child trafficking

UN reports on the global trafficking trade (largely in women and children) place it as the third most profitable trade, after drugs and guns, for organised criminal enterprises. The estimated worldwide turnover is $7 billion per year. Reports by the International Organisation on Migration (IOM, 2003) and UNICEF (UNICEF Innocenti Research Centre, 2003) identified South Africa as a destination, transit and origin country for trafficking of women and children, with victims transported to and from a range of African and non-African states. Regional research has identified trafficking of children within South Africa (Higson-Smith & Richter, 2004).

Research identifies particular dimensions to child trafficking. This includes the use of various means to entrap victims, including threats, persuasion, deception, coercion and debt bondage (ILO & IPEC, 2004). Perpetrators include recruiters, intermediaries, transporters, employers, brothel operators, corrupt migration police, and customs officials, and families and friends. Children can be sold and resold (UNICEF, 2003b).

Particular forms of trafficking recorded worldwide include the use of children for domestic and non-domestic work, begging (Frankel, 2001), commercial sex work, and the selling of children, through pornographic Internet sites, to paedophiles or paedophile rings (UNESCO, 2005). Research in South Africa suggests evidence of internal and cross-national trafficking of children for domestic labour (Budlender, 2003), commercial sex work, as personal sex slaves (IOM, 2003), or into forced marriages (South African Law Reform Commission, 2005).

Little is known about the extent of trade in children's organs, although some reports suggest their use for medical purposes or as 'muti' (McGibbon, 1992), and trade

between Mozambique and South Africa (Gastrow & Mosse, 2002). The trade in illegal adoption is, again, distinguished by a lack of research (South African Law Reform Commission, 2005). Anecdotal reports from international social services and child welfare societies suggest possible trafficking of children and street children for this purpose.

The core indicators we recommend in Part 2 of this volume for child trafficking share many aspects with those of CCSE. Again, the CPR, child helplines and official data, such as immigration data, are combined to attempt an understanding of the extent of the problem. In addressing the need (stressed in the new Children's Act and the Amendment Bill) for more stringent legal responses to trafficking, we propose indicators around bilateral extradition agreements and prosecution of corrupt officials as well as those involved in all stages of trafficking.

Again, education and awareness may reduce the susceptibility of vulnerable groups to trickery and deceit used by traffickers. Services aiming at intercepting the trafficking process include use of the CPR and awareness raising amongst staff in key services. It is important to keep in mind that trafficked children will also need to access services that address the types of labour (such as CCSE and domestic slavery) into which they have been trafficked.

Service provision in South Africa to combat child trafficking has been identified as minimal (Molo Songololo, 2005). Reported international approaches, guided by the CRC Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, include public information and awareness raising for communities at risk (for example in Benin), and strengthening of multilateral and regional co-operation to fight the trafficking trade (for example in Côte d'Ivoire, Mali, Benin and Togo) (ILO & IPEC, 2004).

Further responses include identifying locations where trafficked children are working (UNICEF, 2003b), awareness raising amongst officials (for example, India's National Action Plan), and increased criminal punishment of perpetrators (US Department of State, 2004). Services for victims of trafficking are crucial, such as reception and safe transit facilities, education and vocational training as established in Mali (UNICEF, 2004a), as are services for communities at risk of targeting by traffickers, such as income-generating projects for families whose children have been trafficked or for victims of trafficking (for example in Togo).

Legislation and policy

South African Constitution

Section 28 of the Constitution identifies entitlements of children in South Africa to be protected from abuse, and stipulates that persons under 18 years of age have a right to be protected from work that is exploitative, detrimental to their schooling, or detrimental to their social, physical, mental, spiritual or moral development.

Further constitutional rights relevant to harmful labour, commercial sexual exploitation and trafficking, include the right to shelter, basic healthcare services

and social services (Section 28(1)(c)), including rehabilitation following exploitation and trafficking. Section 29 provides the right to basic education and Section 28(1)(d) the right to protection.

Section 28(1)(b) gives every child the right to family care, parental care or appropriate alternative care when removed from the family environment. This is important given that loss of family support is a risk factor for trafficking and exploitive labour. The state has an obligation to see that appropriate alternative care is provided to children who are particularly at risk following loss of family care, or when children leave the family as a result, for example, of abuse, violence and severe neglect. Given that poverty is a major driver of children's involvement in exploitive labour and related practices, poverty alleviation and family support are particularly important preventive interventions (see sections 26 and 27 of the Constitution).

Section 39(1)(b) of the Constitution requires that when interpreting the Bill of Rights, international law 'must be considered'. A number of international instruments to which South Africa is signatory apply to the subject under discussion.

International obligations

The CRC and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3 in this volume) place harmful labour, trafficking and commercial sexual exploitation within the broader definition of abuse (for a detailed examination of the international and national legislation pertinent to child abuse, see Chapter 14 in this volume). Relevant articles of the CRC and the AC are listed below.

- CRC articles 3, 6, 19, 23, 24, 26, 27, 34, 36; AC articles 4, 5, 13, 14, 16, 27: Ensuring the survival, health and development of the child; provision of an adequate standard of living; protection from violence, abuse, neglect and exploitation detrimental to the child's welfare.
- CRC Article 28; AC Article 11: Right to an education, and state responsibility to encourage attendance and reduce dropout. AC Article 12: Right to rest, leisure, play, and participate in cultural life.
- CRC Article 32; AC Article 15: States to protect children from 'all forms of economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's physical, mental, spiritual, moral, or social development' (in both formal and informal sectors). The AC specifically highlights the ILO instruments to be followed regarding minimum ages for employment, regulation of hours and working conditions, and penalties and sanctions for their enforcement. Further, under the AC, states are required to 'promote the dissemination of information on the hazards of child labour to all sectors of the community'.
- CRC Article 19; AC Article 16: States to protect against 'torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse'.
- CRC articles 7, 9; AC Article 19: Right to parental care and protection and, where possible, to live with parents. CRC Article 18 and AC Article 20 state that parents have the primary responsibility for the care of their children. The state must render appropriate assistance to families that are stressed – a measure that

reduces the risk of children being exploited.

- CRC articles 10, 22; AC Article 23: (relevant to children trafficked to South Africa from other states) Unaccompanied refugee children or children internally displaced to be reunited with families or, where no parents, to be afforded state protection. CRC Article 20; AC Article 25: Children deprived of their family environment to be afforded special protection.
- CRC Article 21; AC Article 24: Adoption to take place only when legal, and inter-country adoption only when no suitable care is available in the country of origin. Specifically, that inter-country adoption 'does not result in trafficking or improper financial gain', and that bilateral or multilateral agreements regarding trafficking are sought.
- CRC Article 34; AC Article 27: States to take measures against i) the inducement, coercion or encouragement of a child to engage in sexual activity, ii) the use of children in prostitution or other sexual practices, and iii) the use of children in pornography.
- CRC Article 33; AC Article 28: States to prevent the use of children in the production or trafficking of drugs.
- CRC Article 35; AC Article 29: States to prevent the abduction, trafficking or sale of children by any persons (including their parents), and the use of children in begging.

South Africa has also ratified a number of international conventions that bear on exploitation and child labour. ILO Convention 182 on the WFCL was ratified in 1999, and requires the country to take time-bound measures to eliminate the worst forms of child labour. The four pre-defined worst forms of child labour are:

(a) all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour;
(b) the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances;
(c) the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties;
(d) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.

Specific state responsibilities include (Article 7): the prevention of the engagement of children in the worst forms of labour, to remove and rehabilitate, and to provide children removed from these labour circumstances with education.

The South African government also ratified a number of earlier ILO conventions providing an essential foundation to policy designed to comply with Convention 182. They include:

- Convention No. 105 (of 1957) concerning the Abolition of Forced Labour, which was ratified in March 1997;
- Convention No. 29 (of 1930) concerning Forced or Compulsory Labour (it was also ratified in March 1997); and
- Convention No. 138 (1973) concerning Minimum Age for Admission to Employment was ratified in March 2000, and the minimum age was set at 15 years.

It is of course noteworthy that South Africa only recently ratified these treaties which had been in the international arena for many years. The apartheid state obviously ignored them.

Commercial sexual exploitation and trafficking

Ratifications in this regard include:

- The UN Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography of 2000 (ratified in June 2003);
- The UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, supplementing the UN Convention against Transnational Organized Crime of 2000 (ratified in February 2004); and
- The UN Convention for the Suppression of the Traffic in Persons and the Exploitation of the Prostitution of Others (1949, ratified in October 1951).

Section 281 of the Children's Act (No. 38 of 2005) ratifies the UN Protocol to Prevent Trafficking in Persons, the Hague Convention on International Child Abduction (articles 274–275), and Article 256(1) ratifies the Hague Convention on Inter-Country Adoption.

South African legislation

Children's constitutional rights and obligations in relation to international law are reflected in a range of progressive legislation, including:

- The BCEA (No. 75 of 1997) and the BCEA Amendment Act (No. 11 of 2002), which prohibit the employment of anyone under 15 years (the minimum school-leaving age) or who is over 15 years but under 18 years of age if the employment is either inappropriate for the age of the child, or if the work places the child's well-being and development at risk, or if it has been prohibited by the Minister of Labour through regulations.
- The Prevention of Organised Crime Act (No. 121 of 1998) implicates adults who facilitate the access of others to a child for sexual activity of any nature. Activities specified include rape, kidnapping, indecent assault, unlawful carnal intercourse with a girl or boy under a specified age, and soliciting or enticing a girl or boy to the commission of an immoral or indecent act.
- Common Law identifies the illegality of sexual assault of children, including statutory rape.
- The Sexual Offences Act (No. 23 of 1957) proscribes the abduction of those under 18 years for sexual acts.
- 2004 amendments to the Films and Publication Act (No. 65 of 1996) make illegal the possession, creation, production, distribution, importing, accessing, advertising or promotion of child pornography images, with a maximum penalty of 30 years. ISPs are legally required to block access to child pornography sites. Photography shops, those repairing computers and members of the public are required to report incidence of child pornography. South African citizens who commit child pornography offences whilst abroad can be prosecuted on their return home.

- Under the Drugs and Drug Trafficking Act (No. 140(3) of 1992) all supply of scheduled substances is criminalised, although the Act does not specify children's involvement.

The Children's Act and the Children's Amendment Bill

The Children's Act (No. 38 of 2005) and the Children's Amendment Bill (No. 19 of 2006) provide an extensive legal framework for addressing harmful child labour, commercial sexual exploitation (including pornography), and trafficking of children (including illegal adoption). They explicitly address areas (specifically CCSE and trafficking) that have been neglected, or scattered, in existing legislation. The reader is referred to the relevant Act and Bill, which are available online.[6]

Recommended indicators for harmful child labour, CCSE and child trafficking

Challenges

There are a number of challenges associated with the collection of data on these problems. Firstly, there is a lack of clarity as to whether or not national surveys will be able to provide regular data on children's work. A draft module to be used in follow-up surveys to the SAYP was developed with the intention of collecting data every three to four years, a timetable considered appropriate in the context of the HIV/AIDS pandemic (DoL, 2003). As yet, this has not been used and repeats of the SAYP or particular modules seem unlikely at this point.

A further challenge in the use of survey data lies in the fact that the methodologies are vulnerable to significantly undercounting children's participation in potentially harmful work activities. For example, children who completed the 2000 Time Use Survey reported much longer hours of paid and unpaid domestic work than respondents in the SAYP (Budlender & Bosch, 2002). This difference in figures flags one of the challenges in measuring children's work participation and forming an accurate picture of the problem one is trying to address.

As we have already noted, data on illegal, taboo and underground activities are notable for their unreliability. This is not a problem unique to South Africa – a recent review of literature on child prostitution and trafficking noted trends of poor quality research and the reification of numerical 'guesstimates' as facts:

> The overwhelming majority of publications…are characterized by muddled, low-level or misunderstood theories, badly thought-out and applied research methods, poor data and inadequate analysis. (Ennew et al., 1996)

Further measurement difficulties include the inevitable under-representation of the problem through any form of report-driven data collection, comparable to data on incidence of rape and incest. This can lead to a 'catch-22' situation whereby increased investigation into the incidence of harmful labour, CCSE and trafficking will result in more identification of cases, and an apparent rise in the problem (as has been the case with child sexual abuse in the US – see Chapter 14 in this volume).

We will not attain reliable numbers or proportions of children experiencing harmful labour, commercial sexual exploitation and trafficking. However, we can find out more than we currently know, through the disaggregation of existing administrative data and by conducting a realistic set of commissioned studies. We can also increase our understanding of geographical areas at high risk for recruitment of children into these practices, and areas with a high density of children undergoing such work. We can develop services to assist and prevent these abuses of children, and use indicators to monitor the accessibility and quality of those services.

Because mandatory reporting of these forms of child abuse is required by the Children's Act (No. 38 of 2005), the CPR system (see Chapter 14) could prove to be an effective resource for monitoring of all forms of child abuse including harmful labour, CCSE, involvement in pornography and the various forms of trafficking as defined by the Act. However, at present the CPR does not make provision for inclusion of these forms of child maltreatment. Of course, the quality of the data on the register will depend fundamentally on inputs as well as resource factors. In at least one province, the Western Cape, the Register is not operating as intended, with numerous problems in data collection, entry and validation (Dawes, Willenberg et al., 2006).

Recommendations for recording incidence

Reporting systems such as South African Police Services data and CPR data will inevitably only capture those cases which come to the attention of state services. Whilst we will never be able to capture all incidences, a useful supplement to this data could be telephone-call data from welfare agencies and services such as ChildLine. However, these data must be used with caution as cases cannot be validated.

As noted above, the DoL has suggested that policy implementation should be focused on very poor, deep rural areas such as former 'homelands' (DoL, 2003). Site-specific studies to monitor changes in child work should therefore be located in these areas. We have noted that chronically poor urban areas should also be monitored for risks to children's involvement in crime by adults.

Chapter 14 in this volume outlines comprehensive requirements for the provision of a national CPR. In addition to the basic information which is to be collected in the CPR, information that captures child labour, child commercial exploitation and child trafficking should be included as indicated below.

Recommendations for the collection of basic incidence data on the CPR

Is there evidence of one of the following specific types of abuse?

- Exploitative/harmful child labour:
  - Domestic labour;
  - Non-domestic labour;
  - Use of children in the drug trade.
- Child commercial sexual exploitation:
  - Use of children as commercial sex workers;
  - Use of children as domestic sex slaves;
  - Use of children in pornography.

- Trafficking of children:
  - For use in domestic/non-domestic labour;
  - For use in CCSE (including pornography);
  - For use in the organ trade;
  - For illegal adoption.

In line with the incidence data on child abuse and neglect, rates of child exposure to harmful labour, commercial sexual exploitation and trafficking for a particular period that are reported at national and provincial level should be expressed as rates per 100 000 children, stratified by age and gender for each type of abuse.

The following age stratifications would be appropriate for annualised reporting and are based on the labour legislation and associated documents such as the CLAP:

- All children under 18 years of age, disaggregated by gender; and
- Children from 0–14 years (children under 15 may not be employed) and 15–17 (inclusive).

Where possible, data on small geographic areas are required to provide a sense of those in which children are particularly vulnerable, which services require support, and to inform staffing levels. All chapters in the child protection section of this volume address staffing levels as a key indicator of service quality (for example social worker–child ratios). We have not supplied specific recommendations in this regard in this chapter and suggest that the ratios provided for child protective services staff in Chapter 15 be considered. Trafficked and exploited children should enter social services and related services and will therefore be covered by the same norms that apply to other maltreated children.

For child protective services, those using the register should also be aware of the overlapping nature of some of these problems, and recognise that inclusion on one category of the register (i.e. commercial sexual exploitation) may suggest the need to investigate further regarding other categories such as trafficking.

Existence of and access to services

A key element of the indicator system is the monitoring of both provision and quality of services aimed at preventing and responding to harmful labour, CCSE, and child trafficking. These exploitative practices must be addressed at both the 'supply' and 'demand' sides (for example, reduce 'supply' of children at risk for trafficking by improving education around trafficking in rural areas, and reduce 'demand' for trafficked children by enforcing the Children's Act through the courts). Finally, the need for rehabilitative services is outlined. Indicators that measure the phenomena discussed above are presented in Part 2 of this volume.

Conclusion

Core indicators are presented in Part 2. Note that in this instance, more than 20 core indicators are included due to the fact that several phenomena are monitored here. It must be stressed once more that due to the illicit and hidden nature of the phenomena, data availability is likely to be extremely poor. The approach taken in this chapter is to focus on strengthening (currently very inadequate) information systems and improving services to affected children.

It is important to note that these indictors are not to be used in isolation and are intended to complement those indicators and guidelines presented in chapters 4, 12, 14, 15 and 17 in particular. Whilst those chapters address some of the background drivers for harmful child labour, CCSE and child trafficking, this chapter attempts to define the indicators which are unique and specific to these 'worst forms' of child exploitation.

As we have suggested, chronic poverty coupled with high rates of HIV infection and mortality are likely to constitute particular risks for their exposure to these forms of child abuse and exploitation. We therefore need to be particularly vigilant of situations where children are living in highly affected households and communities, both in the countryside and the cities. Such conditions are likely to be useful early warning indicators for the abuses we have discussed here.

We have not provided a table of additional indicators. A central reason is that there is so little data in this area as to render the effort relatively pointless at this time. Our view is that specific research studies are required to tease out the more complex aspects of the problems we have discussed in this chapter. We suggest that such studies focus on populations of children at risk (such as those on the streets and children affected by HIV), and geographic areas affected by high HIV prevalence, orphaning and poverty. Another site for research in trafficking and commercial sexual exploitation, for example, would be border crossings, truck stops and areas that local informants know to be areas where children are particularly at risk.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 The inclusion of illegal adoption and the organ trade as categories within 'trafficking' identifies the common factors of the use of children for adults' commercial gain.

2 General Household Survey (Stats SA, 2004b) data suggest that 0.6 per cent of children (orphaned or otherwise) in South Africa were living in child-headed households in June 2004. This figure equates to roughly 107 000 children, but should be treated with extreme caution considering the very small sample of child-headed households recorded in the survey. The 2001 Census suggests a similar proportion but, given some problems with the data on child heads of household recorded by enumerators, should also be treated with caution.

3 Further information on the use of children in criminal activities and organised crime is provided in Chapter 16 in this volume.

4 Notably, all incidence figures presented for the following sections must be interpreted as estimates only (and in some cases 'guesstimates').

5 This is an ongoing initiative and no findings had been released at the time of writing (2006).

6 See <http://www.welfare.gov.za/>.

CHAPTER 14

Monitoring child abuse and neglect

Andrew Dawes and Mihloti Mushwana

Introduction: objectives and scope

A sector review of child abuse conducted by the Community Agency for Social Enquiry on behalf of Save the Children Sweden (2003) noted that there was no national monitoring system in place to provide estimates of the extent of child maltreatment (abuse and neglect) in South Africa. At the time of writing, this remains the case, although the Children's Act (No. 38 of 2005) provides for national and provincial Child Protection Registers (CPRs) that can be used for monitoring purposes.[1]

Establishing the extent of child abuse and neglect with any accuracy is a daunting task, and the challenges are recognised in countries with the most developed systems (Curtis et al., 1998; AIHW, 1999, 2003; Goldman & Padayachi, 2003).

Nonetheless, as is recognised in the Department of Social Development's (DoSD's) *Working Document: National Policy Framework and Strategic Plan for the Prevention and Management of Child Abuse, Neglect and Exploitation* (DoSD, 2004a), South Africa needs to improve its capacity to measure the extent of child abuse and neglect. The data are currently very inadequate, and are drawn from different sources that use different types of evidence and different definitions of the problem. This situation gives rise to widely differing incidence estimates. Examples include reported crime data from police records (using crime categories), conviction rates from the justice system, allegations of abuse reported to child welfare agencies, data from specialist clinical services for abuse survivors, and case records from children's phone-in crisis agencies such as ChildLine (Marshall & Herman, 2000; Higson-Smith et al., 2004; Van Niekerk, 2004).

While all these sources of information have their uses, there is a need for a standard system that can provide reasonable estimates (they will never be very accurate) of the scale of the problem provincially and nationally. To aid services planning, data are particularly needed at small geographical area level in order to map the occurrence of abuse, and ensure that services are adequate to reach those in need (Dawes, Borel-Saladin et al., 2004). In addition, South Africa's reporting responsibilities in terms of the Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) necessitate a system that contains the best child abuse and neglect data we can provide.

The purpose of this chapter is to present proposals for priority indicators, measures and data sources for monitoring the incidence and prevalence of child abuse and neglect. These are traditionally clustered with child labour and trafficking and exposure to armed conflict under the rubric of *child protection*. Trafficking,

commercial sexual exploitation and labour are dealt with in Chapter 13 in this volume. This chapter also does not address services to children found in need of care (covered in Chapter 15).

We commence with an outline of the rights and policy environments that should inform our approach to child abuse and neglect. The chapter then proceeds to outline South African and international efforts to monitor the incidence and prevalence of child abuse and neglect (including the challenges). We draw on the Canadian Incidence Studies (CIS) in particular (Trocme, Machaarin et al., 2001; Trocme, Fallan et al., 2003). The final section presents proposals for the regular tracking of child abuse and neglect that are aligned with South African policy. Tables containing recommended core and additional indicators are provided in Part 2 of this volume.

Rationale

A rights-based approach to monitoring of child abuse and neglect

Following the approach outlined in Chapter 2 of this volume, and in terms of the child's right to protection, it is necessary to ask:

- What is the scale of the problem in regard to child abuse and neglect, and who are the most vulnerable children?
- What legal measures exist to ensure children's protection and how well do these provisions work?

In terms of services, it is necessary to ask: what is the extent of access to appropriate services in the case of abused children, and what is the quality of those services?

Addressing these questions comprehensively is beyond the scope of this chapter. However, they will inform the discussion which follows.

As a signatory to the CRC in June 1995 and the African Charter on the Rights and Welfare of the Child (AC – see Appendix 3 in this volume) in January 2000, South Africa is bound to ensure that the rights contained in these instruments are protected and advanced. As noted in the conceptual chapters in this volume (chapters 1 and 2), in a rights approach to monitoring it is profitable to group the articles of the CRC that apply to the issue in question. We have grouped articles of the CRC and the AC pertinent to this area. The AC articles are placed after those from the CRC:

Group 1 – Foundation group (these are articulated in Chapter 1 and are not repeated here).

Group 2 – Protection group: CRC articles 19, 36; AC articles 5, 14, 16: Ensuring the protection of children from violence, abuse, neglect. Article 19(2) of the CRC and Article 16 of the AC refer to the obligation of the states to support carers in their duty to protect children. Disabled children require particular protection (CRC Article 23; AC Article 13).

Group 3 – Treatment group: CRC articles 24, 39; AC articles 4, 14: Actions taken should be in the best interests of the child; the child has the right to treatment and rehabilitation.

Articles relevant to commercial exploitation, labour and trafficking are taken up in Chapter 13 which deals with these issues.

As noted in Chapter 2, several considerations should be borne in mind when designing a rights monitoring system, particularly in the case of child abuse.

First, one needs to define the phenomenon clearly. The data needed to capture the phenomenon must be specified. Where there are gaps, information systems need to be set up in order to capture the essential data. A series of questions also needs to be asked to inform the development of the system, the most important being what rights pertain in the domain (child abuse and neglect), and what the reciprocal duty-bearer responsibilities are for the problem. Finally, what mechanisms of the state exist to attend to the needs of abused and neglected children?

The appropriate age and gender stratifications must be made in reporting. The Committee on the Rights of the Child requires stratifications by other criteria including rural, urban and ethnic origin (this is highly dependent on the data environment).

In the context of the HIV/AIDS epidemic and deep poverty, many children are likely to be vulnerable to abuse and neglect and, where appropriate, the particular risks faced by these children should be tracked by disaggregation. For example, child abuse and neglect statistics compiled from the CPRs should identify children who have lost caregivers and who are in the care of kin and other foster situations. Children with disabilities are also particularly vulnerable and should be identified from the CPR and other appropriate data systems.

South African constitutional and other legal provisions

Recently, the national DoSD published a working document on the prevention and management of child abuse and neglect. That document provides coverage of the legislative framework that applies to child abuse and neglect. Other commentary on state and civil society responses to the problem of child abuse is available in comprehensive reviews of the situation (Save the Children Sweden & CASE, 2003; Gallinetti, 2004b; Richter, Dawes et al., 2004; September & Blankenberg, 2004). The key points follow.

Section 28 of the Constitution outlines the government's commitment to the fulfilment of children's rights and is aligned with a number of provisions of the CRC.

Echoing Article 3 of the CRC, Section 28(2) states that 'the child's best interest is of paramount importance in every matter concerning the child'. Section 28(3) defines a child as under 18 years of age. Indeed it may be argued that the Constitution sets a higher standard than the CRC.

Specific rights pertinent to child abuse and neglect include children's justiciable rights:

- Section 12 which guarantees the right to freedom and security of the person (regardless of age) and the right to be 'free from all forms of violence from either public or privates sources'. The Constitutional Court (in the case of Carmichele)

ruled that this right obliges the state to act and protect people from violence, sexual violence and the threat of sexual violence (pers. comm. Dutschke and Proudlock, University of Cape Town's Children's Institute, November 2005);
- 'to basic nutrition, shelter, basic health care services and social services' (1(c)), which addresses protection from *neglectful* circumstances. These rights are in addition to the general protections and socio-economic rights afforded to all South Africans in the Bill of Rights (see Appendix 2 in this volume) (Streak & Wehner, 2004);
- 'to be *protected from maltreatment, neglect, abuse, or degradation*' (1(d), italics ours). This provision clearly specifies protection from the relevant insults.

Apart from these most pertinent clauses, the Constitution specifies children's rights to protection from 'exploitive and age inappropriate or dangerous work' (2(e) and 3(f)).

South Africa has also ratified the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography. Involvement of children in these practices is criminalised by the Sexual Offences Act (No. 23 of 1957) and the Film and Publications Act (No. 65 of 1996) (see Chapter 13 in this volume).

The Care Act (No. 74 of 1983) – to be replaced by the Children's Act and the associated Children's Amendment Bill (No. 19 of 2006) (once passed) – makes provision for the protection of children in need of care through the investigation of allegations of abuse and neglect, as well as indicating the appropriate action to be taken should the allegations be substantiated (see also Chapter 15 in this volume). The new Act and the Bill also have provision for mandatory reporting of abuse by certain professional groups.

Other legislation of relevance includes:
- The Prevention of Family Violence Act (No. 133 of 1993), which requires persons responsible for children to report suspected cases of abuse to the police, child welfare commissioner or social worker (see mandatory reporting below). The provisions of this Act will be replaced by the new Children's Act, which will be the sole statute dealing with the mandatory reporting of child abuse and neglect.
- The Domestic Violence Act (No. 116 of 1998), which provides for restriction orders on perpetrators of domestic violence.
- The Schools Act (No. 56 of 1996), which bans corporal punishment in schools. The education department also has provisions for disciplinary action against teachers and pupils who abuse children. Corporal punishment is also outlawed in residential childcare institutions, youth care centres and secure facilities.
- The Common Law provides for prosecution of violence and sexual assault of children (rape – statutory and attempted; indecent assault – common and grievous bodily harm; incest; crimen injuria). The specific crime of neglect and ill-treatment of children can also be applied in the case of child physical abuse. A problem remains in the law though – that of the parental defence that they applied reasonable chastisement to the child in the exercise of their parental responsibility.
- The Sexual Offences Act covers abduction of all under 21 years for sexual acts. Note that a 'child' for these purposes is under 21. Section 14 prohibits hetero-sexual acts with a child under 16 years, and homosexual acts under the age of 19.

This Act will be replaced by a new statute of the same name which was before Parliament at the time of writing. It should be passed into law in 2007.

The education, health and social development departments are all concerned with addressing problems associated with child abuse and neglect, with the latter taking the lead. According to the DoSD (2004a) draft plan, the Department of Health is constructing guidelines for healthcare staff for managing child abuse and neglect.

As noted, the DoSD (2004a) has drawn up a working document entitled *National Policy Framework and Strategic Plan for the Prevention and management of Child Abuse, Neglect and Exploitation*. Similar documents that outline policies and protocols are in place in each province. However, at all levels, many of these policies and procedures are either in draft form or not developed to the extent envisaged in the provincial plans (Save the Children Sweden & CASE, 2003; September & Blankenberg, 2004).

Provincial protocols and child protection committees established for the multisectoral management of child abuse exist (on paper if not in practice) in all provinces. Functioning is highly variable. Local committees, the level that should be the most important, are very poorly distributed and, where they exist, functioning is commonly compromised (September & Blankenberg, 2004).

Mandatory reporting and registers

Section 42 of the Child Care Act (No. 74 of 1983) mandates specific groups for reporting suspicions of abuse to the relevant child protective services. Another body of the law, Section 4 of the Prevention of Family Violence Act (No. 133 of 1993), requires any *persons in a position of responsibility for a child* to report suspicions of abuse to the social services or child protection authorities (for example the police) (DoSD, 2004a).

At present, the DoSD draft document states that, 'Local authorities are meant to liaise with the provincial government to determine which child protection functions should be decentralized…' (2004a, p. 87). This language suggests the probability of regional variation with respect to the mechanisms used to capture data on abused children.

As the responsibility for implementation of the reporting system is intended to rest with local and district level authorities under the direction of the provincial social development departments, it makes sense for an abuse and neglect monitoring system to be aligned with that system. In 2003, registers were being developed in five provinces. September and Blankenberg stated at the time that they 'could not establish the full extent of the operation of the CPRs in the respective provinces' and 'the rationale, financing and monitoring mechanisms…could not be established' (2004, p. 31).

Challenges and risks associated with reporting systems

Mandatory (mandated) reporting was introduced in certain of the states in the US and the United Kingdom (among other countries) following Kempe et al.'s (1962) 'discovery' of the battered-child syndrome.

While reporting has merit in compiling incidence data (for purposes of intervention, prevention and research), a number of important limitations have been noted in

countries where the system is in place. In the US, for example, Melton (2005b) notes that:

- The scope of the problem was underestimated, leading to a significant investigatory burden on social services. When the system was introduced, additional resources were not supplied to US agencies to record cases and to investigate them;
- The result was that the limited resources available went to investigation rather than family support (the focus is on investigation and prosecution);
- The US system is punitive and not supportive to vulnerable families: 'mandated reporting has transformed child welfare agencies into investigatory bodies with diminished involvement in the provision of social services per se' (Melton, 2005b, p. 14);
- Perhaps of most concern in terms of resource efficiency, *two-thirds* of US reports of child maltreatment are *not substantiated* for one reason or another.

These points drawn from a relatively sophisticated child protection system should cause us to pause before constructing registers that are not themselves properly resourced, and which direct inadequate protection resources to mandatory investigations rather than to support services for children in need.

Notwithstanding these points, Article 19(2) of the CRC *requires* South Africa to implement a system for the 'identification, reporting, referral (and) investigation' of child abuse and neglect, and to develop 'effective procedures for the establishment of social programs to provide necessary support for the child and those who care for the child'.

Given the significant effort that needs to be put into investigations, we need to minimise four potential unintended negative outcomes.

First, due to a lack of resources, investigations will take significant time to complete. Under these conditions witnesses may be deterred from coming forward (or face intimidation), and many reports may not be substantiated because the resources required to undertake a thorough investigation are simply not available (that is, false negative reports are very likely).

Second, inadequate investigations may equally lead to false positive identification of abusers with inevitable harmful consequences to those individuals. Slow investigations that lead to inconclusive or unsubstantiated findings also place huge strain on persons who may be innocent.

Third, social welfare staff may be inclined to raise the bar for cases that require investigation (because they do not have the resources to investigate all cases reported), thereby screening out cases that might have needed attention. These practices would lead to under-reporting.

Fourth, systems that call for reporting and which fail to respond swiftly to provide the necessary services further *increase* the risk to the child. This is very probable in South Africa given the extremely limited services that exist.

South African social services scholars have also pointed to the expense of a system that focuses on law enforcement rather than on adequately supporting an ailing and entirely under-resourced welfare service (Loffell, 2004). A mandatory reporting

system and a register *must* have specific human, financial and technical resources allocated to the system if it is to be at all efficient and effective.

The reporting system should not focus only on a punitive approach. We strongly support Melton who argues for 'friendly systems of monitoring and control':

> Help – and if necessary, monitoring and control – ought to be built into primary community settings in a manner that minimizes intrusions on privacy and that improves the everyday quality of life for children and families, whatever their vulnerability and needs. (2005b, p. 16)

How this is to be done is beyond the scope of this chapter, but it is suggested that local child protection services be charged specifically with combining their monitoring and investigatory roles with the primary task of sensitive prevention and assistance to vulnerable families and children. Clearly action must be taken in cases of abuse and neglect, particularly when this is the route that is indicated for the protection of children. Such action must be accompanied, as is stated in the CRC in Article 2, by 'effective procedures for the establishment of social programs to provide necessary support for the child and those who care for the child'.

The question remains: are the CPRs and associated reporting systems likely to constitute a sound system for measuring the incidence of abuse and neglect? At this stage we do not know as, at the time of writing, the system was not properly in place. Certainly it is likely to be of more use for monitoring incidence than for tracking individual children (one of its intentions).

The DoSD has called for monitoring and evaluation to be an integral component of the child protection system. They also charge provincial governments with 'monitoring the investigation of reports' (2004a, p. 100), and note the need for 'national tools and instruments to assess, monitor and evaluate direct service interventions' (2004a, p. 94).

Both these initiatives could be built around the reporting system and would address the demands of the CRC noted above.

The new Children's Act and the associated Bill will translate the DoSD recommendations into law (including provisions for national and provincial CPRs).

Data capture procedure for the CPR

According to the Children's Act, the purpose of Part A of the CPR is:

(a) to have a record of abuse or deliberate neglect inflicted on specific children;
(b) to have a record of the circumstances surrounding the abuse or deliberate neglect inflicted on the children referred to in paragraph (a);
(c) to use the information in the Register in order to protect these children from further abuse or neglect;
(d) to monitor cases and services to such children;
(e) to share information between professionals that are part of the child protection team;
(f) to determine patterns and trends of abuse or deliberate neglect of children; and
(g) to use the information in the Register for planning and budgetary purposes to prevent the abuse and deliberate neglect of children and protect children on a national, provincial and municipal level.

Point (g) above is particularly important as it should enable monitoring of government spending on child protection that is related to the information supplied on the Register.

Despite the challenges noted above, the CPR is intended to provide for administrative data on incidence, and seeks to support the tracking of these children, as well as informing services planning at local level, as envisaged by the DoSD's draft plan for child abuse and neglect.

The categories of information below are mandatory in terms of the Act. They are quoted verbatim from Part A of the register as provided in Chapter 7 of the Children's Act (Part B contains details of perpetrators and persons deemed not fit to work with children). The following points are included in Section 114(2)(a):

(i) the full names, surname, physical address and identification number of the child;
(ii) the age and gender of the child;
(iii) whether the child has a disability and if so, the nature of the disability;
(iv) whether the child has a chronic illness and if so, the nature of the chronic illness;
(v) the nature and a brief account of the incident, including the place and date of the incident;
(vi) the full names, surname, physical address and identification number of the parents or care-giver of the child; and
(vii) the name and physical address of the institution, child and youth care centre, partial care facility or shelter or drop-in centre, if the incident occurred at such a place.

Similar data are required in cases where there is a conviction, but adding the following in Section 114(2)(b):

(v) the full names, surname, physical address, identification number and occupation of the convicted person;
(vi) the nature and a brief account of the charge and conviction, including the place and date of the incident of which the person was charged; and
(vii) details of the relationship between the convicted person and the child.

And in the case of a finding by a children's court, the same identifying information is required in Section 114(2)(c), but with the following added:

(v) a brief summary of the court's reasons for finding the child to be in need of care and protection;
(vi) information on the outcome of the court's finding on the child;
(vii) the full names, surname, physical address and identification number of the parents or care-giver of the child; and
(viii) a brief summary of the services rendered to the child found to be in need of care; and
(ix) any other prescribed information.

The CPR therefore provides a set of most appropriate administrative data that can be used for an indicator system. Data on services rendered to the child are very important for measuring children's access to services following abuse or placement in terms of the new Children's Act.

Throughout the country the goal is for district level social welfare offices to gather case data from local welfare agencies and from reports made directly to the office and recorded on the appropriate form. The process should be managed by the supervising district social worker. The information should be entered into a database that is linked to the central provincial CPR and ultimately the national CPR (pers. comm. Ms M. de Bruin, Coordinator, CPR, Provincial Administration of the Western Cape, 26 January 2005).

The CPR only deals with cases that are reported through the DoSD system (normally via District Offices). It will not necessarily integrate data reported to hospitals or educational institutions, unless the child's case is also processed in the welfare system (which should be the case under the mandated reporting system). Therefore, there is a degree to which parallel systems will inevitably be in operation and no composite aggregated data set is likely to be available. Other vulnerable children such as those on the streets, or under court order in foster care and residential facilities, are not necessarily captured on the system (see chapters 12 and 15).

It is also important to note that counts of abused or neglected cases derived from the register will contain duplicates if children are reported more than once in a counting period, and it will be crucial to make a distinction between cases and children when producing composite figures.

In spite of the difficulties raised above, it is clear that mandatory reporting and registers will soon be part of the South African child protection policy landscape.

This system should be designed to ensure the best possible indicators of the numbers of abused and neglected children who come to the attention of the child protection system, so as to provide at least some indication of the scale of the incidence. The system must also permit data to be obtained on a range of other pertinent factors (see below).

The quality of the data on the register will depend fundamentally on inputs as well as resource factors.

It is essential that common definitions of abuse and neglect are used if those who capture the data are to be counting the same phenomena.

Monitoring and measuring child abuse and neglect: matters of definition

Prior to deciding on the indicators, definitions need to be clarified. Sound definitions of abuse and neglect are a source of ongoing debate. This is in large measure due to the different purposes for which they are designed (legal, training, research, etc.). As far as possible, definitions need to be clear and aligned with the predominant practice of the state (where appropriate). The constructs must be well defined and give rise to valid measures. These are significant challenges, which we deal with below.

We refer frequently to the CPR. It is not a research tool, but adequate for monitoring the incidence of abuse and neglect that is likely to be associated with statutory procedures. Also, it is the administrative data system from which incidence

information should be most readily available at least cost. We are aware, however, that the register is not functioning at all optimally at present – at least not in the Western Cape (Dawes, Willenberg et al., 2006). The register is intended to focus on children most clearly in need of court-ordered protective intervention by state agencies, and is only likely to cover cases in which indications of abuse or neglect are considered sufficiently clear and concrete to warrant an official investigation, with a strong possibility of statutory action. It is doubtful whether the CPR will receive ongoing information about incidents of repeated abuse once the initial registration has taken place – except where it comes to the attention of a previously uninvolved practitioner or concerned community member (pers. comm. Dr Jackie Loffell, Johannesburg Child Welfare, November 2005).

Research studies require particular care with definitions, as will be outlined below where appropriate.

Definitions 1: What is a child?

In keeping with the South African Constitution and the Children's Act, a child is a person under 18 years of age. It is therefore appropriate that this be the cut-off point for recording data on child abuse and neglect in most instances. However, the case of sexual abuse does present particular problems. Consensual heterosexual relations are permissible at 16 years. For homosexual relations the age is 19 years (Sexual Offences Act No. 23 of 1957), so currently homosexual relations between children over 16 years are criminalised.

Obviously, in the case of sexual abuse, consensual heterosexual relations between persons 16 years and over should *not* be counted as abuse. The higher cut-off for homosexual relations is not appropriate from an equity point of view and should be brought in line with the 16-year-old limit. It is of interest that for the crime of abduction, a child is under the age of 21 years – a problem of legal harmonisation.

Definitions 2: What is child abuse?

Child abuse may be regarded as active and deliberate maltreatment of a child while neglect could generally be regarded as more passive in nature – as acts of omission rather than commission.

There are a variety of definitions used in South Africa. This presents problems when comparing study results and administrative data.

Our point is supported by Finkelhor (1994), who notes that comparisons across research studies and social service reporting agencies are very problematic when definitions are neither common currency, nor sufficiently precise. Such confusion results in different estimates of abuse, and affects service planning. Any consideration of the scope of child abuse must therefore begin with a clear definition.

The definition used by the DoSD follows. This is the legal definition used in South Africa and is based on that used by the International Society for the Prevention of Child Abuse and Neglect:

> [child abuse] constitutes all forms of physical and or emotional ill-treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation resulting in actual harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. (DoSD, 2004a, p. 113)

An important point to observe here is that the definition includes the phrase 'resulting in actual harm to the child's health'. As other authors have pointed out, such a definition confounds the act of abuse or neglect with its consequences (Straus & Kantor, 2005).

This causes several problems, an obvious one being that a child who has been sexually abused but shows no 'actual harm' is excluded by the definition – it is unlikely that this would have been the intention of the authors.

It is therefore preferable to remove causes and consequences from these definitions for purposes of both monitoring and research. The above definition is not adequate as it stands (it also confounds neglectful behaviour with abuse).

Elsewhere the DoSD document provides a more refined formulation which states that:

> Abuse in relation to a child means any form of harm or ill-treatment deliberately inflicted on the child, and includes:
> (a) assaulting a child or inflicting any other form of deliberate injury on a child;
> (b) sexually abusing a child;
> (c) committing an exploitive labour practice in relation to a child;
> (d) exposing or subjecting a child to behaviour that may psychologically harm a child;
> (e) deliberately neglecting a child;
> (f) deliberately failing to protect a child from any of the above. (2004a, p. 7)

The Children's Act has taken a relatively narrow approach to definition. The section on interpretation defines child abuse as follows:

> 'abuse', in relation to a child, means any form of harm or ill-treatment deliberately inflicted on a child, and includes:
> (a) assaulting a child or inflicting any other form of deliberate injury to a child;
> (b) sexually abusing a child or allowing a child to be sexually abused;
> (c) bullying by another child;
> (d) a labour practice that exploits a child; or
> (e) exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.

There is some similarity with the DoSD document, but with additions such as (c). In that regard, a minor child who bullies another is perpetrating child abuse.

The definitions above are for legal purposes rather than scientific investigation, and are in some cases too loose for research. Also, they need to be operationalised further so that those who capture data are using the same understandings. We proceed to provide guidelines below for defining and understanding physical abuse, sexual abuse and neglect in turn.

Definitions 3: What is physical abuse?

The CIS of child abuse, one of the most extensive and sophisticated of its kind, defines physical abuse as being evident when the child (under 17) is 'suspected to have suffered or to be at substantial risk of suffering physical harm at the hands of his or her alleged perpetrator' (Trocme et al., 2001, p. 12).

The CIS is a research study and stratifies kinds of physical abuse into three subtypes (Trocme et al., 2001, pp. 30–31):

1. Shaken baby syndrome: 'Brain or neck injuries have resulted from the infant being shaken.'
2. Inappropriate physical punishment: 'Child abuse has occurred as a result of inappropriate punishment (e.g. hitting with hand or object) that has led to physical harm or put the child at risk of harm. The judgement of appropriateness is based on many factors including the severity of harm or potential harm, the amount of force used, the type of punishment relative to the age of the child and the frequency of punishment. The distinction between this category and "other physical abuse" is that in the former, the abusive act is performed within a context of punishment whereas in the latter there is no clear punitive or corrective context.'
3. Other physical abuse: 'Any form of physical assault that is inflicted on a child such as intentionally burning a child or hitting the child in a manner that does not appear to be intended as punishment.'

One of the problems with these CIS definitions is that the person recording the information must make a judgement as to certain intentions of the person who has injured the child ('does not appear to be intended as punishment'). It may, however, be useful under certain circumstances to differentiate between intended punishment, and acts that occur with no punitive intent.

This level of information would not be necessary for collection of primary provincial and national level reporting from administrative data. It would, however, be useful data to obtain in more intensive research on the problem, along the lines of the CIS.

Recommended definition of physical abuse

The Children's Act does not use the term 'physical abuse'. Rather, it appears that point (a) ('assaulting a child or inflicting any other form of deliberate injury to a child') would capture the essence of this form of abuse. It would seem to include physical punishment, as the term 'assault' is not limited.

The issue of outlawing corporal punishment will be debated in the National Council of Provinces once the Children's Amendment Bill comes before that body. As it stands, Section 139(1) reads:

> A person who has control of a child, including a person who has parental responsibilities and rights in respect of the child, must respect the child's right to physical integrity as conferred by section 12(1)(c), (d) and (e) of the Constitution.

The Bill outlaws corporal punishment in all courts at child and youth care centres, partial care facilities and shelters.

The DoSD (2004a) does define physical abuse in a manner that would cover Trocme et al.'s (2001) subtypes. While bullying is not specified, it covers the idea of assault as used in the Children's Act.

The CPR definition is appropriate for present purposes, and is taken from the CPR manual of the national DoSD:

> Physical abuse is any act or acts which results in inflicted injury or death to a child or young person. Associated signs include but are not restricted to: bruises and welts, cuts and abrasions, fractures or sprains, abdominal or head injury or injury to internal organs, strangulation or suffocation, poisoning, burns and any repeated injury for which explanation is inadequate or inconsistent. (DoSD Directorate Children, 2004, p. 45)

Unfortunately the register does not specify that the injury must be non-accidental, which of course is assumed.

A monitoring system should include a method of measuring the frequency or chronicity of the abuse. Obviously a pattern of ongoing abuse is likely to have more serious outcomes than an isolated incident (depending on its nature). The CPR is not likely to be useful for this purpose (see above), and incidence studies should be used instead.

Definitions 4: What is sexual abuse?

It is never possible to obtain accurate data on child sexual abuse as this is an illicit and secret activity. Incidence studies and registers only capture the very tip of the iceberg. Prevalence studies are more likely to be accurate.

Child sexual abuse commonly has two basic elements that should be part of the definition of sexual abuse used in a monitoring system. There is wide agreement on these basic conditions in the literature (Finkelhor, 1994, p. 33):

1. sexual activities involving a child, and
2. abusive conditions, which exist when:
   - the child's partner has a large age or maturational advantage over the child; or
   - the child's partner is in a position of authority or in a caretaking relationship with the child; or
   - the activities are carried out using force or trickery.

Of course, more than one of these conditions may apply. All indicate unequal power between perpetrator and child, which is likely to be associated with a lack of consensuality.

The sexual activities referred to above are intended for the stimulation of the perpetrator (as in the DoSD definition above), and include both contact and non-contact abuse (see below).

The question of what constitutes a 'large age gap' is a matter of debate and there is no South African guidance on this question. In addition, as we have noted in relation to the Sexual Offences Act, sexual relations between a 17-year-old and a 15-year-old (a small age gap) constitutes a criminal act even if it is consensual (although not necessarily prosecuted).

It is worth noting that a third of reported sexual offences in the UK are committed by persons under 18 years (Erooga & Masson, 1999). Comparable figures for South Africa are not available, but it is well recognised that young people are a significant perpetrator sector (Wood et al., 2000).

It is important to be able to separate those sexual behaviours exhibited by children that are abusive from those that constitute sexual experimentation, and which can occur in pre-pubertal as well as pubertal children (see below).

Authorities tend to agree that carefully constructed national incidence studies may provide the best incidence estimates (Finkelhor, 1994). Examples include the US National Incidence Studies (National Clearing House Child Abuse and Neglect Information, 2004) and Trocme et al.'s (2001) CIS.

The US National Incidence Studies stratify sexual abuse into seven types (National Clearing House Child Abuse and Neglect Information, 2004, p. 33):

1. Sexual activity completed: 'Included oral, vaginal or anal sexual activities.'
2. Sexual activity attempted: 'Included attempts to have oral, vaginal or anal sex.'
3. Touching/fondling genitals: 'Sexual activity involved touching/fondling genitals.'
4. Adult exposing genitals to child: 'Sexual activity consisted of exposure of genitals.'
5. Sexual exploitation: Involved in prostitution or pornography: 'Included situations in which an adult sexually exploited a child for purposes of financial gain or profit.'
6. Sexual harassment: 'Included proposition, encouragement, or suggestion of a sexual nature.'
7. Voyeurism: 'Included activities in which a child was encouraged to exhibit himself/herself for the sexual gratification of the alleged perpetrator. The sexual exploitation/pornography code was used if the voyeurism included pornographic activities.'

This degree of disaggregation is not necessary for primary indicators of child sexual abuse. It is, however, a useful and well-validated list that can be used for more extensive research purposes.

Recommended definition of child sexual abuse

The CPR definition of sexual abuse is appropriate for present purpose, and covers most of the points raised above. The definition below is taken from the CPR manual of the national DoSD:

> Sexual abuse is any act or acts, which result in the exploitation of a child or young person, whether with their consent or not, for the purposes of sexual or erotic gratification. This may be by adults or other children or young persons. Sexual abuse may include but are [sic] not restricted to the following behaviour:
> - Non-contact-abuse: exhibitionism (flashing), voyeurism (peeping), suggestive behaviour or comments, exposure to pornographic materials or producing visual depictions of such conduct.
> - Contact abuse: genital/anal fondling, masturbation, oral sex, object or finger penetration of the anus/vagina and/or encouraging the child/young person to perform such acts on the perpetrator.

- Involvement of the child/young person in exploitive activities for the purposes of pornography or prostitution.
- Rape, sodomy, indecent assault, molestation, prostitution and incest with children. (DoSD Directorate Children, 2004, p. 46)

The register definition fits well with recommendations made by Finkelhor (1994). It includes both contact and non-contact abuse, and includes several of the categories in Trocme et al.'s (2001) system and those outlined by the DoSD (2004a).

It also includes reference to commercial sexual exploitation and the use of children in pornography (see Chapter 13 in this volume).

Finkelhor draws attention to the importance of assessing the aversive conditions that exist in abuse situations. They exist when:

> the child's partner (sic) has a large age or maturational advantage over the child; or the child's partner is in a position of authority or is in a caretaking relationship with the child; or the activities are carried out against the child using force or trickery. (1994, p. 33)

As with physical abuse, the CPR is unlikely to be able to capture chronicity and this will have to be determined by surveillance and incidence studies.

Recommendation regarding sexual abuse perpetrated by those under the age of 18 years

Following Erooga and Masson (1999), a juvenile sexual offender (or child sexual abuser) may be defined as a person under 18 who commits a sexual act with a child i) against the victim's will, ii) without the victim's true consent, or iii) in an aggressive, exploitive, or threatening manner.

Definitions 5: What is neglect?

Neglect is arguably one of the most difficult conditions to define as it has more cultural loading (other than in extreme forms) than the previous categories (Straus & Kantor, 2005). The core conceptual issue is to find a way of specifying 'omissions of care (unmet needs) rather than *abusive* actions' (Straus & Kantor, 2005, p. 20, italics ours).

The CIS definition is as follows:

> Child neglect includes situations in which children have suffered harm, or their safety has been endangered as a result of the caregiver's failure to provide for or protect them. Unlike abuse, which is usually incident specific, neglect often involves chronic situations that are not as easily identified as specific incidents. (Trocme et al., 2001, p. 35)

Note that it includes the indicators that the child has been harmed. There is debate about whether or not harm should be included (see the position advocated by Straus and Kantor below). Usefully, this definition does draw attention to chronicity, which illustrates a pattern of neglect over time.

The CIS identifies eight subtypes of neglect (Trocme et al., 2001, p. 35):

1. *Failure to supervise or protect leading to physical harm:* 'The child suffered or was at risk of suffering physical harm because of the caregiver's failure to supervise

and protect the child adequately.' This includes injury to child as a result of parents' actions such as drunk driving.

2. *Failure to supervise or protect leading to sexual abuse:* 'The child has been or was at substantial risk of being sexually molested or sexually exploited, and the caregiver knew or should have known of the possibility of sexual molestation and failed to protect the child adequately.'
3. *Physical neglect:* 'The child has suffered or was at substantial risk of suffering physical harm caused by the caregiver's failure to care and provide for the child adequately. This includes inadequate nutrition/clothing, and unhygenic and/or dangerous living conditions. There must be evidence that the caregiver is at least partially responsible for the situation.'
4. *Medical neglect:* 'The child required medical treatment to cure, prevent, or alleviate physical harm or suffering, and the child's caregiver did not provide, refused or was unavailable or unable to consent to the treatment.'
5. *Failure to provide treatment for mental, emotional or developmental problems:* 'The child was at substantial risk of suffering from emotional harm as demonstrated by severe anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or suffering from a mental, emotional, or developmental condition that could seriously impair the child's development. The caregiver did not provide, refused, or was unavailable or unable to consent to treatment…' This clause includes learning disabilities, school behaviour problems and developmental delays, as well as non-organic failure to thrive. It excludes treatment for criminal conduct.
6. *Permitting maladaptive/criminal behaviour:* 'A child has committed a criminal offence with the encouragement of the child's caregiver, or because of the caregiver's failure or inability to supervise the child adequately.'
7. *Abandonment/refusal of custody:* 'The child's caregiver has died or was unable to exercise custodial rights and did not make adequate provisions for care and custody, or the child was in a placement and the caregiver refused to take custody.'
8. *Educational neglect:* 'Caregivers knowingly allowed chronic truancy (5 days or more a month), failed to enroll the child, or repeatedly kept the child at home.' If the child had been experiencing problems associated with school and treatment had been offered, the case would be coded as failure to provide treatment.

Emotional neglect is difficult to define because incidents are not clear, and its effects emerge over time. In the CIS four categories were used (Trocme et al., 2001, pp. 36–38):

1. *Emotional abuse:* The child has 'suffered or was at risk for suffering from mental, emotional, or developmental problems caused by overtly hostile, punitive treatment, or habitual or extreme verbal abuse (threatening, belittling etc.)'.
2. *Non-organic failure to thrive:* 'A child under 3 has suffered a marked retardation or cessation of growth for which no organic reason can be identified. Failure to thrive cases in which inadequate nutrition is the identified cause were classified as physical neglect.' Non-organic failure to thrive is generally considered to be a form of emotional neglect but is classified separately due to its particular features.
3. *Emotional neglect:* 'The child has suffered from or is at substantial risk of suffering from mental, emotional or developmental problems caused by inadequate nurturance/affection.'

4. *Exposed to family violence:* 'A child has been a witness to, or has been involved with family violence within his/her home environment. This includes situations in which the child indirectly witnessed the violence (e.g. saw the physical injuries on his/her caregiver the next day).'

It will be evident that emotional abuse – an active abusive orientation to the child – is included under neglect in the Canadian system. Arguably, this is problematic for South African purposes because the DoSD categorises this is a form of abuse rather than neglect.

For purposes of the present research, the South African approach will be used as noted above under the section headed 'Definitions 2'.

Recommended definition of neglect

Straus and Kantor stress the importance of separating the act from resultant harm (note that Trocme et al. [2001] do not do this):

> [if] the measure (of neglect) is based on harm to the child, the prevalence of neglect will be *vastly underestimated* because a large percent of neglected children *will show no measurable harm*. (2005, p. 22, italics ours)

We therefore caution that neglectful behaviour and the harm to the child *must be measured separately* so that they are not conceptually confounded. If we do not do this, we cannot know 'to what extent the measure or assessment of neglect describes the behavior of the caregiver or the effect on the child' (Straus & Kantor, 2005, p. 22).

Given the importance of aligning with definitions used in the policy sector (provided they are adequate), for practical purposes we recommend the use of definitions provided by the CPR. Having said that, it is evident the CPR *does indeed conflate* the act with the harm as will be evident below – the problematic phrase is: 'which results in'. This is not a satisfactory situation, but we will have to live with it for administrative data purposes.

Usefully, the definition stresses 'any act or failure to act' on the part of the caregiver, but problematically, it does not distinguish between circumstantial and deliberate neglect. Failure to act might be due to circumstances beyond the caregiver's control. Most surveillance studies make this clear, as indeed does the DoSD document. It is not appropriate that caregivers who cause neglect due to their circumstances (poverty) will be captured on the CPR.

In what follows, psychological neglect compares with emotional neglect as used by others. We quote from the CPR manual (DoSD Directorate Children, 2004, p. 46):

> *Psychological abuse or neglect:*
>
> Psychological abuse or neglect is any act or failure to act by the parent and/or caregiver, which results in, impaired psychological and/or emotional functioning and/or development of a child or young person which may be expressed as anxiety, withdrawal, aggression, depression, or delayed development. It may include but are [sic] not restricted to:
> - Rejection, isolation or oppression; Deprivation of affection or cognitive stimulation; Inappropriate and continued criticism, threats, humiliation, accusations and expectations or towards [sic] the child or young person;

Exposure to family violence; Corruption of the child or young person through exposure to, or involvement in, illegal or anti-social activities; and Exposure to the negative impact of the mental or emotional condition of the parent/ caregiver or anyone living in the same residence as the child or young person.

Neglect:

Neglect is any act or failure to act by the parent or caregiver which results in impaired physical functioning or development of or injury to a child or young person, such as persistent hunger, thirst or malnutrition, inadequate clothing or inadequate hygiene or living conditions. Failing to ensure education, when resources exist. It may include but are [sic] not restricted to:

- *Physical neglect:* failure to provide the necessities required to sustain the life of the child or young person; Neglectful supervision: failure to provide appropriate adult supervision of the child or young person. Leading to an increased risk of harm;
- *Medical neglect:* failure to seek, obtain or follow through with medical care for the child or young person, resulting in their impaired functioning or development; Abandonment: leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning; Refusal to assume parental responsibility: such as unwillingness or inability to provide appropriate care or control for the child; and Educational neglect: failure to provide for the child's educational needs, such as schooling, support and stimulation.

With regard to abandonment, it is of note that the definition above is intended to refer only to situations in which the child has *deliberately* been left in a life-threatening situation. Abandonment can be regarded as an extreme form of neglect, but it much more commonly takes the form of leaving the child in a safe place where he or she is likely to be found and cared for.

In the new Children's Act an *abandoned child* is interpreted as meaning: 'a child who–
(a) has obviously been deserted by the parent, guardian or caregiver; or
(b) has, for no apparent reason, had no contact with the parent, guardian, or caregiver for a period of at least three months.'

The Children's Act definition, which is the same as that used by the DoSD (2004a, p. 7), states that neglect is 'the failure by those responsible for the child to meet his/her basic physical, emotional, intellectual and social needs'. The Act does not elaborate on forms of neglect.

Ideally, a monitoring system should include a method of measuring the *frequency or chronicity* of neglectful acts (as applies to monitoring abuse). However, such data are much more likely to be captured in purpose-designed surveillance studies.

Common data and definitions of abuse and neglect must be used by all agencies that contribute to provincial and national reporting. Therefore, if the CPR is to be used as the basis for monitoring, as we have noted above, it is absolutely essential that the *same definitions, data fields, and data protocols as outlined above must be used in all social work districts in all provinces*. If not, it will not be possible to aggregate the information to national levels.

The registers must make provision for recording the child's identity number (or another unique identifying number) to control for data duplication at the point of data cleaning prior to analysis.

Recommended basic information to be collected for recording incidence

Chalk et al. note that, in the US:

> Our current knowledge about children who have been abused and neglected comes primarily from cases that have already been identified and reported to child protection agencies, rather than population based samples identified through survey data or community studies. This heavy reliance on administrative records puts greater emphasis on cases that are more likely to come to the attention of social service caseworkers. (2002, p. 4)

Reporting systems therefore inevitably underestimate true incidence, and population-based studies are needed to capture data on those who are not reported.

Despite their limitations, it is our view that welfare agencies rendering child protection and rehabilitation services are likely to provide more reliable estimates of the incidence of the problem than the general South African Police Services (SAPS) crime information system. In part, this is because the incidence of child abuse and neglect is not reliably obtained from SAPS crime data. SAPS measures reported crime by offence category (for example, rape, attempted rape, statutory rape, cruelty to children, etc.). These data are recorded using different definition criteria to that we have referred to above. Nonetheless, sexual and physical assaults on children that are reported to the police are often all we have to go on and should indeed be used even though it provides only a very rough estimate of the problem. Call data from agencies such as ChildLine can also be useful to track patterns in children's concerns when they telephone the service. Again, these data must be used with great caution as cases cannot be validated.

If we are to describe the extent and nature of the child abuse and neglect problem and track it over time, we need certain basic information to be collected as fully as possible by all those who have contact with the child on his or her entry into the child protection and services system (the CPR staff, the child welfare agencies, the police and the hospitals).

We suggest that the basic information that follows be collected in the same manner by all agencies. It is based on the literature and is aligned to the provisions of the Children's Act for the CPR. Every agency should cover all the basic components recommended, adding others if required for their own administrative or professional purposes. This would enable a baseline of data to be established for each agency, and eliminate variability of data recording on child abuse and neglect across agencies.

Recommendations for the collection of basic incidence data

Who was the victim?

Name, age sex, identity number, disability status, basic family information (children in statutory and alternative care), and actual residential address at the time of the incident. Alternative address and contacts particularly to enable tracking when children are likely to move between locations (for example, city to countryside).

Who are the caregivers?

Name, physical address and identification number of the parents or caregiver of the child; and the name and physical address of the institution, child and youth care centre, partial care facility or shelter or drop-in centre, and/or a school if the incident occurred at such a place.

Who was the perpetrator (or neglectful person or institution)?

This is a problematic question, and often it is not easy to answer. But where possible, the perpetrator's probable age level (or the actual age) and relationship to the child is essential. Such data help to describe perpetrator-related risk factors when linked to the time and place of the abuse.

What happened?

An account of the incident, including the location (if possible the actual street address or identifiable place of the abuse for geo-coding purposes), time and date of the incident. Was it one incident or has it been going on for some period of time (indicator of chronicity and probable harm caused)?

What services was the child referred to?

- This question is crucial for tracking the child through the services system; and
- What is the status of relevant court processes (where applicable)?

Specific incidence and prevalence research studies

Incidence studies

The CPR will take several years to be operational in all districts and provinces and it will take some time before CPR data can be used with any confidence. For this reason, a South African national incidence study should be undertaken as soon as possible in order to provide baseline data. A representative sample of agencies that routinely receive reports of child abuse and neglect in the welfare system should be selected, and the methodology should follow the lead of the CIS (Trocme et al., 2001). The study should be repeated with the same social services districts and agencies every five years. Using the same agencies would serve to strengthen their

own data-gathering procedures, as well as providing a consistent set of data collection areas over time (the districts within which the agencies operate).

Prevalence studies

Incidence data are necessarily limited to those cases that are reported (Wynkoop et al., 1995). Community prevalence studies conducted on adults (on their childhood experience of possible abuse and neglect) can provide a more substantial picture as it includes those who may have been abused but who were not reported on.

A nationally representative prevalence survey on child abuse and neglect should therefore be conducted. The sample should include young adults between the ages of 18 and 24 years (in line with the retrospective prevalence component of the UN Study of Violence to children).[2] This age limit protects children from the secondary traumatisation that could occur with a child survey, while reducing problems with recall (Widom & Shepherd, 1996; Widom & Morris, 1997). In collaboration with the International Society for the Prevention of Child Abuse and Neglect (IPSCAN), the UN Secretary General's *Study on Violence Against Children* has designed a set of instruments for determining the prevalence of child maltreatment. These tools include adult retrospective maltreatment measures.[3]

In supporting the child's right to participation (Willenberg & Savahl, 2004), and stressing the critical importance of hearing children's voices in policy development, many would argue for a participatory study of abuse and neglect with children. Although in principle we support this idea, the ethical issues are considerable. Any study would have to ensure that children who report abuse are provided with the relevant services. However, receipt of the necessary services is most unlikely in a low resource context such as South Africa. Secondly, such research may cause harm through secondary traumatisation. We would therefore strongly caution against surveys or participatory studies which question children about abuse.

Morbidity rates and reporting stratifications

Child abuse and neglect morbidity rates for a particular period that are reported at national and provincial level should be expressed as rates per 100 000 children, stratified by age and gender for each type of abuse and neglect.

The following age stratifications would be appropriate for annualised reporting:

- All children under 18 years of age (as used in the CPR process);
- Children from 0–11 years and 12–18. This stratification aligns with those commonly used in police and hospital data;
- Children aged 0–5 as they are particularly at risk for both physical and emotional neglect and physical abuse.

Some may feel it is appropriate to stratify by population group. We would suggest not. A rationale for such a practice is required. There is no reason to expect that population group membership (based in any event on apartheid constructs) will explain any of the variance in abuse and neglect. If anything, it is socio-economic status that is the more important variable.

For *provincial* purposes, annualised records should also be stratified by smaller geographic areas to provide a sense of areas in which children are particularly vulnerable, which services require support, and to inform staffing levels. These could include social work districts, police precincts and magisterial districts.

Further stratifications by local government electoral ward or place name are important to track risks in particular neighbourhoods and to inform protection strategies (see chapters 3 and 4 in this volume).

Similarly, and where possible, the location of abuse and neglect in particular sites such as the home and the school should be captured to support protective service planning. The CPR makes this possible, as does the Department of Education's Labour Relations data and Safe Schools data in some provinces. Perpetrator characteristics (for example intra-familial vs. non-kin and age) are also useful for the design of preventive strategies.

Indicators (core and additional) that measure the phenomena discussed above are presented in Part 2 of this volume.

Recommended indicators for monitoring child abuse and neglect

The full list of indicators, measures and potential data sources for all indicator types and levels is presented in the tables in Part 2. The first table includes the core (or priority) indicators, while the second table includes a list of additional indicators.

The discussion above has largely addressed Type 1 indicators (child status) in terms of the indicator typology outlined in Chapter 2 of this volume. It is of course essential that indicators for risk factors in the home and the neighbourhood are included, and that service access and quality is addressed in order to tap duty-bearer responsiveness to these problems. These matters are addressed in the indicator recommendations that follow.

As with Type 1 indicators, risk factors for child abuse and neglect in the home (Type 2 Indicators: Family and household environment), the neighbourhood (Type 3 Indicators: Neighbourhood and surrounding environment), and services for child abuse (Type 4 and 5 Indicators: Service access and Service quality) are very difficult to capture in a routine monitoring system, as the administrative and survey data to support it is lacking. Therefore, a limited set is included in the core indicator table, and a more extensive set in the additional indicator table. Most of the indicators for these types would require new data to be collected as part of routine administrative systems. Other more detailed information, particularly as regards service access and quality, would have to be collected in purpose-designed surveys and service audits.

Core indicators of child abuse and neglect are appropriate for situation reports, and only to a limited extent for monitoring policy outcomes. Once they are functional, this data should be drawn from the CPRs and from other sources such as the courts (to monitor the outcome of children's court inquiries and criminal cases). Prior to that time, it will be necessary to conduct purposive baseline studies. We have included a limited number of Type 2 (risks in the home), Type 3 (neighbourhood

risks and supports), and Types 4 and 5 (service access and quality) indicators in the core list. In terms of services, we have drawn on national policy guidelines to measure the extent to which the service support systems are in place at local, district and provincial level. Without these structures in place, the policy cannot function and the services will not be supported. Similarly, we have included a limited set of core indicators for social work services, child protective services in the police (the Family Violence, Child Protection and Sexual Offences Units), and the courts. While these data are of limited availability and are not easy to gather, it is essential that steps be taken to strengthen administrative data systems to permit routine low-cost monitoring of service access and quality. The core indicators were chosen with regard to their importance and with data availability in mind. The quest to obtain good data is very important given the seriousness of the problem. Therefore, rather than focusing only on core indicators that are available in existing data sets, we have included indicators in the core set that we believe should be designed and collected as soon as possible.

Additional indicators of child abuse and neglect provide a more disaggregated picture and are crucial for a more thorough analysis of the situation. They are normally collected in studies that are used to inform policy, policy evaluation and the assessment of programme implementation and outcomes. Examples include data on the age and gender of the perpetrator, and the month, day and time of day when an incident occurred (not appropriate for neglect). Investigation of Type 3 indicators is appropriate at this level, including the specific geo-coordinates of the place where the abuse or neglect occurred, so as to be able to identify the socio-economic and other population parameters of the area, and track other environmental features that may place the child at risk. In addition, audits of service access (Type 4 indicators) and quality (Type 5 indicators) are located in the additional set. Most of this data will in time be available from the CPR and from agency databases, and should be reported as needed by local planning and child protection authorities. The CPR should be designed to facilitate the easy generation of such reports.

From a resource-efficiency point of view, it is recommended that additional indicator data be collected less frequently, and on a purposive basis. The indicators should be read in conjunction with the indicators associated with chapters 7, 13 and 15.

Conclusion

Monitoring child abuse and neglect is a significant challenge. This is acknowledged across the world. At best it is only possible to provide incidence estimates that reflect a small proportion of the true situation. Retrospective prevalence studies among adults are likely to go further toward providing a more accurate picture, although these too have their limitations – for example, memory of these events may well be affected by trauma, among other factors.

We currently have no representative data of either form in South Africa. There is a need for good incidence studies which can inform funding for services and provide information on quality. A recent study of the quality of child protection data in the Western Cape government sector pointed to significant problems with the CPR, among other systems. It is not the register itself that is problematic. Rather, the

difficulty lies in resourcing the system and in improving data quality. Currently it is not an adequate source of child protection data as required in the new Children's Act (Dawes, Willenberg et al., 2006). Ultimately the register can be a useful tool and a cheap source of child protection data – cheap because it relies on administrative data. However, this will only be the case if it functions as intended and has the staff to maintain it.

While we do not have accurate data, several sources tell us that the rates of child maltreatment in this country are appallingly high. The indicators recommended for this chapter in Part 2 of the volume will permit us to monitor how well we are doing to reduce the scale of the problem and provide the affected children with the care and support they need.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 The authors are grateful to Lucie Cluver, Jackie Loffell, Ingrid Willenberg and Sharon Kleintjies for comments on drafts of this chapter.

2 UN Study of Violence to children, <www.childrenandviolence.org>.

3 These tools are available at <http://www.ipscan.org/questionnaires.htm>.

CHAPTER 15

Monitoring the situation of children in statutory care

Jackie Loffell

Introduction: objectives and scope

This chapter deals with indicators of the rights and well-being of children who have been found to be 'in need of care' in terms of the Child Care Act (No. 74 of 1983), and also those who fall within the equivalent category in terms of the Children's Act (No. 38 of 2005), which at the time of writing was not yet in effect. Addendum A at the end of this chapter provides the precise legal definitions involved in both the current and the proposed legislation. The children at issue are those who have come to the attention of the children's court, which has judged them to be in need of intervention, using state authority, to protect them from maltreatment or destitution and, where necessary, to provide them with substitute care and associated services. As children in a state of vulnerability due to lack of adequate family care, and as wards of the state, these children have a clear claim on public resources needed for their healthy growth and development, as was confirmed by the Constitutional Court in the watershed Grootboom judgement in 2001.[1] The chapter will also cover children alleged but not yet confirmed to be in need of care, and to a limited extent those placed in adoption, in terms of the same legislation.

Rationale

A rights-based approach to monitoring of children in care

All the rights of children as set out in the international instruments to which South Africa is a party, and in the Constitution and various South African statutes, are of course applicable to children in substitute care. Mention is made here of those which specifically apply to such children, and of some that may be overlooked or that present special challenges where children in statutory care are concerned.

United Nations Convention on the Rights of the Child

The UN Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) refers to a number of rights which are not included in the South African Constitution. They are mentioned in the present discussion because they are reflected in some very pertinent official documents, as will become apparent. The following clauses of the CRC are relevant for the purposes of this chapter:

- Article 2: children's rights must be applied to all without discrimination;
- Article 3(1): the best interests of the child are a primary consideration in all actions taken on behalf of the child;

- Article 3(3): institutions, services and facilities responsible for the care or protection of children must conform to standards established by competent authorities;
- Article 6: the survival and development of the child must be ensured;
- Article 9(1): a child shall not be separated from his or her parents against their will, except when competent authorities decide that this is in the best interests of the child;
- Article 9(3): a child who is separated from one or both parents has the right to maintain personal relations and direct contact with them, except if contact is contrary to the child's best interests;
- Article 12(1): State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child;
- Article 12(2): provides that children have the right to be heard in any judicial and administrative proceedings;
- Articles 19(1 & 2) and 20(1) address child protection. Under these articles, states are required to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, and to take steps to support maltreated children and those who care for them, and to make provision for judicial involvement;
- Article 20(1, 2 & 3) stipulates that children who have been removed from their families are entitled to special protection by the state, including alternative care. Continuity in a child's ethnic, religious, cultural and linguistic background must be considered. Following Article 25, the treatment of children placed in care (and otherwise in treatment) is subject to periodic review. Children in statutory care have the right to be protected from discrimination, and to practise their religion, language and culture (Article 30). Refugee children have the same protection rights as any other child (Article 22);
- Adoption is covered in Article 21. The best interests of the child are paramount and adoptions may only be authorised by competent authorities. Inter-country adoption (21(b&c)) may be considered as an alternative if an appropriate placement cannot be found in the child's country of origin, provided that the country into which the child is adopted has standards equivalent to (or better than) those existing in the case of national adoption. The placement must not result in improper financial gain for those involved (21(d)). Countries should conclude bilateral agreements to ensure that the placement of the child in another country is carried out by competent authorities or organs (21(e));
- Article 23 refers to children with special needs. Children with disabilities are entitled to a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate active participation in the community. Subject to available resources, states are responsible for providing assistance to the child and caregivers that is appropriate to the child's condition and to the circumstances of those who care for the child. This assistance should where possible be free and should ensure that the child has access to and receives education, training, healthcare services, rehabilitation services, preparation for employment and recreation opportunities.

African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child (see Appendix 3 in this volume) echoes most of the above provisions.[2] They will not be repeated here as the wording is for the most part very similar.

Other international instruments

A number of international human rights instruments to which South Africa is party have implications for statutory care and protection services, but space does not permit the mention of all of them. However, some are of specific relevance because they highlight gaps in our system. One is Article 7(2)(b) of Convention 182 of the International Labour Organisation (ILO) on the worst forms of child labour, which requires that there be provision for the removal of children from activities which have been designated as being among the worst forms of child labour, including commercial sexual exploitation, and for their rehabilitation and social reintegration (see Chapter 13 in this volume for a discussion of the monitoring of the rights of children involved in exploitative labour and trafficking).

Another is the Hague Convention on Inter-country Adoption, which provides safeguards to ensure that children are not unnecessarily removed from their country of birth, and that where inter-country adoptions are considered to be appropriate, they proceed in accordance with the rights and best interests of the children concerned. Furthermore, Article 23(1) of the Covenant on Civil and Political Rights states that the family is entitled to protection by the state, and Article 24(1) states that the child has the right to special measures of protection as required by his or her status as a minor. Finally, the International Covenant on Economic, Social and Cultural Rights[3] also provides in Article 10 that the state is obliged to protect families, and that mothers must be given special protection before, during and after childbirth. This Covenant also recognises that children are entitled to special measures of protection.

The South African Constitution

A number of the provisions of the CRC are taken up directly in the Bill of Rights (see Appendix 2 in this volume). Of particular relevance are the following:

- The right to family care or parental care, or to appropriate alternative care when removed from the family environment (Section 28(1)(b));
- The right to be protected from maltreatment, neglect, abuse or degradation (Section 28(1)(d));
- The right of the child to have his or her best interests treated as being of paramount importance in every matter concerning him or her (Section 28(2));
- The right to social services (Section 28(1)(c));
- The right to dignity (Section 28(10));
- The right to equality (Section 28(9)).

Also of direct relevance, given that children are found to be in need of care and ordered into various forms of care by the courts, and are thereafter dealt with in terms of various administrative processes, are the following:

- The right to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result (Section 28(1)(h)); and

- The right to administrative action which is lawful, reasonable and procedurally fair (Section 33).

Some rights which apply to all children, but which may pose specific challenges in the case of children in statutory care, are the rights to language and culture (Section 30), and the right to education (Section 29).

The Child Care Act and the Children's Act

The statute which defines the categories of children who may be considered to warrant state intervention due to being 'in need of care' is the Child Care Act (No. 74 of 1983), which also governs the way in which such children are to be dealt with. This Act pre-dates the Constitution and the CRC and does not provide adequately for the rights of children as recognised in the CRC and other instruments. It is soon to be replaced by the Children's Act (No. 38 of 2005), which has been passed but, at the time of writing, had yet to be amended by the Children's Amendment Bill (No. 19 of 2006). This Bill will add the responsibilities of provincial government to the national competencies that are at present covered, before the Act will take its final form.

As the Child Care Act and its Regulations stand at present, a child found to be in need of care by the children's court will in terms of Section 15(1) be placed either:

- With that child's present caregiver under the supervision of a social worker, under specified conditions;
- In foster care under the supervision of a social worker;
- In a children's home; or
- In a school of industries.

The court order in question will have a maximum duration of two years, after which there must be a review of the situation (Section 16). Within that period, social work services are to be delivered for the purpose, if possible, of reintegrating the child within his or her family after resolving the problems which led to the placement (Section 16; Regulation 15). Failing this, activities directed to some other form of permanent reintegration of the child in the community, preferably within a family environment, should take place. If continuation of the present placement is required, a social worker's report recommending this course of action will be submitted and considered by an official of the provincial Department of Social Development (DoSD), who will issue or decline to issue the relevant order. An order which is not renewed will, unless the child is transferred to some other form of care, simply lapse and the child will revert to his or her initial legal status.

The incoming Children's Act will provide for a much wider range of options for the children's court (Section 46). New possibilities would include placement of the child in 'shared care' – for example, a child who is at risk due to weekend drinking on the part of a parent could be placed in foster care or a children's home over weekends, but with the parents under supervision during the week. Other new possibilities are placement in a facility for the care or training of persons with disabilities, or a secure care facility, or a rehabilitation centre for persons addicted to drugs or alcohol, none of which is currently provided for. A caregiver could be ordered to participate in some form of treatment or training, or the family could be ordered into a family preservation programme.

Provision is also made for consideration of the child's age in relation to the length of time spent in care, for purposes of determining whether the parental rights and responsibilities of the parents should be terminated, possibly allowing for adoption to take place (Children's Amendment Bill, Section 135(2)).

The Child Care Act provides for the establishment of state places of safety, secure care facilities and children's homes (sections 28, 28A and 29), the registration of children's homes run by non-governmental organisations (Section 30(1)), and the regulation and monitoring of all such facilities (regulations 30–35). Similarly, the Children's Amendment Bill provides for the establishment, regulation and registration of child and youth care centres (sections 194–196).

Relevant policy documents

The main government policy documents relating to children in statutory care are those developed by the Inter-Ministerial Committee on Young People at Risk (IMC) in the late 1990s. Of relevance for present purposes are the IMC's *Interim Policy Recommendations* (1996) and draft *Minimum Standards* for child and youth care (1998). While these titles suggest temporary status, they are the basis of the DoSD's Developmental Quality Assurance (DQA) process for children's residential care centres, and also for the assessment and review systems which social workers are expected to carry out for each child in statutory care. These documents take into account the Regulations to the Child Care Act which govern practices in children's facilities and case management by social workers. The *Minimum Standards* document provides a list of 21 rights of children in residential care (see Addendum B to this chapter), most of which would also be applicable to children in other forms of care. These rights are the basis for a detailed set of standards, which are formulated in such a way that they can be used as indicators for monitoring, as discussed later in this chapter. Also of relevance is a policy process which has, under various titles, been in progress since 1995 and is nearing completion in the form of the *National Policy Framework and Strategic Plan for the Prevention and Management of Child Abuse, Neglect and Exploitation*. A working paper relating to this process has been completed by the DoSD and will in due course be submitted to the Cabinet for approval (DoSD, 2004a).

Challenges in the South African context and suggested approach

The task of selecting indicators for children in statutory care in South Africa is greatly complicated by the state of the service network which is responsible for addressing the needs of such children, in particular the social welfare component.[4] Statutory care services are a category within child and family welfare services, which have been described as 'operating without the support of a grounded, integrated or coherent philosophical framework, appropriate infrastructure, effective human resources and norms and standards guiding intervention' (September & Blankenberg, 2004, p. 59). These services also form part of a broader child protective system which includes the courts, the police, educational and health services and a range of other sectoral components. The structures involved, especially where these

are run by NGOs, are characterised by poor resourcing and extreme overload, with high staff turnover and frequent vacancies (DoSD, 2004a). Training and support for personnel are generally in short supply, and levels of experience tend to be low. The bureaucratic demands involved in case management for children entering and/or remaining in care are already very onerous, and measures which are too burdensome will often simply not be carried out. Alternatively, time spent on them will be at the expense of direct services to children and families. This is a 'chicken and egg' situation, in that one of the reasons why the sector has such difficulty in commanding more resources is likely to be the fact that it cannot produce the concrete data needed to justify them.

In a paper on children in need of care prepared for a study entitled *The State of Children in Gauteng* for the Office of the Premier in that province in 2003, the following problems were noted (Loffell, 2003):

- Many of the subsidised organisations which delivered statutory services to children in need of care were failing to submit the required monthly statistics reflecting the nature and extent of their work to the Gauteng DoSD's Welfare Management Information Systems Subdirectorate (WMISSD) for collation and analysis, hence the information available from that unit was seriously incomplete.
- The format in which the WMISSD data were collected was in any case of little help in identifying trends in services. The categories used indicated how many children were in particular categories of longer-term statutory care (children's homes, foster care, etc.) in any given month, but did not indicate critical issues such as the situation of children for whom children's court enquiries had been opened but not yet finalised, the numbers who had entered statutory care over a particular period and for what reasons, what kinds of services were being delivered and with what frequency and intensity, how long the children were staying, or where they were going when they left.
- The NGOs involved operated under a host of different auspices and mandates, without any uniform system of data collection.
- Data from the children's courts did not show how many children (as opposed to how many families) were coming before the courts, the reasons why they were coming, or the types of order made.

These factors are likely to apply in most if not all provinces, especially those in which most of the relevant service delivery is carried out by NGOs. It is at present not possible to form even a very basic picture of the population of children who are in the statutory care system, and even less possible to gauge what is happening to these children in terms of intensity, quality and impact of services. Hence, the sophisticated systems of indicators which are in place in the UK and the US, for example, would simply be impossible to implement here on a broad scale at this stage.

In general, social workers are the case managers for children in statutory care. Effective tracking of these children, and monitoring of their well-being and the services on which they depend, should as soon as possible be computerised. Every social worker should be able to electronically record baseline data and new information or changes to the situation of each child for whom he or she is the case manager, and these data should be collected at a central point. However,

this will undoubtedly take considerable time to materialise. In the meantime, the introduction in every DoSD office and child and family welfare organisation of a Register of Children in Care, in which key demographic and socio-economic features would be noted, along with key events and the implementation of essential tasks, would be a start towards building a meaningful database.

A beginning could be made by introducing the simplest and most user-friendly indicators, even if these are fairly crude, to gain an understanding of the broader population of children in statutory care. More qualitative indicators and those which involve tracking of children as they move through the care and protection system – or the 'child and youth care system', as it is more often termed in official documents – could be introduced in a sample of sites in each province, and adopted incrementally as the system becomes more realistically resourced and individuals are better able to use them.

The IMC *Minimum Standards* referred to above are already the basis for the DoSD's assessment process in residential care facilities, and the results of these assessments, even if they are small in number at present, could help in building up a picture of the extent to which our facilities are ensuring that children actualise their rights.

Small, focused research studies using more complex indicators could point to issues which should be included in broader monitoring processes. The *National Policy Framework and Strategic Plan for the Prevention and Management of Child Abuse, Neglect and Exploitation*, mentioned earlier, provides for the setting up (in partnership with research and academic institutions) of a clearing house for research and information on child abuse, neglect and exploitation (DoSD, 2004a), which would further assist in promoting co-ordinated data collection.

Recommended indicators for monitoring children in care

Broad baseline indicators

Ennew, in her outline of levels of indicators required for the monitoring of children's rights, refers to the need for *baseline indicators* which 'establish the current situation and…provide a reference point for future work' (1997, p. 11). At this stage we have only a hazy idea of the size of the population of children in statutory care, an even hazier knowledge of its demographics, and almost no knowledge at all of the rates and patterns of movement into and out of this system. This makes it impossible either to monitor trends or to plan properly for the financial and human resourcing of this system.

To achieve a reasonably coherent picture of the population of children in care, the following sets of indicators are suggested (measurement details are provided in the indicator tables in Part 2 of this volume):

Children entering statutory care: initial phase

The children in focus for this purpose would be those for whom short-term statutory protective action has been taken, normally involving placement away from the biological parents or regular caregiver with a 'form 4' authorisation and/or a children's court retention order.[5] This is suspected to be quite a large group of children, in a state of particular vulnerability. Such children are in a critical phase

within the child and youth care system, in which the intention is that intensive assessment and planning should be carried out and the most appropriate form of ongoing care selected (IMC, 1996). 'Permanency planning' to identify the desired outcomes and the necessary steps towards an ultimate long-term arrangement should be commenced during this phase. Such planning is included in the Care and Development planning processes which form a critical component of the IMC model. Many of the affected children have experienced abuse which has been recently exposed, causing a major family upheaval for which the child will feel responsible and may be overtly blamed by others. Some may have been over-hastily and even unnecessarily removed by inexperienced or overzealous social workers or police officers. The placement process will often have been traumatic, with current social work and police caseloads and training deficits leading to a situation in which minimal preparation, support or information has been provided to the child, the biological family or the statutory caregiver. Heavy social work and children's court caseloads, staff vacancies and a lack of longer-term placement possibilities lead to endless postponements of the court proceedings and to children lingering in places of safety for months and even years. Of particular concern in this phase are infants and very young children, who often remain for lengthy periods in institutional placements which are unsuited to their needs, and who may permanently lose the opportunity of a placement in a family due to the damaging effects of such environments on their development.

Hence, it is vital that children in the first phase of care be included in the monitoring process. The following indicators would be of assistance.

- Children placed on emergency (form 4) orders in terms of Section 12(10) of the Child Care Act, and reasons for such placement;
- Children placed on Retention Order in terms of Section 11 of the Act, and numbers placed in each type of placement option pending a children's court enquiry (state places of safety, children's homes, safe houses/emergency foster homes, etc.);
- Children under three years who are placed in each form of temporary care;.
- Reasons for placement;
- Outcomes of children's court enquiries.

It would be important to provide clear definitions of the different forms of care (Lewit, 1993). A 'place of safety' can refer to a host of temporary venues including, for example, a family home, a state place of safety, a children's home or a hospital.

Children committed to statutory care and subsequent movement between different forms of care, and out of care

For those whose children's court proceedings have been finalised, a period of intensive services ending in the reintegration of the child into a stable home situation in the community is intended to follow. The details of such services should be spelled out in a Care and Development Plan, which must incorporate a Permanency Plan, as is discussed below. These children are legally subject to regular monitoring, and a report on their own and their families' progress must be submitted biennially to the provincial DoSD. Social work services are critical to this phase. Essential baseline information for this component of the statutory care population includes at least the following:

- The population of children in ongoing statutory care, in each form of care;
- Children leaving each form of care each year, and destination (alternative form of statutory care, biological family, adoption, independent living arrangement, etc.); and
- The duration of time spent in statutory care, inclusive of initial phase.

Disaggregation of the resulting data by gender, race, age, area and, if possible, socio-economic status would be important for monitoring the targeting and design of services and discerning possible patterns of vulnerability. It is suggested that children aged under three years be the subject of particular scrutiny to determine how many of them are being placed in institutional environments and how long they are remaining there; in addition, it could be argued that there is a particular need to monitor facilities which care for such children with regard to their ability to provide adequate care for them, and to ascertain how long it is taking to place them in adoptive or foster placements (Save the Children UK, 2004). Apart from having crucial implications for the long-term well-being of the children concerned and for success in breaking the cycle of abuse and neglect, attention to these matters could bring about enormous savings in financial terms.[6]

Sites for and methods of data collection

Figures 15.1 and 15.2 show the child's entry into and movement through the statutory care system, and some of the points at which monitoring can take place.

Figure 15.1 Children's movement into care

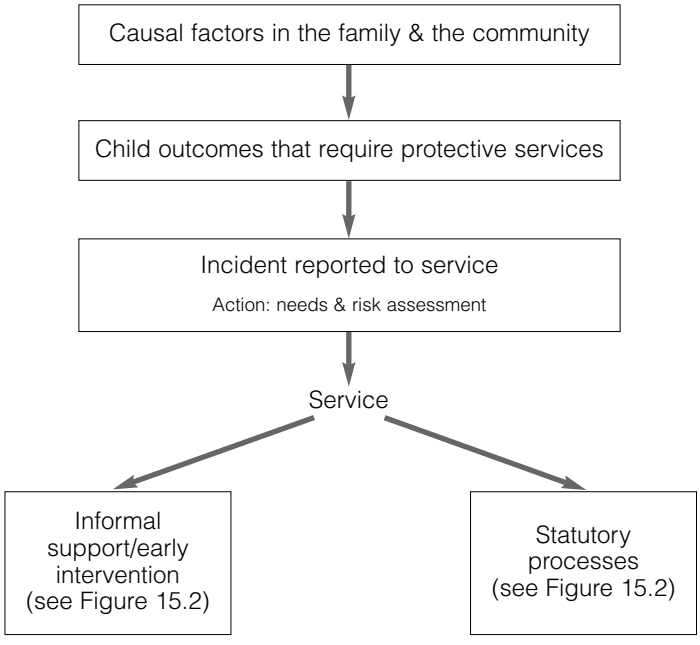
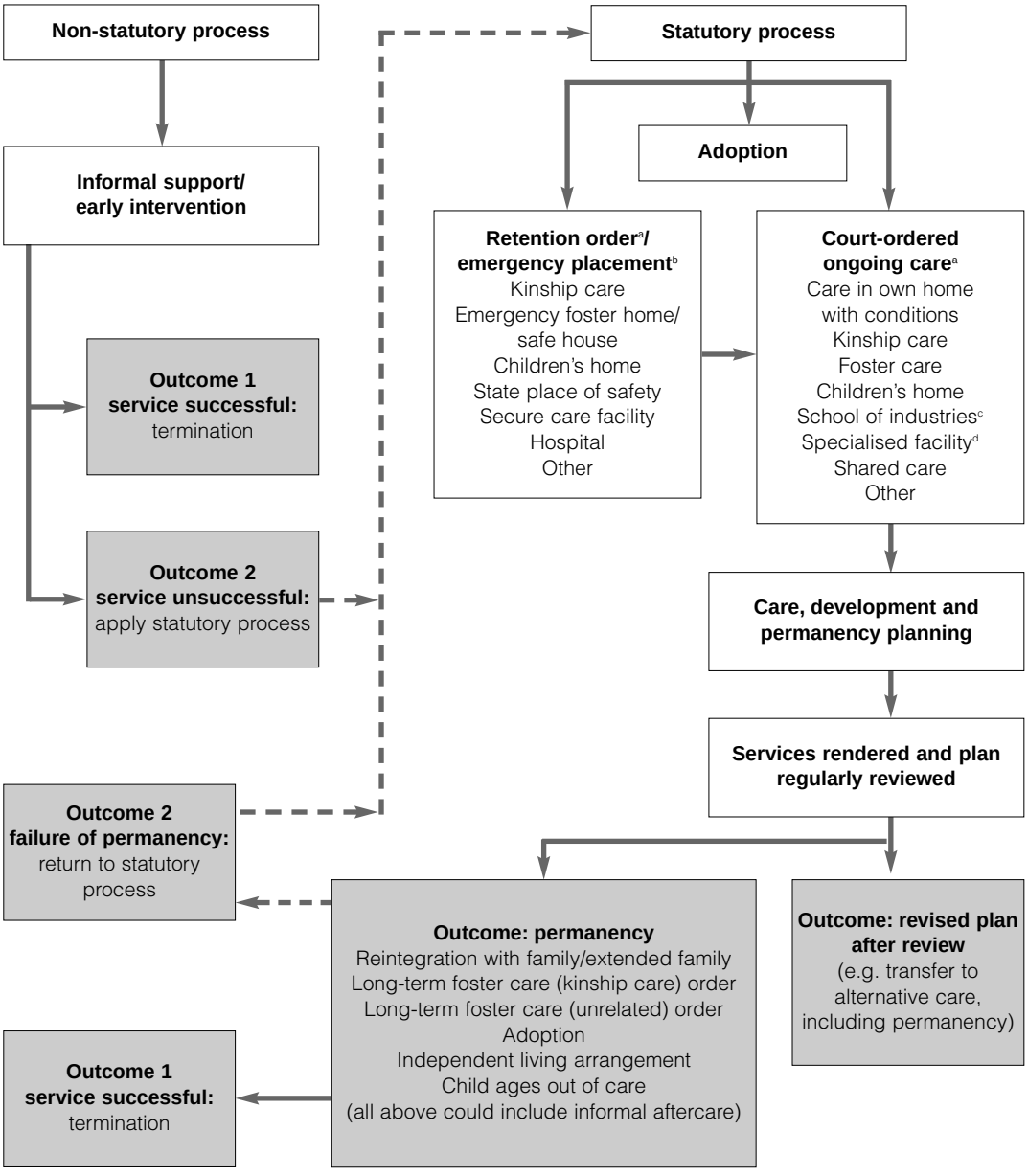


Figure 15.2 Processes and outcomes following needs and risk assessment



Sources: The flowchart incorporates certain options provided for in the Children's Act (No. 38 of 2005) as well as the current Child Care Act (No. 74 of 1983).

Notes:

a Children's court is responsible for this decision

b Police officer or designated social worker is responsible for decision

c Department of Education is responsible for care of child

d Department of Education or Health is responsible for care of child

Remaining tasks are undertaken by DoSD or child protection NGO

→ Service pathways

- - - → Return to statutory process

Every children's court should keep a register which includes every child (rather than every family, as is presently the case) who is brought to its attention after the issuing of a form 4 order, and/or who is placed in a place of safety pending further investigation in terms of Section 11 of the Child Care Act, and/or who is found to be in need of care in terms of Section 14(4) of the Act. This register should also include the reasons why the child has been brought to court, the nature of the order made, if any, and the date of birth of the child plus details of race, gender, language, religious denomination, and so on. These details should be submitted to the national office of the Department of Justice for collation and analysis by the Court Information Directorate.[7] One among the several purposes of collecting such data would be for use in the planning and resourcing of the children's courts, many of which are extremely ill-equipped for their tasks (Loffell in Dawes, 2003).

Each welfare organisation or government department responsible for the management of cases through the courts and subsequent statutory processes should keep a register of children in statutory care, including the form 4 and 'place of safety' phase, on which the above information would be recorded along with the following:

- Reason why child is still in care;
- Date of completion of Care and Development Plan;
- Dates of reviews of plan;
- Annual statement of preferred permanency outcome for child. Options could be posed in a checklist, for example as follows: return to biological family, placement within extended family, adoption, indefinite foster care placement, permanent residential care with supportive relationships in the community, shared care, independent living, other, uncertain (giving reasons);
- Annual statement of level of progress towards permanency. For purposes of examining trends, each such statement should be summarised as follows: 'plan on track', 'plan partially on track', 'no progress', 'case inactive' or 'permanency already achieved' – where, for instance, the child is in long-term foster care with relatives and there is no prospect of changing this situation. The latter option should not apply to any form of institutional care;
- Any movement of the child, for example: i) move to own immediate family, extended family, an unrelated foster family, or an adoptive family; ii) transfer to residential care (specify type); iii) abscondment; iv) discharge from care/independent living;
- The presence of any of a range of problems likely to have a significant impact on the functioning of the child or family. There are a number of factors which could place the child and family at risk of poor outcomes, including (but not limited to) the following, which could be noted via a checklist: alcohol abuse in child, parents or caregivers; abuse of other substances by child, parents or caregivers; family violence other than abuse of child concerned; physical, mental or intellectual disability or chronic illness in child, parents or caregivers. These may or may not be noted as primary reasons for children coming into care. It would be useful to develop an idea of the role they are playing in the lives of these children, and of the extent to which successful outcomes for children in care, as well as broader prevention programmes, will depend on services which take these into account.

Discussion

All the information referred to above should be collated via an annual audit of children in statutory care, which could be carried out by the national DoSD or a research body contracted by that department, in association with the provincial DoSDs and the relevant NGOs. The national DoSD's Directorate: Monitoring and Evaluation might play a key role here. In addition, this information could become part of a regular national child survey as proposed in Chapter 2 of this volume. Relevant research units attached to universities could assist with such a survey where they are in place. The Child and Youth Research and Training Programme at the University of the Western Cape and the Children's Institute at the University of Cape Town are options worth considering.

Data regarding the reasons why children are entering statutory care would assist in monitoring causative factors and the extent to which these are being addressed in policy and planning processes. Such information would be useful in assessing whether children are coming into care unnecessarily, perhaps due to lack of proper training and support of personnel, or whether they are in care because essential community services and support systems are missing or malfunctioning. Strategically valuable information would become available regarding the degree to which family violence and addictions are implicated in children's reception into and remaining in care. The presence of physical, intellectual or psychiatric illness or disability as factors in the lives of the children and families in question would also be a significant issue. Such information would provide an idea both of how the relevant forms of care need to be equipped and of what types of service are needed by the children and their families.

Information regarding the reasons for placement would also provide a rough indication of the percentage of cases in which children are entering statutory care purely or mainly due to poverty (see Chapter 3 in this volume), and in which placement could be prevented if some form of financial support were in place. As child poverty is a major underlying cause of children coming to the attention of the welfare system, the indicator table associated with this chapter (see Part 2 of the volume) also includes a poverty indicator. It is most desirable that child poverty is mapped (Noble, Babita et al., 2006) at small-area level so that preventive interventions can be put in place to reduce the risk of children being in need of care. The incidence of children coming into care can be mapped onto regions of the country using children's court data, and this approach can provide a guide to the areas that are in particular need of support. The data can also suggest areas in which court and social work services need more resources (Dawes, Long et al., 2006).

These are crucial issues as South Africa's already fragile childcare and protection system buckles under the strain of vast numbers of children whose relatives seek financial support through having them formally placed in their foster care (Johannesburg Child Welfare Society, 2004). The recent flood of such cases into the child and youth care system, due to the impact of HIV/AIDS and to increased awareness of the state Foster Care Grant, is placing immense strain on the thinly stretched court and welfare systems.

Various debates have centred around how this situation should be managed (SA Law Commission, 2001; Meintjies et al., 2003). There have been calls for many years from child and family welfare agencies for a form of assistance to the families concerned

which does not involve the children's courts or social work services, and also for an adoption grant which would enable parents of low income who cannot afford to lose the Foster Care Grant to adopt children who have been in their care in stable circumstances for a substantial period. But proposals by the SALRC for an 'informal kinship care grant' and an adoption grant have to date been rejected, and such cases appear set to continue to flood the system for the present. This is having very serious consequences, not only for the children whose caregivers are facing long delays in having their requests for foster care placement processed by overloaded courts and welfare structures, but also for children who are in the system due to abuse, neglect or abandonment. These children are receiving even less adequate services than in the past because the system is submerged in foster care applications from impoverished families. This whole situation is one which calls for urgent investigation and ongoing surveillance.

Monitoring based on the suggested information would also make it possible to form some tentative impressions about the overall impact of HIV/AIDS on the statutory care system. While there is a commonly held view that statutory care will not be viable as the main thrust of the nation's response to children whose caregivers die or are incapacitated due to HIV/AIDS, there is no doubt that many of them should and will find their way into statutory care.

Detailed analysis of the poverty and HIV/AIDS-driven cases entering the system will assist in improving our understanding of the issues to be addressed both in capacitating the statutory care system and in broad-based programmes designed to provide alternatives to statutory care. Additional indicators will no doubt emerge in this process.

Qualitative indicators

Once we have the necessary baseline information about the population of children in care, we can begin looking at what is happening to these children during the placement process and thereafter, and the extent to which the care and case management to which they are exposed meets recognised standards. This involves, inter alia, some degree of tracking of the situation of individual children.

The IMC model: a comprehensive monitoring system

A comprehensive system for monitoring the progress of the child in care, including a set of indicators for monitoring services to them and the realisation of their rights, is provided by the IMC's (1998) draft *Minimum Standards for the South African Child and Youth Care System*. These indicators relate to the four levels of service identified by the IMC, namely 'prevention', 'early intervention', 'statutory process' and 'continuum of care', and are phrased in terms of the experience of the children themselves and the performance of duty-bearers, including those in management as well as direct providers of care and services. The standards are presented as outcomes, typically in the following forms:

- Young people confirm that…(specific rights and needs have been attended to by caregivers);
- Service providers ensure that…(specific duties are carried out or principles upheld);
- Service providers are given…(by management, the means of carrying out specific responsibilities).

Areas covered include 'outcomes', 'programme practices' and 'management actions' in the following areas: prevention; family preservation; engagement/reception; assessment and referral of the child; processes surrounding the arrest of a young offender and associated diversion programmes; access to legal representation, court process and sentencing (both immediately after arrest and later on in criminal proceedings); prohibition of certain behaviour management methods and identification of reportable incidents; information-giving regarding the rights of young people; management of complaints from young people; physical environment; emergency and safety practices; transitional planning for care and services; privacy and confidentiality; emotional and social care; healthcare; behaviour management; developmental milieu and climate; care plan; individual development plan; review of these plans; development opportunities and programmes; therapeutic programmes; education; and disengagement from care. Further detail has yet to be provided in the case of foster care. However, many of the standards are generic to all forms of care, and many of those designed for use in residential care would also be applicable to foster care. The intention of care providers in terms of the IMC model is to prevent the separation of the child from his or her family and community through preventive and early intervention services. If statutory placement is unavoidable, service providers must seek the most empowering and least restrictive available care option.

Another rights-based framework for the monitoring of the quality of services to children in need of care is Save the Children UK's (2004) *Quality Indicators for Child Care Programmes for East and Central Africa*, which covers very similar ground to that covered by the IMC's indicators, although it is differently organised. Save the Children's framework has the added benefit of being specifically designed for a range of contexts including 'institutions, foster care, community care programmes, child-headed households, small group homes, etc.' (2004, p. 7). It also includes a helpful set of 'contra-indicators' for each principle. Some features could usefully be incorporated into the IMC framework, which has the advantage of having been developed in South Africa and taken through a broad consultative process, and already being widely known by organisations providing care to children, especially those delivering residential care services. The IMC framework is also in use as a monitoring tool, having been built into the DQA process used by the DoSD in assessing residential care services. Regular reviews (six-monthly) and documentation of certain components, such as those relating to Care Plans and Individual Development Plans, are required for every child in care, whether served by the DoSD or by an NGO. These plans and reviews are potentially a rich source of data for monitoring children's progress in care.

A major problem with the IMC's model is that its use for monitoring on a large scale is at present not practically possible. The IMC's indicators run to more than 50 pages, and specific indicators regarding children in foster care still need to be added. The implementation of the model depends on feedback from the child, caregivers and persons in management, which has to be obtained through lengthy interviewing and observation processes conducted by skilled and experienced people. Assessments of this kind are intended to be carried out within the framework of the DQA process mentioned above.[8]

The intention, at least when the system was first introduced, was that a DQA process should first be carried out internally by the structure concerned (for present

purposes, a child and family welfare organisation or children's residential facility) and then externally by the DoSD or a body appointed by this department. The latter component involved a team of between two and four people working over a period of two to six days, and a key outcome was supposed to be an Organisational Development Plan to ensure the progress of the organisation towards the required standards. The process was intended to be repeated biennially. In practice the DQA processes seem to have happened very sporadically. This is likely to be due in large measure to the lack of resources available for purposes of the review itself, let alone those needed to actually implement the standards in question. Similarly, the paperwork which is associated with the Care and Development Plans and the review of these plans is extremely onerous. Social workers complain of being unable either to meet the official demands in this regard, or to carry out the work which the plans require between the writing of one report and the next, especially with the spiralling caseloads which are a feature of services at present.

Hence, a monitoring system based on the IMC framework can at this stage probably be seen as an ideal towards which to strive. The framework should as far as possible in the interim be used for self-monitoring and programme development. The *Minimum Standards* indicators could also be used in focused research, perhaps using a small sample of DoSD offices, child and family welfare organisations, and state- and NGO-run residential facilities from each province. For purposes of across-the-board monitoring, a greatly reduced number of indicators, which will coincide or overlap with issues addressed in the IMC indicators, will be necessary. Possibilities are explored in the remainder of this chapter. In addition, general movement in the direction of the IMC standards in the sector as a whole could be assessed by monitoring the numbers of child and youth care facilities in which the IMC minimum standards have been systematically integrated into management systems and practice, either as an entire package or in part.

Meanwhile, what would be both feasible and highly desirable would be for the IMC *Minimum Standards* to be used as the basis for calculating realistic workloads for the sector, and for budgeting accordingly. Focused studies could then be periodically implemented to determine the extent to which these standards are being upheld in a sample of services, such as those for which the DoSD conducts DQAs (or their equivalent, if a new approach is introduced) in a given year. Ultimately, if and when the task of transforming the child and youth care system in accordance with these standards has been completed, a monitoring system based on the regular and universal application of these indicators, as well as regular analysis of the Care and Development Plans and the reviews thereof, could be put in place.

For the present, it is further suggested that certain areas which are strategically important for the qualitative assessment of services should be singled out for attention, and that indicators in these areas should as far as possible be used across the broad population of children in care. These are: permanency planning; contact between key service providers and the child; contact between key service providers and the child's family; contact between key service providers and foster parents; access to needed services; level of participation in decision-making; incidence of unplanned termination of placement; extent to which continuity is maintained in the child's cultural, linguistic and religious environment; and incidence of physical or sexual abuse while in care. Each will be discussed below.

Permanency planning

Indicators of this kind would assist in monitoring the implementation of the constitutional right of the child 'to family care or parental care, or to appropriate alternative care when removed from the family environment' (Section 28(1)(b)), and also the right of children as stated in the CRC not to be separated from their parents against their will, and to maintain contact with their parents (9(1) and 9(3)).

Permanency planning is undertaken for purposes of ensuring that a child is able to grow up within the context of stable family relationships. Children who remain in temporary care for protracted periods without a sense of security and belonging are vulnerable to the development of emotional and behaviour problems, and may have enduring difficulties in forming lasting, healthy relationships. It is in the first place important to ensure that children are not unnecessarily separated from their families, whatever forms those families may take. If such separation does occur, the permanency planning approach requires that the children be restored to their own families, or placed in substitute family environments, sufficiently quickly for their developmental needs to be met (Maluccio et al., 1986).

Hence, it is necessary in each case to clearly identify the reasons why the child has needed to leave the family, the goals which need to be achieved in order to overcome these problems, and the tasks to be undertaken by parents and/or other caregivers, service-providers and, if appropriate, the child him- or herself, in order to achieve this end. Alternative options, such as placement with members of the extended family or adoption by an unrelated family, should be held in reserve in case efforts to restore the child to the original family are not successful. Permanency planning in terms of the IMC model is incorporated into the child's Care and Development Plan, which should be reviewed twice yearly.

In South Africa, for legal and practical reasons, it is very difficult to make legally secure permanent care arrangements outside the biological nuclear family except by adoption (SA Law Commission, 2001). This situation is partially addressed in Section 135(2) of the Children's Amendment Bill (19 of 2006), in terms of which parental responsibilities and rights over a child who has been in care could be terminated and handed over to someone else after the child has spent a specific period in care. This period would be six months in the case of a child aged three years or younger, one year for a child aged between three and seven years, and two years for a child of seven years or older.

There is also an obligation placed on the court to aim, in the issuing of its orders, at securing stability in the child's life, and to consider various options towards this end such as placing the child with the parent under supervision, or making the child available for adoption (Section 157). The social worker presenting a report to the court on the child's situation would be required to provide details of family preservation strategies which have been considered or attempted, to present a documented permanency plan which takes into account the child's age and stage of development, and to address the causes of the separation in her or his work with the family (Section 157(1)(b) and (2)). Provision is also made for clarification of the status of children who appear to be abandoned, so as to overcome the current problem of children remaining in limbo for up to two years before certain courts will declare them to be abandoned and allow them to be adopted (Section 157(3)).

Indicators for permanency planning include:

- The proportion of children for whom Care and Development Plans, drawn up in accordance with accepted guidelines, are in place;[9]
- The proportion of children for whom these plans are on track;
- The proportion of children who are in contact with their families to the extent envisaged in the plans;
- In cases where permanency planning and implementation are not on track, the percentage for whom there is evidence of revised planning and intensive action to prevent the child from continuing to drift in care.

Successful permanency planning and the implementation of permanency plans require an organisational philosophy and a system of practice which are in keeping with this approach (National Resource Centre for Foster Care and Permanency Planning, 2004). In addition, this approach calls for a range of back-up services which can be used to help overcome problems and deficits faced by family members in meeting their own needs and those of their children in care. These may include state grants, family or marital counselling, day care provision, treatment for addictions, respite care in the case of a child with a severe disability, life-skills education or vocational training, to name but a few. The development of indicators for the existence of adequate resource provision and adequate agency infrastructure is an important task in its own right.

Data as regards the existence of and progress with permanency planning and implementation could be entered on the Register of Children in Care mentioned above, collated at each service point, and channelled to the provincial and national DoSDs.

The above discussion applies to children who are in forms of care which are not regarded as already being permanent. Children who are in the long-term care of relatives and have entered the child protection system mainly for reasons of poverty, for instance, require a different service and monitoring framework, as in most cases they will remain permanently where they are. Also, they will generally not be adopted, because at present there is no provision for financial support for adopted children, unless they qualify for the much smaller Child Support Grant. Hence the plea from many quarters, as mentioned earlier, for these children to be dealt with via the social security system, where possible supported by community-based supportive programmes, so that the statutory care system can be reserved for children who are in care because of abuse, severe neglect or abandonment. For present purposes, such children would need to be treated separately from others when monitoring permanency processes. The emphasis here would be on the children's overall care and well-being, with nutritional status, health, and access to essential services being key considerations. Indicators applicable to children in the general population could be used for this purpose. Should differences emerge between children in long-term kinship care and the broader population of children, these could be useful in designing supportive programmes.

Contact between key service providers and the child

The nature and intensity of contact between the child and direct caregivers such as foster parents or child and youth care workers is a critical issue for assessment via close-up processes such as the DQA. However, contact with the next level of service

providers is also an area in need of attention. This pertains particularly to Article 19(2) of the CRC which provides that there must be effective procedures for the establishment of services and programmes which provide, inter alia, 'necessary support for the child and for those who have the care of the child, as well as for…treatment and follow-up of instances of child maltreatment'. While the quality of this contact would need to be addressed by focused studies of selected services, the frequency of contact is at least a rough indicator of service delivery. The frequency of the child's contact with the social worker managing the case, and with specialised service providers such as psychologists or remedial practitioners of various kinds, as well as the voluntary counsellors or 'befrienders' who are engaged by some children's facilities and foster care organisations, would be the target for measurement here. It is recognised that the present lack of norms and standards for services is a serious problem, and efforts to establish benchmarks are beginning to emerge within the context of the DoSD's Integrated Service Delivery Model (DoSD, 2005a), as well as the various costing processes which have been undertaken with regard to incoming legislation such as the Child Justice Bill (No. 49 of 2002) and the Children's Act and Amendment Bill.

Contact between service providers and the child's family

Similarly, the number of contacts by social workers, volunteers and other service providers with parents and/or other members of the child's family offer a rough indication of the extent to which they are being actively engaged in services. Such services are a critical aspect of permanency work. They are normally aimed at strengthening the child's relationships with the parents and other family members, overcoming problems which have led to placement, and/or helping to prevent problems with the care of siblings who may still be at home.

Such contacts also involve helping both the child and the parents or other family members to deal with painful emotions in relation to one another. This is often necessary in order to free a child to form new relationships, if possible with the support of the parents. Such work may be required to enable the child to move into foster care or adoption if there is no prospect of returning home in the near future or at all. The number of contacts with family members could be recorded each month, perhaps on the organisation's Register of Children in Care, and an annual average could be calculated. Again, more intensive investigation would be needed to assess the intensity and quality of the contact with services.

Contact between service providers and foster parents

A common situation for foster parents in South Africa is for them to see a social worker during their initial screening process and at the time of a children's court enquiry when a child is placed in their care, and then not again until the biennial Section 16(1) report is due to be submitted (Loffell, 2003). Generally, this means that the family in question and the child in their care are receiving no meaningful social work services.[10] Such services are intended, inter alia, to include the types of assistance below:

- Monitoring the well-being of the child and helping him or her deal with previous negative experiences, feelings about the care situation, and issues relating to his or her biological family.

- Helping the caregiver interpret and manage the behaviour of the child in care. Many such children, due to their past experiences, will show behaviour and competencies at a level which is behind their chronological age. Some will act out previous traumatic events in the form of violent, aggressive or sexually precocious conduct. They will almost inevitably, sometimes after a long 'honeymoon' period, engage in 'testing out' behaviour. This arises from fear in the child that he or she will be rejected by the new caregivers, as well as a need to find out what is and is not accepted in the new environment. Sometimes, in children who have undergone repeated changes of placement, there is such a strong conviction of their own unworthiness and inability to be loved that they will actively try to precipitate a rejection. A child who has been at the centre of conflicts in the past may generate conflicts in the new family, sometimes of such intensity that vulnerabilities (in a marriage, for instance) may be aggravated. Alternatively, a biological child of the foster parents may fall victim to physical or sexual abuse by the foster child. Consequently, skilled help for the family as well as for the foster child is critical, and failure to deliver this contributes to the risk of a traumatic disruption of the placement.
- Supporting the natural children of the foster parents to adjust to the presence of the newcomer. Without sufficient help, a biological child of the foster family may feel insecure after the advent of the newcomer, sometimes to a point where a crisis develops.
- Facilitating and dealing with the feelings of all role-players regarding contacts between the child and the biological family, which can have explosive impacts within the foster home.
- Facilitating linkages with services in the community, including the school and healthcare systems, therapeutic and remedial services of various kinds, and recreational and skills development opportunities.
- Helping the foster family deal with the departure of the child from their care, whether this is due to disruption, or to a planned move back to the biological family, or to another long-term arrangement.

The quality and effectiveness of services to the foster family are complex issues which could usefully be the subject of focused research. This should cover the nature and extent of selection processes, orientation and training as well as ongoing services. For broad monitoring purposes the number of contacts with the foster family, along with contacts with the child in care as discussed above, are probably the only viable indicators at this stage. As mentioned, these should form part of the annual audit of the Register of Children in Care.

Access to needed services

Article 19(2) of the CRC requires 'effective procedures for the establishment of social programmes to provide necessary support' for children who have been maltreated and their caregivers, and for 'treatment and follow-up' in such cases. This is in addition to the broader rights of all children to have their basic needs met. It follows that there is an obligation to ensure access to a range of services for children in care. In the US, children in foster family care, which is the most frequently used form of substitute care in that country, have been found to have a high rate of physical and mental health problems, disabilities, developmental problems and scholastic

difficulties (Vandivere et al., 2003). This is not surprising given the adverse experiences which typically result in children being brought into care. But there is great variability in the South African context as to the availability of services needed by children, whether in or outside the care system. In most areas, free or subsidised services are overstretched where they do exist, and there are many areas in which they are not available at all, or are inaccessible to the children in question.

The Care and Development Plan, which is supposed to be in place and regularly reviewed in the case of every child in care, should identify services needed by each child and family. It should be possible, then, to find out whether they are being linked to the services which they are assessed as needing and, if not, why not. Reasons could include the non-existence of a needed service in the area in question, lack of affordable transport, inability to pay even a small fee, or cultural or language barriers. Accessibility problems are especially likely to affect impoverished foster parents and emerging, underdeveloped children's homes. The suggested Register of Children in Care could be structured so as to provide for the noting of services needed, whether they are accessible, and if not, why not.

Level of participation in decision-making

Article 12(1) of the CRC provides that children who are capable of forming their own views have the right to express those views freely in all matters affecting them, and for these views to be given due weight in accordance with their age and maturity. The implication is that efforts must be made to ascertain children's views on issues such as where and by whom they should be cared for, and what the plan for their future should be. The IMC (1998) *Minimum Standards* require, inter alia, that children be fully prepared for and involved in their own assessment processes, the development of their Individual Development Plans and Care Plans (which include permanency issues), and in regular reviews (every six to eight months) of these plans, as well as in more mundane decision-making in the daily care situation, especially where such decisions are about themselves (see standards R4M, R4N, R4O and R4P). The Register of Children in Care could provide for confirmation as to whether the child has participated in the decision-making process, and whether the decisions made were in line with the child's wishes. This would not cover the quality of such involvement, but should serve to prompt the practitioner to engage the child in the planning and review process.

Unplanned termination of placement

Given the emphasis in childcare practice on seeking continuity and permanency for the child in care, disruption of placement is something to be prevented where possible. Reasons for disruption may be the death, illness or incapacity of the caregiver – especially likely in situations where children are being cared for by elderly relatives, who make up a substantial proportion of the current corps of foster parents – or inability or unwillingness of a caregiver to continue the caregiving arrangement. This can occur for many reasons, including a crisis in the life of the caregiver, or unmanageable tensions within a foster family. Such tensions may be generated or heightened when a child joins the household with emotional and behavioural difficulties arising from past experiences. Difficulties in accepting the role played by the child's family of origin in his or her life may also contribute to

placement disruption. The intention behind the 'supervisory' services delivered by social workers to foster families, and by initial recruitment, screening and training processes, is to select families on the basis of their capacity to deal with the challenges of foster care, and to support families through difficult periods to enable them to persevere. However, it is not possible to predict just how the chemistry of the new relationship is going to turn out, and termination of the placement may become necessary for the child's sake and that of the foster family.

In the case of residential care, there may be pressure from staff to move a child whose behaviour is difficult to manage out of a facility, usually to an environment which is 'more restrictive' and at a 'deeper level' of the child and youth care system in terms of the IMC framework, for example a school of industries or a secure care facility. Such moves are generally frowned upon by policy-makers and became extremely difficult after the introduction of 'Project Go', which was put in place some years ago to implement the IMC model. There were complaints from children's facilities that they were being forced to keep children who were a danger to themselves or others, and whom they did not have the resources to manage. Some facilities began routinely refusing to receive 'difficult' children with behaviour problems, in case they found themselves unable to move them should they later become unable to control them. This situation was symptomatic of a number of realities which remain common in children's homes, such as:

- Ongoing problems experienced by children's homes in attracting, training and retaining competent staff, so that removing a child may too often be seen as the solution to a problem; and
- A severe shortage of accessible specialised services, either residential or outpatient, for children with severe problems such as physically violent or sexually aggressive behaviour, addiction to drugs, or psychosis.

Monitoring of the annual incidence of unplanned placement termination, with an analysis of the reasons given, could highlight areas in which service provision needs to be strengthened and additional programmes introduced. The frequency with which children move 'deeper into the system' should be specifically noted. Again, this information could be extracted from a well-designed Register of Children in Care.

Extent to which continuity is maintained in the child's cultural, linguistic and religious environment

Both Article 20(3) of the CRC and Section 40 of the Child Care Act (No. 74 of 1983) require that the child's cultural and religious background be taken into account when placement decisions are made. Section 20(3) of the CRC adds ethnicity and language to these considerations. Maintaining continuity for the child in all or any of these respects is often difficult in the South African context, where there is typically a scarcity of available placement options. Foster and adoptive families are in short supply and the need for a family life may be regarded as the most pressing issue, especially for very young children. Residential care centres are called on to equip themselves to deal with children of multiple cultures but are not always successful in this regard. These factors typically have to be balanced with other aspects of the child's rights and needs.

For children in residential or foster care, the abovementioned register could contain an item reflecting whether or not the child's care situation reflects their background in terms of religion, language and/or culture, wholly or partially. This is also an issue for attention in the case of adoption, through which many children are diverted from the statutory care system. With infants there is often no knowledge of their heritage other than their broad ethnicity, and even this is often not clear. Nevertheless, there are widespread concerns about the placement of children outside of their cultural context, and especially outside of the country of their birth (Mosikatsana, 1997). The Registrar of Adoptions within the DoSD is already keeping statistics as to the number of transracial adoptions which are approved annually, and it may be possible for this unit to include more detail in its data collection as regards religion and culture. Inter-country adoptions are at present in most cases both transracial and transcultural, and data for this group would be of particular relevance. Monitoring of this issue should be considerably easier once the Children's Act has been consolidated and brought into effect. The Act as passed in 2005 already provides for a register of waiting adopters and children eligible for adoption in South Africa, and stipulates that an inter-country placement will be possible only when local options have been excluded, unless there is a pre-existing relationship between the child and the applicants.[11] This register should also facilitate cultural matching in domestic adoptions.

Incidence of physical or sexual abuse while in care

Abuse in care is one of the secondary hazards facing children who are referred into the statutory protective system. This is an aggravated breach of the child's right to be protected from maltreatment, neglect, abuse or degradation, as per Section 28(1)(d) of the Constitution. Physical or sexual abuse in a statutory care context, such as a children's home or foster home, falls within the ambit of mandatory reporting by a social worker, child and youth care worker or person managing a residential facility who becomes aware of such abuse, as provided for in Section 42(1) of the Child Care Act. Such reports must be followed by entry in the national Child Protection Register (CPR) provided for in Regulation 39B associated with this Act. Adherence to the reporting requirement is at this stage very patchy, and it remains to be seen whether the CPR and the associated reporting system will prove to be a useful means of monitoring the incidence of child maltreatment (see Chapter 14 in this volume). But the national DoSD is working systematically to make this mechanism operate as intended, and as these efforts bear more fruit, the CPR should begin providing some meaningful data regarding known cases of abuse in care, as part of the incidence of abuse generally. Focused research would make it possible to investigate the nature of and responses to abuse, so as to improve the management of abusive incidents, and to develop more effective preventive strategies (see Chapter 14 for recommendations regarding indicators of service quality for abused and neglected children).

Impact indicators

Assessment of the impact of care and services is extremely difficult in the South African context because of the lack of local norms for the well-being of children generally, the multiple cultural variables involved, and the highly unstable state of

service contexts, to name just a few of the challenges. The use of scales developed elsewhere in the world which can help assess the impact of services on variables such as self-esteem, depression, behaviour problems and the like is problematic in the statutory care context (Loffell, 1996). This may change as more locally appropriate tools are developed, and as services become more stable and better resourced. However, certain indicators could be put in place in at least a sample of care settings for targeted studies which could help give a rough indication of the progress which children are making in care. The work of Olds et al. (2004) has shown that aspects of development and behaviour can usefully be monitored to examine the impact of services in the child's own home. Such approaches could be adapted to examine the impact of services to children in court-ordered care in their own homes and also those in out-of-home care, and to point to areas of special concern. Areas for examination could include patterns of growth and development in younger children, and scholastic progress in those who are of school-going age. It should be borne in mind that such indicators are subject to many confounding variables and will be uneven in their usefulness, and also that the relevant data would have to be supplemented by information of other kinds.

Growth

Growth levels relative to the norms for the general population have long been recognised as an indicator of the overall care and well-being of infants and young children. 'Failure to thrive' may be a symptom of abuse or neglect, and positive interventions can lead to improved development (Chalk et al., 2002; Krugman & Dubowitz, 2003; Vandivere et al., 2003). In the South African context, failure to thrive is of course often caused by poverty and associated malnutrition rather than by maltreatment. Growth monitoring instruments are subject to practical difficulties associated with their administration which can affect their accuracy. Also, score comparisons across different socio-economic and ethnic groups may be problematic (Pettifor, 2003). Nevertheless, the monitoring of growth levels on entry into care and at regular intervals thereafter could provide some indication of the general state of well-being of the population of younger children in care, and of shifts in their well-being over time. In particular, this type of monitoring can be useful in work with individual children and their caregivers. The Road to Health Charts which are routinely used by public clinics to monitor growth in children up to five years of age could be used for this purpose, and the results could be included in the aforementioned annual audit.

Developmental level

As with growth, children in care tend to lag behind in their developmental milestones. In the US, survey data for the broad child population revealed those in foster care as being at high risk for neurological and cognitive developmental delay (Vandivere et al., 2003). Narrowing of the developmental gap is generally a sign of improvement in the child's overall well-being, particularly in infants and pre-school children. A number of developmental assessment scales are available – one is central to a programme which has been specifically developed for the South African context, and for caregivers across different levels of qualification and literacy. This is the START (Strive Towards Achieving Results Together) programme offered by the Sunshine Centre organisation, which offers services to children with intellectual

disabilities and their families and caregivers. This programme is the result of collaboration between the Sunshine Centre and what is now the Memorial Institute, previously known as the Transvaal Memorial Institute for Child Health and Development. Well-known local experts from a range of disciplines have been involved in its development.

The START programme was originally initiated to assist children with disabilities; however, it can be generalised to other groups of children as it is based on normal phases of development in the following areas: gross motor, fine motor, communication, and activities of daily living (Solarsh et al., 1990). It covers eight developmental stages in each of these dimensions, from birth to age three. In a series of user-friendly manuals it provides checklists with indicators of normal development at each stage, and outlines simple activities through which a developmentally delayed child can be helped to make progress. The programme has been adapted for use in the child's own home by the parent or caregiver, and a distance-learning module is being piloted. Broadcast of the relevant activities on public radio in various South African languages is being considered for the latter purpose. In addition, the programme is in the process of being extended to cover ages four to seven. This system has been used with success in the local context for well over a decade, and can be used in a range of care settings to combine baseline assessment, remediation and ongoing monitoring.

It is suggested that the START programme be used to monitor children's developmental progress and the impact of care, especially as provided by institutions caring for children aged under three years, as these have been identified as an especially vulnerable group. The programme could also be introduced into foster care settings, as well as into prevention and early intervention services in intact families.

It is recognised that the use of this system could present practical difficulties for overloaded, inadequately staffed organisations, and that the collation and analysis of the emerging data would present challenges. Nevertheless, this is one of the few possibilities which present themselves for monitoring the well-being and development of children in care in a fairly direct way, and for gaining some idea of the impact of the care environment on younger children. It is recommended that such an approach initially be piloted in selected facilities in each province.

Scholastic progress

Neglected and physically abused children, especially the former, tend to underachieve at school. This may be the result of delayed development or organic harm resulting from abuse and/or deprivation, or of emotional problems arising from such experiences. The proportion of children who are at the appropriate grade level for their age would be a crude and very partial indicator, easily accessible through school report cards, of children's overall adjustment in the school environment. Comparison between the progress of these children with those of the general school-going population could shed some light on educational interventions which need to be considered for children in care. Factors such as dropout, retention and throughput rates among children in care would be significant in this regard. More detailed study of the progress of individual children could help in assessing changes in their general well-being over time, and in examining the quality of caregivers' linkages with the

educational system on behalf of the children in their care. Where children 'age out' of the care system (see below), the level of education or vocational training which they have attained could be an indicator of the extent to which they have been equipped for future employment during their time in care (Bradshaw, 2004).

It would be necessary, of course, to exercise much caution in the interpretation of school results, and to allow for factors such as the widely divergent quality of school environments experienced by different children in care, which are known to impact heavily on the progress of learners.

A number of indicators relevant to these recommendations are included in chapters 8 and 9 in this volume and are not repeated here. However, key measures of developmental outcome are included in the additional indicators provided in the indicator table for this chapter in Part 2 of the volume.

Data on children 'ageing out' of care

Data on youth who are no longer defined as children for the purposes of the Child Care Act would be significant from a number of points of view. Firstly, these numbers may give an indication of the extent to which services designed to reintegrate children into their own or alternative families are succeeding or failing. The length of time these young people have been in care, and their numbers in relation to the broader population of children in care, would over time give some indication of how well the relevant services are working. Such data might also help identify circumstances under which reintegration is less likely, and more emphasis is needed on the development of independent living skills. The number of youth who have such skills on leaving, as measured by an appropriate instrument(s), would in itself be a useful indicator.

Finally, youth ageing out of care are likely to carry with them physical, emotional and social difficulties arising from their troubled earlier lives (Wertheimer, 2002). An analysis of services they need versus the availability of such services to them would highlight gaps in the service system, and help identify possibilities for bridging these gaps. It is suggested that an 'exit report' be required for each young person leaving care by reason of age. This could provide a useful means for monitoring trends and patterns in the needs of this group. Thereafter, follow-up studies would give valuable insights into the conditions and the needs of the statutory care system.

At present there is no system in place for the routine monitoring of youth leaving care, although there have been occasional small studies of groups who have left specific facilities. Frequently the files in question are simply closed without further ado. The lack of any statutory requirement or specific financing provision for aftercare services to this group are obviously contributory factors, combined with the pressure of large numbers of younger children on social work caseloads. The best that could be achieved from the available data is an annual analysis of such cases by residential care facilities, child and family welfare agencies and the DoSD. Large-scale follow-up research would require targeted funding and a clear policy shift. Such a shift is recommended, as it would allow for a consolidation of the investment of resources which has been made in these young people, who are entering a new and vulnerable phase when they leave care – also bearing in mind that many of them will soon be parents to the next generation of children.

Systemic indicators

Apart from the need to keep track of the children coming into statutory care and what is happening to them, it is necessary to monitor the overall system which is set up to provide them with the necessary care and services. This involves examining the extent to which statutory care options are in place for those who need them, whether the available options are suited to the needs of those who require them, and whether they are resourced and managed in a manner which allows for delivery commensurate with the rights of the children concerned.

A number of the indicators mentioned earlier in this chapter relate to the performance of duty-bearers, particularly social workers and child and youth care workers, who are responsible for services to children and their families. The IMC's *Minimum Standards* reflect outcomes i) as experienced by the child, ii) as brought about or facilitated by duty-bearers, and iii) as provided for by management (IMC, 1998). 'Management' has different levels and dimensions, especially in a multilayered system of accountability and authority such as operates in statutory care services. These are often managed by NGOs, but regulated and partially funded by government. Frontline duty-bearers need appropriate policies, systems, supports and resources at all the relevant levels in order to carry out their obligations.

Below are key issues to be monitored in relation to the overall functioning of the statutory care system.

Availability of placement possibilities

There is a need for planners at the national and provincial levels to assess how many placement vacancies in the various categories (adoption, foster care, children's homes, specialised facilities, etc.) are required for children who are coming into the system. This should be done while also taking into account, and giving due priority to, services which could prevent the need for placement. Indicators of the extent of any shortfall would include the number of children waiting in state places of safety or secure care facilities due to a non-availability of suitable vacancies, and instances reported by DoSD offices and NGOs of children who remain at home while at unacceptable levels of risk due to a lack of placement options. Children who remain in care arrangements which are unsuited to their needs, for example infants and very young children in institutional settings, should also come into this equation (see above). A survey showing availability of placement opportunities relative to need could form part of the aforementioned annual audit.

Provision for specific groups of marginalised children

There are categories of children who tend to be marginalised from the care and protection system or to be inadequately provided for if they do make their way into it. The need here is to gain some idea of the scope of the problem and of whether the structures involved are attempting to include these children. These groups include children with disabilities, foreign children and those exposed to commercial sexual exploitation and trafficking (see chapters 10 and 13 in this volume).

Children with disabilities should be receiving particular attention in the light of Article 23 of the CRC. However, there is often a reluctance to admit them to care because of a lack in the foster care and residential care systems of the specific

staff training and resources needed by these children. The SALRC (SA Law Commission, 2001) recommended that the special resourcing needs of caregivers of these children be taken into account, inter alia, in state funding of such services, a recommendation which has not been carried over into the Children's Act. It is important to establish the extent of the need for care and protection services for children with disabilities, and the extent to which such children have been absorbed. The aforementioned Register of Children in Care could be used to monitor the latter issue. Research into the experiences of organisations serving children with disabilities could help point out problems and areas of resistance which need to be overcome.

Children who are victims of commercial sexual exploitation and trafficking have particular needs and problems which require specialist attention, and the programmes in place in regular children's facilities in general do not meet their needs (see Chapter 13 in this volume). The SALRC (SA Law Commission, 2001) recommended that research be conducted into the extent of child commercial sexual exploitation, and that specific budgeting be undertaken for the necessary rehabilitation programmes, of which only a handful are in existence at present. Such research is being carried out under the auspices of the ILO's TECL (Towards the Elimination of the Worst Forms of Child Labour) desk, in association with the Department of Labour (DoL) and the DoSD, along with several other state departments. This is a step within a policy and strategy process targeting several designated 'worst forms' of child labour, including commercial sexual exploitation and trafficking, within the intersectoral Child Labour Programme of Action led by the DoL. A major issue for monitoring at this stage is the extent of services for such children when they are extricated or manage to escape from traffickers, brothels and so forth. It is suggested that the national DoSD sets up a database of all known programmes of this kind, and collects information as to how many children are being reached by them, relative to the numbers that emerge from the TECL research process as being in need of assistance. Funding could then be set aside for the necessary services, and the level of such funding relative to the need could be monitored from year to year.

Foreign children, among whom are victims of commercial sexual exploitation and trafficking, are vulnerable to marginalisation from every type of service, including those which make up the statutory care and protection system. This is in clear contravention of Article 1 of the CRC which prohibits discrimination on a range of grounds including nationality. Foster parents are unable to access grants to help them support such children because they do not have the necessary 13-digit identity number. The Immigration Act (No. 13 of 2002) does not provide for differential treatment of children, and Department of Home Affairs' officials tend to simply deposit many such children at border posts without making any arrangements for their reception. The requirement of the Refugee Act (No. 130 of 1998) that unaccompanied minors be taken before the children's court to determine whether they are in need of care is widely ignored, and there have been instances of such children even being refused access to the court. Monitoring of the situation of these children could begin with a requirement that police and immigration officials record the identifying details of all such children and the nature of action which has been taken regarding them. The children's courts could do likewise, and foreign children

who do find their way into statutory care should be identified as such in the Register of Children in Care, along with any difficulties experienced in linking them with essential services. Monitoring of this kind should help in assessing the extent to which the statutory care system is providing for foreign children in a manner in keeping with the requirements of the CRC.

Issues pertaining to the children's courts

The children's court, as already mentioned, is the 'gateway to the child and youth care system' and as such plays a central role in the outcomes experienced by such children. The aforementioned HSRC study on children in Gauteng (Dawes, 2003) pointed to an overloaded system, and one in which many children's courts are not 'child-friendly' in their physical arrangements or functioning. A great many problems relating to the functioning of these courts were identified by the SALRC in its Discussion Paper on the Review of the Child Care Act (SA Law Commission, 2001). The SALRC recommended far-reaching changes to the structure and functioning of these courts in its draft Children's Bill (2002). These included provision for appropriate selection and training of personnel, and for flexibility in the rules of evidence to enable presiding officers to allow for the special needs of children, as well as assurance of legal representation for children in a number of specified situations. The SALRC also recommended the transfer to the children's court of certain powers from the high court, to allow for access by children and families who lack the means to approach the latter. These widely-supported reforms were removed from subsequent drafts.

Meanwhile, although there is a systematic process under way of making courts 'child-friendly' for the purposes of dealing with criminal cases in which children are the victims, no such planned attention is in evidence with regard to the children's courts. Indicators relating to the quality of the criminal courts are included in the indicator tables in Chapter 16 of this volume. Attention must be paid to the manner in which the children's courts function. Many of the same problems face both types of court. Indicators for children's courts are contained in the indicator tables for this chapter.

It is suggested that baseline surveys and ongoing monitoring of functioning associated with these indicators be conducted by the Court Information Directorate.

Human resource issues in social work and residential childcare services

Children who have been affected by maltreatment require care and services far beyond what is required to attend to their basic physical needs. The staffing of services to such children must reflect this reality. The levels of attention paid to the selection, training, supervision and support of staff are key indicators of the quality of such services. Both Save the Children UK's (2004) standards for East and Central Africa and the local IMC (1998) *Minimum Standards* provide detailed and useful indicators with regard to such issues. These indicators can be applied in the context of intensive DQA processes within individual services or small samples of such services.

On a broader scale, provincial and national indicators pointing to the overall state of services should include the following:

Staff–child ratios in residential facilities

There is a need for clear norms as regards staff–child ratios for residential care which take into account the needs of specific categories of children such as those with physical and intellectual disabilities or severe behavioural disturbances. Adherence to these ratios should be subject to regular monitoring. The norms and the associated monitoring processes should be based on the actual number of staff on duty at any given time in a facility once shifts as per the Basic Conditions of Employment Act (No. 75 of 1997), leave, illness, overtime and other such factors have been taken into consideration. Provision is made for the development of norms and standards for staff ratios in specific settings by the national DoSD in its Integrated Service Delivery Model (DoSD, 2005a).

Levels of qualification, experience and training of staff in residential facilities

A regular audit of these factors via the initial registration process and subsequent progress reports required by the DoSD would make it possible to monitor the proportion of caregivers who have completed the various types of available training, and the levels of experience among practitioners in child and youth care. A Further Education and Training Certificate in Child and Youth Care offered by the National Association of Child Care Workers has recently been registered with the South African Qualifications Authority as a level 4 qualification. This has subsumed some previously available qualifications. Standards at more advanced levels have been generated and a tertiary qualification at level 7 is in the process of being registered. The Durban University of Technology offers a degree course in Child and Youth Care. Unfortunately, tertiary qualifications which were being offered by the University of South Africa are being discontinued, which is a major blow to plans for nationally accessible training at this level. Ways are being sought to overcome this problem. Meanwhile it remains important to monitor skills levels in residential care facilities and more broadly in the child and youth care field.

Levels of experience and training in social workers involved in statutory child protection and care services

All social workers registered in South Africa must have at least a bachelor's degree in social work. A key issue for this group is the extent to which they have received any specific training for work in the field of child protection and statutory care, either in the course of their basic training or thereafter. Recent controversies as to the balance between 'generic' and specialist training in social work have yet to be resolved. However, there is a widespread view among practitioners that this is a field which requires specialist training (DoSD, 2004a). The *National Policy Framework and Strategic Plan for the Prevention and Management of Child Abuse, Neglect and Exploitation*, which is in its final stages of preparation, provides for a training strategy including curriculum development, both intra- and interdisciplinary, for all practitioners involved in child protection, including social workers, police officers, justice personnel, healthcare practitioners and teachers. A baseline audit of levels of experience and training in social workers, along with the other professionals involved, followed by ongoing monitoring of these levels, is needed. Perhaps this could be a task for the HSRC or the DoL.

Levels of selection, internal training, support and supervision of staff

This information could be drawn from DQAs carried out countrywide, preferably on an annual basis once they are more routinely applied. In the meanwhile the relevant assessments could be carried out, using the IMC *Minimum Standards*, with a sample of facilities in each province.

Remuneration of personnel

Salary levels for all categories of social service personnel have always been notoriously poor. Recent improvements to salaries in the civil service have made a substantial difference to the position of state employees, but the situation in NGOs remains critical. This is believed to be a key reason for the rapid staff turnover in the sector (SA Council for Social Service Professions, 2002). Although low salaries are by no means the only factor undermining stability and competence in the statutory childcare workforce, it seems highly unlikely that there will be any real improvement without attention to this fundamental problem. Annual surveys to track the earning levels of the relevant personnel both in and outside of government could be undertaken along with the aforementioned monitoring of levels of qualification.

Social work caseloads

The workloads of child and youth care workers in residential care settings are under some control through the registration process governing these facilities. In terms of this process, a limit is set as to the number of children who can be accepted in any particular facility. However, there is at present no limit to, and no means of monitoring, social work caseloads. It can be argued that overcrowded caseloads are no less dangerous than overcrowded children's homes. Social workers, as the case managers for children who are referred for statutory and pre-statutory protective services, are responsible for linking the child to all the elements of the care and protection system and helping them move through and out of this system. They are also the key providers of core services, including the initial assessment which determines whether a child should be placed in care or provided with preventive services, the locating of placement vacancies, and the preparation of all concerned for the child's entry into care. They must manage cases through the children's court and associated processes, prepare comprehensive reports for the court and thereafter submit follow-up reports and recommendations to the DoSD. They are also responsible for delivering therapeutic services to the child and family, and support to the foster family if applicable, and for arranging any other services which may be necessary. In many agencies these same social workers recruit, select and train or orientate foster and adoptive families. Social work services are thus pivotal to every facet of the child's experience in the care and protection system.

However, the HSRC's (Dawes, 2003) investigation into the state of children in Gauteng indicated that social work caseloads in that province were typically far too high to allow for the delivery of services at an adequate level. Similar and worse scenarios are being reported from other provinces. Critical tasks here are i) the development of realistic caseload norms, based on the time needed for the tasks involved in achieving the desired outcomes, ii) an audit of the current situation on the ground, and iii) the setting in motion of a process of ensuring that there are enough personnel to serve the children in the system. The narrowing of the huge gap

between what is needed and what is in place would be a key issue for monitoring. It is suggested that such monitoring be done by the DoSD in each province and nationally. This should take place at least twice annually, given the speed with which children are currently being brought into care and the low rate at which they seem to be leaving. Meanwhile, the national DoSD's (2005a) Integrated Service Delivery Model has provided for a process of establishing viable caseload norms for every service context. The research which was recently carried out for the costing of the incoming Children's Act has meanwhile produced useful interim data for this purpose (Barberton, 2006).

Budgetary indicators

The budget process is 'the key instrument of government planning and implementation' (Creamer, 2004, p. 1). The national and provincial budget allocations for services to children are crucial indicators of official commitment to the realisation of the rights of children (Robinson & Biersteker, 1997). Since the advent of democracy, a wealth of research has been carried out, particularly by the Institute for Democracy in South Africa (IDASA) Children's Budget Unit, and data which indicate expenditure on children in various sectors have increasingly become available. There has, however, tended to be a focus, as far as the DoSD is concerned, on expenditure on children's social security grants, including the Foster Care Grant and the Child Support Grant, which has been growing exponentially. However, far less information is available to help track expenditure on children's services, which is buried in the allocations to the provinces and, at that level, in provincial allocations to NGOs and per capita subsidies to facilities run by these organisations.

The Constitutional Court in the Grootboom case (see endnote 1) concluded that parents have the primary responsibility for the care of their children, but that for those who do not receive the necessary care of their families, the state has a specific duty to provide the required services. Questions arise as to the extent to which this obligation is being honoured. Although statutory social services can be considered to be a core responsibility of the DoSD, they were deprioritised in recent years in that department's financing policy (DoSWPD, 1999). The intention has been that the long-standing pattern of state social welfare service expenditure, in which the largest amounts have gone to statutory care and associated processes, must be reversed, so that the largest allocations go to primary prevention and early intervention services. In this way, in theory, fewer children would come into care. The problem has been that the socio-economic factors which are pushing children into care are far beyond the means available to the social service sector to address, and consequently it appears that the numbers of children in care have not been decreasing, but increasing.

In a more recent financing policy document, the emphasis on the turnaround described above has been dropped, and mention is made of child protection services as one of several categories of service that are 'chronically under-budgeted'. However, there is no attention given to how this is to be corrected (DoSD, 2004b).

In recent research commissioned by the national DoSD, amounts paid by the state for the care of children in its own facilities were found to be substantially higher than those contributed in per capita subsidy to NGOs. Many of the latter organisations

were experiencing severe financial problems which impacted negatively on their ability to deliver services at acceptable standards. The level of state funding relative to the actual costs of caring for children was found to be steadily shrinking. Habitual delays in payment as well as inadequacy of subsidies were among the problems experienced, as were high turnover of childcare staff and social workers due to factors such as inadequate salaries, excessive workloads and job insecurity (DoSD & SADPER, 2004). One of the recommendations flowing from this research was that a realistic cost per child be calculated and used as the basis for funding, with the state paying 85 per cent of this amount and the balance being funded through NGO fund-raising. In addition, measures were suggested for ensuring the timeous payment of subsidies and for the smooth running of the partnership between government and the relevant NGOs.

The degree to which funding of statutory care correlates with the cost per child of services which are compliant with the rights of the child would be a key indicator of the ability of residential care facilities to deliver what is expected of them. Costing of the same sort is urgently needed for foster care, and indeed for all services associated with the statutory care system. The DoSD has been engaged in the development of a new costing model for services, amidst complaints by NGOs of a lack of adequate consultation in this regard (National Welfare, Social Service and Development Forum, 2004). Assuming that further consultation occurs, and once the model is in place, a process of monitoring the national and provincial budgets for statutory childcare service provision will be of key importance in efforts to improve the present system. For this to occur, it will be important to define the boundaries of the relevant services to children, and to distinguish between the relevant allocations, including those for services run by NGOs as well as those run by the DoSD. IDASA's budgetary monitoring programme would be the logical base for starting such a tracking process. The amount of funding which NGOs manage to raise from non-governmental sources would also be a useful indicator of the strength of these services and the ability of the sector to progress.

Concluding remarks

Establishing a system of indicators in relation to children in the South African statutory care and protection system is a formidable task. The issues outlined above are by no means exhaustive, but constitute early pointers to the state of children in care, which could be profitably addressed.

Addemdum A Children in statutory care: definitions

In terms of Section 14(4) of the Child Care Act (No. 74 of 1983), the criteria in terms of which a children's court may find a child to be 'in need of care' are as follows:

(a) the child has no parent or guardian; or
(b) the child has a parent or guardian who cannot be traced; or
(c) the child:
    (i) has been abandoned or is without visible means of support;
    (ii) displays behaviour which cannot be controlled by his or her parents or the person in whose custody he or she is;

(iii) lives in circumstances likely to conduce to his or her seduction, abduction or sexual exploitation;
(iv) lives in or is exposed to circumstances which may seriously harm the physical, mental or social well-being of the child;
(v) is in a state of physical or mental neglect;
(vi) has been physically, emotionally or sexually abused or ill-treated by his or her parents or guardian or the person in whose custody he or she is; or
(vii) is being maintained contrary to section 10.[12]

In terms of Section 150(1) of the Children's Act (No. 38 of 2005), a child is 'in need of care and protection' if that child:

(a) has been abandoned or orphaned and is without any visible means of support;
(b) displays behaviour which cannot be controlled by the parent or caregiver;
(c) lives or works on the streets or begs for a living;
(d) is addicted to a dependence-producing substance and is without any support to obtain treatment for such dependency;
(e) has been exploited or lives in circumstances that expose the child to exploitation;
(f) lives in or is exposed to circumstances which may seriously harm that child's physical, mental or social well-being;
(g) may be at risk if returned to the custody of the parent, guardian or caregiver of the child as there is reason to believe that he or she will live in or be exposed to circumstances which may seriously harm the physical, mental or social well-being of the child;
(h) is in a state of physical or mental neglect; or
(i) is being maltreated, abused, deliberately neglected or degraded by a parent, a caregiver, a person who has parental responsibilities and rights or a family member of the child or by a person under whose control the child is.

Addendum B Rights of children in residential care

As a result of the South African Constitution and the ratification of the UN Convention on the Rights of the Child, South African children who are placed or detained in a residential care centre have special protections and rights as indicated below (IMC, 1998, pp. 13–14):

1. The right to know their rights and responsibilities.
2. The right to a plan and programme of care and development, which includes a plan for reunification, security and lifelong relationships.
3. The right to participate in formulating their plan of care and development, to be informed about their plan, and to make changes to it.
4. The right to expect that their plan and programme is based on an appropriate and competent assessment of their developmental needs and strengths which is undertaken, where possible, in the context of their family and community environments.
5. The right to a regular review of their placement and care/developmental plan.
6. The right to be consulted and to express their views, according to their abilities, about significant decisions affecting them.
7. The right to reasonable privacy and to possession of their personal belongings.
8. The right to be informed of behaviours expected by service providers and of the consequences of not meeting the service providers' expectations.
9. The right to care and intervention which respects their cultural, religious and linguistic heritage and the right to learn about and maintain this heritage.
10. The right to regular contact with family, parents/guardians and friends unless a legal order or the care/development plan indicates otherwise or unless they choose otherwise.
11. The right to the involvement of their family and/or significant others in their care/development plan, unless proved to be not in their best interests, and the right to return to live in their community in the shortest appropriate time.
12. The right to be free from physical punishment or inappropriate isolation.

13. The right to age-appropriate, positive disciplinary measures.
14. The right to protection from all forms of emotional, physical, sexual and verbal abuse.
15. The right to education appropriate to their age, their aptitude and their ability.
16. The right to send and receive mail which is not read by others. In those rare cases when mail must be read by a service provider, the child has a right to be present or give permission for mail to be read without being present.
17. The right to be informed that prohibited items may be removed and withheld.
18. The right to respect and protection from exploitation and/or neglect.
19. The right to opportunities of learning which develop their capacity to demonstrate respect and care for others.
20. The right to an interpreter if language or disability is a barrier to consulting with them on decisions affecting their custody or care and development.
21. The right to privacy during discussions with families and/or significant others, unless this can be shown not to be in the best interests of the child.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 2001(1) SA46 (CC)

2 See Article 3: non-discrimination; Article 4: best interests of the child; Article 13: children with disabilities; Article 16: child abuse and torture; Article 23: refugee children.

3 This has been signed by South Africa, but has not been ratified. In light of Section 39 of the Constitution, this convention must still be used to interpret the rights in the Bill of Rights, including Section 28.

4 The term 'social welfare' has been replaced to a large extent by 'social development' in official parlance. It will, however, be used in this chapter to avoid the difficulties which often arise in distinguishing care, support and protection services directed to vulnerable groups from pure development approaches, and from other human services such as health and education.

5 In the recommendations of the IMC, this phase was identified as level three (statutory processes within the child and youth care system), the others being level one (prevention), level two (early intervention), and level four (continuum of care). Levels three and four have since been combined, presumably because of the overlap of role-players and processes involved. However, there remains a need to monitor the initial phase because of its strategically critical nature.

6 Residential care is by far the most costly childcare option. From the point of view of government, the speedy movement of children into family care, especially adoption, creates enormous savings. These savings continue down the line – children who linger in temporary forms of care, especially institutional environments, become increasingly likely to remain in care. Those who suffer severe emotional damage in this process are at far higher risk of ultimately entering the criminal justice system, at huge cost to the taxpayer.

7 Regional reporting is a difficult issue because regions under the Department of Justice do not correspond with the provincial boundaries used by other departments.

8 The DQA system was originally intended for all services operating with DoSD funding, as set out in the department's Financing Policy for Developmental Social Welfare Services (DoSWPD, 1999). The framework for assessment of children's homes was part of this system. The *Policy on Financial Awards to Service Providers* (DoSD, 2004c) has since been brought into operation and this document refers in more general terms to 'monitoring and evaluation' arrangements rather than the DQA system. However, it seems likely that an assessment framework at least similar to that which has been used in the past for the assessment of children's homes, based on the IMC standards, will continue to be used for this purpose.

9 Such a plan is based on a developmental assessment and is drawn up with the participation of the child and his or her family and other significant persons. The care plan includes an 'exit plan' outlining the intended steps towards overcoming the problems which resulted in the child coming into care, and the process for reintegrating him or her into the family or community, as well as an

individualised plan which sets out the goals which the young person can hope to achieve while in care, and the services to be used in pursuit of these goals.

10 An exception could be a situation where an agency has developed a strong corps of volunteers, particularly experienced foster parents, to provide the necessary support.

11 Section 232, Section 261(5)(g) and Section 262(5)(g), Children's Act (No. 38 of 2005).

12 Section 10 requires that, in the case of a child aged less than seven years, anyone other than a relative or a recognised hospital or children's facility must obtain authorisation from the court in order to provide care for that child for more than two weeks. This is intended to help prevent trafficking in young children and unethical adoption practices.

CHAPTER 16

Monitoring children in conflict with the law

Lukas Muntingh

Introduction: objectives and scope

The South African criminal justice system is notorious for violations of children's rights. During apartheid thousands of children were detained without trial. Many were tortured and otherwise abused by the security and criminal justice systems (McLachlan, 1983; Dawes, 1994; Reynolds & Dawes, 1999). Juveniles were frequently sentenced to whippings for a variety of offences (McLachlan, 1983).

In the post-apartheid period, problems in the correctional system remain (Children's Rights Project, 1997). Media reports have highlighted violations of children in custody. For example, Grootvlei Prison warders were found to have been complicit in trading children for sex with adult prisoners (Sekhonyane, 2002). Another example is the ten children that died in state custody between January 1999 and 30 April 2000 (Muntingh, 2003).

However, it can safely be assumed that most children who enter the justice system are already vulnerable. By the time a child is arrested, a number of risk factors are likely to have been present in the child's life. Arrest is therefore often an indicator of family, social and economic support systems which have failed the child, and in South Africa it is predominantly poor (and black) children who come into conflict with the law.

The purpose of this chapter is to develop indicators which enable monitoring of what happens to children in the criminal justice system, rather than monitoring why children come into conflict with the law. In addition, it focuses on monitoring compliance with broad policy statements that can be traced back to the United Nations Convention on the Rights of the Child (CRC – see Appendix 1 in this volume) and on monitoring child outcomes, rather than on the outputs of the applicable system(s).

The chapter does not cover the implementation of particular child justice legislation (such as the envisaged Child Justice Act[1]), save for where the legislation or outputs relate directly to or are of *critical* value in determining the outcomes of children in conflict with the law, as in the case of the rule requiring assessment of the child within 48 hours of arrest.

Like other sectors, the South African criminal justice system is characterised by substantial information gaps, and where they exist, data are often collected and managed in a manner that does not facilitate communication with other

information systems. Effective monitoring is reliant on high-quality, accurate and accessible information that feeds into an accountability mechanism with a clear and comprehensive mandate supported by the resources required to exercise that mandate. Systematic information collection by means of reliable and valid indicators would facilitate addressing systemic problems, and would prevent isolated and uncoordinated responses to individual incidents.

Rationale

A rights-based approach to monitoring children (under 18) in conflict with the law

Two critical points relate to monitoring the rights of children in conflict with the law. First, is the state accepting its responsibility towards protecting the rights of children who have come into conflict with law? Second, is this protection (services, legislation, policies and implementation thereof) of an acceptable standard?

State Parties are obliged to create a facilitative environment for compliance with the CRC, with specific reference to i) overall obligations (see Article 3 of the CRC), ii) reporting duties (see Article 44 of the CRC), and iii) legislative and policy framework (see Article 4 of the CRC). State Parties to the CRC have a number of broad obligations to adhere to which create a particular framework for treating and dealing with children, including children in conflict with the law. In the criminal justice context, this means that children need to be afforded special protection and that reintegration (see Article 39 of the CRC) should be the overall purpose of services aimed at children in conflict with the law. This also relates to the reporting of State Parties in terms of the CRC.

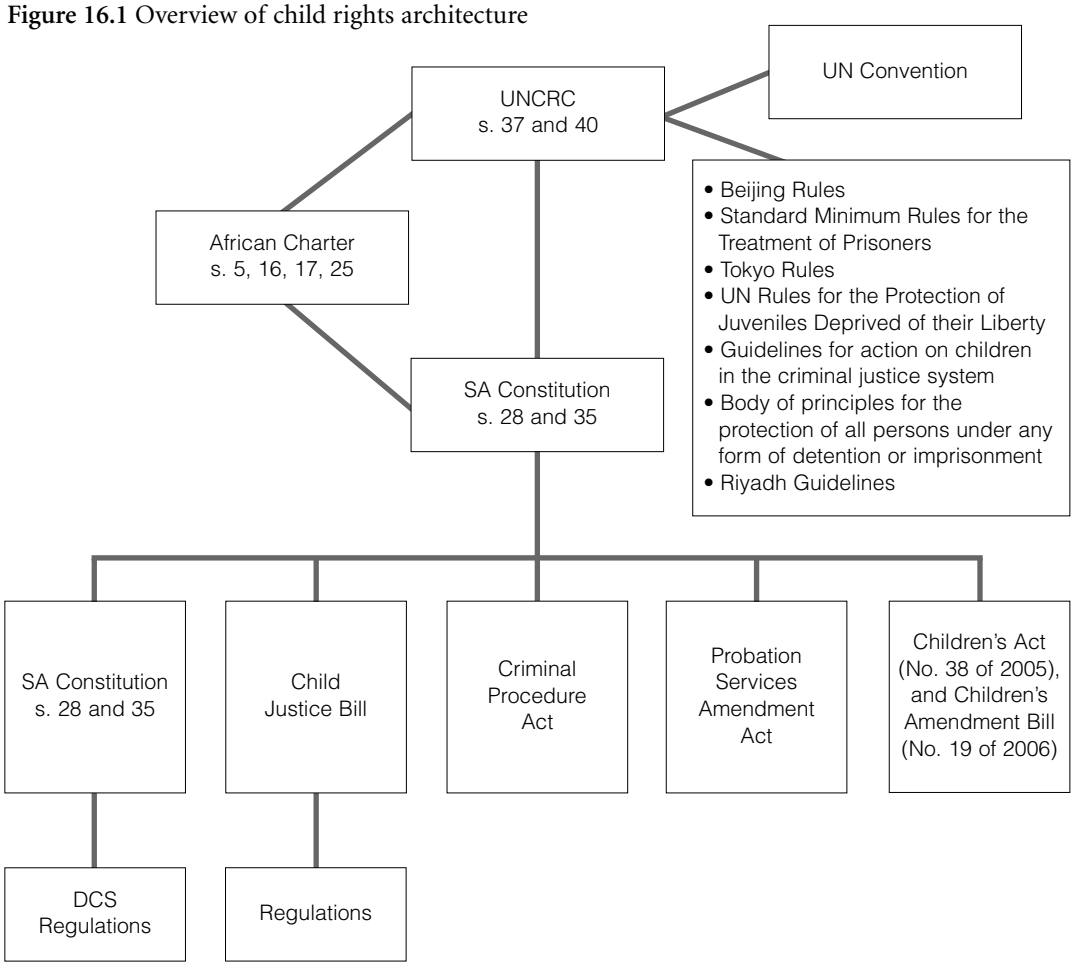
South African constitutional and other legal provisions

The CRC articulates a set of principles aimed at protecting children against various forms of victimisation, discrimination, marginalisation and exclusion. The criminal justice system sets a particular context for these rights to be protected in – a context that in most instances works against the best interests and well-being of the child.

The CRC deals specifically with children in conflict with the law in three articles, namely 37, 39 and 40. Article 37 affords protection against torture, and cruel, inhuman and degrading treatment; Article 39 focuses on rehabilitation and reintegration; and Article 40 on the administration of juvenile justice.[2] Some additional and supporting provisions are made in other articles (including the foundation principles covered in Chapter 2 of this volume), but the rights directly relevant to children in conflict with the law are dealt with in the three aforementioned articles.

When considering the rights of children in conflict with the law, it soon becomes apparent that there is a fair amount of overlap between the different international instruments, and that all statements and policies can be traced back to a limited number of core values underpinning the CRC. Attempts to develop indicators for monitoring these broad-spectrum core values would not be useful, as indicators

Figure 16.1 Overview of child rights architecture



need to be specific, quantifiable and supported by qualitative statements. Furthermore, the value of indicators lies in their connectedness to a system of accountability relating to a course of action (Saporiti, 1996).

Figure 16.1 illustrates the overall architecture as it applies to the rights of children in conflict with the law.

The CRC, in articles 37, 39 and 40, sets the foundation for other instruments. The African Charter on the Rights and Welfare of the Child (see Appendix 3) corresponds in many instances directly with the CRC. The UN Convention Against Torture (UNCAT) protects persons suspected of a crime and those already convicted, from torture and inhumane and degrading treatment or punishment. A recent addition in 2002 is the Optional Protocol to the Convention Against Torture (OPCAT), which provides for national and international visiting mechanisms to facilities where people are detained.[3] Over the years, a range of instruments (standards, guidelines and bodies of principle) has been developed. They provide further clarity on the rights of children in the criminal justice system, as well as preventing their entry into the criminal justice system. These include:

- UN Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment;
- UN Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules);
- Standard Minimum Rules for the Treatment of Prisoners;
- UN Standard Minimum Rules for Non-custodial Measures (Tokyo Rules);
- UN Rules for the Protection of Juveniles Deprived of their Liberty;
- Guidelines for Action on Children in the Criminal Justice System;
- Body of Principles for the Protection of all Persons under any form of Detention or Imprisonment;
- UN Guidelines for the Prevention of Juvenile Delinquency (Riyadh Guidelines).

The South African Constitution (Act No. 108 of 1996), in sections 28 and 35 respectively, describes the rights of children as well as the rights of arrested, detained and accused persons. Three core pieces of legislation currently regulate the situation of children in conflict with the law. These are the Correctional Services Act (No. 111 of 1998) (CSA),[4] the Criminal Procedure Act (No. 51 of 1977) (CPA) and the Probation Services Amendment Act (No. 35 of 2002). There were also one Act and two Bills before Parliament at the time of writing (November 2006) which will have a significant impact on the situation of children in conflict with the law, once they are enacted. The most significant is the Child Justice Bill (No. 49 of 2002) (CJB),[5] which establishes a criminal justice process for children in conflict with the law. The Children's Act (No. 38 of 2005) and the associated Children's Amendment Bill (No. 19 of 2006) aim to define the rights and responsibilities of children, and is an attempt to consolidate the legislation relating to children.

A guide to applying the CRC is provided by Hodgkin and Newell (2002). Their work provides checklists to assist State Parties and civil society in the monitoring process. These checklists do, however, remain subject to effective indicator development. They also provide detailed discussions of each article.

Priority areas for monitoring

The criminal justice system is dynamic. Its functioning is dependent on the decisions made by officials. The decision to release a child to his or her caregivers, or to detain him or her, has important consequences for the child's development. The availability of information to inform decisions is critical in preventing the child from moving 'deeper into the system'. The criminal justice system is not set up to deal with individual characteristics and needs, but with cases in terms of strict rules: one action opens up a new, but limited, set of rigid options. Furthermore, once a decision has been made and implemented, it is difficult to reverse. The power to reverse decisions does not lie with the accused.

The first step towards managing the risks posed by the criminal justice system to young offenders is the development and implementation of legislation and policy that deal exclusively with children in conflict with the law, as required in Article 4 of the CRC and Beijing Rule 2.3. If such legislation and policy are absent, it means that children will either be dealt with in the same manner as adults or, through a process of unco-ordinated legislation and procedure, children will 'fall through the cracks' of the system, as has been the situation in South Africa for many years.

There are specific steps or stages in the criminal justice system which need to be managed and, thus, monitored closely. The first is arrest. The moment a child is arrested, they engage in a relationship which is unequal in power and which places their well-being at risk. The CRC and other instruments such as the Child Justice Bill (CJB) clearly discourage arrest, as the worst child rights abuses often occur in the stage directly after arrest prior to the child's first appearance in court (if there is a first appearance) (UNICEF ICDC, 1998). Torture, poor holding facilities, denial of access to family and services are some of the common abuses at this stage. For a comprehensive description of children in South Africa's prisons see Children's Rights Project (1997), European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT, 2004) and South African Police Services (SAPS, n.d.).

The CRC and other instruments repeatedly urge State Parties to use detention as a measure of last resort, and encourage the use of alternatives (Beijing Rules, Rule 10.2; Tokyo Rules, Rule 6). A child justice system which discourages detention is thus not one which is lenient or 'soft on crime', but rather one which is in compliance with key children's rights instruments. Child justice systems which discourage detention aim to avoid the involvement of the formal court system and purely punitive responses wherever possible, and give special importance to constructive community-based solutions (UNICEF ICDC, 1998). Research has shown that deterrence or punitive interventions may increase antisocial and offending behaviour, while residential settings diminish the positive effects of otherwise appropriate interventions, and enhance the weak or negative effects of inappropriate interventions (Andrews et al., 1990; Lipsey & Wilson, 1993; Lipsey, 1995; McGuire & Priestley, 1995). Alternatives to detention, particularly community-based interventions which target multiple aspects or contexts of the child's life (for example family, peers), are most effective in encouraging behavioural change and reducing offending behaviour (Lösel, 1993; Mulvey et al., 1993; McGuire & Priestley, 1995; Rutter et al., 1998). As such, non-custodial interventions tend to foster integration rather than alienation.

In what follows, indicators[6] for monitoring the situation of children in conflict with the law are presented accompanied by a short description, unless the indicator is self-explanatory. Seven classifications (six refer to stages of the justice process) are used to group the indicators that are discussed below and summarised in the tables in Part 2 of this volume:

- Indicators for monitoring the legislative and policy environment and for multiple stages of the justice system;
- Indicators for monitoring arrest, including detention, release to appear, and assessment prior to first appearance;
- Indicators for monitoring children awaiting trial in custody post first court appearance;
- Indicators for monitoring diversion and diversion programmes;
- Indicators for monitoring the trial;
- Indicators for monitoring sentencing and sentenced children;
- Indicators for monitoring reintegration.

Indicators for monitoring the legislative and policy environment and for multiple stages of the justice system

Indicators in this section are categorised according to the typical stages of the criminal justice process, for example, arrest, diversion, trial, and sentencing. There are, however, a number that apply to most, if not all, stages of the process. Instead of repeating these in the following sections in each discussion, they are presented here as a consolidated set. Indicators for monitoring the state's overall obligations and the legislative and policy environment are also presented below.

Type 5 indicator: Service quality

The South African country report to the CRC is comprehensive and complies with reporting requirements regarding child justice (CRC 3.1).[7]

An assessment of the comprehensiveness of the State Party report can be done by means of a comparison of the subsequent shadow reports submitted by non-governmental organisations in that country, as well as by referring to comments of the committee on previous reports. The country report requires a substantial amount of research in preparation, but this should also be followed with an equally rigorous verification and monitoring process from one report to the next. The 'comprehensiveness' and standard of the country report is in itself an indicator of government's commitment to compliance with the CRC. The extent to which a country report complies with the General Guidelines is therefore an indicator of its 'comprehensiveness'.

The data required from State Parties in relation to articles 37 and 40 are as follows:[8]

- Alternatives to deprivation of liberty, frequency with which they are used, and disaggregated data on the children concerned;
- Disaggregated data on all children deprived of their liberty – unlawfully, arbitrarily and within the law – and on the reasons for, and period of, deprivation of liberty;
- Details of cases concerning children who have been deprived of their liberty, including the percentage of cases in which legal or other assistance has been provided, and in which the legality of the deprivation of liberty has been challenged before an appropriate authority, together with the results of such challenges (paragraphs 139, 141 and 145);
- Disaggregated data on the children alleged as, accused of, or recognised as having infringed the penal law, inter alia by age, gender, region, rural/urban area, national, social and ethnic origin, offence and disposition (paragraph 137).

Type 5 indicator: Service quality

An integrated legislative framework regulating children in the criminal justice system is in place (CRC 3.2, 4, 40.3, 40.4).

The existence of comprehensive legislation dealing with all children's issues is key to protecting the rights of children, particularly in the criminal justice system, where children are vulnerable to rights violations. This has been an accepted principle since the late nineteenth century in western legal systems, with the first juvenile justice system being introduced in Illinois in 1899 (UNICEF ICDC, 1998). The international instruments listed earlier in the chapter go a long way in assisting State Parties in

formulating legislation and policy that are in line with the CRC. The key issue, however, is the existence of legislation describing the procedures, processes, rules, rights and obligations applicable to children in conflict with the law, and those who deal with these children. In South Africa, many of the ills suffered by children in the criminal justice system can be traced back to the absence of appropriate legislation or to poorly formulated legislation.

There are a number of ways in which the existence of an integrative legislative framework can be assessed, including:

Number of judgements and comments against the provisions of the Child Justice Act/Bill (CJB 2(a))

The Constitutional Court performs a vital function in terms of testing legislation against the Constitution, and employs international instruments as well as international case law to support its judgements. It was indeed the Constitutional Court that outlawed corporal punishment in *S v. Williams* in 1995,[9] aligning South African legislation and practice with the Bill of Rights (see Appendix 2 in this volume) and the CRC. The CJB, when enacted, will need to survive constitutional scrutiny. Rulings against the envisaged Act will indicate whether or not it complies with the Constitution, and ultimately the CRC.

The South African legal system further makes provision for the Supreme Court of Appeal and the high court to comment on, and issue orders relating to, the state's failure to provide adequately for children in the criminal justice system.

Existence of specialised courts and procedures for children (CRC 40.2(b))

The CRC deals with the requirement for specialised courts[10] for children in Article 40.2(b). Their existence improves the situation of children in conflict with the law for a number of reasons.

First, specialised personnel are required who are familiar with children's rights, the reasons why children come into conflict with the law, and what constitutes appropriate responses to such children. The United Nations Children's Fund (UNICEF) Indicators for Juvenile Justice (see Appendix 8 in this volume) require that the availability of specialised staff be expressed as a per 1 000 ratio of arrested children for the following categories of personnel: judges, lawyers, prosecutors, police and social workers (probation officers) (Skelton, 2004).

Second, the existence of specialised courts gives true expression to the right of children within the criminal justice system to special protection, as outlined in Article 3.2 of the CRC.

Compliance with specialised procedures (CRC 40.2(b))

Article 40.2(b) provides guidelines for ensuring procedural fairness that can be divided into specific procedural requirements (for example privacy and protection of identity).

It is also necessary to make available information on the compliance of each jurisdiction with the specialised procedures in terms of domestic legislation. Where there is non-compliance, research should establish the reasons and the extent to which it impacts negatively on children's rights.

The number of jurisdictions designated as one-stop child justice centres

This is an important measure because it denotes the ability of the government to provide accessible, comprehensive and focused services to arrested children. The centres are of particular significance in areas where substantial numbers of children are arrested, such as urban areas.

The existence of requirements in policy and legislation to ensure that services are of an acceptable quality (for example accreditation, licensing) (CRC 3)

It is not enough that the state merely accepts its responsibility for children; it also has a quality control function in the execution of these responsibilities. The absence of standards, accreditation and licensing creates enormous risks for children, especially in the criminal justice environment where an element of coercion is omnipresent. Events over the last five years at the Noupoort Christian Care Centre in the Northern Cape bear testimony to this.[11] The CJB accepted this principle from the CRC, and in Section 49 it outlines the requirements for diversion programmes, placing the duty of accreditation with the director-general of the Department of Social Development (DoSD). The Correctional Services Act also makes reference to the treatment of children in conflict with the law as it relates to support services, diet, notification of caregivers and so forth. This measure therefore aims firstly to identify gaps in standard setting, and secondly to assess the quality of existing standards and the requirements to meet these standards. An accountability mechanism (such as accreditation and licensing as well as inspections) should form an integral part of any service quality standards.

Type 5 indicator: Service quality

The existence of a body or bodies responsible for overseeing the services to children (CRC 3).

A body overseeing services to children in the criminal justice and related systems is key to ensuring that:

- Children receive services that are of the appropriate quality;
- A body of knowledge and research is developed over time to reflect and inform the local context;
- There is an avenue for complaints and grievances with regard to services.

Such a body or bodies would furthermore continue to inform policy and legislation, and generate data on the existence and execution of mandatory and unannounced visits by judges and magistrates to facilities where children are detained.

Type 5 indicator: Service quality

Detention facilities for children are inspected at least once per annum (Children's Bill, 297).

The Children's Bill and the Correctional Services Act (through the Judicial Inspectorate) make provision for unannounced visits to facilities where children are detained. The frequency, duration and timing of these visits are important indicators of the commitment of oversight bodies to detention conditions which comply with the legislative requirements. Frequent visits have by now been accepted as an effective method to prevent torture, abuse and ill-treatment of detained persons, and one of the key purposes of OPCAT is the establishment of a frequent system of such visits.[12]

Type 5 indicator: Service quality

Revision of the age of criminal capacity to 10 years with a rebuttable presumption of lack of capacity up to 14 years (CRC 40.1, 40.3(a)).

The CRC does not prescribe the age of criminal capacity, but states that it must be included in domestic legislation. The Beijing Rules (in Rule 4.1) assist somewhat in this regard, stating that it should be determined with due consideration to the emotional, mental and intellectual maturity of the child. These guidelines do not, however, provide sufficient guidance on this matter, and the age of criminal capacity still ranges from 7 years (for example South Africa, Ireland and Zimbabwe) to 18 years (for example Belgium, Guatemala, and Uruguay).

The age of criminal capacity has always been a hotly debated issue in jurisprudence, and is likely to continue to be as it has implications for children as a societal group.[13] It reflects the way in which a criminal justice system (and society) defines childhood and crime and, based on these understandings, what constitutes appropriate responses. As such, age stands central to comprehensive legislation and policies which deal with children, as required in terms of Article 3.2 of the CRC. At present, the age of criminal capacity in South Africa is set at seven years, and the CJB proposes moving it up to ten years, with a rebuttable presumption of lack of criminal capacity for the age category 10 to 14 years. These age categories and our understanding thereof determine the decisions made regarding the child after their arrest.

Type 5 indicator: Service quality

Constitutionality of retroactive legislation (CRC 40.2(a)).

Section 35.3(l) of the Constitution effectively prohibits retroactive legislation, so this is a relatively easy issue to monitor. The Constitutional Court rulings as referred to above can be utilised as an additional measure.

Type 5 indicator: Service quality

Use of the presumption of innocence by courts (CRC 40.2(b)).

Whilst this presumption forms a fundamental principle of the South African legal system, it is often tested in practice when children come into conflict with the law. Due process principles are frequently adapted to accommodate the 'best interests' of the child. This is nowhere more apparent than in the decisions around diversion where there is often a considerable amount of pressure (if not coercion) on the child to accept the offer of diversion without the guilt or responsibility of the child being established to a reasonable degree. Whilst this is not an issue which can reasonably be monitored on a continuous basis, it is justified to periodically conduct research addressing this issue to assess how this presumption operates in practice, and is safeguarded.

Type 5 indicator: Service quality

Assessment of automatic review of custodial sentences for children under 16 years (CRC 40.2(b)).

The South African legal system has a comprehensive apparatus in place in the lower and higher courts for the appeal of decisions. In the case of children below the age of

14 years, there is an automatic right of appeal and, consequently, there is no need to apply for leave to appeal.

The CJB in Section 80 states that Chapter 30 of the CPA (which deals with the review of criminal proceedings in the lower courts) applies to all children convicted in terms of the CJB. In addition, all cases of children below the age of 16 years receiving sentences of imprisonment will be subject to automatic review before a judge of the high court. Reviewing of decisions is an important component of developing jurisprudence and is likely to increase in importance once the CJB becomes law.

Whilst the law makes provision for review, and this has been long established in principle and practice in our legal system, the results of this review mechanism, as well as its consequences for children, need to be monitored. A growing body of case law emanating from the new child justice legislation will provide additional information on the review process.

Type 5 indicator: Service quality

Children contribute to the development of legislation and policy (CRC 12.1).

Measuring children's participation in decision-making is perhaps one of the most difficult requirements to measure. To some extent the requirement is a legislative and policy requirement as articulated in Article 4 of the CRC in the sense that there must be provision for input from the child.

An example of this in existing legislation is the provision in Section 18(4)(e) of the Child Care Act (CCA), which stipulates that children over the age of ten must consent to adoption. Similarly, Section 6 in the Divorce Act makes provision for input from the child. In addition, the CJB in 32(6), for example, places a duty on the probation officer to encourage the child's participation during the assessment.

Indicators designed to assess child participation are lacking and will require research to develop. The Committee on the Rights of the Child has proposed that states should review the extent of implementation of Article 12, which implies asking children about their experiences and the degree to which they believe that their views are heard and respected:

> The Committee recommends, further, that the State Party undertake a regular review of the extent to which children's views are taken into consideration and of the impact this has on policy, programme implementation and on children themselves. (cited in Hodgkin & Newell, 2002, p. 167)

Type 1 & 5 indicators: Child status and Service quality

Deaths in the child justice system (CRC 6.1).

Deaths in custody[14] are perhaps the crudest indicator of the safety of children when placed in the care of the state. Of particular concern are deaths due to unnatural causes and sudden upsurges in mortality figures or suicide rates.

The duty of the state is to provide safe custody, as articulated in the relevant legislation, including the Constitution. All deaths in prison are to be reported to the

Office of the Inspecting Judge (OIJ),[15] and all deaths in police custody must be reported to the Independent Complaints Directorate (ICD) in terms of Section 53(8) of the South African Police Service Act (No. 68 of 1995). In addition, the ICD makes provision for various classes of complaints, and deaths in custody are regarded as Class 1 complaints (the highest priority of complaints which must be investigated) (ICD, n.d.). All deaths in facilities operated by the DoSD and the Department of Education (DoE) must be reported in terms of the Regulations accompanying the CCA. Children serving a sentence of correctional supervision, or who are released on parole, are covered by the CSA provisions.

A serious shortcoming in current provisions is that there does not appear to be an explicit legislated duty on places of safety, reform schools and any other secure care facilities to report deaths of children in custody to a central authority. In addition, there is as yet no system for reporting deaths of children participating in diversion programmes. It is essential that the implementation of a reporting system be incorporated into the diversion minimum standards.

Type 1 & 5 indicators: Child status and Service quality

Children subject to torture, abuse, cruel and inhuman treatment while in the care of the state (UNCAT; CRC 37.1(a), 19.1).

Allegations of torture[16] and cruel and inhuman treatment or punishment can be reported to a number of institutions such as the ICD, OIJ, the South African Human Rights Commission (SAHRC), the Public Protector, or the South African Police Services (SAPS). The emphasis will be placed here on the ICD and the OIJ,[17] as these bodies have been set up specifically to provide oversight over the police and prisons. The ICD's complaints classification system regards this type of complaint as a Class 3 complaint, which applies to any SAPS member alleged to have committed an offence,[18] or who is allegedly guilty of police misconduct which involves serious bodily injury resulting in inpatient hospital treatment while an individual is in police custody. The complaints lodged with the Independent Prison Visitors systems (IPVs) are recorded electronically and can be traced back to specific institutions where children are being held. It is important to monitor trends in complaints of this nature, and investigate the resolution of said complaints (Gallinetti, 2004a).

A significant challenge is the reporting of torture in the absence of a legal definition. For the purpose of this indicator the UNCAT definition formulated in 1987 should be used:

> For the purposes of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

It should be noted that bodies like those overseeing prisons and the police do not exist for facilities managed by the DoSD and the DoE. The OPCAT, when signed, would facilitate a visiting mechanism to all detention facilities.

In the absence of a legal definition, it is difficult to investigate and collect information on allegations of torture. Efforts should be dedicated to investigating alleged cases of torture, abuse and maltreatment (CRC 19.1), including the number of complaints lodged, as this will indicate the state's willingness and capacity to respond to such allegations. Data from the ICD on Class 3 complaints will provide valuable information, as will complaints lodged with IPVs.

Conviction rates of alleged cases of torture, abuse or maltreatment (CRC 19.1) in terms of the envisaged criminalisation of torture legislation, as well as information from the ICD and the OIJ, will indicate the commitment of the state and the judiciary to protecting the rights of children from individual officials who misuse their positions of authority.

Type 4 indicator: Service access

Cases reported to the Public Protector, the Commission on Gender Equality (CGE), the SAHRC, the OIJ and any other body resulting from alleged discrimination in the criminal justice system against a child (CJB 3(g); South African Constitution [SAC] 9(3)).

The CGE, ICD, SAHRC and OIJ (through the IPVs) provide children (and their parents) with four accessible complaints mechanisms, and cases reported to these bodies therefore provide information on the manner in which children are treated in the criminal justice system in terms of Section 9(3) of the South African Constitution.[19] The national Public Protector can investigate the following:

- Improper prejudice suffered by the complainant or another person, for example as a result of:
  - abuse of power
  - unfair, capricious, discourteous or other improper conduct
  - undue delay
  - the violation of a human right
  - any other cause brought about, or decision taken by the authorities
- Maladministration;
- Dishonesty or improper dealings with respect to public money;
- Improper enrichment;
- Receipt of improper advantage.

It is, however, debatable how quickly these bodies, especially the SAHRC, ICD and CGE, can follow up on complaints. On a longitudinal basis, complaints to these bodies and the results of investigations will provide important information on the situation of children in the criminal justice system. It has also been reported that whilst there are multiple reporting bodies provided for in the Constitution and that they are indeed reporting as mandated, there is no co-ordination of the complaints between the bodies nor are there thorough follow-up mechanisms and procedures once a complaint has been lodged with any of the bodies and referred from one to another (OSF, 2004). This will naturally need to be corrected.

Type 1 & 5 indicators: Child status and Service quality

Children injured in state custody by those responsible for the child (CRC 6.2; SAC 28.1(d)).

All persons received into and in police custody that are injured or who have sustained an injury or illness and require medical attention (including hospitalisation) are reported as such on the prescribed form, the SAP 70. In addition, the SAP 70 is cross-referenced in the SAP 14, which records all persons in police custody at that police station. The SAP 14 records all the relevant biographical details (including age) of the detained person, and as such forms the basis for compliance with Rule 7.1 of the Standard Minimum Rules for the Treatment of Prisoners. This information can then with relative ease be collected on a regular basis, especially in jurisdictions that have been designated as a one-stop child justice centre (in terms of Section 84 of the CJB).

In prisons, all new admissions are assessed by a paramedic and a doctor. It is also the duty of the medical staff at prisons to do regular cell visits to enquire about prisoners' health concerns and complaints. Places of safety are regulated by the CCA and the Minimum Standards for the Transformation of the Child and Youth Care System. Both these stipulate that serious injuries or illnesses requiring hospitalisation fall under the category of 'reportable incidents'.

Type 4 indicator: Service access

Services provided to children in detention (sentenced and unsentenced in terms of the Education Act, Child Care Act and Correctional Services Act [Section 19]).

Facilities offer services which meet the psychological, educational, health, spiritual and recreational needs of children serving custodial sentences (CSA 69(1), 69(2), 19.2; CRC 28.1).

Type 5 indicator: Service quality

Record keeping of arrests and detention of children is in compliance with the UN Standard Minimum Rules for the Treatment of Prisoners (in Rule 7.1 and 7.2), and South African regulations.

Type 5 indicator: Service quality

Capacity of secure and residential facilities to hold children apart from adults, and segregate genders (CRC 37.1(c); SAC 28.1(h)).

The ability to keep children separate from adults is highly dependent on the capacity of secure and residential facilities to do so. This capacity needs to be monitored on a continuous basis, and should include assessments of whether children are being detained in overcrowded conditions.

Detention facilities at police stations are often of an unacceptable nature – small police stations in particular frequently have only two cells (one for males and one for females), and therefore have no capacity to keep children separate from adults.

Indicators for monitoring arrest, including detention, release to appear, and assessment prior to first appearance

Based on the international instruments and domestic legislation, the following summarises the policy position on arrest, assessment and referral. Where arrest is necessitated by the crime and circumstances, the actions of the police need to be closely monitored against well-defined standards and procedures. Arrest should as soon as possible be followed by an assessment of the child by a suitably qualified person (such as a probation officer) who is required to gather information on the personal, social and familial circumstances of the child, so as to inform the decisions made by relevant criminal justice officials, and ensure that they are in the best interests of the child. Decisions should be guided by following the least restrictive measures, minimising exposure to the hardships of the criminal justice system and due process. The proposed mechanism is the preliminary inquiry (Section 38 of the CJB), which is an informal, pre-trial procedure of an inquisitorial nature with the purpose of directing matters away from the formal court procedures.

The emphasis in this section is on the police and their conduct. Although not responsible for it, the police play an important role in ensuring that the assessment takes place on time.

Type 1 indicator: Child status

Children arrested (CRC 40.1).

The number of children arrested in a jurisdiction is the primary indicator of the number of children entering the criminal justice process. As such, all subsequent steps and measures are measured against the number of children that were arrested. At a minimum, it is required to establish accurately the number of children arrested, stratified by age, in a particular jurisdiction over a particular period of time. Additional variables can be added depending on the quality and reliability of data being collected, such as time and date of arrest, race, gender, language, and so on. It is the duty of the police to record all arrests on the Case Administration System, and records should therefore be available from that source.

Section 6.1 of the CJB prohibits the arrest of a child who is under the age of ten years, and further instructs the police official concerned to take the child home or to a placement facility, and inform a probation officer within 48 hours. The age issue is therefore significant not only when it comes to trial, as it pertains to criminal capacity, but also at the first stage of arrest. The number of children arrested who are found to be under the age of ten years then becomes a significant indicator as to how the police apply the legislation. Even in the absence of Section 6.1, the number of children aged ten years or younger who are arrested is also significant, as it reflects children's position in the criminal justice system.

It is also important to take into account the offence profile (including the category of offence/s) of arrested children (CRC 40.1). Children are primarily arrested for property offences (theft, shoplifting, damage to property and possession of stolen goods) and victimless crimes (Muntingh, 2003). Children's involvement in crime, as well as the types of crimes for which they are arrested, assists us in understanding trends, and also in understanding society's perceptions of children and crime.

Arrests are always subject to policing policy, and as such become a less than reliable indicator of children's involvement in crime. There is also the informal 'policy' of police officers who, in the presence of diversion programmes, tend to ask the misguided question, 'Why arrest them if nothing is going to happen?' Despite these undermining factors, offence profiles of arrested children continue to inform us of what it is that children are arrested for, and whether we agree with the policing policies and practices.

Type 1 indicator: Child status

Placements of children prior to first appearance (CJB Chapter 4).

Section 16(1)(a)(i) of the CJB makes provision for a child to be released by a police officer into the care of their caregiver or another appropriate adult prior to first court appearance. Monitoring the use of this provision will indicate the police's willingness and ability to limit the child's exposure to the criminal justice system, as well as the use of detention as a measure of last resort.

Type 1 indicator: Child status

Children in detention in police cells for over 48 hours (CRC 9.1).

The reason for collecting this information is self-evident and is already a requirement of SAPS regulations as pertaining to the SAP 14. The number of children in detention in a particular jurisdiction should be further disaggregated in terms of i) the average number of children in detention per week/month/year, ii) date-specific counts, for example at month end or on Mondays, iii) new admissions to police custody, iv) number of children who have been in custody for less than 48 hours, and v) children in custody for more than one week.

Type 5 indicator: Service quality

Children are assessed using a standard assessment system prior to the preliminary inquiry (CJB Chapter 5).

Section 49 of the CJB provides for the establishment of minimum standards for diversion programmes. The drafters of the standards[20] established early on in the research process that the effectiveness of diversion programmes is highly dependent on the use of a standardised and comprehensive assessment tool (as required in terms of Section 27 of the CJB). The assessment process is key to all the steps that follow and, as such, signifies a vital component of a child justice process. The existence of and consistent utilisation of the assessment tool is thus a critical feature of a well-functioning child justice system.

From the Probation Services Amendment Act (No. 35 of 2002) – as well as the CJB – it follows that the number of assessments should correspond to the number of arrests. The number of assessments is usually a reflection of the DoSD's ability to provide sufficient capacity to assess the approximately 160 000 children arrested annually in South Africa (Muntingh, 2003). The purpose of the assessment is defined as follows in the CJB (Section 27):

- To assess whether a child may be in need of care for purposes of referring the child to a children's court;
- To estimate the age of the child if the age is uncertain;

- To establish the prospects for diversion of the matter;
- To formulate recommendations regarding the release or detention and placement of the child;
- To gather information relating to previous convictions, pending charges, and any previous participation in diversion; and
- In the case of children below the age of ten years, establish what measures need to be taken.

Type 1 indicator: Child status

Timely assessments of arrested children (CJB Chapter 5; Probation Service Amendment Act [Act No. 35 of 2002]):

- Children assessed within 48 hours;
- Children assessed after 48 hours but before 7 days;
- Children assessed after 7 days of arrest.

Forty-eight hours is the deadline set in the CJB for attending the preliminary inquiry, which must be preceded by an assessment of the arrested child. The Probation Services Amendment Act (in Section 4B) states that the assessment must be done before the first court appearance (which must take place within 48 hours of arrest) but, if not completed, the court may request that it is and postpone the first hearing for not more than seven days.

Existing figures based on an analysis done in Gauteng province indicate that less than one-third of arrested children were assessed (Muntingh, 2003).

Type 1 indicator: Child status

Preliminary inquiry outcome (CJB Chapter 8): diversion, prosecution, conversion to children's court inquiry.

Type 1 indicator: Child status

Illegal detentions of children (CRC 9.1).

Such detention will in all likelihood only be identified through a review and/or inspection process which finds that the warrant of detention is invalid, or the circumstances of the arrest were not legal.

Type 1 indicator: Child status

Children who are arrested but no further action is taken (arrested children who are not assessed do not appear in court or before a prosecutor) (CJB Chapter 4).

Arbitrary detention and detention without being charged are serious rights violations. There have been numerous anecdotal reports from various parts of the country that police arrest children and keep them in custody for anything from a few hours up to a couple of days, only to release them without being charged. The international instruments, as well as the domestic legislation, are clear on the prohibition of this practice. To develop an adequate process flow picture in a specific jurisdiction, and its adherence to the prescriptions of the CJB, will require sifting through records to identify the number of arrests, assessments, court appearances and appearances before a prosecutor. This data will additionally point to barriers and breakdowns in the process.

Type 1 indicator: Child status

Children accompanied by parent/guardian at first court appearance (CRC 40.2(b)).

The police have the responsibility to inform the parents/guardian of a child's arrest and to provide information on the child's court appearance (date, time, etc.). The absence of a parent/guardian can have grave consequences for the child, as it is often the case that magistrates remand such children to custody until the next court appearance.

Type 1 & 4 indicators: Child status and Service Access

Children at first court appearance with legal representation (CRC 40.2(b)).

Legal representation remains a luxury for most children in conflict with the law, especially at first court appearance. Legal representation at first appearance is, however, critical, especially if a parent or guardian is not present. It is for this reason that the CJB in Section 78(1) states that the child may not waive their right to legal representation under certain circumstances. Section 76 of the CJB further places responsibility with the legal representative of a child, and compliance with these specific obligations will provide further insight into compliance with the rights of children in conflict with the law.

Type 5 indicator: Service quality

Judicial decisions are informed by the assessments of arrested children (CJB Chapter 6 Section 35).

Provision is essentially made for three options:
- Referral to a prosecutor;
- Referral to a preliminary inquiry;
- Referral to a child justice court.

Type 5 indicator: Service quality

Record keeping of arrests and detention of children (UNSMR 7.1).

The UN Standard Minimum Rules for the Treatment of Prisoners (in Rule 7.1 and Rule 7.2) is firm that the authorities must keep clear records on detained persons.[21] Poor quality record keeping contributes to children 'getting lost' in the system, especially if they are transferred from one police station to another. As referred to above, the SAPS are obliged to keep records on all persons in their custody in the SAP 14 form.

Type 5 indicator: Service quality

Children's experience of their treatment by the police and private security agents.[22]

Children's experience of the police is a qualitative indicator; consequently, this information will not be recorded in administrative data capturing systems, or collected on a continuous basis. This data will in all likelihood require a specific research project to collect the relevant information including, for example, information on how the child was apprehended, how the police communicated with the child, whether the child understood why she or he was being arrested, whether the child was assaulted, and so forth.

Many children are arrested in public spaces that are policed by private security companies, and it is therefore logical that these agents of security will apprehend children who are suspected of having committed crimes. Over the years it has also become apparent that it is often not the police, but rather private security agents who are responsible for some of the worst assaults during arrest.[23] In the absence of a clear oversight mechanism (such as the police's ICD), private security firms are not as accountable as the police are in this regard. This is a serious gap in oversight architecture, and highlights the importance of monitoring children's experiences of police and private security agents.

Indicators for monitoring children awaiting trial in custody post first court appearance

As previously noted, detention poses a tremendous risk for the rights of children, particularly in the awaiting trial or unsentenced phase, and should therefore be avoided as far as possible. The undefined and transient status of awaiting trial in custody makes it difficult to allocate and sustain services to such detainees. Practical and logistical problems such as high turnover rates complicate matters, resulting in few or no services being rendered to children awaiting trial. Where such detention is used as a measure of last resort, this needs to be closely monitored to ensure that the child's rights are protected. Article 37 of the CRC (as cited in Hodgkin & Newell, 2002) states that any detained child should be protected from:

- Torture;
- Other cruel, inhuman or degrading treatment or punishment;
- Capital punishment;
- Life imprisonment without possibility of release;
- Unlawful or arbitrary deprivation of liberty.

The article sets out conditions for any arrest, detention or imprisonment of the child, requiring that it is:

- In conformity with the law;
- Used only as a measure of last resort; and
- For the shortest possible time.

Article 37 also requires that detained children:

- Are treated with humanity and respect for the inherent dignity of the human person;
- Are treated in a manner which takes into account the needs of a person of his/her age;
- Are separated from adults unless it is considered in the child's best interest not to do so;
- Maintain contact with his/her family, through correspondence and visits, save in exceptional circumstances;
- Have the right to prompt access to legal and other appropriate assistance;
- Have the right to challenge the legality of the deprivation of liberty before a court or other competent, independent and impartial authority;
- Have the right to a prompt decision on such action.

Indicators relevant to this stage of the criminal justice process include:

Type 1 indicator: Child status

Placement of children awaiting trail, and placements of sentenced children (CRC 37.1(b), 9.1, 20.1).

Children awaiting trial, and those awaiting deportation, may be detained in places of safety, prisons, secure care facilities, immigration centres or police cells, or released into the care of their parents or guardians. It is important to monitor orders for the placement of awaiting trial and sentenced children because children's well-being and rights are at risk while in custody.

The trends in the number of children awaiting trial in custody are highly indicative of the effectiveness and efficiency of the criminal justice system. Data from the Department of Correctional Services are readily available, while figures from institutions managed by or on behalf of the DoSD are not as accessible. The number of children detained at deportation centres is also not readily available and steps will need to be taken to establish a clear process for this.

Type 1 & 5 indicators: Child status and Service quality

Detention cycle time of children awaiting trial (CRC 37.1(b)).

The average detention cycle time is the average duration from when an accused person is admitted to custody for the first time until that matter is adjudicated (convicted and sentenced or acquitted), and the person is released or transferred to a section for sentenced offenders. This figure varies substantially between district courts and regional courts. More serious matters that are heard in regional courts take longer to adjudicate than those heard in district courts, which deal with lesser offences. In 2002 the average detention cycle time for district court cases (all age categories) was estimated to be approximately 100 days, while the average detention cycle time for regional courts was estimated to be approximately 300 days.[24]

Type 1 & 5 indicators: Child status and Service quality

Children detained awaiting trial in excess of 180 days (CJB 2(d)).

Whilst the Constitution guarantees the right to a speedy trial,[25] it provides no definition of what a speedy trial is, so it is impossible to ascertain how long a person can legitimately be detained awaiting trial.[26] In the case of children, it is particularly important to deal with matters expeditiously. Six months is regarded as a more than sufficiently long period to deal with a criminal matter involving a child, and children remaining in custody longer than six months need to be identified and action needs to be taken.

This indicator serves as a proxy indicator for a range of other services and requirements pertaining to children. Section 342A of the CPA (as amended by the Judicial Matters Second Amendment Act [No. 55 of 2004]) requires the Director of Public Prosecutions to submit a detailed report, twice a year, to the Minister of Justice on the awaiting trial population. The minister must in turn submit this report to Parliament.

Type 5 indicator: Service quality

- Children under the age of 14 years awaiting trial in prison and police cells.
- The use of non-custodial measures for children awaiting trial, and the

effectiveness of non-custodial measures in securing children's attendance at trial, can be monitored by assessing the proportion of children:

- Released into care of parents (CRC 37.1(b));
- Released on bail (CRC 37.1(b)) and bail amounts for children (CRC 40.2(b));
- Placed under house arrest (CRC 37.1(b));
- Placed under Section 62(f) of the CSA (CRC 37.1(b)).

There are a range of options not involving pre-trial detention available to the police and to the courts, and these need to be monitored on a continuous (monthly) basis, as they provide information on the number of children awaiting trial in custody in each particular jurisdiction, and point to levels of overcrowding.

Type 5 indicator: Service quality

Detention facilities for children have educational, health and social services (CSA 19.1(a), 19.2; CRC 20.3).

The CSA stipulates in Section 38(2) that only sentenced prisoners with a sentence of longer than 12 months are entitled to a sentence plan. The sections dealing with unsentenced prisoners (46–49) do not make provision for programmes and other services to unsentenced prisoners. Thus, most awaiting trial prisons in South Africa render no services to children relating to education and development. However, detained children have a right to services which respond to their social, religious, recreational and psychological needs. In the absence of these services, as is often the case, children are deprived of their rights to development and protection.

Children's participation in educational programmes, especially in schooling when they are still of school-going age (under 16 years of age), is critical for their development. During the often lengthy periods children spend awaiting trial in custody, they should be able to continue with their schooling.

Indicators for monitoring diversion and diversion programmes

Diversion should be used as far as possible in order to limit children's exposure to the risks of the criminal justice system. Article 40(3) of the CRC requires the establishment of such measures for dealing with children without resorting to judicial proceedings. Diversion is further encouraged in Rule 11 of the Beijing Rules. Diversion programmes should, however, be of an acceptable standard to ensure that the child receives quality services and that their rights are protected. Such standards are contemplated in Section 49 of the CJB. To this end, standards are being developed to ensure compliance in terms of service provider requirements, as well as programme outcomes. Diversion programmes should encourage the child to take responsibility, build dignity and self-worth, and foster a sense of community and belonging.

Type 1 indicator: Child status

Children diverted from the justice system (for each type).

The diversion of cases at the earliest opportunity is an important indicator of the willingness, skills and ability of the police and prosecution service to utilise the intended legislation to limit the child's exposure to the criminal justice system.

Type 4 indicator: Service access

Equity in the diversion system.

Diversion services are accessible to all arrested children without discrimination, as indicated by data disaggregated by age, race, gender, and offence.

The profile of diverted cases in terms of the variables listed above should show whether or not discrimination or unfair application of existing policies and guidelines is occurring.

Type 4 indicator: Service access

Geographical accessibility and type of accredited diversion service providers (CRC 40.1; CJB Section 49).

Children's access to diversion services will be highly dependent on service availability in all jurisdictions. The availability of such services and the type of services available in a specific area will impact on arrested children's experience of the criminal justice system. Diversion services have to date developed mainly in and around urban centres, and accessibility is a major challenge in rural areas.

The nature of diversion programmes available to children is also significant as they impact on the quality of services that the child and their family receive. Whilst some types of programmes can be made available and accessible fairly easily, others are hamstrung by limited resources and high caseloads.

Type 1 indicator: Child status

Compliance of children with diversion conditions.

The compliance of children with the conditions of diversion is the first measure of programme effectiveness. Although this point can be debated, a high level (80%+) of compliance does indicate that the programme participants show a sufficient level of commitment to completing the programme. A low level (less than 50%) of compliance suggests that the programme may have significant problems, which are contributing to more than half of diverted cases returning to court for prosecution. Problems may include logistical issues (such as transport to programme sessions), or the selection of programme participants to specific programmes, or the quality of facilitation.

Type 5 indicator: Service quality

Compliance with diversion minimum standards in terms of service providers, requirements and programme outcomes (CRC 6.2; CJB Section 49).

Compliance with the overall requirements of the diversion minimum standards will need to be verified on a regular basis with service providers. The DoSD is charged with this responsibility in terms of its licensing and accreditation obligations.

Type 5 indicator: Service quality

Recommendations for diversion in assessments are accepted by the prosecution service.

The purpose of this indicator is to assess the application of guidelines issued by the National Prosecuting Authority, as well as the recommendations made by probation

officers conducting the assessments. Whilst there are no norms to be followed (for example, 50 per cent of cases should be diverted), data on diversion recommended compared to diversion accepted provide information on how the prosecution interpret the purpose of diversion and the application of guidelines. This data can further be related to offence profiles comparing different jurisdictions.

Indicators for monitoring the trial

When it is indeed necessary to prosecute a child, the trial must be conducted in a manner which is fair, promotes the participation of the child, and is in accordance with due process principles as outlined in the CRC and the Constitution. The aim is to balance the interests of the child with the interests of justice. To this end, the CJB (Section 57(5)(a–b)) places a duty on the presiding officer to elicit additional information as may be required, to protect the child from such cross-examination which is inappropriate to the age and understanding of the child, and to ensure the prejudicial fairness of the hearing, including preventing undue hostility.

Type 1 indicator: Child status

Child-friendly courts are in place, as indicated by the proportion of children receiving legal representation (CRC 37.1(d); CJB 76, 77, 78); receiving requested interpretation services (CRC 40.2(b)); and whose hearings are held in camera (CRC 40.2(b); CJB 57(6)).

Very few children appear with legal representation, especially in district courts. Despite many reported flaws and problems related to legal representation, it fulfils an important function in overseeing the rights and interests of the child, especially when a sentence is being contemplated.

One of the primary measures of the accessibility of the trial is the availability and utilisation of interpretation services. In addition, trial accessibility measures should include assessments of children's participation in the proceedings at various stages.

Type 1 indicator: Child status

Adjudication results of court cases (CJB chapters 5, 9): acquitted; convicted; Children's Court Inquiry conversions; diverted.

Type 5 indicator: Service quality

Decisions overturned due to non-compliance with the constitutional provisions as outlined in Section 35(3)(a)–(o), 4 and 5.

Type 1 indicator: Child status

Children prosecuted in the rebuttable age margins (7–10/10–14) (CRC 40.3(a); CJB Chapter 2).

Indicators for monitoring sentencing and sentenced children

When children are convicted by a criminal court, the sanction imposed should be proportionate to the offence, taking into account the age, abilities and maturity of

the child. The sanction itself should place the emphasis on the reintegration of the child; consequently, the number of children sentenced to imprisonment is of critical importance, as is the length of custodial sentences (Article 37 of CRC).

When custodial sentences are imposed, these should be for the shortest possible period. Article 37 further bars the death penalty, life imprisonment without the option of parole, and any cruel, inhuman or degrading treatment and/or punishment.

In Article 4.4, the CRC urges State Parties to have available in the legislation a range of dispositions such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes; and other alternatives to institutional care to ensure that children are dealt with in a manner which is appropriate to their well-being and proportionate both to their circumstances and the offence.

The Beijing Rules provide further guidance with regard to the adjudication of cases in Rule 17:

- The disposition of the competent authority shall be guided by the following principles (17.1):
  (a) The reaction taken shall always be in proportion not only to the circumstances and the gravity of the offence but also to the circumstances and the needs of the juvenile as well as to the needs of the society;
  (b) Restrictions on the personal liberty of the juvenile shall be imposed only after careful consideration and shall be limited to the possible minimum;
  (c) Deprivation of personal liberty shall not be imposed unless the juvenile is adjudicated of a serious act involving violence against another person or of persistence in committing other serious offences and unless there is no other appropriate response;
  (d) The well-being of the juvenile shall be the guiding factor in the consideration of her or his case.
- Capital punishment shall not be imposed for any crime committed by juveniles (17.2).
- Juveniles shall not be subject to corporal punishment (17.3).
- The competent authority shall have the power to discontinue the proceedings at any time.

Type 1 indicator: Child status

Sentencing practices in the child justice system (CRC 37.1(b)) as assessed by determining the proportion of:

- Children sentenced to life imprisonment (CRC 37.1(a));
- Children receiving prison sentences of longer than 18 years (CRC 37.1(a));
- Children sentenced to non-custodial options and profile (CRC 40.4, 9.1).

The significance of age in sentencing practices stems from the *S v. Nkosi* (2002)[27] case – on appeal, Judge Cachalia overturned a life sentence to 18 years imprisonment, stating that 'despite the peculiar wording of Section 51(3)(b), the legislature intended children aged between 16 and 18 years of age to be treated more leniently than those offenders who have turned 18 and are consequently deemed to be more

mature'. This leniency was also remarked upon previously in *S v. Blaauw* (2001)[28] by Judge Van Heerden. In *S v. Nkosi* (2002) there is also an alleged implicit understanding that a child should not be sentenced to imprisonment for longer than they have been alive.

Type 5 indicator: Service quality

Detention of children in prisons is in compliance with the provisions of the CSA and other relevant legislation (CRC 37.1(c)).

Provisions would include whether prisons comply with dietary requirements as set out in the CSA and other regulations (CSA 8.2); complaints laid by children against state care (see IPVs) (SAC 28.1(d)); and notifications sent to parents and relevant authorities informing them of the detention of the child (CSA 13.6(c)(i)).

The CSA and its accompanying regulations have set down guidelines with regard to the detention of children, and the services which should be available to them. Compliance with these guidelines reflects legal compliance.

Type 1 indicator: Child status

Educational qualification attainment of children in custody (CRC 28.1 [The right to education]).

Continued education and support whilst serving a sentence forms the basis for meeting the requirements of Article 40 of the Convention (rights accorded to children in trouble with the law). If children serving custodial sentences do not have access to these services because they are not available due to capacity constraints, they are deprived of a right to which they would have been entitled as free citizens.

Type 1 indicator: Child status

Number of children held in solitary confinement (CSA Section 25).

A reading of the legislation (the CSA) does not reveal a restriction on this form of punishment for children. The same legislation in Section 52(2) does, however, require that the penalty of solitary confinement may only be imposed once confirmed by the OIJ.

Type 5 indicator: Service quality

Parents and guardians are informed of detention and transfers of children by the Commissioner of Correctional Services (CSA 13.6(c)(i)).

Type 5 indicator: Service quality

References in the UNCAT country report to alleged and confirmed cases of torture and ill-treatment where the victims were children serving custodial sentences (CRC 37.1(a)).

The UNCAT country report will provide a valuable resource in addressing allegations of torture and ill-treatment. It also provides an official record of problems identified and steps taken to remedy problems.

Type 1 & 5 indicators: Child status and Service quality

- Custodial sentences overturned upon review (CJB Chapter 12).
- First time offenders receiving custodial sentences (proportionality) (CJB 3(f)).
- Children serving full sentences.
- Children released early on parole/correctional supervision.
- Facilities where people are detained are subject to inspections at least once per annum (CB 297).

Type 5 indicator: Service quality

Detention of children in prisons is in compliance with the provisions of the CSA and relevant legislation (CRC 37.1(c); CSA 8.2, 19).

Sections 8.2 and 19 of the CSA make special mention of children and it is particularly Section 19 that refers to education and other support services that are of critical importance in the reintegration process. The Constitution places a further obligation with regard to the detention of children in that it must not be done except as a last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child:

- Should be detained only for the shortest period of time;
- Has the right to be kept separately from detained persons over the age of 18 years; and
- Should be treated in a manner, and kept in conditions, that take account of the child's age.

Type 5 indicator: Service quality

Staff–child ratios in custodial facilities (CRC 39).

Staff–child ratios are an indicator of service quality. The ability to supervise children adequately during detention is highly dependent on the availability of qualified staff. Injuries and deaths can often be traced back to children being left unsupervised for extended periods. In the majority of cases of child deaths in custody there is a strong indication that the police or other supervisory staff were not providing adequate care and supervision, which created opportunities for assaults, suicides and escapes, leading to fatal consequences (Muntingh, 2003).

This is an especially important issue in South African prisons, which function on a shift system involving children being locked up at 3pm and released at 7am the following day. If there are staff shortages during the lock-up period, this can pose serious risks to the welfare of these children.

Indicators which provide information on staff–child ratios should also pay particular attention to the availability of additional support staff such as social workers, psychologists, and educational staff.

Indicators for monitoring reintegration

The overall purpose of a child justice system is to facilitate the (re)integration of children who have come into conflict with the law, so that they may assume their position in society as productive citizens. The UN Rules for the Protection of Junveniles Deprived of their Liberty (Rule 79) states that:

> All juveniles should benefit from arrangements designed to assist them in returning to society, family life, education or employment after release. Procedures, including early release, and special courses should be devised to this end.

Rule 80 states:

> Competent authorities should provide or ensure services to assist juveniles in reestablishing themselves in society and to lessen prejudice against such juveniles. These services should ensure, to the extent possible, that the juvenile is provided with suitable residence, employment, clothing and sufficient means to maintain himself or herself upon release in order to facilitate successful reintegration. The representatives of agencies providing such services should be consulted and should have access to juveniles while detained, with a view to assisting them in their return to the community.

In its recommendation to the former Yugoslav Republic of Macedonia, the Committee on the Rights of the Child was quite specific as to what is required in terms of reintegration services:

> 'Recognizing the existence of psychological assistance facilities under the auspices of the Centres for Social Work, the Committee, nevertheless, remains concerned at the absence of measures to provide for the physical and psychological recovery and reintegration of children who have been the victims of crime, and of children who have participated in judicial proceedings or who have been confined in institutions.' In the light of Article 39 of the CRC, the Committee recommends that State Parties 'urgently establish appropriate programmes to provide for the physical and psychological recovery and reintegration of such children and that these mechanisms be used in the administration of juvenile justice'. (as cited in Hodgkin & Newell, 2002, p. 167)

To create a comprehensive picture of the factors promoting reintegration would require a research design that is sensitive to the broad range of circumstances and characteristics of ex-offenders which determine individual outcomes. Such research would also need to take context and local conditions into account, including risk factors for recidivism or reoffending, and assess how they compare to international findings (Social Exclusion Unit, 2002).

The overlapping risk factors and problem areas in a child's life are important focal areas for future research studies, but for the present purposes only those indicators which are *most feasible* (in terms of measurement and data sources) are recommended.

Type 5 indicator: Service quality

The effectiveness of all services in reintegrating children in conflict with the law.

The primary purpose of all services aimed at children in conflict with the law is to reduce reoffending. The number of children who do not reoffend within a reasonable period (18 months) after exiting a custodial facility or diversion programme is therefore a key indicator of the success or effectiveness of rehabilitation services to children in conflict with the law.

Type 5 indicator: Service quality

Re-imprisonment of children and young people.

The re-imprisonment of offenders aged between 18 and 20 years who have already served a term of imprisonment for an offence committed as a child provides a fairly robust indicator of the level of reintegration and rehabilitation attained as a result of a custodial sentence served. Whilst arrest and conviction rates may give some indication of reintegration, data of such a nature are very difficult to collect and are not always reliable.

Type 1 indicator: Child status

Compliance of children with non-custodial sentencing options.

Type 5 indicator: Service quality

Child criminal record expungements executed by the South African Criminal Bureau and the director-general of the DoSD in terms of Section 82(5) and Section 82(6) respectively per year (CJB Chapter 13).

The expungements of records are subject to the offender not being convicted of a further offence and will give some indication of re-conviction rates.

Conclusion

This chapter has attempted to develop an indicator framework for children in conflict with the law which is based on CRC articles and domestic legislation. From the above discussion, it is clear that the indicator development process, and subsequent monitoring, will be greatly facilitated by the existence of one comprehensive legislative and policy framework. This is not yet the case in South Africa, although the CJB will attempt to deal with the administration of child justice, thus setting out the procedures for dealing with children in the criminal justice system.

In the development of indicators based on international law it is important to ensure that indicators are compatible across different jurisdictions. To address this issue, UNICEF convened a meeting in November 2003 in New York with the goal of developing a very limited set of indicators that would monitor juvenile justice (Skelton, 2004). The set includes nine categories (see Appendix 8 in this volume for the full list):

- Children in detention;
- Duration of detention;
- Children coming into contact with the juvenile justice system;
- Existence of a juvenile justice system;
- Separation from adults;
- Conditions for control of quality of services for children in detention;
- Protection from torture, violence, abuse and exploitation;
- Prevention;
- Aftercare.

All UNICEF's categories are covered in this chapter, barring prevention, which was beyond the scope of the chapter since the purpose was to monitor the well-being of children who have already come into conflict with the law.

It is worth noting in conclusion that the indicators developed for the purposes of this chapter, particularly the core indicators, were included not only because of their desirability, but also with consideration to the feasibility of implementing them. Consequently, the presented indicators are those which are not only necessary, but also (to a greater or lesser extent) practical because of the availability, accessibility, robustness, and accuracy of data on children in conflict with the law.

The indicators described above are reflected in the tables in Part 2 of this volume. In a number of instances, the indicators discussed above are blended in the tables in order to promote clarity and consistency. For example, indicators for quality of detention for awaiting trial and sentenced children appear together in the indicator tables. However, as will be noted, the sections in the tables follow the indicator section heading in the chapter text.

Notes

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 An assumption is being made with regard to the Child Justice Bill – it is assumed that only minor changes will be made to its current content, and that major structural features of the Bill will remain intact, such as diversion and the preliminary inquiry.

2 The term used in the UN literature is 'juvenile justice' whereas this term has been replaced in South Africa with the term 'child justice'. The latter will be used in this chapter except when quoting UN documents.

3 The OPCAT has been open for signature since 2003 but, despite expectations, South Africa has not signed it.

4 Minor changes have been made to the legislation such as an amendment to the 1959 CSA in 1994 (Correctional Services Amendment Act [Act No. 17 of 1994]) to change the provisions for the detention of unsentenced children in prison.

5 The development of the Child Justice Bill was initiated in the 1990s but is yet to be enacted. Consequently, there has been little law reform since 1990 as it pertains to children in conflict with the law.

6 The distinction between core and additional indicators is made in the tables in Part 2 of this volume and not in the body of the text.

7 The relevant section, article or rule of the international instrument or domestic legislation is indicated in brackets throughout the text.

8 General Guidelines regarding the form and contents of periodic reports to be submitted by State Parties under Article 44, paragraph 1(b) of the Convention. CRC/C/58. Adopted by the Committee at its 343rd meeting (thirteenth session) on 11 October 1996 in UNICEF (1999).

9 In *S v. Williams* in 1995, the Constitutional Court ruled on 9 June 1995 that a sentence of whipping as provided for juvenile sentencing in terms of Section 294 of the Criminal Procedures Act (No. 51 of 1997) was unconstitutional and hence unlawful.

10 'Court' may mean any competent authority.

11 The Noupoort Christian Care Centre provides a drug addiction treatment service that concentrates on physical exercise, religion and physical isolation. Other questionable practices have also been reported from the Noupoort Christian Care Centre. In recent years two 'patients' died whilst locked up in a cell.

12 Article 1 of the OPCAT (2002) states: 'The objective of the present Protocol is to establish a system of regular visits undertaken by independent international and national bodies to places where people

are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.'

13 Based on developing case law, the age of criminal capacity is continuously tested and two recent cases reported in Child Law Matters Vol. 1, July 2004, bear testimony to this.

14 Custody refers to all forms of internment in relation to the criminal justice system such as police cells, prisons, places of safety, reformatories, children's homes and immigrant detention centres.

15 CSA (No. 111 of 1998) Section 15.2.

16 It should be noted that torture is not classified as a crime in South Africa, and is defined as assault or attempted murder, should a criminal charge arise from such an allegation. The Department of Justice is in the process of drafting a Criminalisation of Torture Bill, as is required in terms of Article 4 of the UN Convention against Torture, which South Africa ratified on 18 December 1998. South Africa has as yet not met its reporting obligations in terms of said convention.

17 The Judicial Inspectorate receives complaints from prisoners according to the following categories as outlined in the 2003/04 Annual Report (Fagan, 2004): Appeal, Assaults, Bail, Communication with families, Conditions, Confiscation of possessions, Conversion of sentences, Corruption, Food, Healthcare, Hunger strike, Inhumane treatment, Legal representation, Mechanical restraints, Medical release, Parole, Rehabilitation programmes, Remission, Transfers, and Other.

18 Abuse of power that has a significant community impact in terms of injuries caused; numbers of persons affected; amount of money involved; or period of time during which it occurs; Arson; Assault with intent to cause grievous bodily harm or attempted murder; Abduction; Defeating the ends of justice; Forgery or issuing a forged document knowing it to have been forged to a value of R50 000 or greater; Fraud; Indecent assault; Perjury; Public violence; Intimidation; Kidnapping; Malicious damage to property; Participation in a criminal syndicate; Possession of stolen property; Rape; Receiving of stolen property; Robbery; Corruption; Sodomy; Theft; Torture; Extortion; Incitement, conspiracy or attempt to commit any of the offences listed above.

19 South African Constitution (No. 108 of 1996), Section 9(3) of the Bill of Rights: 'The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.'

20 NICRO was contracted by the DoSD to develop the minimum standards for diversion. The report is available from the DoSD. See also Dawes and Van der Merwe (2004).

21 Rule 7(1): In every place where persons are imprisoned there shall be kept a bound registration book with numbered pages in which shall be entered in respect of each prisoner received:
(a) Information concerning his identity;
(b) The reasons for his commitment and the authority therefore;
(c) The day and hour of his admission and release.

(2) No person shall be received in an institution without a valid commitment order of which the details shall have been previously entered in the register.

22 Research conducted by the author in Windhoek, Namibia (for the Legal Assistance Centre [LAC]), incorporated a short questionnaire on the child's experience of the police into the assessment interview. This enabled the LAC as well as the Namibian police to identify problems quickly and monitor trends (contact author for details).

23 Research conducted by author for LAC in Windhoek, Namibia, and personal observations.

24 Presentation by the Department of Correctional Services to the National Council on Correctional Services, 2002.

25 See Section 35(3)(d) of Act 108 of 1996.

26 Of the total awaiting trial population of 48 306 on 31 July 2004, 22 019 or 45.5 per cent had been awaiting trial for more than three months, and 1 390 for more than 24 months (contact author for details).

27 2002(1) SACR 135 (W).

28 2001(2) SACR 255 (CPD).

CHAPTER 17

A monitoring dilemma: orphans and children made vulnerable by HIV/AIDS

Andrew Dawes, Amelia van der Merwe and René Brandt

Introduction

This chapter addresses the situation of children who have been orphaned by AIDS and those who are commonly referred to as having been made vulnerable by the epidemic. As will be evident, indicators for children affected by HIV and AIDS have been mainstreamed throughout the volume. Toward the end of the process of developing the indicators for this project, we took the decision to include a contribution on children orphaned and made vulnerable by HIV and AIDS. This is because considerable attention is being paid both internationally and locally to the development of indicators for so-called orphans and vulnerable children (OVCs). It is *not* our intention to entrench practices which wittingly or otherwise consolidate the category of 'children orphaned by AIDS', thereby contributing to the special treatment of these children at a cost to others who may be as vulnerable and in need of support.

We are concerned about the OVC category in spite of its currency (see also Bray, 2003b). Our contribution seeks to both interrogate the construct and contribute to the debate regarding monitoring systems and indicators for children who are commonly labelled as OVC. We focus on the psychosocial risks and consequences associated with the epidemic, which go beyond narrow health considerations (UNICEF, 2004b, 2005e, 2005b). Chapter 5 in this volume provides indicators for HIV/AIDS that are health- and treatment-related, and will not be repeated here.

The chapter includes a discussion of some of the conceptual challenges and debates relevant to this question and recommends that they remain the subject of ongoing engagement in the development and application of indicators.

Background

Sub-Saharan Africa accounts for only 10 per cent of the world's population. However, 64 per cent of those living with AIDS reside in the sub-continent – 5.5 million of them are South Africans (18.8 per cent of the country's adults). An estimated half of all adults who acquire HIV become infected before they are 25, which emphasises the particularly high rates of infection among children and young people (Eaton et al., 2003).

In examining the psychosocial risks and consequences associated with HIV and AIDS our attention was drawn to a major conceptual challenge that has significant implications for interventions and for monitoring systems. That is, the manner in which we define those children affected by AIDS both for targeting for humanitarian assistance and for monitoring purposes. The definitions of an 'orphan', 'a child made vulnerable by HIV/AIDS', and a 'vulnerable child' need to be clear and precise. While the definition of an orphan in the context of AIDS is unusual (see below), the latter two constructs are particularly problematic.

In the first instance, the problem has its roots in the development of responses to children affected by AIDS.

Initially, and as the death rate due to AIDS rose in Africa, concerns were raised regarding the corresponding rise in orphaned children and the need to address their situation. These children, labelled as 'AIDS orphans', were regarded as highly vulnerable, and were identified for targeted interventions. Of course orphaning will remain an appropriate concern, increasingly so in South Africa as the impact of caregiver death increases its toll on the children who remain behind.

Foster (2006) observes that orphans remain the focus of humanitarian assistance to children affected by HIV/AIDS. However, many children are rendered vulnerable by the epidemic, but are not orphans. Examples include those living with ill carers, and those excluded from school due to stigma, and also as a result of inability to afford fees (as a consequence of loss of income due to illness in the household).

The term 'orphans and vulnerable children' entered the lexicon of the humanitarian aid community and government response as it became evident that the 'orphan' focus was too narrow. This linguistic compromise recognised the need for a broader view, beyond orphaning, of the effects of the epidemic on households and children. While this is a necessary development, the concept is not clear enough to guide the development of a concise and accurate definition of a distinct population of children that can guide efforts to intervene and monitor the situation of the population in question. It is therefore necessary to define the population and identify the manner in which it is distinct.

In the term 'OVC', what is particularly unclear is the meaning of 'vulnerable'. Does this term only encapsulate those 'made vulnerable by HIV and AIDS', and furthermore, what does this mean? Or does it encapsulate children who are vulnerable due to a range of other risks that are not a function of HIV and AIDS?

The second central reason for problems with definitions in this field is related to the hidden nature of HIV and AIDS. As UNICEF (2005b) has noted, we commonly do not know the HIV status of the adults or children (or the causes of death) in most settings in which we want to monitor or intervene. UNICEF's (2005b) response to this problem has been to recommend the use of proxy measures in high-prevalence communities to estimate the number of children who are affected by high adult mortality and morbidity.

The definition below therefore identifies children who have had a parent or an adult household member die or become chronically ill (cause of death is not specified). In contexts with high HIV prevalence, this kind of definition is likely to be a relatively reliable proxy for children affected by HIV and AIDS. According to UNICEF (2005b,

p. 17), the definition of a child made vulnerable by HIV and AIDS is an individual below the age of 18 who:

i) has lost one or both parents, or
ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or
iii) lives in a household where in the past 12 months at least one adult died and was sick for three of the twelve months before he/she died, or
iv) lives in a household where at least one adult was seriously ill for at least three months in the past twelve months, or
v) lives outside of family care (i.e. lives in an institution or on the streets).

As will be evident, a feature of the AIDS epidemic is the unusual use of the term 'orphan' (see also Monasch & Boerma, 2004). One is prompted to ask why it is that the AIDS epidemic has given rise to a definition in which a child who has lost only one parent is deemed to be an orphan. This is not mere semantics but has consequences for how we count children.

While UNICEF's attempt to address the definition challenge in the case of high-prevalence communities has merit, the potential for inclusion of children made vulnerable by other illnesses and causes of mortality remains. In South Africa, this may serve well for purposive monitoring of high-prevalence communities, but perhaps not for national level monitoring. This is because there is considerable variation in HIV prevalence across communities, and there are many other causes of morbidity and mortality that are not AIDS-related (see chapters 5 and 7). At a national or provincial level, therefore, the UNICEF proxy approach to identifying 'children made vulnerable by HIV and AIDS' may not be appropriate. It risks including too many children who are vulnerable for other reasons, and will distort targeting efforts.

UNICEF (2005b, p. 17) recognises that 'establishing a measurable definition of "vulnerable" is a bigger challenge' than defining orphanhood. We therefore remain challenged by the meaning and operationalisation of the term 'vulnerable' – a construct which could potentially describe a range of populations that require protection (for example very poor children, children on the streets, trafficked children, abused and neglected children, etc.). There are many features of vulnerability (or risk factors) that are common both to children affected by HIV and AIDS and to other groups of vulnerable children, but there are also some features that are particular to children affected by HIV and AIDS. We explore this issue below.

Vulnerable children: particularities and commonalities

There is emerging consensus that there has been undue focus on children orphaned by AIDS in particular, and that the allocation of services on the basis of this vulnerability is likely to be both inappropriate and inadequate in addressing the needs of children most at risk. Since the situation of children affected by HIV and AIDS is often similar to that of children made vulnerable by poverty, attempts to single out the former group – particularly orphans – from the rest of the population of very vulnerable children are problematic (Loening-Voysey & Wilson, 2001; Save the Children UK, 2003; Richter, Manegold et al., 2004). A review by Save the

Children UK (2003) recognises the complexity of responses to children affected by HIV and AIDS, and recommends that the management of orphanhood should occur within the context of poverty.

It is well recognised that in the South African context, the majority of children are rendered vulnerable by poverty and all its associated challenges to child development and outcomes. Many children, particularly those in poor communities, are also affected by domestic and community violence (see the other chapters in this section). Thus, poverty and violence are two key features of vulnerability which are common to most groups of children requiring protection.

What is clear is that the combined impact of high levels of poverty and living in a community with high HIV prevalence, presents the greatest threats and challenges to children's well-being. This is because children's outcomes are most likely to be detrimentally affected where there are multiple risks to development and functioning, which cumulatively and over time undermine children's well-being; young children are at particular risk (Werner & Smith, 1992; Foster, 2006). Consequently, it is in these multiple-risk communities that the most vulnerable children are likely to reside.

Studies that have attempted to examine the specific contribution of HIV and AIDS have found that they typically serve as an additional stressor in households, families and communities already at risk due to poverty, single parenthood and high levels of exposure to violence (Forsyth et al., 1996; Wild, 2001; Forehand et al., 2002; Brandt, 2005b). These household and environmental features constitute risks to the emotional and psychosocial well-being of caregivers and their children. Consequently, in some domains of functioning, children may exhibit a level of disruption in functioning beyond which the impact of (parental) HIV infection does not result in a marked effect. Further, research has shown that the stage of illness in an infected caregiver, rather than their HIV status per se, places children at risk (Foster, 2006). This is an important point given the fluctuating course of the illness and the fact that wider availability of antiretroviral regimens has the potential to reduce (if not eliminate) the periods of symptomatic illness which have been found to make children most vulnerable.

HIV and AIDS has its most immediate impact on children's home environments. Where the caregiver is ill, she is commonly no longer able to contribute regularly, if at all, towards the economic security of the household, and her capacity to provide emotionally responsive care for her children is challenged (Brandt, 2005a). This increases the vulnerability of all the children, but particularly the very young, especially in contexts within which social support is lacking (Richter, 2003; Brandt, 2005a; Sherr, 2005a, 2005b; Swartz et al., 2005). Older children may be withdrawn from school (or struggle with finding time for school work) as a consequence of having to undertake domestic and subsistence agriculture roles, including seeing to the well-being of sick caregivers (Hunter & Williamson, 2002; Wilson et al., 2002; Bray 2003a, 2003b). Some will be required to seek work to replace the income lost as a consequence of the carer's illness. If the carer dies, this may lead to the children having to move into the care of relatives; heading households if there are no kin to take care of them or their siblings; or losing their homes (if it is appropriated by relatives). Outcomes of children affected by these challenges include reduced child

survival and health status, compromised safety (through the loss of support and supervision), as well as the risk of maltreatment and neglect. Furthermore, children orphaned or made vulnerable by HIV are at increased risk for emotional and psychological problems, and disrupted attachment relationships which results in difficulties with social interaction (Wilson et al., 2002; Brandt, 2005a). These children are also at risk for reduced guidance, discipline and positive support from adults and peers, which lessens the chances of children developing positive identities and the skills required for participation in the world of work.

HIV/AIDS differs from other chronic illnesses in that there are long periods during which caregivers are asymptomatic, but once manifest, it is associated with particularly painful and debilitating symptoms. However, at this stage in our knowledge, the extent to which the effects on children are different from other chronic illnesses, such as cancer or diabetes, is not clear.

The stigma associated with HIV and AIDS could potentially be a determining factor, differentiating the effects on children who are orphaned or made vulnerable by HIV and AIDS from those affected by other chronic illnesses. Stigma increases the likelihood of social exclusion and isolation (Giese, Meissels et al., 2003).

Responses to orphanhood

Due to the growing number of children orphaned as a result of parental/caregiver AIDS, residential care has increased in Africa (Williamson, 2005). Results from a study conducted in six African countries show that of the institutions for children orphaned by AIDS included in the study, 35 per cent have been established since 1999 (UNICEF, 2003a). This is despite a vast literature documenting the detrimental effects of institutional care on child development and outcomes (e.g. Sloutsky, 1997; Giese & Dawes, 1999; Zeanah et al., 2003; Williamson, 2005; Browne et al., 2006; Johnson et al., 2006). Among the most significant risks to child well-being associated with residential care is that it reduces children's opportunities to form a stable attachment to a specific adult (Williamson, 2004). The separation or loss of a primary caregiver has repeatedly been linked to emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment (Bowlby, 1984, 1985a, 1985b). In addition, the longer the child remains in residential care, the greater the likelihood that they will suffer significant, long-term difficulties in developing and maintaining relationships with others (Sigal et al., 2003). It is clear that if we seek to improve the outcomes and well-being of children orphaned as a result of parental/caregiver AIDS, institutional care is not the answer and should only be considered as a last resort. Community-based alternatives are not only less likely to involve the violation of children's fundamental rights to survival, protection, development and participation, but also constitute a more effective and cost-efficient response to increasing numbers of children orphaned as a result of parental/caregiver AIDS (Williamson, 2005).

Residential care is costly – the cost per child in residential care is significantly higher than the cost of a child in family care (Williamson, 2005). In fact, the annual cost for one child in institutional care in Tanzania was shown to be ten times that of supporting a child in foster care (Ainsworth & Over, 1997). Consequently,

Williamson cautions against a proliferation of institutions, noting that this response strategy is an inappropriate and expensive approach.

Community-based interventions are more cost-efficient, more likely to meet children's developmental needs, and are less likely to violate their rights.

The policy and legislative environment

Notwithstanding the fact that children affected by AIDS have the same rights to survival, protection and development as enjoyed by other children, they often struggle to realise these rights and acquire access to services they desperately need (Jacobs et al., 2005). Several chapters in this volume cover the range of rights that are applicable to vulnerable children (see chapters 3, 5, 8, 9 and 15 in particular) – these will not be repeated here.

South Africa has a number of policies to address the situation of vulnerable children. The most relevant are the Integrated Management of Childhood Diseases; the National Integrated Plan for Children Infected and Affected by HIV/AIDS; the National Strategic Framework for HIV and AIDS and Sexually Transmitted Infections (STIs) for the period 2000–2005; the Guidelines for the Management of HIV Infected Children 2005; and the Policy Framework for Orphans and Other Children Made Vulnerable by HIV and AIDS 2005 (which outlines the framework for the protection and provision of comprehensive and integrated developmental services for orphans and vulnerable children in six key strategic areas). The Department of Social Development's National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa 2006–2008 (hereafter the DoSD National Plan) is most relevant to the current discussion.

The Education White Paper and the recently developed Integrated Plan for Early Childhood Development (ECD) in South Africa 2005–2010 (Tshwaragano Le Bana), among others, also address the situation of children affected by HIV/AIDS.

School fee waiver procedures have recently been amended to broaden and facilitate access to free schooling in terms of sections 39(4) and 61 of the South African Schools Act (No. 84 of 1996).[1]

In addition, and most significant, in terms of the Education Laws Amendment Act (No. 24 of 2005), the national Minister of Education is authorised to identify categories of schools that may not charge any school fees. The categories are stratified in terms of the quintiles used to classify schools, with the poorest schools in the first and the best off schools in the fifth quintile. As soon as this system is in place, it will be possible to measure the proportions of children in non-fee-paying schools, as well as those at fee-paying schools who have been exempted from fees (provincial comparisons can be problematic as the quintiles are empirically derived and differ across provinces).

The Integrated Plan for ECD specifically flags the provision of services to children (0–6 years) in families and communities affected by HIV/AIDS.

The DoSD National Plan arises from a set of strategic priorities, and it is evident that systemic supports as discussed above are integral to its formulation. The most relevant strategic priorities are:

1. Strengthening and supporting the capacity of families to protect and care for OVC; focusing on expanding treatment for infected children and their families; ensuring sustainable food security systems for OVC and their families; ensuring succession planning for each OVC; development of skills training programmes for child-headed households and ensuring that mechanisms are in place to provide psychosocial support to OVC and their families.
2. Mobilising and strengthening community-based responses for the care, support and protection of OVC; placing focus on mobilising and organising for early identification of OVC; developing the capacity of communities to respond to OVC; increasing participation of local authorities in the care and support of OVC; developing co-ordination mechanisms for programmes at community level; identifying and supporting good practice models for the nurture and care of OVC and establishing and maintaining a database of services at a local level.
3. Ensuring that legislation, policy, strategies and programmes are in place to protect the most vulnerable children; placing focus on monitoring, evaluating and aligning policies and legislation; creating and strengthening mechanisms that support delivery of strategies and programmes at all levels; ensuring operational alignment within and among government departments and across all sectors; developing and maintaining a co-ordinated national database that supports the implementation of the policies, strategies and programmes and ensuring that comprehensive curricula and training programmes that support OVC and their families are available.
4. Ensuring access of OVC to essential services; focusing on reviewing current essential services and service delivery mechanisms to determine whether rights of OVC are realised; developing and strengthening programmes that make essential services accessible to OVC and supporting resource mobilization for the implementation of programmes that make essential services accessible to OVC.
5. Raising awareness and advocacy to create supportive environments for OVC; focusing on developing a comprehensive stakeholder communication strategy; creating general awareness of OVC at every level of society and advocating for the rights of the child at every level of society. (2005b, pp. 2–3)

The DoSD National Plan includes a set of programme objectives, activities and associated indicators that are stratified into five domains and which measure:

- Access to treatment for infected children and their primary caregivers, so as to ensure survival of caregivers (and reduce orphaning) as well as prevent transmission of the virus (PMTCT – prevention of mother-to-child transmission) (see also Chapter 5 in this volume);
- Access to food security for children and their families to reduce the risks of mal- and under-nutrition and to ensure positive growth (see also Chapter 5);
- The extent to which succession planning is mainstreamed into intervention programmes for OVC;
- Provision of vocational and skills training programmes to child-headed households to ensure self-sufficiency and to support these vulnerable families;
- Provision of psychosocial support to OVC and their families.

A major difficulty in both the Integrated Plan for ECD and the DoSD National Plan is that *neither* provides an operational definition of a vulnerable child. While they may well be using the UNAIDS and UNICEF definitions (themselves problematic

with respect to the construct), this is not stated. This is unfortunate as it is likely to lead to confusion among those tasked with targeting and monitoring the population in question. The importance of adopting a standardised, measurable definition of children orphaned and made vulnerable by HIV and AIDS in all countries has been emphasised by UNICEF (2005b), and steps should be taken towards ensuring that this recommendation is fulfilled.

The UNAIDS (2005) strategic approaches to children affected by HIV and AIDS are detailed below. Apart from the country level approaches, they are similar to those developed by South Africa (which has taken the UN approach into account):

- Efforts to strengthen the capacity of vulnerable families;
- Mobilising and strengthening community-based responses to children orphaned and made vulnerable by HIV/AIDS;
- Ensuring access to essential services for orphans and vulnerable children;
- Ensuring that governments protect the most vulnerable children;
- Raising awareness to create a supportive environment for children affected by HIV/AIDS.

An indicator system for children affected by HIV and AIDS should draw on the research literature as well as be aligned with the policies and programmes outlined above. There are four primary reasons. First, alignment permits monitoring of international obligations and policy recommendations. For example, UNAIDS recommends that in all countries, responsibility for national co-ordination of monitoring the situation of adults and children affected by HIV and AIDS, as well as the relevant programme responses, should rest with national AIDS councils. UNAIDS has established a Country Response Information System that seeks to facilitate greater information. National level monitoring indicators 'track the success of the national response as a whole. They give programme managers and decision-makers an idea of whether the sum total of all efforts intended to benefit children orphaned and made vulnerable by HIV and AIDS in a district, region or country are making any difference in terms of slowing the epidemic spread of HIV and reducing its impact on individuals and families' (UNICEF, 2005b, p. 18).

The second reason follows from this point. Alignment enables stakeholders to monitor government's performance in areas that it has identified for response to the epidemic, in line with international and national benchmarks.

Third, various government departments are using (and developing) indicators for this purpose and these should be included in the minimal set used for monitoring purposes. Finally, if one aligns with the state system (at least in relation to core indicators), the data are likely to be more readily available.

The search for good indicators to identify vulnerable children and track interventions for their benefit is far from over. UNICEF (2005b) has produced a set for monitoring national responses to children affected by HIV/AIDS that has ten domains which need to be monitored at the national level (see Appendix 9 in this volume). Some can be accessed via regular surveys and administrative data while others require purpose-made studies, for example, psychosocial support. UNICEF continues a process to refine the psychosocial indicators. Much more needs to be done to identify the best measures and improve their reliability and validity.

The UNICEF set is necessarily very limited, and does not cover a range of consequences of the epidemic on children, households and communities. Specific studies are required to explore the situation in more depth. It is also important to distinguish between high-level indicators for monitoring the prevalence, situation and services available to children affected by HIV and AIDS, and those needed to monitor the outcomes of particular programmes and policies.

We have identified the major definitional problems with identifying children affected by HIV and AIDS in the UNICEF system. Appendix 9 presents the indicator set they recommend. In the table, the term 'measurement tool' refers to the type of study required in each instance. The term 'orphan' includes all orphaned children, including those whose caregivers have died of causes other than AIDS. As noted above, UNICEF (2005b) uses caregiver mortality as a proxy measure and recommends that it is most appropriate for use in high-prevalence contexts (even though it is intended for national-level reporting). In our view, due to the problems with defining orphans and vulnerable children, it should be used with caution in contexts where prevalence is very uneven across the country and where there is a wide and significant range of other causes of adult morbidity and mortality.

A comprehensive guide to the measures is available in UNICEF (2005b) (which is a set of guidelines in development).

Recommended indicators

To ensure alignment with international systems, national policies and plans of action our approach to monitoring the well-being of children orphaned and made vulnerable by HIV and AIDS is informed by the UNICEF list. It addresses the main UNAIDS recommendations for national response, speaks to the Save the Children UK (2003) report, and includes indicators relevant to South African policy documents. The full set in Appendix 9 covers the policy goals and domains set by the South African National Plan for OVC released in 2005.

It must be emphasised that despite the conceptual difficulties raised earlier in the chapter, some of which are reflected in the UNICEF list, their approach is recommended in order to be aligned with international practice. Indicators based on locally agreed upon definitions and measures that do not share wider consensus are of limited use.

While we strongly recommend ongoing consideration of the complexities of what is meant by *addressing the needs of orphans and children made vulnerable by HIV and AIDS* (and therefore how we define these groups), in the absence of another more sophisticated standard, the UNICEF approach has many strengths. For one, although it monitors the numbers of orphans and other vulnerable children separately, it does not identify children on the basis of the HIV status of a parent, caregiver or household member and assesses service provision and other needs for the group as a whole.

The measurement tools specified in Appendix 9 should be seen in light of the fact that many countries do not have sound administrative data systems and may not have regular surveys. In South Africa, there are several sources that can provide at

least some of the data needed to obviate the need for expensive national surveys. That said, and given the challenges in obtaining data on the additional indicators in Appendix 9, the focus of regular monitoring should be on the core set.

UNICEF notes that children 'living with or affected by HIV/AIDS, or in countries with high prevalence rates face an extremely high risk of exclusion from access to essential services, care and protection, as parents, teachers, health workers and other basic service providers fall sick' (2005b, p. 16). For this reason, the indicators include measures of service access, such as free schooling, social grants, healthcare and other services. Data from schools (including those in which children are exempted from fees) are available from the Department of Education, and some of the other data are available from the Departments of Health and Social Development.

We suggest that the additional set in Appendix 9 be captured when required for specific purposes, such as the identification of vulnerable children in areas of the country that have high HIV/AIDS prevalence, and where planning for intervention is required.

It is also recommended that the HIV and AIDS vulnerability indicator information is combined with poverty data, as the most vulnerable families are those living with AIDS and in poverty (see the discussion of poverty measurement in Chapter 3 in this volume).

Over and above the set of ten indicators outlined in Appendix 9, we recommend that the following additional domain (adapted from UNICEF and UNAIDS) be monitored as part of the core set:

- HIV knowledge:
  - Comprehensive knowledge of HIV (in 15–24 year olds);
  - Knowledge that condom use can prevent HIV transmission (in 15–24 year olds).

As this chapter was being finalised, recommendations for survey questions to measure the psychosocial well-being of adolescents living in communities affected by AIDS were submitted to UNICEF New York by Snider and colleagues (2006). The document provides a review of recent literature on adolescent psychosocial measures used in African research, as well as survey questions that tap a set of core domains for assessing household, community and personal measures of youth vulnerability, resilience and psychosocial outcomes. The domains are:

- *Caregiver's emotional health-seeking behaviour:* The stability and emotional health of parents is an important determining factor of psychosocial outcomes in children.
- *Caregiver exposure to domestic violence:* Domestic violence is a serious risk to children's psychosocial well-being, and the stability and well-being of caregivers. It is more likely to occur more often in households under severe strain.
- *Use of (harsh) physical punishment or maltreatment in the home:* Use of harsh physical punishment in the home is a serious risk to children's psychosocial well-being and is likely to increase in compromised households.
- *Community maltreatment, exploitation, stigma and discrimination:* Stigma is a known risk to children and households affected by AIDS. It can result in maltreatment and is associated with social exclusion.

- *Caregiver report of youth's emotional health (and health-seeking behaviour):* Parents tend to under-report children's internalising of emotional problems, while emphasising 'naughty' behaviour (that may also be a sign of emotional distress). However, in any community, the need to consult an authority (medical, faith healer, counsellor or traditional healer) indicates serious concern for children's psychosocial health.
- *Caregiver report on youth's internalising, externalising and risk behaviours:* This domain captures caregivers' assessments of the psychosocial health of youth in key areas (caregiver reports of externalising and risk behaviours are likely to be more accurate than youth self-report; the reverse is true for internalising behaviours).

In the case of domains appropriate for adolescent self-report, the same domains are advised with the addition of measures of the social connectedness or isolation of the child and also exposure to work (work demands on children may increase in the context of AIDS, as noted above).

The recommendations are still to be approved by UNICEF, and must be subject to validation and reliability testing. For this reason they are not included here. The document is available from UNICEF East and Southern Africa in Nairobi and from the first author of this chapter.

The recommended indicators are listed in the table in Chapter 17, Part 2, of this volume. They include policy goals, objectives and measurement parameters, including definitions of the numerator and denominator for each indicator, and possible sources for these data. Prevalence and treatment indicators related to HIV/AIDS are included in Chapter 5.

Finally, due to the similar needs of children who are affected by HIV and AIDS and other vulnerable children (particularly those living in poverty), we recommend that purposive surveys (where administrative data are not readily available or appropriate) be conducted in communities that meet both these criteria. This is where the UNICEF (2005b) system will be of particular assistance.

Note

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

1 Published for comment in GG No. 27068 of 8 December 2004.

PART II

The indicators

How the indicators work

The tables of indicators that follow include the following components (working from the left-hand column):

- Column 1: A suggested policy goal for each indicator;
- Column 2: The type of indicator (for example Child Status), and the reason for its use (see below for a brief definition of the five types of indicator used);
- Column 3: A description of how the indicator is measured, including definition and measure (these are sometimes blended), and the source where data may be obtained (if data are available). Recommendations regarding sources are provided where these were not adequate at the time of publication.

Indicator types

Type 1: Child status indicators

These measure the status of the child. Examples include child mortality, reading ability, immunisation status, and whether the child has been a victim of abuse.

Type 2: Family and household environment indicators

These measure the structure and quality of the child's primary home-care setting. Examples include children's access to services such as electric light, sanitation and potable water; and the economic and health status of the caregivers (for example TB or HIV infection). Structural variables could include whether the household is headed by a child, and whether the children are cared for by an elderly person or a single mother. They include risks of injury such as paraffin stoves.

Type 3: Neighbourhood and surrounding environment indicators

These measure specific geographical spaces such as neighbourhoods, enumerator areas, and so on. They are the spaces outside the home where children grow up. They include services such as clinics and playgrounds, as well as roads. They include people who can support children and others who put them at risk (criminal elements). This indicator set permits small-area indices of child risk and well-being to be constructed in order to provide information for policy targeting.

Type 4: Service access indicators

These describe children's access to services.

Type 5: Service quality indicators

These measure service inputs. They measure the provisioning (for example, the supply of money) for the services, and could include whether the care of children in residential settings for children is up to standard in terms of the regulations. As is evident from Figure 2.1, the indicators are informed by rights that are granted to South African children that draw on three bodies of law. The first includes international instruments ratified by the country (for example the CRC), the second is the South African Constitution, and the third includes Acts and regulations that speak to the situation of children. Indicators are also informed by bodies of research evidence and, finally, by the specific policies and programmes of the sector for which indicators are developed. The most important piece of legislation affecting children is the Children's Act (No. 38 of 2005), and the associated Children's Amendment Bill (No. 19 of 2006) which should come into effect in 2008. Until that time the Child Care Act (No. 74 of 1983) remains in force.

It is essential to stress that an indicator system is 'live' and rarely fixed. Indicator systems must be adjusted as the need arises, and should be able to respond to changes in the service environment. However, the system should not be too flexible. Certain core indicators must remain constant so as to facilitate tracking of changes over time.

Neighbourhood indicators

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce poverty and protect children's right to survival, protection and development.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Neighbourhood income deprivation **Reason for use:** Monitor the poverty level of neighbourhoods.	**Definition & Measure:** Proportion of people in a neighbourhood experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Statistics South Africa); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.
Improve children's educational and occupational success.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Neighbourhood affluence **Reason for use:** Monitor the affluence level of neighbourhoods.	**Definition:** Neighbourhood residents who have professional and managerial occupations (codes 1 and 2). **Measure:** Proportion of affluent residents over 25 years in a neighbourhood. **Source:** Census **Period:** Every 10 years
	Type 3 Indicator: Neighbourhood & Surrounding Environment Employment deprivation **Reason for use:** Indicator of human capital.	**Definition:** Population (15–65 years inclusive) who are: 1. Unemployed (using official definition, i.e. did not work in 7 days prior to Census night, wanted to work and available to start within a week, had taken steps to work or start self-employment in previous 4 weeks). 2. Not working because of illness or disability. **Measure:** Proportion of unemployed people in a neighbourhood. **Source:** Census **Period:** Every 10 years **Note:** This measure is used in the PIMD.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Education deprivation **Reason for use:** Indicator of human capital (key for adolescents).	**Definition & Measure:** Proportion of people in a neighbourhood with no schooling at secondary level (highest level is Grade 7) or above. **Source:** Census **Period:** Every 10 years
Improve the health of children and their caregivers, so increasing the likelihood of improving a range of child outcomes.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Health deprivation **Reason for use:** Monitor the impact of HIV/AIDS, violence and other health issues.	**Definition & Measure:** Average years of potential life lost. (Denominator: Number of deaths in the neighbourhood in the 12 months prior to Census night). **Source:** Census **Period:** Every 10 years
Ensure the right to protection and optimal development.	**Type 2 Indicator: Family & Household Environment** Household crowding **Reason for use:** Crowding measures are objective; but the experience of crowding is culturally framed and subjective. High levels of crowding have been associated with poor outcomes and are a risk for child abuse.	**Definition:** Crowding is measured on a continuous scale. Richter (1989) uses a person–habitable room ratio. There is no accepted South African definition of 'crowding'. The Canadian National Occupancy standards set household bedroom requirements according to these criteria: No more than 2 people per bedroom; parents or couples share a bedroom; children aged <5 years, either of same or opposite sex, may reasonably share a bedroom; children aged <18 years of the same sex may reasonably share a bedroom; a child aged 5 to 17 years should not share a bedroom with one aged <5 of the opposite sex; single adults aged 18 years and over and any unpaired children require a separate bedroom.[2] The Canadian standards are no doubt too high for a developing country but serve as a guideline. **Measure:** Average person–habitable room ratio for children <5 years and <9 years. The proportion of children <9 co-sleeping with sexualised older children and adults should be determined – this will be possible where a single habitable room is available for the household. **Sources:** Census and other household surveys; the HOME Inventory could be used in research studies for this purpose. **Period:** Every 10 years (more frequently using other household data)

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the supervision of children.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Childcare burden **Reason for use:** Caregiver stress increases the likelihood of inadequate supervision of children.	**Definition:** The burden placed on caregivers through low availability of other adults to share childcare. **Measures:** 1. Proportion female-headed households. 2. Ratio of children to adults. 3. Ratio of men to women. 4. Proportion elderly. **Source:** Census **Period:** Every 10 years
Reduce violence to children.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Violent crime rate **Reason for use:** Monitor children's exposure to violent crime and children's rights to safety and protection.	**Definition:** Violent crimes as defined in the Common Law and other Statutes: murder, common assault, assault with grievous bodily harm, and ill-treatment of a child reported to the South African Police Services (SAPS). Crime incidence rates are calculated per 10 000 or 100 000 depending on the size of the population. **Measures:** 1. Murder and attempted murder rate per 10 000. 2. Violent crimes to children per 10 000. 3. Child rape rate per 10 000. **Source:** SAPS crime statistics **Period:** Annual
Increase children's access to services.	**Type 4 Indicator: Service Access** Access to services **Reason for use:** Monitor access to the services necessary to meet children's health, education, recreation, literacy and safety needs.	**Definition:** Access to facilities is determined by response to the question: Are the following located in the neighbourhood? • A primary care clinic • A well-baby and family-planning clinic • A primary school • A high school • Recreation facilities (parks, swimming pools, sports grounds, movie theatres) • A library • A police station And: Whether the household has access to a telephone (Denominator: number of households in the neighbourhood). And: • The number of children that can be accommodated in neighbourhood childcare facilities (Denominator: number of children <6 living in the neighbourhood); • The number of children that can be accommodated in neighbourhood after-school and holiday-care facilities (Denominator: number of children aged 7–18 in the neighbourhood).

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔		And: • The number of supermarkets per 10 000 residents; • The number of businesses per 10 000 residents. **Measure:** The existence of appropriate facilities in the neighbourhood. **Sources:** City data files; Census. **Period:** Every 10 years

Notes:
1 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.
2 See <http://www.stats.govt.nz/analytical-reports/affordability-report/technical-notes.htm#crowding>.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve communication through the formation of social networks in neighbourhoods.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Ethnic heterogeneity **Reason for use:** Points to disrupted community networks.	**Definition & Measures:** 1. Number of different ethnic groups in the neighbourhood. 2. Number of different languages spoken in the neighbourhood. **Source:** Census **Period:** Every 10 years
	Type 3 Indicator: Neighbourhood & Surrounding Environment Residential mobility **Reason for use:** Points to disrupted community networks.	**Definition & Measures:** 1. Proportion of neighbourhood residents who moved into their current home in the last 5 years. 2. Proportion of neighbourhood residents who moved into their current home in the last year. **Source:** Census **Period:** Every 10 years
	Type 3 Indicator: Neighbourhood & Surrounding Environment Community relationships **Reason for use:** Points to the presence of social networks.	**Definition & Measure:** Number of community groups such as neighbourhood watches. **Source:** Key community informants **Period:** Every 10 years if feasible.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase children's access to services.	**Type 4 Indicator: Service Access** Community development initiatives **Reason for use:** Monitor opportunities for families to access opportunities for material and social improvements.	**Definition & Measure:** Number of development initiatives in the neighbourhood. **Period:** Every 10 years if feasible.
Reduce environmental problems that are hazardous for children's development.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Pollution and waste dumps. **Reason for use:** Monitor health hazards to children.	**Definition & Measures:** 1. Levels of (e.g.): lead and other heavy metals; air pollutants; noise. 2. Number of waste dumps in the neighbourhood. **Period:** Every 10 years if feasible.

Indicators for monitoring child health

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children living in poverty.	**Type 1 Indicator: Child Status** Child poverty **Reasons for use:** Child poverty is associated with the widest range of insults to child survival, health and development, including mortality. Appropriate for national and international reporting: State of the World's Children; Millennium Development Goals (MDGs).	**Definition & Measure:** Proportion of children in households experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Statistics South Africa); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.
Accelerate implementation of the National Action Plan for HIV and AIDS		
Reduce HIV prevalence among young people aged 15–24 years.	**Type 1 Indicator: Child Status** HIV prevalence in 15–24-year age group. **Reason for use:** Measure of the prevalence of the disease in a high-risk age group.	**Definition & Measure:** Proportion of sampled pregnant women aged 15–24 years attending antenatal clinics who test positive for HIV. **Source:** Annual HIV antenatal seroprevalence survey (DoH) **Period:** Annual
	Type 1 Indicator: Child Status HIV prevalence in pregnant children. **Reason for use:** Measure of the prevalence of the disease in a high-risk group.	**Definition & Measure:** Number of HIV-positive pregnant children (<18 years) per 100 pregnant children. **Source:** Antenatal HIV seroprevalence survey (DoH) **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the incidence of HIV infection in children.	**Type 1 Indicator: Child Status** Infant HIV incidence rate **Reasons for use:** Measure of an important cause of child morbidity.	**Definition:** Children born to HIV-positive women who are polymerase chain reaction (PCR) positive at 6 weeks of age in a given period. **Measure:** Proportion of children born to HIV-positive women who are PCR positive at 6 weeks of age. Source: Provincial Prevention of Mother to Child Transmission (PMTCT) Programme **Period:** Annual
Expand treatment for infected children and their primary caregivers		
Increase the PMTCT coverage (to 95% by 2010).	**Type 4 Indicator: Service Access** Antiretroviral therapy (ART) cover in eligible newborns. **Reasons for use:** Marker of health systems' ability to prevent new HIV infections in children.	**Definition & Measure:** Number of newborns receiving prophylactic ART per 100 babies born to HIV-positive pregnant mothers. **Source:** PMTCT surveillance (DoH) **Period:** Annual
Increase access to ART for children (to reach 55 000 children by 2009).	**Type 4 Indicator: Service Access** Highly active anti-retroviral therapy (HAART) cover in eligible children aged 0–12 and 13–17 years. **Reasons for use:** Marker of health systems' ability to manage symptomatic HIV infection/AIDS in children.	**Definition & Measure:** Number of children (aged 0–12 and 13–17 years) receiving HAART per 100 children eligible for HAART. **Source:** ART roll-out surveillance (DoH) **Period:** Annual
Increase access to ART for adults – in particular for caregivers with children (to reach 450 000 by 2009).	**Type 4 Indicator: Service Access** HAART cover in eligible adults. **Reasons for use:** Adult access to ART will reduce orphaning. Marker of health systems' ability to manage symptomatic HIV infection/AIDS in adults.	**Definition & Measure:** Number of adults (>18 years) receiving HAART per 100 adults eligible for HAART (stratified by gender and into adults with children as far as possible). **Source:** ART roll-out surveillance (DoH) **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce child mortality		
Reduce the number of infants dying in the first 28 days of life.	**Type 1 Indicator: Child Status** Neonatal mortality rate **Reason for use:** Measure of care and support provided to newborns and young infants.	**Definition:** Deaths <28 days of age per 1 000 live births in same calendar year. **Measure:** Proportion of deaths <28 days of age in same calendar year. **Sources:** Stats SA; South African Demographic and Health Survey (SADHS); Maternal Registry. **Period:** Annual
Reduce the incidence of diarrhoeal disease in children under 5 years.	**Type 1 Indicator: Child Status** Proportion of diarrhoea in <5s at health facilities. **Reason for use:** Measure of an important cause of child morbidity.	**Definition:** Diarrhoea is defined as 3 or more watery stools in 24 hours, but any episode diagnosed and/or treated as diarrhoea after an interview with the adult accompanying the child should be counted. **Measure:** Children <5 years presenting to health facilities with diarrhoea per 1 000 <5-year-old attendances in a given period. **Sources:** District Health Information System (DHIS); SADHS. **Period:** Monthly
Reduce the incidence of respiratory disease in children under 5 years.	**Type1 Indicator: Child Status** Proportion of acute lower respiratory tract infections (pneumonia) in <5s at health facilities. **Reason for use:** Measure of important cause of child morbidity.	**Definition & Measure:** Children <5 years presenting to health facilities with acute lower respiratory tract infections (pneumonia) per 1000 <5-year-old attendances in a given period. **Sources:** DHIS; SADHS. **Period:** Monthly
Vaccinate 90% of children against measles.	**Type 5 Indicator: Service Quality** Measles 1st dose coverage. **Reason for use:** Measure of quality of health service (immunisation).	**Definition:** Children <1 year who received measles first dose. **Measure:** Proportion of children <1 year who received measles first dose per population of infants eligible for the vaccine (Denominator: Mid-year estimate of target population [<1 year olds]). **Source:** DHIS **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Combat non-communicable diseases		
Increase the percentage of children at age 6 years who are free of caries (to 50% by 2010).	**Type 1 Indicator: Child Status** Children at age 6 with no caries. **Reasons for use:** Measure of oral health.	**Definition:** Children at age 6 with no caries. **Measure:** Proportion of children at age 6 with no caries. **Source:** DHS Oral Health Survey **Period:** Annual
Reduce the mean number of decayed, missing and filled teeth (DMFT) at age 12 years (to 1 by 2010).	**Type 1 Indicator: Child Status** Mean number of DMFT in children at age 12 years. **Reasons for use:** Measure of oral health.	**Definition:** Children with DMFT at 12 years. **Measure:** Proportion of children with DMFT at 12 years. **Source:** DHS Oral Health Survey **Period:** Annual
Improve the nutritional status of children		
Reduce the prevalence of stunting among children less than 5 years.	**Type 1 Indicator: Child Status** Stunting rate **Reasons for use:** Measure of nutritional status of children. May indicate economic hardship, infection or neglect. To identify children in Early Childhood Development services to be monitored for follow-up action. Appropriate for national and international reporting: State of the World's Children; Convention on the Rights of the Child; United Nations Children's Fund; Multiple Indicator Cluster Survey; MDGs.	**Definition & Measure:** Children under 5 years with more than 2 standard deviations below the median height for age reference value in a defined population of <5s in a given period (per 100 children in that population in the same period). **Sources:** Provincial and national departments of Health (DoH); SADHS; Food Consumption Survey; periodic nutrition surveys. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the prevalence of wasting among children under 5 years.	**Type 1 Indicator: Child Status** Wasting rate **Reasons for use:** Measure of nutritional status of children.	**Definition & Measure:** Proportion of children more than 2 standard deviations below the median weight for height reference value in a defined population of under-5s per 100 children under the age of 5 years in that population in the same period. **Sources:** Provincial and national DoH; SADHS; Food Consumption Survey; periodic nutrition surveys. **Period:** Annual
Reduce childhood overweight and obesity.	**Type 1 Indicator: Child Status** Overweight and obesity rates **Reasons for use:** Measure of nutritional status of children.	**Definitions:** 1: Overweight: Children with weight for height over 2 standard deviations from the norm (reference population median). 2: Obesity: Children with a body mass index (body mass in kg divided by the square of the height in m) equal to or more than 30kg/m^2. **Measure:** Children at school entry who are overweight or obese per 100 children in the relevant age group in that population in the same period; optionally also at 10 and 15 years. **Sources:** Provincial and national DoH; SADHS; Food Consumption Survey; periodic nutrition surveys. **Period:** Annual
Reduce severe malnutrition in children under 5 years.	**Type 1 Indicator: Child Status** Severe malnutrition rate **Reasons for use:** Measure of nutritional status of children.	**Definition & Measure:** Children aged 0–5 years who weigh below 60% expected weight for age (new cases that month/year) per 1 000 children in the target age group. **Source:** DHIS **Period:** Annual
Promote breastfeeding.	**Type 1 Indicator: Child Status** Breastfeeding: 1. Initiation rates 2. Exclusive breastfeeding rate 3. Duration of breastfeeding **Reasons for use:** Measure of uptake and success of breastfeeding.	**Definition:** Exclusive breastfeeding rate: Percentage of living children receiving only breast milk from birth to various ages. **Measures:** 1. Proportion of newborn children exclusively breastfed at hospital discharge or immediately after birth. 2. Proportion of 6-month-old children receiving only breast milk or expressed breast milk. 3. Proportion of 12-month-old children receiving breastfeeding at 12 months. Each of above per 100 live births in the same period. (Denominator for all: Live births in the same period.) **Sources:** SADHS; periodic nutrition surveys. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the prevalence of iron deficiency among children under 5 years.	**Type 1 Indicator: Child Status** Iron deficiency rate **Reasons for use:** Measure of nutritional status and dietary intake.	**Definition & Measure:** Number of children <5 years of age with evidence of iron deficiency anaemia in a defined population per 100 children under the age of 5 years in that population in the same period. **Sources:** SADHS; periodic nutrition surveys. **Period:** Annual
Reduce the prevalence of vitamin A deficiency among children under 5 years.	**Type 1 Indicator: Child Status** Vitamin A deficiency rate **Reasons for use:** Measure of nutritional status and dietary intake.	**Definition & Measure:** Number of children <5 years of age with biochemical evidence of vitamin A deficiency in a defined population and a given period per 100 children under the age of 5 years in that population in the same period. **Sources:** SADHS; periodic nutrition surveys. **Period:** Annual
Reduce the prevalence of iodine deficiency among children under 5 years.	**Type 1 Indicator: Child Status** Iodine deficiency rate **Reasons for use:** Measure of nutritional status and dietary intake.	**Definition & Measure:** Number of children <5 years of age with evidence of iodine deficiency in a defined population and a given period per 100 children under the age of 5 years in that population in the same period. **Sources:** SADHS; periodic nutrition surveys. **Period:** Annual
Reduce the prevalence of low birth weight (<2.5 kg).	**Type 1 Indicator: Child Status** Low birth weight rate **Reasons for use:** Indicator of the socio-economic status and health of the community in general. Also a measure of maternal health during pregnancy.	**Definition & Measure:** Number of children born with a birth weight <2.5 kg in a defined population and in a given period per 100 live births in the same population and period. **Sources:** Stats SA; Maternal Registry; SADHS; periodic surveys; hospital midwife obstetric unit records; Perinatal Problem Identification Programme (PPIP). **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
To improve youth and adolescent health		
Reduce proportion of births attributable to girls aged 15–19 years.	**Type 1 Indicator: Child Status** Teenage birth rate **Reason for use:** Teenage pregnancy disrupts the life of a child and her offspring.	**Definition & Measure:** Proportion of all live births during a specific year which are to women who are between 15 and 20 years of age, irrespective of marital status per 100 births among women of all ages. **Source:** SADHS; Maternal Registry. **Period:** Annual
Reduce the number of teenage pregnancies.	**Type 1 Indicator: Child Status** Teenage pregnancy rate **Reason for use:** Teenage pregnancy disrupts the life of a child and her offspring.	**Definition:** Women aged 13–19 who are mothers or who have ever been pregnant. The number of women who are mothers at the time of the survey is a more restrictive definition. **Measure:** Number of pregnancies in females aged 13–19 years per 1 000 females aged 13–19 years in the same period. **Source:** SADHS **Period:** Annual
Improve clinical management and care at all levels of the healthcare delivery system		
Promote breastfeeding by accrediting maternity units with 'baby-friendly' status (60% by 2009).	**Type 5 Indicator: Service Quality** Baby-friendly hospitals and maternity facilities **Reason for use:** Measures ability of midwife obstetric units and hospitals to promote successful breastfeeding.	**Definition & Measure:** Number of accredited baby-friendly hospitals and maternity facilities per 100 health facilities with maternity beds. **Source:** DoH: Baby-friendly hospital initiative assessments **Period:** Annual
Implement the Integrated Management of Childhood Illness (IMCI) strategy (90% of facilities are saturated – i.e. >60% coverage – with IMCI trained healthcare providers by 2009).	**Type 5 Indicator: Service Quality** Primary healthcare facilities equipped to implement IMCI. **Reason for use:** IMCI is the approach chosen by the health department to deliver primary care to children <5.	**Definition & Measure:** Number of facilities with at least 60% of their staff who are IMCI trained in a given period per 100 primary healthcare facilities. **Source:** DoH national IMCI co-ordinator statistics **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the use of drugs in children aged under 5 years in primary care facilities.	**Type 5 Indicator: Service Quality** Sick children receiving drug management that conforms to IMCI guidelines. **Reason for use:** IMCI is the approach chosen by the health department to deliver primary care to children <5.	**Definition & Measure:** Number of children correctly managed by primary health-care nurses in spot assessments at selected primary health-care clinics in a given period per 100 nurses evaluated for prescribing practices during the same period. **Sources:** DoH IMCI health facility survey; supervisory visit reports. **Period:** Annual
Increase the number of PHC clinics offering youth-friendly services (to 100% by 2009).	**Type 5 Indicator: Service Quality** Youth-friendly clinic cover **Reason for use:** Youth-friendly clinics have been established to promote access to, and utilisation by, youth of appropriate health services.	**Definition & Measure:** Number of clinics which are youth friendly per 100 clinics. **Source:** DoH provincial reports **Period:** Annual
Increase availability of termination of pregnancy (TOP) services at community health centres (to 50% of all centres by 2009).	**Type 4 Indicator: Service Access** TOP facility cover **Reason for use:** While facilities have TOP-designated status, they often do not provide this service.	**Definition & Measure:** Number of designated facilities providing TOP in the public sector per 100 designated TOP facilities. **Source:** DoH TOP statistics **Period:** Annual
Increase the proportion of districts with at least one genetically trained healthcare provider (to 70% of districts by 2009).	**Type 5 Indicator: Service Quality** Genetics services cover **Reason for use:** Genetically trained staff required to provide basic genetic services.	**Definition & Measure:** Percentage of districts rendering a basic genetic service as part of the comprehensive primary healthcare service. **Source:** DoH provincial reports **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase the proportion of districts implementing the new standardised birth defects data collection tool (to 50% by 2009).	**Type 5 Indicator: Service Quality** Compliance with birth defect surveillance policy. **Reason for use:** Measure of success of the surveillance system.	**Definition:** Sites are required to report on Neural Tube Defects, Albinism, Down Syndrome and cleft lip and palate birth defects. **Measure:** Proportion of sites that report birth defects. **Source:** DoH Birth Defects Surveillance System **Period:** Annual

Note:
1 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce child mortality		
Reduce the number of infants dying in the first year of life.	**Type 1 Indicator: Child Status** Infant mortality rate **Reasons for use:** Important determinants of infant mortality are access to safe water, sanitation, nutrition and the level of mothers' education. Determining factors within the health system include the quality of maternal care, availability of vaccines given in the first year of life, and effective referral systems. Proxy measure of determinants of survival, including socio-economic and health service status of a country.	**Definition & Measure:** The infant mortality rate is the number of deaths of infants <1 year of age, in a given period of time, per 1 000 live births in the same period. **Sources:** Stats SA; Health and Demographic Surveillance System. Presently available at national and provincial level only. **Period:** Annual Notes on data collection: Unless the birth registration system is complete, infant deaths in particular may not be registered, which may seriously bias the result. Retrospective questions about the survival of children ever born included in censuses and surveys, and analysed using indirect estimation procedures, are considered to be reliable sources. Surveys using maternity histories, in which women are asked to give the date of birth and age of death (if applicable) of each live-born child, are used in many household surveys, but care must be taken to avoid age misreporting and to be sure that there is a complete report of infant deaths.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of stillbirths and early neonatal deaths.	**Type 1 Indicator: Child Status** Perinatal mortality rate **Reason for use:** Measure of antenatal care as well as neonatal services.	**Definition:** The number of perinatal deaths per 1 000 births. **Measure:** Sum of stillbirths (≥28 weeks gestation or 1 000g or more) + early neonatal deaths (≤7 days of age) per 1 000 live births + stillbirths in same calendar year. Note: Current World Health Organisation definition of perinatal mortality rate is different from the definition used in South Africa, being the number of deaths from 24 weeks gestation/500g to 28 days neonatal life. **Sources:** Stats SA; SADHS; DHIS; hospital data; PPIP; Maternal Registry. Presently available at national and provincial level only. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children dying in the first 5 years of life.	**Type 1 Indicator: Child Status** Under-5 mortality rate (U5MR) **Reasons for use:** Principal indicator of human and economic progress used by UNICEF. U5MR measures an end result of the development process rather than an 'input' such as per capita calorie availability. U5MR reflects a wide variety of inputs: the nutritional health and the health knowledge of mothers; the level of immunisation and ORT use; the availability of maternal and child health services (including prenatal care); income and food availability in the family; the availability of clean water and sanitation; and the overall safety of the child's environment. The U5MR is less susceptible to averages, it is more difficult for a wealthy minority to affect a nation's U5MR, and it therefore presents a more accurate picture of the health status of the majority of children.	**Definition:** The <5 mortality rate is the probability of children dying between birth and their fifth birthday, expressed per 1 000 children born alive. **Measure:** Number of deaths between birth and exactly 5 years of age per 1 000 live births in same calendar year. **Sources:** Stats SA; SADHS. Presently available at national and provincial level only. **Period:** Annual **Notes on data collection:** Complete vital registration systems, sample registration systems and demographic surveillance systems, where available, provide good estimates of child mortality. Retrospective questions about the survival of previous children from censuses and surveys, analysed using indirect estimation techniques, are considered reliable sources. Demographic surveys using maternity histories, in which women are asked to give the date of birth and age of death (if applicable) of each live-born child, are used in many household surveys. The preceding birth technique can be used in antenatal clinics, maternity clinics, and at the time of immunisation, to provide a useful recent estimate of the probability of dying by age 2 years at a local level.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children dying of preventable causes in the first 5 years of life.	**Type 1 Indicator: Child Status** Cause-specific mortality rates **Reasons for use:** Measurement of cause-specific mortality is needed: • To establish the relative public health importance of the different causes of death; • To evaluate trends over time, especially as a method of evaluating the probable impact of intervention programmes; • To investigate the circumstances surrounding the deaths of children for devising effective actions to decrease mortality; • To investigate reasons for differing rates of infant and child mortality among geographic areas, and to evaluate the effectiveness of specific public health interventions in controlled settings.	**Definition:** Mortality from a specific cause in children aged <5 years. **Measure:** Dependent on the specific cause, but similar to <5 mortality rate. **Sources:** Stats SA; SADHS. Presently available at national and provincial level only. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Combat communicable diseases and reduce mortality and morbidity		
Eradicate polio (by 2008).	**Type 1 Indicator: Child Status** Declared polio free. **Reason for use:** Confirmation of eradication of polio.	**Definition & Measure:** Number of confirmed cases of polio in given period.. **Sources:** DoH disease notification system; polio surveillance system; National Health Laboratory service. **Period:** Quarterly
Eliminate measles (by 2008).	**Type 1 Indicator: Child Status** Annual confirmed cases of measles. **Reason for use:** Confirmation of eradication of measles.	**Definition & Measure:** Number of confirmed cases of measles in given period. **Sources:** DoH disease notification system; measles surveillance system; National Health Laboratory service. **Period:** Quarterly
Eliminate neonatal tetanus.	**Type 1 Indicator: Child Status** Annual confirmed cases of neonatal tetanus. **Reason for use:** Confirmation of eradication of tetanus.	**Definition & Measure:** Number of confirmed cases of tetanus during the first 28 days of life in a given period and defined population. **Source:** DoH disease notification system **Period:** Quarterly
Improve the nutritional status of children		
Reduce the prevalence of underweight among children less than 5 years (to <4.7% by 2015).	**Type 1 Indicator: Child Status** Underweight rate. **Reason for use:** Measure of nutritional status of children. MDG target.	**Definition & Measure:** Number of children more than 2 standard deviations below the median weight for age reference value per 100 children under the age of 5 years in that population in the same period. **Sources:** SADHS; DHIS; periodic nutrition surveys. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve clinical management and care at all levels of the healthcare delivery system		
Increase the number of health districts with more than 90% full immunisation coverage (to 95% of districts by 2009).	**Type 4 & 5 Indicators: Service Access and Service Quality** Proportion of children <5 years who have been fully vaccinated. **Reason for use:** Measure of coverage and success of immunisation programme and of health system functioning.	**Definition:** Fully immunised children have received all the Expanded Programme of Immunisation (EPI) vaccines by the age of 5 years. **Measure:** The number of children 0–5 years inclusive who are fully immunised, divided by the population <5 years (based on mid-year estimates of number of children <5 years and number of required doses for each vaccine). **Source:** DHIS **Period:** Monthly; annual.

Indicators for monitoring child and adolescent mental health

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the prevalence of risk behaviours.	**Type 1 Indicator: Child Status** Risk behaviours in the following domains: alcohol, tobacco and other drug use; interpersonal violence; road-related behaviour; sexual behaviour. **Reason for use:** All the risk behaviour domains listed address key public health priorities.	**Definition:** As defined in the instrument used by the Adolescent Health Research Institute at the University of Cape Town (Addendum A to Chapter 6, this volume). **Measure:** Proportion of children reporting each risk behaviour. **Source:** Research study for this purpose or routine monitoring. **Period:** Among school students, regular monitoring, about every 4 years. **Notes:** If the instrument is used in other populations, such as out-of-school youth or youth in juvenile justice facilities, then the period will be determined by research needs or specific studies.
Reduce the incidence of suicide.	**Type 1 Indicator: Child Status** Non-fatal suicide attempts behaviour.[1] **Reason for use:** Indicator of risk for future completed suicide and current and future psychopathology.	**Definition:** Self-inflicted destructive behaviour that is intended to result in death. **Measure:** Self-report or health facility routinely available data. **Source:** Research study for this purpose or routine monitoring. **Period:** Annual
	Type 1 Indicator: Child Status Suicide **Reason for use:** Fatal conclusion of the suicide pathway.	**Definition:** Death by suicide as concluded at an inquest. **Measure:** Number of deaths by suicide. **Source:** National Injury Mortality Surveillance System **Period:** Ideally annually, as there is a high degree of year-on-year variation that should be smoothed.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the prevalence of mental disorder.	**Type 1 Indicator: Child Status** Functional impairment **Reason for use:** Provides dimensional indication of impairment which is important in intervention decision-making.	**Definition:** Level of functioning as per norms of the Children's Global Assessment Scale or Columbia Impairment Scale or similar. **Measure:** Proportion of children with impairments. **Source:** Research study for this purpose or routine monitoring. **Period:** Among school students, regular monitoring, about every 4 years.
Improve and monitor budgetary allocations to child and adolescent mental health services (CAMHS) in accordance with policy. Improvement of funding to enable better access to CAMHS of sufficient quality to meet their needs.	**Type 4 & 5 Indicators: Service Access and Service Quality** Annual provincial budget allocations to CAMHS. **Reason for use:** Monitors whether budget share for CAMHS is increasing in real terms. Monitors whether budget follows the CAMHS policy guidelines of the Department of Health (DoH).	**Definition:** Annual budgets allocated for CAMHS. **Measure:** Rand amount allocated for CAMHS per year compared with previous annual allocations. **Sources:** Provincial DoH; provincial Treasuries. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the quality of CAMHS.	**Type 5 Indicator: Service Quality** Ratio of staff with training in CAMH per population of children with mental health needs, stratified by professional group. **Reason for use:** Assists in monitoring the quality of CAMHS for children.	**Definition:** Training varies according to the professional group involved. **Measure:** Proportion of staff in each discipline with training in CAMH in a facility or service using a self-report instrument validated by official certificates. **Sources:** Research study for this purpose or DoH administrative data. **Period:** Every 5 or 10 years
	Type 5 Indicator: Service Access Ratio of staff to population of children with mental health needs for each professional group. **Reason for use:** Assists in monitoring the quality of mental health services for children.	**Definition:** Facilities in a service that achieve the staffing norms for CAMHS specified in Dawes, Lund et al. (2004). **Measure:** Proportion of CAMHS which meet staff–patient norms or standards.[2] **Sources:** Research study for this purpose or DoH administrative data. **Period:** 5 to 10 yearly

Notes:
1 Although this could be regarded as a risk behaviour, it has been addressed separately owing to its importance.
2 Staff–patient ratios only are included in the columns on measurement parameters.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve child mental health.[1]	**Type 1 Indicator: Child Status** Range of key diagnoses. **Reason for use:** Good indicator of mental health in a comprehensive sense.	**Definition:** Diagnostic status according to the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. **Measure:** Proportion of children with each key diagnosis in a study using the Diagnostic Interview Schedule for Children. **Source:** Research study for this purpose. **Period:** To be determined in specific studies.
	Type 1 Indicator: Child Status Exposure to trauma and presence of post-traumatic stress disorder (PTSD). **Reason for use:** Trauma and its sequelae are important for South African youths.	**Definition:** Trauma items based on international studies and local circumstances; PTSD based on the DSM and using a measure such as the Harvard Trauma Scale. **Measure:** Proportion of children with PTSD.[2] **Source:** Research study for this purpose. **Period:** Occasional, on a research basis or in response to specific traumatic circumstances.
	Type 1 Indicator: Child Status Childhood depression **Reason for use:** A common pathological state in childhood.	**Definition:** Depression based on phenomenological studies of scale originator (Beck Depression Inventory). **Measure:** Proportion of children who meet the criteria for depression. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis or in response to local needs assessment.
	Type 1 Indicator: Child Status Childhood anxiety **Reason for use:** A common pathological state.	**Definition:** Anxiety has several forms – it may be experienced as a substantiated feeling of impending doom, or unfounded worries about a range of issues, or as an irrational fear of a situation, activity, or object (Fyer et al., 1995). Suggested measure is the Self-Rating Anxiety Scale (Zung, 1971). **Measure:** Proportion of children who meet the criteria for anxiety. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis or in response to local needs assessment.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
	Type 1 Indicator: **Child Status** Disruptive behaviour disorders (DBD) **Reason for use:** Common disorders with high burdens.	**Definitions:** Based on the criteria used in the DSM. The suggested measure is the DBD Rating Scale based on the DSM. **Measure:** Proportion of children with a specific DBD or any DBD. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis or in response to local needs assessment.
Reduce the prevalence of mental disorder and risk behaviour and promote healthy development.	**Type 1 Indicator:** **Child Status** Connection with others. **Reason for use:** Mediator of psychopathology and risk behaviour, and promoter of healthy development.	**Definition:** Warm, nurturing, accepting, loving and supportive relationships with significant others. **Measures:** Proportion of children who indicate their connectedness to others on the following: 1. Adult – ten-item[3] acceptance subscale from the revised Child Report of Parent Behavior Inventory. 2. Peer – two items, with reference separately to their best friend and boyfriend/girlfriend. 3. Neighbourhood – four-item scale measuring how often the youngster spent time with neighbours, parents of friends, community leaders and church leaders. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis.
	Type 1 Indicator: **Child Status** Regulation **Reason for use:** Mediator of psychopathology and risk behaviour, and promoter of healthy development.	**Definition:** Supervision, monitoring, rule and limit setting by caregivers. **Measures:** Based on studies using the following: 1. Adult – five-item monitoring scale inquiring how much the adult caregiver 'really knows' how the youngster spends their time and who they spend it with. 2. Peer – eleven-item measure of peer delinquency. 3. Neighbourhood – five-item scale measuring the presence of social disorganisation in the neighbourhood. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis.
	Type 1 Indicator: **Child Status** Autonomy **Reason for use:** Mediator of psychopathology and risk behaviour, and promoter of healthy development.	**Definition:** Being permitted to experience, value and express one's own thoughts and emotions. **Measure:** 8-item scale. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 1 Indicator: Child Status** Self-esteem **Reason for use:** Mediator of psychopathology and risk behaviour, and promoter of healthy development.	**Definition:** Evaluation of oneself, including feelings of self-worth. **Measure:** Based on studies using a self-esteem questionnaire. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis.
	Type 1 Indicator: Child Status Leisure boredom **Reason for use:** Mediator of psychopathology and risk behaviour, and promoter of healthy development.	**Definition:** Subjective perception of leisure boredom. **Measure:** Based on studies using the Leisure Boredom Scale. **Source:** Research study for this purpose. **Period:** Occasional, on a research basis.
Improve access to CAMHS.	**Type 4 Indicator: Service Access** Use of services and barriers to use. **Reason for use:** Use – indication of demand for and access to services. Barriers – suggests steps to increase service access.	**Definition:** Use of services and barriers to use. Suggested measure: 'Child school information and service use' model of the National Institute for Mental Health (NIMH) Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. **Measure:** Proportion of children reporting use of services.[4] **Source:** Research study for this purpose. **Period:** Occasional, on a research basis.
Improve access to specialist services for alcohol and drug abuse.	**Type 4 Indicator: Service Access** Access to specialist alcohol and other drug treatment centres. **Reason for use:** Assists in monitoring children's access to specialist services.	**Definition:** Source of referral; type of treatment received; primary and secondary substances of abuse; modes of use; whether the person received treatment prior to the current episode. Data for each of the items mentioned above and recorded by the South African Community Epidemiology Network on Drug Use (SACENDU). **Measure:** Proportion of children who report alcohol and drug use on the SACENDU system and who access a form of treatment. **Source:** Use (SACENDU) surveillance system. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the quality of CAMHS.	**Type 5 Indicator: Service Quality** Waiting time for receipt of appropriate services. **Reason for use:** To monitor delays in receipt of necessary mental health services.	**Definition & Measure:** Time from symptom onset to receiving appropriate services. Recommended instrument: 'Child school information and service use' model of the NIMH MECA Study. **Source:** Research study for this purpose. **Period:** 5 or 10 yearly
	Type 5 Indicator: Service Quality CAMHS services standards **Reason for use:** CAMHS should be monitored to ensure an adequate service standard exists.	**Definition:** Existing standards documents can be used to determine standards (e.g. Muller et al., 2003; Muller & Flisher, 2005a, 2005b, 2006). **Measure:** Number of facilities that meet the criterion for each service standard. **Source:** Audit of facility or service. **Period:** 5 or 10 yearly
	Type 4 Indicator: Service Access Implementation of the National Policy Guidelines of the Directorate of Mental Health and Substance Abuse. **Reason for use:** It is assumed that the existence of relevant policies correlates with service quality.	**Definition:** Whether the province has adopted relevant policies (e.g. child and adolescent mental health, school health). **Measure:** Audit of progress made by provinces judged against indicators of progress. **Period:** Every 5 years

Notes:
1 See the corresponding chapter in Part 1 for a discussion about the need for a primary level or priority indicator to assess child and adolescent mental health status.
2 Exposure to trauma not considered in the columns on measurement parameters.
3 The source for all the items in this section (connection) and the following two sections (regulation and autonomy) is Barber (2000) and Wild et al. (forthcoming).
4 Barriers not considered in the columns on measurement parameters.

Indicators for monitoring child injury morbidity and mortality

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children living in poverty.	**Type 1 Indicator: Child Status** Child poverty **Reasons for use:** Child poverty is associated with the widest range of insults to child survival, health and development. Appropriate for national and international reporting: State of the World's Children; Millennium Development Goals.	**Definition & Measure:** Proportion of children in households experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Stats SA); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.
Reduce child injury morbidity due to transport-related injury.	**Type 1 Indicator: Child Status** Children sustaining non-fatal transport-related injuries. **Reason for use:** Monitor children's right to safety and protection from transport-related injury.	**Definition:** Children involved in non-fatal transport-related (road and other) incidents as drivers, passengers, pedestrians and cyclists. **Non-fatal transport-related injuries:** *1. Injury type: Road traffic injuries* 1.1 Injury subtype: Child as driver 1.2 Injury subtype: Child as passenger 1.3 Injury subtype: Child as pedestrian 1.4 Injury subtype: Child as cyclist *2. Injury type: Other transport-related injuries* **Measure:** Proportion of South African children recorded as presenting with non-fatal transport-related injuries. Sources: National Injury Mortality Surveillance System (NIMSS); private and state clinics and hospitals; Department of Transport (DoT). **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce child injury morbidity due to incidents unrelated to transport and violence.	**Type 1 Indicator: Child Status** Children sustaining non-fatal unintentional injuries unrelated to transport or violence. **Reason for use:** Monitor children's right to safety and protection from unintentional injury.	**Definitions:** Children sustaining non-fatal injuries as a result of unintentional asphyxiation, poisoning, burns, falls, ingestion of foreign objects, sharp objects, blunt objects, machinery, animal bites, being struck against or caught between objects, and other causes. **Non-fatal unintentional injuries unrelated to transport:** *3. Injury type: General asphyxiation (excluding suicidal asphyxiation or asphyxiation resulting from ingestion of foreign object/s)* 3.1 Injury subtype: Near drowning 3.2 Injury subtype: Suffocation 3.3 Injury subtype: Strangulation 3.4 Injury subtype: Choking *4. Injury type: Poisoning* 4.1 Injury subtype: Paraffin ingestion 4.2 Injury subtype: Ingestion of other harmful substances *5. Injury type: Unintentional burn or thermal injuries* 5.1 Injury subtype: Flame burns 5.2 Injury subtype: Scalds 5.3 Injury subtype: Contact burns 5.4 Injury subtype: Other burns (injuries due to electricity, chemicals, explosions, ultraviolet radiation and radioactivity, inhalation burns) *6. Injury type: Falls* 6.1 Injury subtype: Fall on a level 6.2 Injury subtype: Fall from stairs 6.3 Injury subtype: Fall from cot/bed 6.4 Injury subtype: Fall from high chair 6.5 Injury subtype: Fall from playground equipment 6.6 Injury subtype: Fall from other height *7. Injury type: Insertion or ingestion of foreign objects* 7.1 Injury subtype: Asphyxiation 7.2 Injury subtype: Other internal injury *8. Injury type: Sharp object injuries* *9. Injury type: Blunt object injuries* *10. Injury type: Struck against/Caught between objects* *11. Injury type: Injuries from machinery* *12. Injury type: Dog or other animal bites* *13. Injury type: Other injury*[2] **Measure:** Proportion of children recorded as presenting with non-fatal unintentional injuries that are unrelated to transport or violence. **Sources:** NIMSS; Department of Health (DoH); private and state clinics and hospitals. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce child injury morbidity due to violence.	**Type 1 Indicator: Child Status** Children sustaining non-fatal violence-related injuries. **Reason for use:** Monitor children's rights to safety and protection from violence-related injury.	**Definition:** Children sustaining non-fatal other-inflicted and self-inflicted injuries. **Non-fatal violence-related injuries:** *14. Injury type: Assault* 14.1 Injury subtype: Firearm injuries 14.2 Injury subtype: Sharp object injuries 14.3 Injury subtype: Blunt object injuries 14.4 Injury subtype: Other *15. Injury type: Attempted suicide* 15.1 Injury subtype: Firearm 15.2 Injury subtype: Sharp object 15.3 Injury subtype: Blunt object 15.4 Injury subtype: Hanging 15.5 Injury subtype: Near drowning 15.6 Injury subtype: Poisoning 15.7 Injury subtype: Gassing 15.8 Injury subtype: Other **Measure:** Proportion of children recorded as presenting with non-fatal violence-related injuries. **Sources:** NIMSS; private and state clinics and hospitals. **Period:** Annual
Reduce child mortality due to transport injuries.	**Type 1 Indicator: Child Status** Children sustaining transport-related fatalities. **Reason for use:** Monitor transport-related child deaths.	**Definitions:** Children involved in fatal transport-related (road and other) incidents as drivers, passengers, pedestrians and cyclists. **Fatal transport-related injuries:** *1. Injury type: Road traffic injuries* 1.1 Injury subtype: Child as driver 1.2 Injury subtype: Child as passenger 1.3 Injury subtype: Child as pedestrian 1.4 Injury subtype: Child as cyclist *2. Injury type: Other transport-related injuries* **Measure:** Proportion of child fatalities which are as a result of transport-related injuries. **Sources:** NIMSS; mortuaries; DoT. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce child injury mortality due to incidents unrelated to transport and violence.	**Type 1 Indicator: Child Status** Children sustaining fatal unintentional injuries unrelated to transport. **Reason for use:** Monitor child deaths due to unintentional injury.	**Definitions:** Children sustaining fatal injuries as a result of unintentional asphyxiation, poisoning, burns, falls, ingestion of foreign objects, sharp objects, blunt objects, machinery, animal bites, being struck against or caught between objects, and other causes. **Fatal unintentional injuries unrelated to transport and violence:** *3. Injury type: General asphyxiation (excluding suicidal asphyxiation or asphyxiation resulting from ingestion of foreign object/s)* 3.1 Injury subtype: Drowning 3.2 Injury subtype: Suffocation 3.3 Injury subtype: Strangulation 3.4 Injury subtype: Choking *4. Injury type: Poisoning* 4.1 Injury subtype: Paraffin ingestion 4.2 Injury subtype: Ingestion of other harmful substances *5. Injury type: Unintentional burn or thermal injuries* 5.1 Injury subtype: Flame burns 5.2 Injury subtype: Scalds 5.3 Injury subtype: Contact burns 5.4 Injury subtype: Other burns (injuries due to electricity, chemicals, explosions, ultraviolet radiation and radioactivity, inhalation burns) *6. Injury type: Falls* 6.1 Injury subtype: Fall on a level 6.2 Injury subtype: Fall from stairs 6.3 Injury subtype: Fall from cot/bed 6.4 Injury subtype: Fall from high chair 6.5 Injury subtype: Fall from playground equipment 6.6 Injury subtype: Fall from other height *7. Injury type: Ingestion of foreign objects* 7.1 Injury subtype: Asphyxiation 7.2 Injury subtype: Other internal injury *8. Injury type: Sharp object injuries* *9. Injury type: Blunt object injuries* *10. Injury type: Struck against/Caught between objects* *11. Injury type: Injuries from machinery* *12. Injury type: Dog or other animal bites* *13. Injury type: Sudden Infant Death Syndrome* *14. Injury type: Other* **Measure:** Proportion of child fatalities which are as a result of unintentional injuries unrelated to transport. **Sources:** NIMSS; mortuaries. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce child injury mortality due to violence.	**Type 1 Indicator: Child Status** Children sustaining violence-related fatalities. **Reason for use:** Monitor child deaths due to violence-related injury.	**Definition:** Children sustaining fatal other-inflicted and self-inflicted injuries. **Fatal violence-related injuries:** *15. Injury type: Homicide* 15.1 Injury subtype: Fatalities resulting from sharp object injuries 15.2 Injury subtype: Fatalities resulting from blunt object injuries *16. Injury type: Suicide* 16.1 Injury subtype: Firearm 16.2 Injury subtype: Sharp object 16.3 Injury subtype: Blunt object 16.4 Injury subtype: Hanging 16.5 Injury subtype: Drowning/near drowning 16.6 Injury subtype: Poisoning 16.7 Injury subtype: Gassing 16.8 Injury subtype: Other (e.g. intentional burns; intentional suffocation) **Measure:** Proportion of child fatalities which are as a result of violence-related injuries. **Sources:** NIMSS; mortuaries. **Period:** Annual
Identify at risk groups and areas for transport-related and other unintentional injuries and fatalities.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Neighbourhood income deprivation **Reason for use:** Socio-economic disadvantage has been found to impact directly on children's risk of sustaining a range of unintentional injuries.	**Definition & Measure:** Proportion of people in a neighbourhood experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum; • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Source:** Census **Period:** Every 10 years **Note:** This measure is used in the PIMD developed by Noble, Babita et al. (2006). See Chapter 4 in this volume.[3] A PIMD for children will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Enhance the quality of emergency services for children.	**Type 5 Indicator: Service Quality** Adherence to emergency care regulations, norms and standards.	**Definition:** Health facilities providing emergency care to children who adhere to emergency care regulations, norms and standards. **Measure:** Proportion of health facilities which adhere to emergency care regulations, norms and standards. **Source:** DoH **Period:** Annual

Notes:
1 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.
2 This category has been included primarily because anecdotal evidence suggests that injuries which staff are unable or reluctant to classify (for instance in the case of suspected assault) are often recorded as 'falls'. Inserting an 'other' category should reduce the number of erroneously recorded falls.
3 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Plan for rehabilitation of children who are functionally impaired as a result of injury.	**Type 1 Indicator: Child Status** Severity of injury/injuries **Reason for use:** The severity of the injury/injuries indicates the extent of functional impairment. The degree of impairment, in turn, indicates which types of injuries should be prioritised in primary, secondary and tertiary interventions.	**Definition:** Children presenting with minor, moderate, severe non-fatal injuries and fatal injuries at selected site clinics, hospitals and mortuaries. **Measures:** • Minor injury/injuries; • Moderate injury/injuries; • Severe/major injury/injuries; • Fatal. **Sources:** Private and state clinics, hospitals and mortuaries. **Period:** Every 3 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Identify high-risk locations and times for child injury.	**Type 2 Indicator: Family & Household Environment** Injury location and time **Reason for use:** The location at which the injury took place, as well as the time of injury, identifies risk factors for sustaining injuries, which should inform injury prevention interventions.	**Definition & Measures:** 1. Injury location: home (farm, informal settlement, private house and yard, incl. swimming pool); school; recreational setting; road/highway; sea, lake, river, dam, public swimming pool; caregiver place of employment; other place of residence (e.g. peer, extended family member); day-care setting; other. 2. Time of injury: season, day and time of day of first injury presentation at health facility, or arrival at mortuary). **Sources:** Private and state clinics, hospitals and mortuaries. **Period:** Every 5 years
Reduce child injury morbidity and mortality (transport-related and other unintentional injuries).	**Type 2 Indicator: Family & Household Environment** Supervision of child activities **Reason for use:** Monitoring and supervision of child activities has been established as a key protective factor for childhood injury.	**Definitions & Measures:** To be developed in specific research studies. **Source:** Findings from specific research studies. **Period:** N/A
Improve the regulatory environment so as to prevent transport-related and other unintentional injury morbidity and mortality.	**Type 2 Indicator: Family & Household Environment** Safety devices and practices **Reason for use:** The acquisition and use of safety devices in primary care settings, motor vehicles and for bicycles is an important protective factor for childhood injury.	**Definitions & Measures:** To be developed in specific research studies. **Source:** Findings from specific research studies **Period:** N/A

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve caregiver monitoring of children's safety (transport-related and other unintentional injuries and fatalities).	**Type 2 Indicator: Family & Household Environment** Primary caregivers' participation in interventions focusing on active and passive childhood injury prevention strategies. **Reason for use:** The development of caregiver safety-promoting behaviours plays a significant role in preventing childhood injury.	**Definitions & Measures:** To be developed in specific research studies. **Source:** Findings from specific research studies. **Period:** N/A
Reduce risks of children's exposure to violence-related injury at home.	**Type 2 Indicator: Family & Household Environment** Violence-free primary care settings, as indicated by: • Children's exposure to domestic and community violence; • Household safety practices: safe storage of weapons. **Reason for use:** Exposure to violence in domestic and community settings increases the risk of children sustaining violence-related injuries.	**Definitions & Measures:** To be developed in specific research studies. **Source:** Findings from specific research studies. **Period:** N/A

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the regulatory environment so as to prevent transport-related and other unintentional injury morbidity and mortality.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Road and traffic infrastructure **Reason for use:** Traffic safety laws and the condition and maintenance of roads and playground/park equipment are crucial in the prevention of child injuries.	**Definition & Measures:** 1. The enforcement of speed limits in residential neighbourhoods and school zones (traffic calming measures such as speed humps and road narrowing). 2. The separation of motor vehicle traffic from pedestrians and cyclists (pedestrian crossings; bicycle lanes). 3. The creation of off-street play areas appropriate for each developmental level. 4. The condition of the roads (proportion of tarred roads, and proportion of roads which have evidence of damage). 5. The condition and maintenance of playground and park equipment, including the nature and quality of the surfacing. **Sources:** Municipal roads and transport authorities; municipal parks and amenities authorities. **Period:** Every 3 years **Note:** Measures to be standard indicators used by the relevant authorities.
Reduce child injury mortality at home (unintentional injuries and fatalities excluding transport).	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Crowding **Reason for use:** Crowding places children at increased risk of unintentional injury.	**Definition & Measure:** Proportion of households in the neighbourhood experiencing crowding. **Source:** Census **Period:** Every 10 years
Increase children's access to emergency services.	**Type 4 Indicator: Service Access** Distance to the closest health facility which offers emergency services to children. **Reason for use:** The time taken to reach a health facility which offers emergency services to children is important for monitoring adherence to the 'golden hour' principle.	**Definition & Measure:** Accessibility audits of communities and local authorities. **Source:** Findings from accessibility audits of communities and local authorities. **Period:** N/A

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Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 4 Indicator: Service Access** Opening hours of health facilities which offer emergency services to children. **Reason for use:** Opening hours of health facilities have important implications for the timeous receipt of necessary emergency healthcare.	**Definitions & Measures:** To be developed in specific research studies. **Source:** Findings from specific research studies. **Period:** N/A
	Type 4 Indicator: Service Access Ambulances per district **Reason for use:** The availability of ambulances is important for monitoring adherence to the 'golden hour' principle.	**Definition:** Availability of ambulances. **Measure:** The number of ambulances per population at district level (expressed as a ratio). **Source:** DoH **Period:** Every 3 years
	Type 4 Indicator: Service Access Waiting time between sustaining injury and arrival of an ambulance. **Reason for use:** The response time of ambulances is important for monitoring adherence to the 'golden hour' principle.	**Definition:** Time elapsed between sustaining injury and arrival of ambulance. **Measure:** To be developed in specific research studies. **Source:** Findings from specific research studies. **Period:** N/A

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Provide rapid access to and receipt of rehabilitation services.	**Type 5 Indicator: Service Quality** Waiting time between sustaining injury and receipt of treatment. **Reason for use:** Assists in monitoring quality of emergency services for children.	**Definition:** Time elapsed between sustaining injury and treatment. **Measure:** To be developed in specific research studies. **Source:** Findings from specific research studies. **Period:** N/A
Improve the quality of emergency services to children.	**Type 5 Indicator: Service Quality** The presence of staff members in health facilities which offer emergency services to children who are qualified to treat child injuries. **Reason for use:** The availability of trained staff is an important determinant of the quality of treatment.	**Definition & Measure:** Proportion of staff trained in treating child injuries in health facilities offering emergency services to children. **Source:** DoH **Period:** Every 3 years
	Type 5 Indicator: Service Quality Staff–child ratios in health facilities which offer emergency services to children. **Reason for use:** Monitor the quality of emergency services to children. Low staff–child ratios undermine service quality.	**Definition:** Guidelines for staff–child ratios in health facilities which offer emergency services to children are not set. **Measures:** 1. Norms are established for staff–child ratios in health facilities which offer emergency services to children in each province. 2. The proportion of facilities that conform to the norms. **Source:** To be developed **Period:** N/A

Education indicators

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve and monitor child educational performance and outcomes	**Type 1 & 5 Indicators: Child Status and Service Quality** Learner achievement in terms of tests and portfolio. **Reason for use:** Achievement measures are important in establishing the effectiveness of schools in promoting teaching and learning.	**Definition:** Pass mark for Grade 9; literacy and numeracy assessments of grades 3 and 6. **Measure 1:** Proportion of learners passing Grade 9 or learners who pass the Grade 9 common tasks of assessment. **Source:** Department of Education (DoE) **Measure 2:** Proportion of grades 3 and 6 learners who are able to perform adequately on grades 3 and 6 systemic evaluations (recommended that the Western Cape approach be adopted). **Source:** Systemic evaluations conducted by provincial DoE. **Period:** Annual
	Type 1 Indicator: Child Status Learner dropout rates **Reason for use:** Education deprivation is an important human capital indicator, and provides information on the impact of children's environment on their access to schooling.	**Definition:** Children of the appropriate age (7–15 years) who are not enrolled in school. **Measure:** The proportion of children who drop out of school between grades R and 9. (Denominator: enrolled population 7–15 years in grades R–9.) **Note:** Education is compulsory from ages 7–15 years. However, children may enrol in the year in which they turn 6 provided this is prior to July of that year. Normally the denominator would be children aged 7–15 years. **Sources:** DoE Education Management Information Systems (EMIS) Annual Schools Survey; SNAP Survey. **Period:** Annual
	Type 1 Indicator: Child Status Learner repetition rates **Reason for use:** To assess efficiency in the system related to access.	**Definition:** Proportion of learners enrolled in a given grade in a given school year who study in the same grade the following school year. **Measure:** The proportion of children who repeat grades (by grade, age and gender). (Denominator: enrolled population 7–15 years in grades 1–9.) **Source:** DoE EMIS Annual Schools Survey **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
	Type 5 Indicator: Service Quality Learner survival rates **Reason for use:** Children may repeat grades for a number of reasons. Low survival rates may indicate the need for learners to access support.	**Definition:** Cohort of pupils who enrolled in the first grade of an education cycle in a given school year and who reach a given grade without repeating a grade. **Measure:** The proportion of children who reach a given grade without repeating a grade. (Denominator: the number of children in the cohort at Grade 1.) **Sources:** DoE EMIS Annual Schools Survey; SNAP Survey. **Period:** Annual
Protect children from violence. Promote the creation of safe, facilitative learning environments.	**Type 5 Indicator: Service Quality** The existence, operationalisation and effectiveness of policies for safety and security, sexual harassment, orphans and vulnerable children, and learners' and educators' codes of conduct. **Reason for use:** To monitor quality of the learning environment.	**Definition:** The school has a policy that is available in print and which is known and understood by all educators and learners. **Measure:** Proportion of schools which have each of the aforementioned policies in place. **Sources:** DoE; South African Council of Education. **Period:** Annual
Improve the quality of the learning environment.	**Type 5 Indicator: Service Quality** Availability and use of textbooks and learning support materials. **Reason for use:** To monitor quality of the learning environment.	**Definition:** Printed material supplied to the school to support teachers in enacting the curriculum. **Measure:** Proportion of schools which have textbooks and learning support materials available. **Sources:** DoE EMIS; provincial policy documents to DoE on procurement; School Register of Needs Survey. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 5 Indicator: Service Quality** Availability and use of physical resources. **Reason for use:** To monitor quality of the learning environment.	**Definition:** Schools with libraries, school halls, staffroom, head's office, sports area or playground, school garden, piped water, well or borehole, electricity, telephone, first-aid kit, fax machine, typewriter or computer, duplicator, radio, tape recorder, overhead projector, television set, photocopier, toilet, laboratories, fences. Most appropriate resources to be selected. **Measure:** Proportion of schools which have physical resources available. **Sources:** DoE EMIS; provincial policy documents to DoE on procurement; School Register of Needs Survey. **Period:** Annual
	Type 5 Indicator: Service Quality Public expenditure as a percentage of Gross Domestic Product (GDP). **Reason for use:** To monitor quality of the learning environment. A rights-based approach requires that education spending be monitored so as to track changes in the supply of resources to support the right to education.	**Definition:** Total public expenditure on education at every level of administration according to the Constitution of the country, i.e. central, regional and local authorities expressed as a percentage of GDP. **Measure:** Spending on General Education and Training as % of overall budget. (Denominator: the budgetary amount allocated to different programmes.) **Sources:** National Treasury; Medium Term Expenditure Framework; Personnel Salary System (PERSAL). **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor and improve access to education. Monitor equity in education.	**Type 4 Indicator: Service Access** Gross enrolment by race, gender and disability. **Reason for use:** To monitor previously disadvantaged groups' access to education. As part of efforts to monitor access, the impact of fees and compulsory uniforms as barriers to access must also be monitored on a regular basis.	**Definition:** 1. The Gross Enrolment Ratio (GER) refers to the number of pupils enrolled in a given level of education, regardless of age, expressed as a percentage of the population in the relevant official age group. 2. GET = General Education & Training (grades 1–9). 3. FET = Further Education & Training (grades 10–12). 4. Gender Parity Index (GPI) is the ratio of female-to-male value of a given indicator. **Measures:** 1. GER: Pupils in primary or secondary schools/the school age population for primary or secondary level x 100. 2. GER for GET: Measured by dividing total GET school population by the population of 7–15 year olds. 3. GER for FET: Measured by dividing total FET school population by the population of 16–18 year olds. 4. GPI can then be derived by dividing the total number of learners, GET and FET respectively, by the total populations aged 7–15 and 16–18 years in each case. Denominator for GET and FET levels is the school age population. All data should be disaggregated by gender, race and disability. **Source:** DoE EMIS Annual Schools Survey **Period:** Annual
	Type 4 Indicator: Service Access Net enrolment by race, gender and disability. **Reason for use:** It is important to monitor whether previously disadvantaged groups have equal access to education.	**Definition:** Net Enrolment Ratio refers to the number of learners in the official age group for a given level of education who attend school in that level, expressed as a percentage of the total population in that age group. **Measures:** 1. Proportion of primary school age learners enrolled in primary school. (Denominator: the school age population for primary level.) 2. Proportion of secondary school age learners enrolled in secondary school. (Denominator: the school age population for secondary level.) Disaggregated by race, gender and disability. **Source:** DoE EMIS Annual Schools Survey **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the quality of education.	**Type 5 Indicator: Service Quality** Language of instruction and home language. **Reason for use:** Instruction in the child's home language determines whether learners are able to understand and engage with educational material.	**Definition:** The child is taught in the first language in the Foundation Phase (grades R–3). **Measure:** The proportion of children in the designated grades who are instructed in their home language. **Sources:** DoE EMIS Annual Schools Survey; SNAP Survey. **Period:** Annual
	Type 5 Indicator: Service Quality Educator–learner ratios **Reason for use:** Overcrowded classrooms are not conducive to teaching and learning.	**Definition:** Average number of learners per educator at the level of education specified in a given school year. The calculation of the ratio is based on educators and learners expressed as a Full-Time Equivalent. **Measure:** Proportion of schools that meet educator–learner norms. **Sources:** Education Labour Relations Council; DoE EMIS Annual Schools Survey. **Period:** Annual
	Type 5 Indicator: Service Quality Educator qualifications **Reason for use:** Qualified educators are more likely to provide high-quality education and promote positive child educational outcomes.	**Definition:** Relevant levels of tertiary certification. **Measure:** Proportion of educators who are qualified to teach at the level they are teaching. **Sources:** South African Council on Higher Education; EMIS; PERSAL. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase the numbers of orphans attending school and provide support for schools with affected children.	**Type 1 & 4 Indicators: Child Status and Service Access** Orphan school attendance ratio. **Reason for use:** This indicator assesses progress in preventing relative disadvantage in school attendance among orphans versus non-orphans.	**Definition:** Orphan school attendance ratio is the ratio of (1) orphans' school attendance to (2) non-orphans' school attendance. **Measures:** The ratio of orphaned children aged 10–14 compared to non-orphaned children aged 10–14 who are currently attending school. 1. Orphans' school attendance (%) Numerator 1: Number of children who have lost one or both parents and are attending school. Denominator 1: number of children who have lost one or both parents. Alternatively, vulnerable children (children whose parents are chronically ill or whose households have experienced the death of an adult, or whose households contain a chronically ill adult) can be included in the numerator of the ratio. 2. Non-orphans' school attendance (%) Numerator 2: Number of children who are not orphans (according to the above definition) who live with at least one parent and who are attending school. Denominator 2: Number of children whose parents are both still alive and who live with at least one parent. **Source:** DoE EMIS **Period:** Annual **Note:** As stated by UNICEF (2005b), the definition of orphans and vulnerable children has been developed to define a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high. This is the only context in which a ratio of the kind used here might be meaningful.

Indicators for monitoring early childhood development

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children living in poverty.	**Type 1 Indicator: Child Status** Child poverty **Reason for use:** Child poverty is associated with the widest range of insults to child survival, health and development. Appropriate for national and international reporting: United Nations Children's Fund (UNICEF) State of the World's Children; Millennium Development Goals (MDGs).	**Definition & Measure:** Proportion of children <5 and <9 years: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Stats SA); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.
Improve access to prevention of mother-to-child transmission (PMTCT) programmes.	**Type 4 Indicator: Service Access** Antiretroviral therapy (ART) cover in eligible newborns **Reason for use:** Marker of health system's ability to prevent new HIV infections in children.	**Definition & Measure:** Number of newborns receiving nevirapine (or other ART) per 100 babies born to HIV-positive pregnant mothers. **Source:** Demographic and Health Survey (DHS) **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase children's access to ART.	**Type 4 Indicator: Service Access** Highly active antiretroviral therapy (HAART) cover in eligible children aged 0–9 years. **Reason for use:** Marker of health system's ability to manage symptomatic HIV infection/AIDS in children. Monitor ARV uptake, PMTCT and early childhood development (ECD) cover for children. Appropriate for national and international reporting.	**Definition & Measure:** Number of children (aged <5 and 5–9 years) receiving HAART per 100 children eligible for HAART. **Source:** Department of Health (DoH) ART roll-out surveillance **Period:** Annual
Identify the extent to which young children are living with HIV-positive mothers.	**Type 2 Indicator: Family & Household Environment** Prevalence of HIV and AIDS in women with children <5 and <9 years in the same household. **Reason for use:** Indicator of vulnerability especially for very young children. High HIV levels strain resources and safety nets affecting the well-being of all children who live in them. Caregivers who have AIDS (particularly if not on HAART) struggle with childcare.	**Measures:** 1. Proportion of sampled pregnant women attending antenatal clinics who test positive for HIV. 2. Proportion of HIV-positive women with children <5 and <9 years of age. **Sources:** Annual HIV antenatal seroprevalence survey; Human Sciences Research Council (HSRC) HIV/AIDS prevalence surveys. **Period:** Annual where possible, otherwise every 5 years if data are available.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Estimate the numbers of children living with vulnerable caregivers. Ensure the child's rights to appropriate care, survival, protection and optimal development.	**Type 2 Indicator: Family & Household Environment** Caregiver health status **Reasons for use:** Measure of capacity of caregiver to give responsible and adequate care to young child. Associated with child survival and development outcomes. At ECD service level, to identify and monitor children who may have extra support needs, including those who live with aging, ill and disabled caregivers.	**Definition:** Caregiver is over 65 years of age, or is disabled, or has an illness that is incapacitating (has or is eligible for an old age pension or a grant). **Measure:** Proportion of children <5 and <9 years who live with an aged or disabled caregiver, including the chronically sick and those with a psychiatric condition that significantly interferes with daily functioning (has or is eligible for a grant). **Sources:** Census; Social Pensions Database (SocPen); HSRC HIV/AIDS prevalence surveys; SADHS. **Period:** Annual where possible (SocPen), otherwise every 5 years if data are available.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of infants dying in the first year of life.	**Type 1 Indicator: Child Status** Infant mortality rate (IMR) **Reasons for use:** IMR is a basic indicator of well-being and service access. Proxy measure of determinants of survival: socio-economic level and health service access and quality. Determinants of infant mortality include access to safe water, sanitation, nutrition, and maternal education level. Determining factors within the health system include the quality of maternal care, availability of vaccines in the first year of life, and effective referral systems. Appropriate for national and international reporting: UNICEF State of the World's Children; Convention on the Rights of the Child (CRC).	**Definition & Measure:** Number of deaths between birth and exactly 1 year of age per 1 000 live births in same calendar period. Disaggregate by male and female. **Sources:** Provincial and national DoH; SADHS; Stats SA; Maternity Registry. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children dying in the first 5 years of life.	**Type 1 Indicator: Child Status** Under-5 Mortality Rate (U5MR) **Reason for use:** Basic indicator of well-being and service access. Appropriate for national and international reporting: UNICEF State of the World's Children; MDGs; UNICEF Multiple Indicator Cluster Survey (MICS); CRC.	**Definition:** The U5MR is the probability of children dying between birth and their 5th birthday, expressed per 1 000 children born alive. **Measure:** Number of deaths between birth and exactly 5 years of age per 1 000 live births in same period. Disaggregate by male and female. **Sources:** Provincial and national DoH; SADHS; Stats SA. **Period:** Annual
Attain 90% immunisation coverage in the first year of life for all vaccines. 5-year-old children are covered for immunisation boosters.	**Type 4 & 5 Indicators: Child Status and Service Access** Immunisation rate **Reasons for use:** Measure of success of immunisation programme and of health system functioning. Preventive health measure of particular importance for young children who are vulnerable to health risks. Requirement for international reporting: State of the World's Children (up to first year); CRC; UNICEF MICS. To identify children in ECD services to be monitored for follow-up action.	**Definition & Measures:** Fully immunised children are defined at first visit where all required vaccinations are completed. The primary course of immunisation includes BCG, OPV 1, 2 & 3, DTP-Hib. The denominator is the expected doses (based on mid-year estimates of number of children <12 months and number of required doses for each vaccine) in the same period. Immunisation rate is expressed as children aged 0–12 months inclusive having completed primary courses of immunisation per 100 expected doses (in children <1 year) in the same period. The proportion of children 0–12 months inclusive who are fully immunised divided by the population <1 year old in each province. **Source:** District Health Information System (DHIS) **Period:** Monthly; annual.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor the prevalence of childhood disability in children <5 years. Plan for disability services to young children.	**Type 1 Indicator: Child Status** Age-specific prevalence rate of children with 1 or more activity limitations. **Reason for use:** To identify the group of children who require services over and above those required by non-disabled children.	**Definition:** Children <5 and <9 years with a health condition and related impairments, together with activity limitations in one or more domains of functioning. **Measure:** Proportion of children <5 years with a health condition and related impairments, together with activity limitations in one or more domains of functioning. **Sources:** Census; SADHS; DHIS (if a disability demographic variable is included in the survey). **Period:** Every 5 years
Identify children with moderate to severe disabilities for early intervention.	**Type 1 Indicator: Child Status** Children <2 years with moderate and severe disabilities. **Reasons for use:** Early identification of children with developmental disabilities for early intervention. Important for CRC reporting. To identify children in ECD services to be monitored for follow-up action.	**Definition:** Children <2 years screened for developmental disability at 6 weeks, 9 months and 18 months in the provincial primary healthcare system. **Measure:** Proportion of children attending health facilities who test positive using provincial DoH developmental screening tools. **Sources:** Provincial DoH (DHS); facility/ECD service level data – captured on admission forms and from Road to Health Card. **Note:** There are currently no provincial databases of children identified as disabled on screening. These should be established to provide routine administrative data. **Period:** Annual when provincial level data are available; otherwise audit every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the prevalence of wasting among children <5 years.	**Type 1 Indicator: Child Status** Wasting rate **Reason for use:** Measure of the nutritional status of young children. Indicator associated with extreme vulnerability to death, disease and poor developmental outcomes. Appropriate for national and international reporting: State of the World's Children; UNICEF MICS; CRC. To identify children in ECD services to be monitored for follow-up action.	**Definition & Measure:** Proportion of children <5 years with weight for age <2 standard deviations below the median weight for age reference value in a defined population of <5s per 100 children under the age of 5 years in that population in the same period (disaggregate by male and female). **Sources:** Provincial and national DoH; SADHS; Food Consumption Survey. **Period:** Every 5 years if data are available.
Reduce the prevalence of stunting among children <5 years.	**Type 1 Indicator: Child Status** Stunting rate **Reason for use:** Measure of nutritional status of children. May indicate economic hardship, infection or neglect. To identify children in ECD services to be monitored for follow-up action. Appropriate for national and international reporting: State of the World's Children; CRC; UNICEF MICS; MDGs.	**Definition & Measure:** Proportion of children <5 years with more than 2 standard deviations below the median weight for height reference value in a defined population of <5s in a given period. **Sources:** Provincial and national DoH; SADHS; Food Consumption Survey. **Period:** Every 5 years if data are available.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure survival and development of young children. Reduce household food insufficiency and child hunger.	**Type 1 & 2 Indicators: Child Status and Family & Household Environment** Child hunger; household food insecurity (insecure and at risk) **Reason for use:** Under-nutrition and hunger affect attention and concentration and have a major bearing on growth and cognitive development, especially for <5s.	**Definitions:** Household food insecurity, experience hunger: a score of 5 or more on the Hunger Scale Questionnaire of the National Food Consumption Survey (NFCS); At risk for hunger: A score of 1 to 4 is an at-risk household. Child hunger in the last 30 days: An affirmative response to any child question on the NFCS Hunger Scale (as used in the NFCS). **Measures:** Proportions of children <5 and <9 years in food insecure households and at-risk households; proportion households with children <5 and <9 years, in which children were reported to have experienced hunger in the last 30 days. **Sources:** NFCS (national DoH) **Period:** Every 5 years if possible **Note:** Not regularly monitored in this manner. Food insecurity is measured in some other household surveys but not with the degree of precision used in the NFCS.
Improve adult literacy levels. Improve intellectual capital available to children in the home.	**Type 2 Indicator: Family & Household Environment** Caregiver or female household member literacy **Reasons for use:** Caregiver literacy is associated with wide range of positive child outcomes. Appropriate for national and international reporting: State of the World's Children.	**Definition:** The United Nations Educational, Scientific and Cultural Organisation (UNESCO) definition of functional literacy is a person over 14 years who has completed 7 years formal education (Grade 7). For this indicator it is preferable where possible to measure *caregiver* literacy. However, as many surveys do not permit linkages between specific children and caregivers in the household roster, and as females are more likely to care for children than males, literacy in female household members older than 14 years could be used as a proxy. **Measure:** Proportion of children <5 and <9 living in households in which the caregiver is literate/females over 14 years are literate. Alternatively, use the PIMD data for adult education (see child poverty above). **Sources:** Census and other household surveys. **Period:** Depends on survey: Census every 10 years for small-area data (see also PIMD above); other national surveys provide data at more frequent intervals but only at provincial level.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure the right to a name, nationality, and access to social security for young children.	**Type 4 Indicator: Service Access** Birth registrations in children 0–5 and 0–9 years. **Reason for use:** Registrations are essential for access to social security and the public schooling system. Appropriate for national and international reporting: CRC; State of the World's Children; UNICEF MICS.	**Definition:** Children <5 years and <9 years whose births are registered with the Department of Home Affairs (DoHA). **Measure:** Proportion of births not registered relative to estimated population for 0–5 and 0–9 years. **Sources:** DoHA; Stats SA population estimates. **Period:** Annual
Improve access to the Child Support Grant (CSG) and other relevant grants for young children. Ensure the children's right to social security.	**Type 4 Indicator: Service Access** Social grant uptake by eligible children and caregivers. **Reasons for use:** Monitors access of children to social security, which protects their right to an adequate standard of living for survival and development. At ECD service level, to enable intervention and support for qualifying children or their caregivers.	**Definition:** Social grants include the CSG, Care Dependency Grant, Foster Care Grant and food parcels. **Measures:** Proportion of eligible children <5 and <9 years in receipt of the appropriate grant. **Source:** Department of Social Development (DoSD) Social Pension Database (SOCPEN) data **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Access to ECD services of different kinds in accordance with different family needs.	**Type 1 & 4 Indicators: Child Status and Service Access** Gross and net enrolment in ECD centres; gross and net enrolment in Grade R classes. **Reason for use:** Monitors phasing in of Grade R and access to provision for children pre-Grade R. International reporting requirement for education for all (EFA) (3–5 years); UNICEF MICS.	**Definitions:** The Gross Enrolment Ratio (GER) refers to the number of children enrolled in a given level of service, regardless of age, expressed as a percentage of the population in the relevant official age group. The Net Enrolment Ratio (NER) refers to the number of children in the official age group for a given level of service who attend an ECD or educational facility in that level, expressed as a percentage of the total population in that age group (ECD for <5s; Grade R for 5 years). **Measures:** GER and NER for children in registered ECD facilities and Grade R classes. GER and NER for children in Grade R classes. **Sources:** DoSD; Department of Education (DoE). **Period:** Annual **Note:** DoSD does not currently capture by age breakdown though these data are available from the registration and quality assurance forms.
Access to ECD services of different kinds in accordance with different family needs.	**Type 4 Indicator: Service Access** Attendance ratio of children enrolled in registered ECD facilities and Grade R. **Reason for use:** Indicator of value placed on service by parent or capacity of family to allow children to attend. If attendance is significantly lower than enrolment, this could be further explored. International reporting requirement for EFA, UNICEF MICS.	**Definition:** The attendance ratio is the number of days attended in relation to the possible number of days' attendance in the quarter. Poor attendance at a registered ECD facility or Grade R class is defined as: Enrolled children who are absent two or more consecutive days per week for more than a month. **Measures:** Number of days' attendance as a proportion of possible days of attendance at ECD facilities and Grade R. **Source:** ECD facility attendance registers (DoSD). These data are not currently aggregated. They can readily be collected for registered facilities during normal facility reviews. DoE for Grade R data. **Period:** Every 5 years based on special studies.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the quality of ECD services.	**Type 5 Indicator: Service Quality** ECD and Grade R educators with Level 4 or above (or equivalent). **Reason for use:** Training is associated with quality of service delivery. Level 4 is required for Grade R classes and for supervisors of facilities registered with social services. There are several upgrading programmes in the sector for raising qualifications of practitioners.	**Definition:** Number of staff in ECD facilities and Grade R classes, with responsibility for working with children, who have been trained at this level. **Measure:** Proportion of educators with Level 4 and above. **Sources:** This information is not generally available but as this is a key quality indicator, efforts should be made to remedy this problem. Departments of Education and Social Development-registered facilities; could also use Education, Training and Development Practitioners; Sector Education and Training Authorities; and National Learners' Records Database to track increases in trained staff; South African Council for Educators registrations for Level 5 and above. **Period:** Every 5 years based on special studies (should be available annually from administrative data).
Improve local level commitment to holistic ECD servicing.	**Type 4 & 5 Indicators: Service Access and Service Quality** Provision for ECD in Integrated Development Plans (IDP) at local level. **Reason for use:** Monitors implementation of holistic services for young children at local level (measure of political will).	**Definition:** IDPs with specific mention of ECD. **Measure:** IDPs with ECD activities and budgets. **Source:** Local Authority statistics/LPA **Period:** By IDP period which is currently annual in some local authorities but moving to multiple years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Existence of quality public programmes in support of ECD.	**Type 4 & 5 Indicators: Service Access and Service Quality** Public policies in support of ECD are monitored against departmental plans, programmes, budgets and delivery. **Reason for use:** Indicator of political will and departmental capacity – useful for tracking delivery against targets.	**Definition:** A monitoring system is in place. Measure of stage and degree of implementation in accordance with stated policies. **Measure:** Number of departmental programmes for young children being planned, resourced and implemented in the stated time period per department. **Sources:** Relevant departments (DoSD, DoE, DoH): departmental documents and records. **Period:** Every 5 years based on special studies.
Improve intersectoral collaboration for efficient and holistic ECD services.	**Type 4 & 5 Indicators: Service Access and Service Quality** Intersectoral ECD administrative information units are established in all provinces. **Reason for use:** ECD services are intersectoral. For sound planning, data from all relevant sectors should be taken into account. Provinces should establish central information systems from which departments can assess information for planning. Intersectoral planning is required in terms of the Integrated Plan for ECD.	**Definition:** The ECD information unit acts as an information hub and repository for all aggregated data and reports on ECD drawn from all relevant sectors. Functions: The unit is responsible for improving the efficiency and quality of data collection and ensuring smooth administrative data flow within ECD. The unit compiles intersectoral reports based on data from all relevant departments to facilitate planning at provincial and district levels. Reports from the Research, Monitoring and Evaluation, and Developmental Social Services Directorates pertaining to ECD should be housed in this unit. The unit creates a portal that houses ECD data and reports from all sectors and provincial departments, and ensures that the information is made available on the Provincial Government Intranet for access by all departments and directorates concerned with ECD. The unit requires at least the following capacities: The unit is headed by an appropriately senior person with ECD knowledge and research skills. The unit has the necessary staff compliment and equipment. The unit must have the capacity to source data and update information. **Measure:** Number of provincial departments with intersectoral ECD administrative information units by 2008. **Source:** Provincial DoSDs **Period:** Audit conducted in 2008.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improved quality of services, meeting of regulations under ECD service guidelines.	**Type 5 Indicator: Service Quality** Services meeting the registration requirements of the DoE for Grade R classes. Facilities meeting registration requirements of the DoSD for group care of more than 6 children up to 5 years. **Reason for use:** Acts as a composite indicator of quality, which is easy to measure regularly. Quality indicators such as pupil–teacher ratios and practitioner qualifications used in EFA reporting. Provincial departments are required to provide capacity development for ECD service delivery, to keep a provincial register of all registered ECD services and to monitor provision of registered and non-registered ECD services. Monitor compliance with the Children's Act (No. 38 of 2005), and the Children's Amendment Bill (No. 19 of 2006). Monitor compliance with facility regulations; monitor norms and standards for Grade R.	**Definition:** ECD and Grade R facilities that meet minimum benchmarked standards set by the DoSD and DoE. In terms of the ECD guidelines these should include: staff–child ratios, training levels of practitioners, physical standards, nutrition and health requirements, administrative and management requirements, meals and educational programmes. **Measure:** Proportion of facilities and Grade R classes that meet the standards. **Note:** Benchmarks for quality standards should be set and validated. Recommended standard levels: below minimum standard (does not meet registration requirements); at minimum standard (meets registration requirements); exceeds minimum standard (to be determined). **Sources:** DoSD; DoE. **Note the data gap:** A number of facilities are not known to departments. **Period:** Annual (data for registered ECD facilities to be updated on routine inspection visits by district offices).

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve and monitor budgetary allocations to ECD services in accordance with policy. Improvement of funding to enable poor children to access quality services.	**Type 4 & 5 Indicators: Service Access and Service Quality** Annual provincial budget allocations to ECD services. **Reasons for use:** Monitors whether budget share for ECD services is increasing in real terms. Monitors whether budget follows policy commitment to supporting services to families and community-based programmes in integrated plan and guidelines to ECD services.	**Definition:** Annual budgets allocated for ECD services in each relevant department: Social Development, Health and Education (including services to families and community-based programmes). **Measure:** Rand amount allocated for ECD services per year compared with previous annual allocations. **Sources:** Provincial DoSDs; provincial Treasuries. **Period:** Annual
	Type 4 & 5 Indicators: Service Access and Service Quality Registered ECD facility child subsidy cover. **Reason for use:** Subsidies enable poor children to attend facilities; subsidies should assist facilities to improve service quality.	**Definition:** The subsidy is paid by the province to the facility so as to contribute towards salaries and nutrition costs of facilities serving poor communities where fees do not cover running costs. **Measure:** Proportion of children <5 years in registered ECD facilities in receipt of subsidies relative to the estimated eligible population of qualifying children. **Sources:** Provincial departments: subsidy records of provincial departments of education and social development as well as local authorities (also health in some provinces); Stats SA for population estimates. **Note:** Unregistered facilities are not covered. **Period:** Annual

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Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 5 Indicator: Service Quality** Facilities in receipt of state subsidy covering 75% of operational costs. **Reason for use:** Sustainability of a facility is related to staff motivation, ability to offer a feeding programme, equipment available, etc.	**Definition:** Percentage of budget covered by subsidy. **Measure:** Proportion of subsidised facilities with 50% or more of operating costs covered by subsidy. **Source:** Not readily available. Requires a special survey of financial statements of subsidised facilities. **Period:** Every 5 years

Note:
1 See <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Strengthen caregivers' capacity to support child development, and improve the quality of childcare. Promote access to ECD services of different kinds in accordance with different family needs.	**Type 4 Indicator: Service Access** Caregiver support programme participation. **Reason for use:** Increasingly used form of ECD service provision for targeting those families outside of service loop and/or parents of infants.	**Definition:** Parental ECD support programme participation rate: Parents of 0–5 year olds who have participated in parenting education/support programmes for at least 4 months, inclusive of a practical focus on child stimulation. **Measure:** Proportion of parents/caregivers who have participated. **Sources:** DoSD statistics; departmental records and survey of non-governmental organisation (NGO) providers. **Period:** Every 3–5 years inclusive of departmentally funded and registered initiatives and NGO, faith-based organisations (FBOs) and other providers.
Access to ECD services of different kinds in accordance with different family needs.	**Type 4 Indicator: Service Access** Primary caregiver participation in parenting programmes. **Reason for use:** Increasing form of ECD service provision, targeting those families outside of service loop and/or parents of infants, and required in terms of the provincial integrated plan with some provision in Expanded Public Works Programme.	**Definition:** Primary caregivers of children <5 years in the province who have participated in parenting education/support programmes for at least 4 months, inclusive of a practical focus on child stimulation. **Measure:** Number of children of parents who have participated in such programmes (estimation of how many children per parent if this information is not available) for the province and each district. **Sources:** Departmental statistics; special surveys of NGO, FBO and other providers. **Period:** Annual for departmentally funded and registered initiatives; every 5 years inclusive of NGO, FBO and other providers.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Encourage ECD services to monitor service quality.	**Type 5 Indicator: Service Quality** Self-monitoring of ECD service providers. **Reason for use:** As this is an emerging service area, there are many different models. Monitoring and evaluation of their usefulness to parents and impact on young children is necessary to ensure quality.	**Definition:** Programmes measure intervention outcomes for caregivers and their impact on factors supporting the well-being of the young child (including developmental outcomes and access to services such as the CSG). **Measure:** Proportion of programmes with regular monitoring and evaluation activities. **Source:** Survey of ECD service providers **Period:** Baseline study and then as determined by departments.
Identify children at risk for targeted intervention. Identify orphans and children made vulnerable by HIV and AIDS (OVC) and mobilise support.	**Type 1 Indicator: Child Status** Children made vulnerable by HIV/AIDS. **Reason for use:** To monitor the proportion of children who are made vulnerable by HIV/AIDS. Household vulnerability: to assist with targeting households where children are extremely at risk.	**Definition:** A child made vulnerable by HIV/AIDS is below the age of 18 and: • has lost one or both parents; or • has a chronically ill parent (regardless of whether the parent lives in the same household as the child); or • lives in a household where in the past 12 months at least one adult died and was sick for three of the 12 months before he/she died; or • lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months; or • lives outside of family care (i.e. lives in an institution or on the streets). **Measure:** Percentage of children <18 who are vulnerable according to the definition. **Sources:** For the first point above, data are available from the Census and other national surveys. Other items require specific surveys. This indicator is most appropriate for local level early identification of affected children to facilitate effective support. The Speak for the Child Screen is a useful tool for such purposes, as is UNICEF's *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS* (UNICEF, 2005b). Survey local areas where children are most likely to be at risk. **Period:** Every 10 years for Census data; as required for local level interventions.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase the accessibility of services to young children.	**Type 4 Indicator: Service Access** Access to preventive health services (including developmental screening, immunisation, growth monitoring) and curative health services). **Reasons for use:** Young children are especially vulnerable to health risks and early intervention for difficulties is most effective. Children have the right to health services.	**Definitions & Measures:** Accessibility audits of communities and local authorities service provision for each service. **Source:** Not readily available – requires a special survey. **Period:** Periodic
Ensure the right to protection and optimal development.	**Type 2 Indicator: Family & Household Environment** Household crowding **Reason for use:** Crowding measures are objective, but the experience of crowding is culturally framed and subjective. High levels of crowding have been associated with poor outcomes and are a risk for child abuse.	**Definition:** Crowding is measured on a continuous scale. Richter (1989) uses a person:habitable room ratio. There is no accepted South African definition of 'crowding'. The Canadian National Occupancy standards sets household bedroom requirements according to these criteria: No more than 2 people per bedroom; parents or couples share a bedroom; children aged <5 years, either of same or opposite sex, may reasonably share a bedroom; children aged <18 years of the same sex may reasonably share a bedroom; a child aged 5 to 17 years should not share a bedroom with one aged <5 of the opposite sex; single adults aged 18 years and over and any unpaired children require a separate bedroom.[1] The Canadian standards are no doubt too high for a developing country but serve as a guideline. **Measure:** Average person: habitable room ratio for children <5 years and <9 years. The proportion of children <9 co-sleeping with sexualised older children and adults should be determined – this will be possible where a single habitable room is available for the household. **Sources:** Census and other household surveys; the HOME Inventory could be used in research studies for this purpose. **Period:** Every 10 years (more frequently using other household data).

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve access to early intervention programmes for children with additional support needs.	**Type 4 Indicator: Service Access Referral** and accessibility of health services or Education for Learners with Special Educational Needs (ELSEN) teams (Grade R) for children with additional support needs. **Reason for use:** Assist in monitoring the accessibility of relevant services for children with additional support needs.	**Definition:** Disabled children <5 and <9 years who receive learning and other relevant supports (e.g. children are referred to and access occupational therapy in the provincial health services or an ELSEN support programme in Grade R). **Measure:** The proportion of children identified with additional support needs who are referred to and access the relevant health or education support service. **Sources:** Provincial health and education statistics (special surveys); surveys conducted in selected educational facilities; DoE Education Management Information Systems data. **Period:** Periodic
Provide for children's basic needs. Promote children's rights to health and social and economic security through provision of the necessary supports and services.	**Type 2 Indicator: Family & Household Environment** Household food production **Reason for use:** Can have a significant modifying effect on poverty. The integrated plan for ECD specifically flags the provision of services to children (0–6 years), families and communities affected by HIV/AIDS, including access to food security for children and their families to reduce the risks of malnutrition and under-nutrition and to ensure positive growth. These families are likely to be vulnerable to hunger.	**Definition:** The presence of a domestic source of food (food gardens, livestock). **Measure:** Proportion of children in poor households that produce their own food (HOME Inventory may be used for this purpose). **Source:** Not readily available – requires a special survey. **Period:** Periodic

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Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 2 Indicator: Family & Household Environment** Children <5 and <9 years subject to living environment deprivation. Children in households without access to potable water. Children in households without access to adequate sanitation. Children without access to electricity. Children without access to adequate housing. **Reasons for use:** All these indicators are important for children's survival and health. Electricity reduces exposure to pollution, and the risk of burns (due to paraffin stoves), and risks for poisoning through the ingestion of fuels such as paraffin.	**Definition:** Living environment deprivation is defined in the PIMD.[2] Note that a PIMDC will be available once this volume is published. **Measures:** No access to potable water: the proportion of children <5 and <9 years living in households without piped water inside their dwelling or yard or within 200 metres of the dwelling. No access to adequate sanitation: the proportion of children <5 and <9 years living in households without sanitation (pit latrine with ventilation or flush toilet). No access to electricity: the proportion of children <5 and <9 years living in electrified dwellings. No access to adequate housing: proportion of children <5 and <9 years living in a household that is a shack (excluding traditional dwellings). **Sources:** PIMD (and PIMDC when developed); Census; regular household surveys; HSRC South African Social Attitudes Survey (SASAS). **Period:** Every 5 years (use most recent data)

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor quality of early learning environments. Strengthen caregiver capacity to provide a positive relationship and developmental environment that promotes psychosocial development.	**Type 2 Indicator: Family & Household Environment** Stimulation of early learning at home, including language development and numeracy. **Reason for use:** Used in the UNICEF MICS as the data provide key information on the activities that develop language and related capacities. Also indicates caregiver involvement with the child's development. Important for confidence and learning verbal skills, opportunity for participation. Provides evidence of a reading culture in general and age-appropriate children's books indicate an interest in literacy for children. Drawing and writing materials give children opportunities to develop fine motor skills, express themselves and develop an interest in writing.	**Definition:** Stimulation of early learning: A household member over 15 years of age engaged in any of the following activities with children <5 and 5–9 in the past 3 days: read books or looked at picture books; told stories; sung songs; taken the child outside the yard; spent time naming, counting, and/or drawing things. **Measure:** Proportion of caregivers who did each of the above in the period. **Source:** Not readily available **Note:** Can be measured in conjunction with studies of the home-care environment carried out at ECD facilities (that are linked to monitoring the effectiveness of caregiver programmes delivered by the facility). **Period:** Periodic **Note:** Surveys that include MICS early learning module would have to be developed; could also use the MICS module to survey caregivers whose children attend ECD centres and Grade R–3 classes.[3]

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 2 Indicators: Family & Household Environment** The following indicators also cover the quality of the child's early learning and emotional environment: 1. Caregiver affection for the child. 2. Availability of play equipment. 3. Exposure to different experiences with the family. **Reasons for use:** 1. Sensitive caregiving is associated with positive child outcomes and development of self-esteem/ffirmation of the child's importance. 2. Opportunity to be active, practise motor co-ordination, to imagine, create, construct. 3. Exposure to social, musical, artistic, sporting, or commercial events with the family imparts skills and demonstrates values in dealing with the outside world. The child's identity as a family member is publicly affirmed. Exposure to cultural events encourages an understanding of history. Includes	**Definition & Measures:** All to be developed for specific studies of caregivers attending ECD facilities. The HOME Inventory has relevant items. **Source:** Not readily available – requires a special study. **Period:** Periodic **Note:** Indicators in this section are best measured in conjunction with studies of the home-care environment carried out at ECD facilities (that are linked to monitoring the effectiveness of caregiver programmes delivered by the facility).

Policy goal	Indicator and reason for use	Definition, measure, period and data source
	exposure of the child to appropriate children's TV and radio programmes.	
Strengthen the capacity of families to protect and care for children.	**Type 2 Indicator: Family & Household Environment** Comfort **Reason for use:** The range includes conditions that threaten health to those that cause sleep disturbances and other discomforts which interfere with daily life. The indicator estimates whether the key basic personal needs for children are being met.	**Definition:** Suggested items for comfort are availability of a blanket, shoes and two sets of clothes. **Measure:** Proportion of children who have a blanket, shoes and two sets of clothes. **Source:** Not readily available – requires a special survey or study of children attending ECD facilities. **Period:** Periodic
Monitor children's right to safety.	**Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment** Children's vulnerability to violent crime (<9 years). Neighbourhood vulnerability of children. **Reason for use:** Identify areas in which the risk is high. To monitor children's exposure to violent crime and monitor children's rights to safety and protection.	**Definition:** Violent crimes against children <12 as defined in the Common Law and other Statutes: murder, common assault, assault with grievous bodily harm, and ill-treatment of a child reported to the South African Police Services (SAPS). **Measures:** The proportion of children <12 years in each province and in each SAPS zone and precinct who are victims of *all* violent crime (treated per crime category and as a total score based on the sum across all crime categories) per year. **Source:** SAPS **Period:** Annual **Note:** Age and gender disaggregation is *not* available in annual SAPS reports or website statistics. These statistics should be provided by the Provincial Commissioner on a routine basis each year to aid service planning in the province and the districts.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 1 Indicator: Child Status** Traffic-related and unintentional injuries in early childhood. **Reason for use:** Young children are at risk for sustaining traffic-related and unintentional injuries, particularly burns, poisoning, foreign object ingestion and drowning.	**Definition:** Injuries sustained during childhood include fatal and non-fatal injuries related to transport; fatal and non-fatal unintentional injuries unrelated to transport; and fatal and non-fatal violence-related injuries (see Chapter 7 in this volume for detailed definitions). **Measure:** Child injury morbidity and mortality rates. **Sources:** National Injury Morbidity Surveillance System; private and state clinics and hospitals; mortuaries; Department of Transport. **Period:** Annual
	Type 2 Indicator: Family & Household Environment Exposure to domestic violence. **Reason for use:** To monitor the extent of children's exposure to domestic violence.	**Definition:** Children (<5 and <9 years) in households in which parents who participated in a survey admitted to partner violence in the past year. **Measure:** The proportion of parents with children (<5 and <9 years) at home, who admitted to perpetrating or being victims of partner violence in the past year (the number of children <5 and <9 years in the household should be used to indicate the probable numbers of children in each province likely to be exposed to domestic violence). **Sources:** HSRC SASAS (most recent 2003); alternatively, a retrospective survey of adults on their childhood experiences using measures designed for the UN study on violence to children,[4] or another reliable violence exposure measure. **Period:** Every 5 years if feasible. →

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 1 & 2 Indicators: Child Status and Family & Household Environment** Children exposed to physical punishment at home. Caregivers who approve of physical punishment. Caregivers who use physical punishment. **Reason for use:** To monitor the child's right to freedom from violence; monitoring changes in caregiver attitudes and practices.	**Definitions:** The proportions of adults with children (<5 and <9 years) who: i) support the use of physical punishment at home, and ii) use physical punishment. **Measure:** The proportion of adults with children (<5 and <9 years) who: i) support the use of physical punishment at home, and ii) use physical punishment. **Sources:** Adult attitudes and behaviour: HSRC SASAS (most recent 2003); children and retrospective reports; specific studies such as the UN study (not available for South Africa). **Period:** Every 5 years if feasible. A baseline children's study is needed as no representative data currently exist.
Encourage disclosure of HIV status in women with children so as to increase access to services for vulnerable children.	**Type 2 Indicator: Family & Household Environment** Acceptance of caregiver HIV status. **Reason for use:** May encourage disclosure during pregnancy which in turn would reduce the risk of HIV transmission to the infant, and an early death for the child.	**Definition & Measure:** For use with HIV-positive women during pregnancy and after the birth of their child. **Source:** Not readily available – requires a special survey. There is a set of questions in HSRC SASAS (2003) regarding acceptance of diversity, which may be a good starting point for a measure of this nature. See also HSRC HIV/AIDS prevalence surveys. **Period:** Periodic

Notes:
1 See <http://www.stats.govt.nz/analytical-reports/affordability-report/technical-notes.htm#crowding>.
2 See <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.
3 MICS questions at <http://www.childinfo.org/>.
4 <www.crin.org>.

Indicators for monitoring childhood disability

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children living in poverty.	**Type 1 Indicator: Child Status** Child poverty **Reason for use:** Child poverty is associated with the widest range of insults to child survival, health and development. Appropriate for national and international reporting: State of the World's Children; Millennium Development Goals.	**Definition & Measure:** Proportion of children in households experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Stats SA); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.
Monitor the prevalence of childhood disability.	**Type 1 Indicator: Child Status** Age-specific prevalence rate of children with 1 or more activity limitations. **Reason for use:** To identify the group of children who require services over and above those required by non-disabled children.	**Definition:** All children with a health condition and related impairments together with activity limitations in one or more domains of functioning. **Measure:** Proportion of children with a health condition and related impairments together with activity limitations in one or more domains of functioning (disaggregated by age: 0–4 years, 5–9 years, 10–14 years, 15–17years [inclusive]). **Sources:** Census; Stats SA; South African Demographic and Health Survey*; District Health Information System*; population-based national disability surveys; small-scale population-based surveys. **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce preventable causes of impairments and health conditions.	**Type 1 Indicator: Child Status** Cause-specific prevalence rate of children with disabilities. **Reason for use:** Monitoring the causes of impairments will inform disability prevention strategies.	**Definition:** Classification of cause according to the following categories: congenital; infection; trauma; birth injuries; unknown. **Measure:** The proportion of children whose disability is classified according to the above categories. **Source:** Department of Health (DoH) (service-related data) **Period:** Every 5 years
Monitor physical accessibility of the environment.	**Type 3 Indicator: Neighbourhood & Surrounding Environment** Accessibility of local authority facilities to disabled children. **Reason for use:** Assist in monitoring physical accessibility of children's environment.	**Definition:** Compliance with accessibility principles in transport, entrances, exists and insides of buildings, housing, pathways, lighting, signage, etc. **Measure:** Accessibility audit of communities and local authorities. **Source:** Accessibility audit of local authorities **Period:** Every 5 years
	Type 3 Indicator: Neighbourhood & Surrounding Environment Physical accessibility of the child's local school. **Reason for use:** Assist in monitoring physical accessibility of children's education facilities.	**Definition & Measure:** Accessibility of schools in terms of entrances, exits, inside corridors, doors, lifts/stairs, as well as toilets. **Source:** School accessibility audit **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve disabled children's access to rehabilitation services.	**Type 4 Indicator: Service Access** Disabled children in receipt of rehabilitation services. **Reason for use:** Assists in monitoring children's access to rehabilitation.	**Definition:** Disabled children's access to rehabilitation services which address their needs. **Measure:** Proportion of disabled children requiring rehabilitation services who currently receive rehabilitation therapy (including community-based rehabilitation). **Sources:** Surveys conducted in selected facilities; hospital and clinic records; outpatient files. **Period:** Every 5 years
	Type 4 Indicator: Service Access Disabled children's access to assistive devices. **Reason for use:** Assists in monitoring access to assistive devices.	**Definition:** Access to assistive devices which address the needs of the child. **Measure:** Proportion of disabled children issued with appropriate assistive devices. **Sources:** Surveys conducted in selected facilities; hospital and clinic records; outpatient files. **Period:** Every 5 years
	Type 4 Indicator: Service Access Disabled children requiring specialised learning support who currently receive it. **Reason for use:** Assists in monitoring disabled children's access to educational services.	**Definition:** Disabled children who receive learning support. **Measure:** Proportion of school-age disabled learners requiring specialised educational support. **Sources:** Surveys conducted in selected educational facilities; Department of Education (DoE) Education Management Information System (EMIS) data. **Period:** Every 5 years
Increase access to the Care Dependency Grant (CDG) for eligible disabled children.	**Type 4 Indicator: Service Access** CDG uptake for eligible disabled children. **Reason for use:** Assists in monitoring disabled children's access to social security.	**Definition:** Eligible disabled children in receipt of CDGs. **Measure:** Proportion of CDG beneficiaries. **Source:** Department of Social Development's (DoSD's) Social Pension Database (SOCPEN) **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase disabled children's access to education.	**Type 4 Indicator: Service Access** Disabled children attending primary and secondary school. **Reason for use:** Assists in monitoring disabled children's access to education.	**Definition:** Disabled children's access to primary and secondary school. **Measure:** Proportion of school-age disabled children attending different types of educational facilities: mainstream school; full-service school; special needs school; training centre; stimulation centre. **Source:** DoE EMIS[2] data at national, provincial and district levels. **Period:** Annual
Improve the quality of education for disabled children.	**Type 1 & 5 Indicators: Child Status and Service Quality** Pass rates for disabled children. **Reason for use:** Assists in monitoring the quality of education for disabled children.	**Definition:** Disabled children who are passed to the next grade and who pass Grade 12. **Measure:** Proportion of disabled children attending mainstream, full-service, or special needs schools who pass grades 7, 9 and 12. **Source:** National and provincial pass rates for grades 7, 9 and 12 as collected by EMIS. **Period:** Annual

Notes:
1 See <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.
2 EMIS data should be disaggregated by child disability status.
* Denotes potential source, if a disability demographic variable is included in the survey.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor levels of participation and social inclusion of disabled children.	**Type 1 Indicator: Child Status** Social inclusion of disabled children. **Reason for use:** Provides indication of inclusive nature of these groups' activities and whether disabled children are accessing them.	**Definition:** Active participation of disabled children in designated group activities. **Measure:** Proportion of disabled children who are members of youth, recreation, sports, religious and other groups. **Sources:** National disability or youth surveys; smaller-scale surveys developed for specific purposes. **Period:** To be determined in specific studies.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor the psychosocial well-being and mental health of disabled children.	**Type 1 Indicator: Child Status** Mental health status of disabled children. **Reason for use:** Assist in monitoring the mental health needs of disabled children.	**Definition:** Diagnostic status of disabled children according to the Diagnostic and Statistical Manual of the American Psychiatric Association. Recommended assessment tool: Diagnostic Interview Schedule for Children. **Measure:** Proportion of disabled children with any diagnosis. **Source:** Health information systems at local health facilities and schools. **Period:** To be determined in specific studies.
Increase disabled children's access to education.	**Type 4 Indicator: Service Access** Disabled children's attendance of Early Childhood Development (ECD) facilities. **Reason for use:** Assists in monitoring disabled children's access to education.	**Definition:** Disabled children aged 3–6 years attending any ECD facility. **Measure:** Proportion of disabled children attending ECD facilities. **Source:** ECD facilities **Period:** Annual
	Type 4 Indicator: Service Access Placement of disabled children outside of the formal education system. **Reason for use:** Monitoring disabled children's access to no or informal educational facilities.	**Definition:** School-age (5 for Grade R and 6–17 for all eligible children) disabled children who are at home, or in an informal education facility. **Measure:** proportion of school-age children not attending formal school and who are: • At home; or • Attending an informal educational facility. **Source:** Audits through disability sector or population-based surveys. **Period:** Every 5 years
Improve access to the Child Support Grant (CSG) by children with mild disability.	**Type 4 Indicator: Service Access** CSG uptake for disabled children who are not eligible for CDG. **Reason for use:** Assists in monitoring disabled children's access to social security.	**Definition:** Disabled children who are not eligible for CDGs in receipt of CSG. **Measure:** Proportion of CSG beneficiaries (Denominator: Number of CSG beneficiaries who are disabled.). **Source:** Data source is not clear as the CSG application form does not indicate disability status; use of disability sector for information (for denominator: DoSD SOCPEN database). **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Processing CDG application as fast as possible.	**Type 5 Indicator: Service Quality** CDGs processed on time. **Reason for use:** Assists in monitoring disabled children's access to social security.	**Definition:** Adherence to standards for processing CDGs set by the DoSD. **Measure:** The proportion of CDGs processed within the period specified by the DoSD. **Source:** DoSD district and provincial records **Period:** Annual
Provide rapid access to rehabilitation services.	**Type 5 Indicator: Service Quality** Waiting time for first appointment for rehabilitation therapy. **Reason for use:** Assists in monitoring quality of rehabilitation services for disabled children.	**Definition & Measure:** Number of days between referral for rehabilitation and first appointment for assessment and treatment. **Source:** Hospital and clinic records **Period:** To be determined in specific studies.
Improve family-centredness of rehabilitation services.	**Type 5 Indicator: Service Quality** Degree of family-centredness of rehabilitation services as perceived by caregivers of disabled children. **Reason for use:** Assists in monitoring quality of rehabilitation services for disabled children.	**Measure:** Measure of Processes of Care – interviewer or self-administered questionnaire for caregivers. Scoring the questionnaire provides 5 quantitative scores measuring 5 components of family-centred therapy. **Source:** Selected hospital and clinic rehabilitation departments **Period:** To be determined in specific studies.
Improve the quality of rehabilitation services for disabled children.	**Type 5 Indicator: Service Quality** Ratio of trained paediatric rehabilitation staff per 100 000 disabled children. **Reason for use:** Assists in monitoring the quality of special rehabilitation services for disabled children.	**Definition:** Availability of rehabilitation staff who are trained to provide healthcare to children with disabilities. **Measure:** The number of trained paediatric rehabilitation staff per 100 000 disabled children. **Source:** DoH **Period:** Every 5 years

Indicators for monitoring specific difficulties of learning

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Within the policy of inclusive education (DoE, 2001), to provide appropriate learning support for learners with specific difficulties of learning (SDLs).	**Type 1 Indicator: Child Status** Reading performance delay (as proxy for scholastic performance delay). **Reason for use:** As a preliminary screening, to identify learners with SDLs.	**Definition:** Reading performance delay is defined as a score of 0.80 or less on the Reading Performance Index (RPI). **Measures:** 1a. For all Grade 3s, the RPI is calculated from learners' instructional level of performance on a curriculum-based Informal Reading Inventory (performance age divided by chronological age). Proportion of learners with an RPI of 0.80 or less at the end of Grade 3. **Source:** Not currently available, but would be Department of Education (DoE). Measure would have to be designed and validated and regularly used. 1b. An alternative measure that could provide a very coarse screening indicator of children who have difficulties with reading would be: the proportion of learners who do not pass the Grade 3 systemic evaluations. **Source:** Only available for the Western Cape (recommended that the Western Cape approach be adopted); DoE. **Period:** Every 5 years
	Type 4 Indicator: Service Access Educator access to school-based support. **Reason for use:** The school-based support team is the first level of resource for educators to get support in devising and carrying out programmes of assistance for those with SDLs and other disabilities.	**Definition:** Support teams are defined in the *Summary Outline of the Draft National Strategy for Screening, Identification, Assessment and Support* (DoE, 2004a) and the *Conceptual and Operational Guidelines for the Implementation of Inclusive Education: District-based Support Teams* (DoE, 2004b). **Measures:** 1. Proportion of schools with a functioning school-based support team. 2. Proportion of classroom educators (grades 1–6) receiving individual help in relation to SDLs through the school-based support team in a given year. **Source:** DoE Education Management Development Centres (EMDCs) **Period:** Departmental audit every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
	Type 4 Indicator: Service Access Educator access to district-based support. **Reason for use:** The district-based support team is the second level of resource for educators to get more specialised assessment and support in assisting those with SDLs and other disabilities.	**Definition:** Support teams as above. **Measures:** 1. Number of functioning district-based support teams per district in each province. 2. Proportion of schools receiving systemic help relating to SDLs through their district-based support team annually. 3. Number of classroom educators (grades 1–6) receiving individual help in relation to SDLs through their district-based support team annually. **Source:** Not currently available; DoE EMDCs. **Period:** Departmental audit every 5 years.
Improve the quality of special educational services for children with SDLs.	**Type 5 Indicator: Service Quality** Quality of learning support available at the classroom level. **Reason for use:** Assists in monitoring the quality of education support services.	**Definition:** Foundation Phase is grades 1–3 and Intermediate Phase is grades 4–6. **Measure:** Proportion of Foundation and Intermediate Phase educators with post-basic specialised training in inclusive education. **Source:** DoE Education Management Information System (EMIS) **Period:** Audit every five years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 5 Indicator: Service Quality** Perceived usefulness of educator guidance received from school-based and district-based support teams. **Reason for use:** Whether classroom educators have received useful guidance in relation to those with SDLs and other disabilities from the school-based and/or the district-based support teams is an indication of the effectiveness of the respective support structures.	**Definition:** Useful guidance is assistance that the educator found helpful (based on responses to questions in an audit). Support teams as above. **Measure:** Proportion of classroom educators (grades 1–6) who report receiving useful guidance over the past year from: • Their school-based support team; • Their district-based support team. **Source:** Not currently available; DoE EMDCs. **Period:** Departmental audit every 5 years.
	Type 5 Indicator: Service Quality Process of educator-based support for SDLs. **Reason for use:** Whether educators are engaged in continuous programme re-evaluation and adaptation in their process of support for learners with SDLs and other disabilities is an indication of educator competence.	**Definition:** Support must be in terms of the principles of continuous programme re-evaluation and adaptation developed by the Directorate of Inclusive Education (DoE, 2004a). **Measure:** Proportion of classroom educators (grades 1–6) who successfully describe and demonstrate the principle of continuous programme re-evaluation and adaptation in their process of supporting those with SDLs. **Source:** Not currently available; DoE EMDCs. **Period:** Departmental audit every 5 years.

Indicators for monitoring street children

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children living in poverty.	**Type 1 Indicator: Child Status** Child poverty **Reasons for use:** Child poverty is associated with the widest range of insults to child survival, health and development. Appropriate for national and international reporting: State of the World's Children; Millennium Development Goals.	**Definition & Measure:** Proportion of children in households experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Stats SA); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.
Monitor numbers of street children for service planning. Ensure the existence of accessible, quality services for street children.	**Type 1 Indicator: Child Status** Children on the streets **Reasons for use:** Estimate of street child numbers. Track extent of support services for children on the streets.	**Definitions & Measures:** 1. Number of children in registered shelters at the beginning of each month; number of new admissions; average number sleeping each night (per month) (individual children must be counted so as to avoid double counting of children who pass through more than once in the period). 2. Number of children who make contact with a shelter in the month but cannot stay due to lack of accommodation. 3. Numbers of known street children, day strollers and children who are new to the streets who interact with services in a given month. 4. Number of children in shelters and outreach programmes who have informed the staff that they have been involved in commercial sexual exploitation in that month. **Sources:** Possible: registered shelters and outreach programmes; subsidy data and other information that may be held by provincial Departments of Social Development (DoSDs). **Period:** Annual, based on averages of monthly data

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→		**Notes:** All relevant data should be supplied to the provincial DoSDs and aggregated monthly and then annually. There is a risk of double counting in that children may attend more than one shelter or programme in a given period. This will compromise data accuracy but is probably the best data available. 5. Children living on the streets. **Source:** Special surveys of children living on the streets. **Period:** Every 5 years if possible in areas in which the presence of significant numbers of children is evident (as judged by municipal authorities and local non-governmental organisations). **Note:** Homeless children on the streets need to be sampled using the concept of time-location sites, a method of sampling mobile youth populations that minimises bias and adheres to the tenets of probability sampling. Sampling of street children should be confined to children who actually slept on the streets the night before the survey.
Identify high-risk areas to inform preventive service planning.	**Type 4 Indicator: Service Access** Street child origins **Reason for use:** To develop prevention services in areas where these services are most needed.	**Definition & Measure:** Areas from which children come to the streets are the Social Services Districts and suburbs where the child's home is located. These should be mapped on the Geographic Information System and provided to District Office welfare planners so as to render preventive services (particularly strengthening of families in need of support). **Sources:** Possible: street children service provider research study; information that may be held by provincial DoSDs. **Notes:** Data may be available from some shelters and outreach programmes, and will provide a rough estimate of origins. **Period:** Every 5 years →

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 4 Indicator:** **Service Access** 1. Availability of urban street child services. 2. Availability of street child services located outside the central business district (CBD), in communities of origin. **Reason for use:** Monitor street children's access to services.	**Definitions:** Services are directed to children living on the streets as well as day strollers and those who sleep in shelters. 1. There are registered services in each urban area in which there are street children. 2. There are registered services in or close to areas from which high proportions of street children come. Services outside the CBD would be those closest to the sources from which the children originate prior to moving to the streets of the CBD. Registered services are those registered with the local authority and/or provincial DoSD. **Measures:** 1. Number of shelters and drop-in centres registered with the DoSD. 2. Proportion of registered shelters and drop-in centres outside of the CBD and location of these facilities. **Sources:** Possible: known street shelters and programmes; provincial DoSDs. **Period:** Annual
	Type 4 Indicator: **Service Access** Access to physical and mental healthcare services. **Reason for use:** Monitor street children's access to healthcare services.	**Definition:** Street children who have received health services for their physical and mental healthcare needs. **Measure:** Proportion of street children with health problems who receive the necessary physical and mental healthcare (disaggregated by problem – including drug and alcohol abuse). **Source:** Street children service provider research study **Period:** Every 5 years
	Type 4 Indicator: **Service Access** Street children's access to disability services. **Reason for use:** Monitor disabled street children's receipt of services.	**Definition:** The World Health Organisation's International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) should be used. A child with disabilities has a health condition and related impairments together with activity limitations in one or more domains of functioning. **Measure:** Proportion of street children with disabilities who have successfully accessed disability services and have the necessary supports for their specific disability. **Source:** Street children service provider research study **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure the right to name, nationality, and access to services for street children.	**Type 4 & 1 Indicators: Service Access and Child Status** Street children who have birth certificates or identity documents. **Reason for use:** Birth certificates or identity documents are essential for accessing health, social and other services.	**Definition & Measure:** Proportion of children in street shelters who have birth certificates or identity documents (if they are old enough). **Source:** Registered street shelters and outreach programmes – to be collated by provincial DoSDs (research study). **Period:** Every 5 years
Improve the quality of services to children on the streets.	**Type 5 Indicator: Service Quality** Regular assessments of registered facilities. **Reason for use:** Monitor existence and quality of services for street children.	**Definition:** Services for street children are visited and assessed on application for registration at periods set by the relevant statutes or regulations. Use the service provision guidelines of the Inter-ministerial Committee on Youth at Risk. **Measure:** Proportion of registered services that have received assessments and the outcomes of these assessments. **Source:** Provincial DoSDs (research study) **Period:** Every 5 years
Prevent law enforcement abuse of street children.	**Type 1 Indicator: Child Status** Abusive encounters with police officers. Children's experience of their treatment by police officers and security agents. **Reason for use:** Monitor street children's rights to be protected from abuse and their equality before the law.	**Definition:** Abusive encounters are assessed by the child's account and would include verbal abuse and physical assault. The measure is based on the number of encounters for each child surveyed within a specific period. **Measure:** Proportion of encounters with police officers and security personnel that are abusive (according to the child). **Source:** Street children service provider research study **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Prevent law enforcement abuse of street children, and increase children's service access via police.	**Type 5 Indicator: Service Quality** 1. Street child protocols for law enforcement agencies. 2. Law enforcement officers are trained in the street children protocol. **Reason for use:** Prevent abuse of children by law enforcement and increase service access.	**Definition:** Law enforcement agencies have a protocol for dealing with street children that includes both referral to shelters and a ban on abuse. Use the service provision guidelines of the Inter-ministerial Committee on Youth at Risk. **Measures:** 1. Proportion of law enforcement agencies in an area that have such protocols. 2. Proportion of law enforcement officers in each agency who have been trained in the street children protocol. **Sources:** Possible: South African Police Services precincts; private security agencies; metro police (research study). **Period:** Every 5 years
Increase street children's access to education.	**Type 4 Indicator: Service Access** Number of street children attending formal schooling. **Reason for use:** Monitor whether street children have been appropriately placed in school and are staying in school.	**Definition:** Child attends formal schooling while resident in a shelter. Educational assessments used by the Department of Education (DoE) are used to place a child in the appropriate grade based on past scholastic history and current ability. **Measures:** 1. Proportion of children from shelters who have received assessments for placement in ability-appropriate grades (not necessarily age-appropriate grade). 2. Proportion of children from shelters who attend school. **Source:** Registered shelter data supplied to provincial DoSDs. **Period:** Annual aggregates (based on quarterly counts by the shelter while child is in the shelter and for the first year of placement).
Monitor street children's educational performance and outcomes.	**Type 1 Indicator: Child Status** Educational achievement **Reason for use:** Monitor street children's uptake of educational services and educational outcomes.	**Definition:** Literacy according to the United Nations Educational, Scientific and Cultural Organisation's Education for All is Grade 7. **Measure:** Of those street children who could be reintegrated into mainstream education, the proportion who achieve functional literacy and numeracy (Grade 7). **Source:** Alternative learning centres research study **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 5 Indicator: Service Quality** Alternative learning centres are registered as private schools. **Reason for use:** Ensure quality education services.	**Definition:** An alternative learning centre is an educational institution that provides instruction (schooling as well as other skills) to children who are on the streets and outside the formal education system. **Measures:** 1. Proportion of alternative learning centres that are registered as private schools. 2. Proportion of alternative learning centres whose courses meet South African Qualifications Authority standards. **Sources:** DoE; street children service provider research study. **Period:** Every 5 years

Note:
1 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.

Indicators for monitoring child labour, trafficking and commercial sexual exploitation

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve integration of information systems for recording the incidence of harmful labour, trafficking and commercial sexual exploitation (CCSE).	**Type 5 Indicator: Service Quality** Children exposed to the worst forms of labour, trafficking and CCSE are captured on the Child Protection Register (CPR). **Reason for use:** To fulfil the requirements of Child Labour Action Plan (CLAP), the Children's Act (No. 38 of 2005) and the Children's Amendment Bill (No. 19 of 2006).	**Definition:** The CPR is established in terms of standard provincial protocol to record data on worst forms of child labour, trafficking, and CCSE. **Measure:** Number of social services districts and provinces that record data on worst forms of child labour and CCSE on the CPR. **Source:** Not available at present. The Department of Social Development (DoSD) has an agreement with South African Police Services (SAPS), Department of Justice (DoJ), and Department of Labour (DoL) for child labour, trafficking and CCSE cases to be logged on provincial CPR. **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
	Type 5 Indicator: Service Quality An integrated database on the worst forms of labour, CCSE and child trafficking is in place in the national DoSD. **Reason for use:** To facilitate estimates of the problems and for reporting purposes. Data should be integrated at provincial and national level, and co-ordinated by the DoSD. To fulfil the requirements of CLAP, the Children's Act and the Children's Amendment Bill.	**Definition:** The integrated database on worst forms of labour, CCSE and child trafficking collates data from the provincial CPRs and relevant departments under the management of the head of Child Protection in the provincial and national DoSD head office. **Measure:** The database is established and receives data from provincial CPRs and relevant departments. **Source:** National DoSD **Period:** The DoSD provides annual reports.
Reduce the number of children living in poverty.	**Type 1 Indicator: Child Status** Child poverty **Reason for use:** Child poverty is associated with the widest range of insults to child survival, health and development. Appropriate for national and international reporting: State of the World's Children; Millennium Development Goals.	**Definition & Measure:** Proportion of children in households experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Stats SA); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor reports of children experiencing CCSE, production of pornography, and child labour.	**Type 1 Indicator: Child Status** Children involved in: • Worst forms of labour; • Trafficking; • CCSE; • Production of pornography; and • Child labour. **Reason for use:** To monitor incidence of each. Note that as these are illicit activities, the data are not likely to be accurate.	**Definition:** For all, see the Children's Act, the Children's Amendment Bill and other relevant Acts. **Measures:** 1. Number of children reported as being involved in trafficking, CCSE, production of pornography, and child labour. 2. Number of successful prosecutions of those who employ under-age children, and children in harmful labour in a reporting period (disaggregated by sex and age: for CCSE and pornography <12 years, 12–15 years and 16–17 years; and for labour <15 years and 15–17 years). **Sources:** Not readily available at present. Very limited data available. Possibilities: ChildLine; DoJ; SAPS; Molo Songololo and relevant non-governmental organisations (NGOs); cases on websites[2] and the Film and Publications Board toll-free number); specific research studies. **Period:** Every 5 years
Increase prosecution of those who procure children for CCSE.	**Type 5 Indicator: Service Quality** Successful prosecutions of those who procure and use children for CCSE. **Reason for use:** To discourage the prostitution industry from using children, and to monitor the implementation of the Children's Act and the Children's Amendment Bill.	**Definitions:** Procurement and use of children for CCSE. **Measure:** Number of successful prosecutions of those who procure and use children for CCSE. **Source:** DoJ **Period:** Annual
Estimate and monitor the number of children who are working excessive hours.	**Type 1 Indicator: Child Status** Children working excessive hours. **Reason for use:** To monitor the extent of children working excessive hours.	**Definition:** Children <15 years engaging in 12 or more hours per week of economic activities (agriculture, trade, manufacturing, private households), 14 or more hours per week of household chores, and 12 or more hours of school labour (CLAP recommendations). **Measure:** Proportion of children working excessive hours (<15 years). **Sources:** Survey of Activities of Young People (SAYP) or Time Use Survey (TUS); specific research studies. **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor estimates of the number of children whose educational well-being is placed at risk by undertaking any form of work.	**Type 1 Indicator: Child Status** Working children out of school. **Reason for use:** Early warning indicator of families under severe stress.	**Definition:** Children not attending school due to work (stratify by domestic and non-domestic). **Measure:** Proportion of working children who report being out of school (10–14 and 15–17 years). **Source:** SAYP or TUS; specific research studies. **Period:** Every 5 years
Estimate incidence of trafficked children.	**Type 1 Indicator: Child Status** Trafficked children **Reason for use:** To monitor the extent of child trafficking.	**Definition:** Trafficked children (Children's Act definition). **Measures:** 1. Arrests for trafficking in children. 2. Specific research studies conducted from time to time. 3. Estimates provided by NGOs including helplines. 4. Data from detention centres. 5. CPR and integrated DoSD database – see above. **Sources:** No integrated source at present. This data should be incorprated into the DoSD database from the CPR and depatmental reports: SAPS, DoJ, Molo Songololo, other relevant NGOs, Department of Home Affairs (DoHA). **Period:** Every 5 years
Monitor inspections of places of employment that seek to determine the existence of illegal employment of children.	**Type 5 Indicator: Service Quality** Annual DoL inspections for child labour. **Reason for use:** To fulfil the requirements of CLAP, the Children's Act and the Children's Amendment Bill.	**Definition:** The DoL is required to undertake inspections to determine whether illegal working conditions (pertaining to children) exist. **Measure:** Number of DoL inspections of this nature per annum in each province. **Sources:** Provincial DoL; specific research studies. **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Provide services to children experiencing exploitative labour.	**Type 5 Indicator: Service Quality** Appropriate professionals are trained to detect and provide services to children in hazardous child labour, and CCSE. **Reason for use:** To fulfil the requirements of CLAP. This indicator seeks to establish the extent to which these professionals have sufficient understanding of the problem to be able to detect and refer appropriately. Particularly relevant in known CCSE and labour hot spots.	**Definition:** Appropriate professionals include: police prosecutors, health workers, social workers, educators and DoL inspectors. For each professional group: have received training in exploitative, harmful and hazardous child labour practices and CCSE, as well as appropriate grants and services for children who have been involved in these kinds of labour and CCSE. **Measure:** Proportion of DoL inspectors and other relevant professionals who have attended training on exploitative, harmful and hazardous child labour practices, appropriate grants and services. **Sources:** None at present. Possibly DoSD or DoJ; specific research studies. **Period:** Every 5 years
	Type 4 & 5 Indicators: Service Access and Service Quality Services provided to children who have been removed from harmful labour and CCSE. **Reason for use:** To monitor access of these very vulnerable children to appropriate services. To monitor compliance with the CLAP, the Convention on the Rights of the Child (CRC), and the Constitution.	**Definition:** Social grants and health, educational and social services (including therapeutic services and statutory placements) provided to children who have been removed from harmful labour and CCSE. **Measures:** Number of children recorded as removed from harmful labour and CCSE have been referred to appropriate services (including grants). **Sources:** None at present. Possibly DoSD or DoJ; specific research studies. **Period:** Every 5 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the risk of children's exposure to CCSE by providing education.	**Type 4 Indicator: Service Access** The national lifeskills curriculum includes information on risks of CCSE and methods used to persuade/trick children into CCSE. **Reason for use:** To monitor education of children around CCSE.	**Definitions:** Information on risks of CCSE and methods used to persuade/trick children into CCSE is included in the national lifeskills curriculum. **Measure:** The inclusion of this information into the national lifeskills curriculum. **Sources:** None at present. Department of Education; specific curriculum audit. **Period:** Not applicable
Improve access to services for children trafficked across borders.	**Type 4 Indicator: Service Access** Information on services for trafficked children at border points. **Reason for use:** To monitor visibility of service provision to trafficked children.	**Definition:** Information for trafficked children at immigration and emigration points detailing helplines and services. **Measure:** Immigration points displaying posters/leaflets detailing helplines and services. **Source:** DoHA **Period:** Audit every 5 years.
Improve integrity of the immigration process in order to reduce the risk of child trafficking.	**Type 5 Indicator: Service Quality** Immigration officers trained to identify and respond to child trafficking (and illegal adoption). **Reason for use:** To ensure a more sensitive and effective service in compliance with the CRC.	**Definition:** Provision of training in child trafficking for immigration officers. **Measure:** Proportion of immigration officers who have attended training on child trafficking. We recommend the use of End Child Prostitution in Asian Tourism international pilot training project or the International Organisation of Migration curriculum for border police. **Source:** DoHA **Period:** Audit every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve prosecution rate of those involved in trafficking, including those recruiting, selling, transporting, supplying, transferring, harbouring or receiving trafficked children. Also including parents/guardians who sell children.	**Type 5 Indicator: Service Quality** Prosecutions of child traffickers. **Reason for use:** To monitor prosecutions in terms of the Children's Act and the Children's Amendment Bill (when law) and other relevant legislation.	**Definition:** According to the Children's Act: the recruitment, sale, supply, transportation, transfer, harbouring or receipt of children, within or across the borders of the Republic by any means, including the use of threat, force or other forms of coercion, abduction, fraud, deception, abuse of power or the giving or receiving of payments or benefits to achieve the consent of a person having control of a child. **Measure:** Number of child trafficking prosecutions and proportion of reported cases resulting in prosecution. **Source:** DoJ **Period:** Annual
Improve access to services for trafficked children.	**Type 5 Indicator: Service Quality** Magistrates and prosecutors trained to identify and respond to child trafficking (and illegal adoption). **Reason for use:** To ensure a more sensitive and effective service. To comply with the CRC.	**Definition:** Provision of training in child trafficking for magistrates and prosecutors in children's and sexual offences courts. **Measure:** Proportion of trained magistrates and prosecutors. **Source:** DoJ **Period:** Audit every 5 years.
	Type 5 Indicator: Service Quality Agency collaboration protocols in regard to trafficked children are co-ordinated by district child protection officers. **Reason for use:** To facilitate inter-agency collaboration to improve services for trafficked children.	**Definition:** DoSD districts have clearly displayed protocols regarding referral of trafficked children and placement of such children on the CPR. **Measure:** Existence of protocols in each district. **Source:** DoSD district offices **Period:** Audit every 5 years.

Notes:
1 See <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.
2 See <www.childporn@saps.org.za>.

Indicators for monitoring child abuse and neglect

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Reduce the number of children living in poverty.	**Type 1 Indicator: Child Status** Child poverty **Reason for use:** Child poverty is associated with the widest range of insults to child survival, health and development. Appropriate for national and international reporting: State of the World's Children; Millennium Development Goals.	**Definition & Measure:** Proportion of children in households experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Statistics South Africa); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.
Protect children from all forms of violence, abuse and neglect, and make neighbourhoods safe for children.	**Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment** Children's vulnerability to violent crime. Neighbourhood vulnerability of children. **Reason for use:** Identify areas in which the risk is high. To monitor children's exposure to violent crime and monitor children's rights to safety and protection.	**Definition:** *Violent crimes* to children as defined in the Common Law and other Statutes: murder, common assault, assault with intent to do grievous bodily harm and ill-treatment of a child reported to the South African Police Services (SAPS). Stratify by gender and age (0–17; 0–12; 13–17). **Measures:** The proportion of children in each province and in each SAPS zone and precinct who are victims of *all* violent crime (treated per crime category and as a total score based on the sum across all crime categories) per year. **Source:** SAPS **Period:** Annual **Note:** Age and gender disaggregation is not available in annual SAPS reports or website statistics. These statistics should be provided by the provincial commissioner on a routine basis each year to aid service planning in the province and the districts.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment** Abducted, kidnapped and missing children. Neighbourhood vulnerability of children. **Reason for use:** To monitor areas to establish the risk of kidnapping and abduction of children (and also missing children). To monitor children's rights to safety and protection. Identify areas in which the risk is high.	**Definitions:** 1. Kidnapping: Use the SAPS definition in terms of the relevant Statutes; only count *children* (adults may also be kidnapped). 2. Abduction: Use the SAPS definition in terms of the relevant statutes (only children may be classified as having been abducted in terms of the law). 3. Missing children: Reports of missing children to each SAPS precinct who are not recovered within 48 hours and for whom a case of kidnapping or abduction has not been opened. Stratify all by gender and age. **Measure:** The proportion of children who are victims of abduction and kidnapping in each province and in each SAPS zone and precinct per year. **Source:** SAPS **Period:** Annual **Note:** Age and gender disaggregation is not available in annual SAPS reports or website statistics. These statistics should be provided by the provincial commissioner on a routine basis each year to aid service planning in the province and the districts.
	Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment Children's vulnerability to sexual crime. Neighbourhood vulnerability of children. **Reason for use:** Identify areas in which the risk is high. To monitor children's exposure to sexual assault. To monitor children's rights to safety and protection.	**Definition:** *Sexual crimes* to children as defined in the Common Law and other statutes: indecent assault, rape, 'statutory rape', attempted rape, exposure to pornography, and commercial sexual exploitation reported to the SAPS. Stratify by gender and age (0–17; 0–12; 13–17). **Measure:** The proportion of children in each province and in each SAPS zone and precinct who are victims of sexual crimes (per sexual crime category and as a total score based on the sum across all sexual crime categories) per year. **Source:** SAPS **Period:** Annual **Note:** Age and gender disaggregation is not available in annual SAPS reports or website statistics. These statistics should be provided by the provincial commissioner on a routine basis each year to aid service planning in the province and the districts.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Make schools safe for children. Monitor the incidence of violence in schools.	**Type 1 Indicator: Child Status** 1. Learner-on-learner violence and sexual abuse. 2. Educator-on-learner violence and sexual abuse. **Type 5 Indicator: Service Quality** **Reasons for use:** To monitor children's exposure to violence by other children at school. To monitor children's exposure to violence by educators at school. To monitor children's rights to safety and protection – bullying is a form of abuse in the Children's Act. Monitor implementation of the Schools Act (No. 56 of 1996).	**Definition:** Acts of physical and sexual violence (including bullying) on a learner (by another learner or an educator) while under the jurisdiction of the school. All data to be stratified by gender and age (<13 years and >13 years). **Note:** These data are likely to be very coarse given problems with reporting and variations in disciplinary procedures across the country. Further, in the case of educator-on-learner abuse, none of the data below are likely to be an accurate reflection of the situation. **Measure 1:** The proportion of learners in each province and in each Education Management Development Centre district who are disciplined by their school for violence to another learner in a reporting year. **Source:** Provincial departments of education (DoEs) **Period:** Annual **Measure 2:** The proportion of learners in each province who report physical and sexual violence (including bullying) by a learner while under the jurisdiction of the school using measures designed for the UN Study on Violence to Children,[2] or another reliable violence exposure measure. **Source:** Current sources are academic studies only; survey needed. **Period:** Every 5 years **Measure 3:** The proportion of learners in each province who call a Safe Schools call centre and allege physical and sexual abuse and the unlawful administration of corporal punishment in school. **Source:** Safe Schools programmes in each province (DoE) **Period:** Annual **Measure 4:** Educators in each province disciplined for assaults on learners. **Source:** Labour Relations data (DoE) **Period:** Annual **Measure 5:** The proportion of learners in each province who report physical and sexual abuse and the unlawful administration of corporal punishment in a specific victim survey using measures designed for the UN Study on Violence to children (see endnote 2), or another reliable violence exposure measure. **Source:** Current sources are academic studies only. **Period:** Surveys required every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Establish child protection information systems in compliance with policy.	**Type 4 & 5 Indicators: Service Access and Service Quality** Computerised Child Protection Registers (CPRs) are established and are functioning at *district* level in each province. **Reason for use:** Provincial level CPR systems require sound district level CPR functioning and data collection in terms of policy. To monitor compliance with the CPR manual and the Children's Act.	**Definitions:** The CPR is established in terms of the Regulations to the Child Care Act (No. 74 of 1983) and the new Children's Act to record data on incidents of child abuse and neglect and to track children's movement through the services system. All the following conditions must be fulfilled within a time frame set by the department: • Reporters and districts use the same form to capture cases (as prescribed in the regulations), are trained in its use, and receive annual feedback from district offices on how the data are used; • Forms used by services and district staff include the definitions of abuse and neglect categories listed in the CPR manual; • Districts have the appropriate training, support, equipment and staff to enter CPR data; • Raw data for the CPR are no longer sent to head office for capture; • Online system functions so that data captured at district level is available to head office; • All district CPR systems must receive reports from children's courts, welfare services, SAPS and other relevant sources to update the register on a regular basis; • All cases, substantiated or otherwise, must be entered (CPR manual must be followed); • All cases that are not substantiated must be removed (Parts A & B); • Data from service providers in the district are captured regularly on the district CPR; • Data from the district CPR are used for protective services planning at district level; • Districts have access to the CPR manual; cases are recorded accurately in terms of the definitions of abuse contained in the manual; • Districts have dedicated data capture staff sufficient to process forms within one week; • Security arrangements for storage and data capture are in place; • All districts have the necessary Information Technology (IT) in place (data lines of sufficient capacity for the task). **Measure:** The proportion of districts in each province that have a fully functional CPR in place in terms of the above criteria. **Source:** Provincial Departments of Social Development (DoSDs) based on an audit of the CPR in each district. **Period:** Immediately and then every 5 years to monitor progress.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 4 & 5 Indicators: Service Access and Service Quality** Computerised CPRs are established at *provincial* level. **Reason for use:** Each province requires the CPR for service planning and for reporting to national level. Part B of the register is required for checking childcare personnel against perpetrator information. To monitor compliance with regulations and the Children's Act.	**Definitions:** The CPR is established in terms to record data on incidents of child abuse and neglect and to track children's movement through the services system. All the following conditions must be fulfilled within a time frame set by the department: • Each provincial CPR has the appropriate equipment and staff to generate reports from the CPR and alter contents where necessary; • Staff have the appropriate security clearance to generate reports; • Each provincial CPR has the appropriate equipment and staff to generate reports for each district on an annual basis and to generate information on an ad hoc basis for provincial and national government; • Each provincial CPR is used for service planning and budgetary allocations at provincial and district level for child protective services; • Until district offices are functional, the provincial head office has sufficient staff to capture forms within one week of receipt; • All security arrangements contained in the CPR manual, including secure storage space and private space for data capturers, are in place at head office; • All provincial offices have the necessary IT in place, including data lines of sufficient capacity for the task; • In each province, all head offices provide annual reports to each district for purposes of service planning at district level. **Measure:** The number of provinces that have a fully functional CPR in place in terms of the above criteria. **Source:** National DoSD based on an audit of the CPR in each province. **Period:** Immediately and then every 5 years to monitor progress.
	Type 4 & 5 Indicators: Service Access and Service Quality A computerised CPR is established and operational at *national* level. **Reason for use:** To monitor compliance with the Children's Act.	**Definitions:** The CPR is established in terms of the standard provincial protocol to record data on incidents of child abuse and neglect, and permits tracking of children across the country. **Measure:** The national CPR is established and receives data regularly (according to the protocol) from all provinces. **Source:** DoSD **Period:** Not applicable

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure that all provinces have co-ordinated child protective services. Co-ordination of system resources is in accordance with national and provincial policy frameworks for prevention of child abuse, neglect and exploitation.	**Type 5 Indicator: Service Quality** Provincial and district child protection structures and staff are in place: • District child protection officers are in place in every district and have the necessary staff to fulfil their functions; • Provincial, district and local child protection committees in place and operational; • Provincial child protection committee (PCPC) plans are in place; • Local child protection committee (LCPC) plans are in place; • Local services are based on PCPC and LCPC plans. **Reason for use:** To monitor the extent to which policy is implemented and whether child protective services are co-ordinated at all levels of service provision.	**Definitions:** PCPCs are required to be established in each province to provide plans for the investigation, prevention and treatment of child abuse and neglect in terms of policy. Further roles and responsibilities are defined in terms of national and provincial policy. LCPCs co-ordinate plans for the investigation, prevention and treatment of child abuse and neglect at local level. Further roles and responsibilities are defined in terms of national and provincial policy. District child protection officers oversee local functions. Further roles and responsibilities are defined in terms of national and provincial policy. **Measures:** All apply. 1. A provincial child protective services plan is in place. 2. The PCPC is established and meets *at least quarterly* (attendance of each sector should be recorded). 3. District child protection committees are established in every district and meet *at least quarterly* (attendance of each sector should be recorded). 4. The number of districts with child protection officers and the necessary support staff in posts to support local committees, reporting functions in terms of the CPR, as well as oversight of all district services (including 24-hour services). 5. The number of LCPCs established in each district that meets as determined by the district child protection officer. 6. The number of districts with child protective services based on PCPC and LCPC plans. **Source:** DoSD in each province **Period:** Immediately and then every 5 years to monitor progress.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve access to child protective services.	**Type 4 Indicator: Service Access** Access to a 24-hour child protection service. **Reason for use:** To monitor the implementation of child protection policy. Rapid services access is a requirement of child protection policy and necessary if the child is to receive attention as soon as possible after the incident.	**Definition:** Each social services district in each province has standardised 24-hour child protective services available within one hour's travel from the child's place of residence (this principle draws on the 'golden hour' principle for medical emergency services). **Measure:** The proportion of DoSD districts that have a 24-hour service situated so that all children in the province would be able to access the service within one hour's travel time (the measure would be based on the road matrix of the district). **Sources:** Provincial DoSDs; district offices. **Period:** Immediately and then every 5 years to monitor progress.
	Type 4 Indicator: Service Access 1. Family Violence, Child Protection and Sexual Offences Units (FCSs) are established in areas identified as high risk for violence to women and children. 2. The units comply with recommended caseload norms. **Reason for use:** To be able to respond to areas of greatest need and investigate cases effectively. To monitor the implementation of child protection policy, and relevant legislation (e.g. the Children's Act).	**Definitions:** The FCS is a specialised SAPS unit that, among other duties, investigates reports of sexual and other violent crimes to children and prepares matters for criminal prosecution. Staffing should comply with departmental caseload norms for this service of *less than 51 cases* per officer (see below). **Measures:** 1. The number of FCS units established in high-risk areas for violent crime to and abuse and neglect of children, as identified by the provincial and district child protection committees in collaboration with SAPS (on the basis of FCS data) and the Department of Social Services and Poverty Alleviation (on the basis of Department of Justice [DoJ] children's court inquiry data) – for each DoSD district. 2. The number of FCS units that have staffing levels that meet the caseload norm. **Sources:** SAPS; DoJ; DoSD in each province. **Note:** This practice does not currently exist and could be the responsibility of the PCPCs to implement. **Period:** Immediately and then every 5 years to monitor progress.

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Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 5 Indicator: Service Quality** 1. Social worker caseloads for child abuse and neglect are within the norm. 2. FCS officer caseloads are within the norm. 3. Precincts are equipped to deal with child abuse at all times. **Reasons for use:** To monitor resourcing on key services for child protective services. To prevent further traumatisation of abused children.	**Definitions:** Norms for social workers working on child abuse and neglect cases are not set. A recommended norm is 1:20 for *acute* cases of abuse (recommended in the draft national policy framework for child abuse and neglect [DoSD, 2004a]). Norms for FCS officer caseloads are not currently established. A recommended norm is: *1 officer to 50 cases* (including current investigations and matters before the court – based on consultations with FCS staff). **Measures:** 1. Norms are established for social worker and FCS officer caseloads in each province. 2. The proportion of district level social workers in each province with a caseload of *less than 21 acute cases of child abuse and/or neglect at any one time*. 3. The proportion of FCS officers in each province who have *a caseload of less than 51 at any one time*. 4. The proportion of precincts in each province that have at least 1 officer trained to deal with child abuse and neglect on duty (or on call) at all times. **Sources:** DoSD in each province; SAPS. **Note:** These data need to be collected annually by the relevant department as a normal administrative function. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure access to therapeutic services for physically and sexually abused children.	**Type 4 Indicator: Service Access** Access to therapeutic services for abused children. **Reason for use:** To monitor access to therapeutic services for abused children.	**Definitions:** Sexually abused children who have been raped and who have received Post-Exposure Prophylaxis (PEP) to prevent HIV transmission. Physically and sexually abused children who are referred for psychological therapy (counselling by a social worker, psychologist or psychiatrist) and medical intervention. **Measures:** 1. The number of children in each province who presented at a rape survivor centre as a result of sexual assault, in a health department reporting period. 2. The proportion of sexually assaulted children in each province who presented at a rape survivor centre as a result of sexual assault, and *who received PEP*, in a health department reporting period. 3. The number of children who present at specialist tertiary trauma units in each province as a result of physical and sexual abuse in a health department reporting period. 4. The number of children who present at specialist tertiary trauma units in each province as a result of physical and sexual abuse and who are referred for social services and/or psychological therapy in a health department reporting period. **Sources:** Primary and secondary facility data: Department of Health (DoH) (based on data from the clinical forensic surgeons at rape survivor centres). **Notes:** Currently, these data are only stratified by children <14 years, and all other patients. This stratification should be altered by the DoH so that all cases <18 can be counted. *Tertiary data: trauma unit data at tertiary hospitals* This data is only available on request from the relevant facility. It should be routinely incorporated in the proposed child protection information unit. *The CPR* The CPR has the capacity to generate relevant medical, social and psychological services information. Each provincial CPR should be assessed to establish whether or not the system is functioning as it should. Child abuse and neglect service quality audits could be conducted for a child abuse and neglect incidence study. **Period:** All annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Roll out effective child-friendly courts in the DoJ as provided for in various Acts, the Children's Act and regulations.	**Type 4 & 5 Indicators: Service Access and Service Quality** Child-friendly courts in place **Reason for use:** Availability of these services is likely to improve the quality of child testimony, reduce the trauma of court appearance, and improve the conviction rate. To comply with Section 42 of the Children's Act, which provides guidelines for hearings involving children.	**Definition:** A separate children's waiting area should be available for child witnesses at Sexual Offences Courts, and other criminal courts where children are required to give evidence in cases where they are the complainant. Anatomical dolls should be available for child witnesses at Sexual Offences Courts. Closed-circuit television or other appropriate facilities should be available for child witnesses at all courts where children are required to give evidence. Intermediary services for child witnesses should be available at all courts. Facilities for disabled children should be available at all courts. The DoJ Policy on Court Services for Children specifies the services that should be provided, as does the Children's Act. The Criminal Procedures Act makes provision for intermediary and other services at the presiding officer's discretion. The criterion is fulfilled if measures 1, 4 and 5 are met immediately. Other conditions should be progressively met over a specified period (recommended – 5 years). **Measures:** 1. Proportion of courts in each province with properly equipped waiting areas for child witnesses. 2. Proportion of courts in each province with facilities for the disabled child witness. 3. Proportion of Sexual Offences Courts in each province with anatomical dolls available for child abuse cases. 4. Proportion of courts in each province with closed-circuit television or other equally appropriate facilities. 5. Proportion of courts in each province with intermediaries. **Source:** DoJ **Period:** Immediately and then every 5 years to monitor progress.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor the incidence of abuse and neglect.	**Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment** Child Sexual Abuse (CSA) incidence Household and area risks for sexual abuse. **Reason for use:** To monitor children's exposure to sexual abuse and to monitor children's rights to safety, protection and social security. Identify areas in which sexual abuse is prevalent. To monitor the implementation of child protection policy. Basic requirement of a CSA surveillance system to monitor children's right to safety and protection from abuse.	**Definitions:** CSA has two basic elements that must be present to make the classification: • Sexual activity involving a child; • Abusive conditions: the child's partner has a large age or maturational advantage over her/him; or is in a position of authority or is in a caretaking relationship with the child; or the activities are carried out against the child using force or deception. Household and area risks would be obtained by stratifications of the data to determine whether or not the abuse occurred in the household or not and in which social services district it occurred (based on the CPR). Two types of CSA should be monitored: *Contact abuse:* penetration, including penile, digital and object penetration of the vagina, mouth or anus, and non-penetration, including fondling of sexual organs, sexual kissing, or the child touching sexual parts of a partner's body. *Non-contact abuse:* exhibitionism, voyeurism, exposure to pornography, verbal sexual propositions. All data to be stratified by gender and age (0–17; 0–12; 13–17). **Measures:** 1. The proportion of children in each province and in each DoSD district reported to the CPR as having been sexually abused in a specific year (no duplicate children). Disaggregate by contact and non-contact abuse types and by gender. Report per 100 000 of the population within each age stratification. 2. The proportion of children in each province and in each DoSD district reported to the CPR and substantiated as having been sexually abused in a specific year (no duplicate children). Disaggregate by contact and non-contact abuse types and by gender. Report per 100 000 of the population within each age stratification. 3. Proportions of children abused in selected localities (including the home and the suburb). Area risks would be obtained by stratifications of the data to determine whether or not the abuse occurred in the household or not and in which social services district it occurred (based on the CPR). **Source:** The CPR (if operational) **Note:** As the CPR system is not rolled out and functioning in most areas, *a child abuse and neglect incidence study* is urgently required for baseline data. **Period:** Annual if the CPR is used; every 10 years if a surveillance study is used.

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Policy goal	Indicator and reason for use	Definition, measure, period and data source
→		4. Number of children found in need of care due to sexual abuse: record of commissioner's findings at children's court inquiries. **Source:** DoJ records for each children's court in each province. **Period:** Annual 5. Number of children reported to all FCS units in each province for investigation of CSA stratified by SAPS area (each of the 13 FCS units submits weekly and monthly statistics to its area office). **Source:** SAPS **Period:** Annual **Note:** The anti-rape strategy form can provide statistics on the number of rape cases reported at identified police stations and the number of rape victims referred to the victim support programme; the number of cases referred to court; the number of offenders arrested; and the conviction rate. However, a serious limitation is that none of this information is disaggregated by age and gender. It is therefore not possible to use these data to obtain figures on children unless the system is altered. However, victim empowerment programme statistics, submitted monthly to the provincial social crime office, are disaggregated by age and gender. Age and gender disaggregation is not available in annual SAPS reports or website statistics. The provincial commissioner should provide these data on a routine basis each year to aid service planning in provinces and the districts. →

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment** Child Physical Abuse (CPA) incidence. Household and area risks for physical abuse. **Reason for use:** To monitor children's exposure to physical abuse and to monitor children's rights to safety, protection and social security. Identify areas in which physical abuse is prevalent. To monitor the implementation of child protection policy. Identify areas in which abuse and neglect is prevalent for planning purposes.	**Definition:** CPA inflicted on a child by a person who is in a position of responsibility, trust or power in relation to the child (DoSD, 2004), and reported to the CPR (or based on data collected in an incidence study). All data to be stratified by gender and age (0–17; 0–12; 13–17). Household and area risks would be obtained by stratifications of the data to determine whether or not the abuse occurred in the household or not and in which social services district it occurred (based on the CPR). **Measures:** 1. Proportion of children in each province and in each district reported to the CPR as having been physically abused in a specific year (no duplicate children). Report per 100 000 of the population within each age stratification. 2. Proportions of children abused in selected localities (including the home and the suburb). **Source:** The CPR (if operational) **Note:** As the CPR system is not rolled out and functioning in most areas, *a child abuse and neglect incidence study* is urgently required for baseline data. **Period:** Annual if the CPR is used; every 10 years if a surveillance study is used. 3. Number of children found in need of care due to physical abuse: record of commissioner's findings at children's court inquiries. **Source:** DoJ records for each children's court in the province **Period:** Annual 4. Number of children reported to all FCS units in the province for investigation of CPA stratified by SAPS area (each of the 13 FCS units submits weekly and monthly statistics to its area office). **Source:** SAPS **Period:** Annual **Note:** Age and gender disaggregation is not available in annual SAPS reports or website statistics. The Department of Social Services and Poverty Alleviation should request that these statistics be provided by the provincial commissioner on a routine basis each year to aid service planning in the province and the districts. →

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment** 1. Non-circumstantial child neglect incidence. 2. Child abandonment. 3. Household and area risks for neglect. **Reason for use:** To monitor children's exposure to neglect and to monitor children's rights to safety, protection and social security. Identify areas in which abuse and neglect is prevalent for planning purposes.	**Definitions:** 1. Non-circumstantial neglect of a child occurs when those responsible for the child fail to meet his/her essential needs *despite having the means to do so* (DoSD, 2004a). Household and area risks would be obtained by stratifications of the data to determine whether or not the abuse occurred in the household and in which social services district it occurred (based on the CPR). All data to be stratified by gender and age (0–17; 0–12; 13–17 (with the exception of abandonment). 2. Abandonment is the unlawful and intentional exposure and abandonment of an infant in a place or in such circumstances that death from exposure is likely to result (DoSD, 2004a). **Measures:** 1. Proportion of children substantiated as having been neglected in the above manner in a specific year (no duplicate children) as recorded on the CPR (if operational). 2. Number of children under the age of 3 years to have been abandoned in a specific year, based on the record of commissioner's findings at children's court inquiries. **Source:** DoJ (for each children's court in the province) 3. Proportions of children abused in selected localities (including the home and the suburb). **Sources:** CPR (not possible at this stage); DoJ (for each children's court in each province). **Period:** Annual for all types **Notes:** As the CPR system is not rolled out and functioning in most areas at this time, the children's court data is advised. A national child abuse and neglect incidence study is urgently required for baseline data. →

Policy goal	Indicator and reason for use	Definition, measure, period and data source
	Type 1 & 3 Indicators: Child Status and Neighbourhood & Surrounding Environment Children referred to a children's court inquiry. Children referred to a children's court inquiry in each social services district. **Reason for use:** Identify areas in which abuse and neglect are prevalent.	**Definition:** A children's court inquiry is held before a children's commissioner to determine whether or not an order of court is to be made to protect the child from abuse and neglect. **Measures:** 1. Number of children's court inquiries per magisterial district in a reporting year. 2. Number of children's court inquiries in each DoJ district and plotted against the DoSD district in which the court is located. This is a proxy measure of the level of risk of all forms of abuse in the DoSD district. **Source:** DoJ (for each children's court in each province) **Period:** Annual

Notes:
1 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.
2 UN Study on Violence to Children, <www.crin.org>.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Protect children from all forms of violence, abuse and neglect.	**Type 1 Indicator: Child Status** Sexual abuse perpetrated by children. **Reason for use:** To assess the extent to which children are responsible for perpetration of CSA.	**Definition:** A child perpetrator of CSA is <18 years of age and commits a sexual act with a child: i) against the child's will, ii) without the child's true consent, or iii) in an aggressive, exploitive, or threatening manner. *Abusive conditions* exist when the perpetrator is *at least 3* years older than the victim; the victim is pre-pubertal and the perpetrator is sexually mature. **Measures:** 1. The proportion of CSA perpetrators <18 years of age on the CPR for each province. 2. The proportion of CSA perpetrators <18 years of age on the CPR where the case has been substantiated (no duplicate children) for each province. **Source:** CPR 3. Proportion of sexual offenders who are <18 years (diverted and convicted) in each province. **Source:** DoJ **Period:** Annual for all **Note:** As the CPR system is not rolled out and functioning in most areas, *a national child abuse and neglect incidence study* is urgently required for baseline data.
Ensure access to therapeutic services for sexually and physically abused children.	**Type 4 Indicator: Service Access** Access to therapeutic services for abused children. **Reason for use:** To monitor access to therapeutic services for children in need.	**Definition:** Abused children who receive medical and psychological services. **Measure:** The proportion of abused children who are both reported to child protection services and who receive a therapeutic service in each province. **Source:** To be developed for specific child abuse and neglect services quality audits; could be assessed in a *national child abuse and neglect incidence study*. **Period:** Every 10 years
Ensure access to HIV/AIDS prophylaxis for sexually abused children.	**Type 4 Indicator: Service Access** Extent of access to PEP for sexually abused children. **Reason for use:** To monitor the child's right to access to PEP.	**Definition:** Abused children who receive PEP. **Measure:** The proportion of children in each province who have been raped and reported to child protection services and who receive PEP. **Source:** DoH (based on data from the clinical forensic surgeons at rape survivor centres). **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Goals for court case finalisation set by the DoJ are met.	**Type 5 Indicator: Service Quality** Timeous processing of criminal cases involving child abuse. **Reason for use:** To monitor the efficacy of the justice system in matters affecting abused and neglected children. Cases that endure for long periods cause distress to children and families; they are more susceptible to intimidation by perpetrators.	**Definition:** Finalisation refers to the closure of the case following investigation and court findings (where applicable). **Measure:** The proportion of new cases in each province finalised within 6 months. **Source:** DoJ. To be developed for specific child abuse and neglect services quality audits. **Period:** Every 5 years
Conduct a national child abuse and neglect incidence study in order to establish baseline data on substantiated child abuse and neglect, as well as a service audit to monitor all social work, police and judicial services for affected children.	**Type 5 Indicator: Service Quality** The national DoSD has commissioned a national incidence and service quality audit. **Reason for use:** In order to provide more accurate incidence data than presently available and to track incidence over time; to provide data on case loads, service levels, and to inform service planning.	It is recommended that a study along the lines of the Canadian National Incidence Study of child abuse and neglect be undertaken. The study should include an investigation of: • Failure to supervise or protect leading to physical harm; • Physical neglect; • Failure to thrive; • Medical neglect (including mental health neglect); • Educational neglect; • Emotional neglect; The study should evaluate access to and quality of social work, police and judicial services for affected children. **Period:** Every 10 years

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Protect children from all forms of violence, abuse and neglect in the home. Strengthen families in need of support.	**Type 2 Indicator: Family & Household Environment** Exposure to domestic violence **Reason for use:** To monitor the extent of children's exposure to domestic violence.	**Definition:** Children in households in which parents who participated in a survey admitted to partner violence in the past year. **Measure:** The proportion of parents with children at home, who admitted to perpetrating or being victims of partner violence in the past year (the number of children in the household should be used to indicate the probable numbers of children in each province likely to be exposed to domestic violence). **Sources:** Human Sciences Research Council (HSRC) South African Social Attitudes Survey (SASAS) (most recent 2003); other partner violence surveys that may be available. Alternatively, a retrospective survey of adults on their childhood experiences using measures designed for the UN Study on Violence to Children (see endnote 2 above), or another reliable violence exposure measure. **Period:** Every 5 years if feasible.
	Type 1 Indicator: Child Status Children exposed to physical punishment at home. **Type 2 Indicator: Family & Household Environment** Caregivers who approve of physical punishment. Caregivers who use physical punishment. **Reason for use:** To monitor the extent of children's exposure to domestic violence.	**Definitions:** 1. Adults who report being smacked or beaten at home in childhood in a retrospective survey (using measures designed for the UN Study on Violence to Children or another reliable violence exposure measure). 2. Children who report being smacked or beaten at home (using measures designed for the UN Study on Violence to Children or another reliable violence exposure measure). 3. The proportion of adults, with children, who i) support the use of physical punishment at home, and ii) use physical punishment. **Measures:** 1.&2. The proportion of children who report being smacked or beaten at home (child or adult retrospective survey). 3. The proportion of adults with children who i) support the use of physical punishment at home, and ii) use physical punishment. **Sources:** Adult attitudes and behaviour: HSRC SASAS (most recent 2003); children and retrospective reports: specific studies such as the UN study (not available for South Africa). **Period:** Every 5 years if feasible; a baseline children's study is needed as no representative data currently exist.

Indicators for monitoring children in statutory care

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Install an information system for monitoring statutory services to children.	**Type 5 Indicator: Service Quality** Registers of Children in Care are in place in each province. **Reason for use:** To provide a basis for planning and resourcing; to improve monitoring of service quality for children in statutory care, and extent to which currently marginalised groups are being catered for.	**Definition:** A Register of Children in Care is proposed that will track information about children in care. The register will include information on each child (including age, gender, population group, disability status, national origin, reasons for placement; children's movements through the care system; permanency planning). Department of Social Development (DoSD) and non-governmental organisation (NGO) social work caseloads will be included. Other information as may be appropriate. The register would be maintained by each provincial DoSD based on information supplied by district DoSD offices and NGOs. Information would be collated by provincial and then national DoSDs. **Measure:** National DoSD accepts that Registers of Children in Care must be in place in each province. Each province has a functional system in place within 5 years of the decision being taken. **Source:** DoSD **Period:** Ascertain whether the recommendation is accepted and the system is in place within 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve and monitor budgetary allocations to social welfare services for children in accordance with policy.	**Type 4 & 5 Indicators: Service Access and Service Quality** Annual provincial budget allocations to social welfare services for children. **Reason for use:** Monitors whether budget share for children's social welfare services changes over time. Monitors whether budget follows policy commitment to protection of vulnerable children in terms of the Child Care Act (No. 74 of 1983) and the in-coming Children's Act.	**Definition:** Annual provincial budgets allocated for all social welfare services (excluding social grants) to children in each province. The budgets should be stratified to include at least the following: 1. Agency social worker salary subsidies (and the number of posts subsidised per province). 2. Support for statutory services, including subsidies for the various child placement options for children found in need of care (foster care, children's homes, etc.). **Measure:** Rand amount allocated for child social welfare services of all kinds per year compared with previous annual allocations. **Sources:** Provincial DoSDs and Treasuries. **Period:** Annual
Ensure soonest possible access to a permanent, stable environment, preferably in a family context, for children in statutory care. Promote stability and continuity of care for children in statutory placements.	**Type 5 Indicator: Service Quality** Permanency planning for children in statutory care. **Reason for use:** A key indicator of the quality of statutory childcare and protection services, and is central to the question of whether the child will ultimately benefit from the period in statutory care. Can be used to determine acceptable staffing, training and caseload levels.	**Definition:** Care and Development Plans with a permanency component are drawn up for each child in statutory care according to recognised guidelines. The plans are regularly reviewed. Data must be available for each province. **Measures:** 1. The proportion of children in statutory care for whom these plans are in place as required by the DoSD, and for whom the necessary services are being implemented, with back-up plans in reserve in case primary plan does not succeed (e.g. adoption for younger children, preparation for independent living for older teenagers). The participation of children in formulating plans should be recorded. 2. The proportion of children in statutory care for whom these plans are in place and are assessed and reviewed as required by the DoSD. 3. The proportion of children in statutory care for whom these plans are in place, and who are in contact with their families or significant others to the extent envisaged in the plan. **Source:** Not currently being collated. Proposed Register of Children in Care; quality audit to be developed for statutory care services. **Period:** Annual if the Register of Children in Care is established; every 5 years for quality audits.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 5 Indicator: Service Quality** Unplanned termination of statutory placements. **Reason for use:** May indicate inadequate selection or poor levels of support and training of caregivers, and/or abuse in care.	**Definition:** Placements which end prematurely. **Measure:** Proportion of all placements that are terminated due to: i) abuse, ii) illness or death of caregiver, iii) inability of caregiver to manage child's behaviour, iv) rejection by caregiver, v) problems between child and foster sibling. Data must be available for each province. **Source:** Not currently being collated. Proposed Register of Children in Care; quality audit to be developed for specific child abuse and neglect services. **Period:** Annual if the Register of Children in Care is established; every 5 years for quality audits.
Ensure that foster parents receive adequate training and support.	**Type 4 & 5 Indicators: Service Access and Service Quality** 1. Regular support of foster parents in the statutory system. 2. Training for foster parents in the statutory system. **Reasons for use:** Would provide a rough indicator of support provided by social services to foster families that is intended to influence the quality of the care they provide. Crucial service that can also help prevent further abuse to the child while in care.	**Definitions:** Regular support is a minimum of quarterly visits to foster families by the child's caseworker; initial training is the preparation of the foster parents prior to placement; ongoing training includes workshops attended by foster parents while the child is in their care. **Measures:** 1. Percentage of foster parents in each province who received regular support from social workers, social auxiliary workers, other foster parents or volunteers in a reporting year. 2. Percentage of foster parents in each province who have received initial training in a reporting year. 3. Percentage of foster parents in each province who have received ongoing training in a given year. **Source:** Not currently being collated. Proposed Register of Children in Care; quality audit to be developed for statutory care services. **Period:** Annual if the Register of Children in Care is established; every 5 years for quality audit.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure that vulnerable families of origin from which children have been removed are supported to enable the return of the child.	**Type 5 Indicator: Service Quality** Effectiveness of family reintegration services for children placed in care. **Reason for use:** To monitor effectiveness of family support and reintegration work while the child is in care and after his or her return home. Monitor efforts to reduce re-entry into statutory care following family reintegration.	**Definition:** Statutory care should normally be accompanied by family rehabilitation processes to enable the child to return home (other than in cases where reintegration has been excluded, e.g. where parents are deceased or terminally ill, or their whereabouts are unknown, or they have refused services). **Measure:** Proportion of children placed in care during a specific period, who return to their families of origin and do not enter care again. Data must be available for each province. **Source:** Not currently being collated. Proposed Register of Children in Care; quality audit to be developed for statutory care services. **Period:** Annual if the Register of Children in Care is established; every 5 years for quality audits.
	Type 4 & 5 Indicators: Service Access and Service Quality Access of children in care and their families to required external services. **Reason for use:** Children are sometimes brought into care or forced to remain in care because of a lack of supports and services which could enable their families or other caregivers to care for them in the community, or at least to play a more positive role in their lives.	**Definition:** Services with which families of origin may need to be linked include: employment, social security grants, housing, treatment for addictions, parenting skills training, psychological assessment, psychotherapy, disability-related equipment or other services. Services to children include: remedial education, vocational training, disability-related equipment or services, life-skills training, psychological assessment, psychotherapy, treatment for addictions, foster or adoptive family care (for children in institutional care). Care and Development Plans as required by the DoSD are intended to identify services needed, and reviews should show those that are provided. This information should be noted on the proposed Register of Children in Care. Data must be available for each province. **Measures:** 1. Proportion of children in care who receive the necessary services. 2. Proportion of families of children in care who receive the necessary services. **Source:** Not currently being collated. Proposed Register of Children in Care; quality audit to be developed for statutory care services. **Period:** Annual if the Register of Children in Care is established; every 5 years for quality audits.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure that the statutory care system caters for identified marginalised groups.	**Type 4 Indicator: Service Access** Accommodation of groups of children who tend to be excluded from the statutory care system due to lack of suitable programmes, or lack of capacity in existing programmes. **Reason for use:** Children who are victims of commercial sexual exploitation and trafficking, those who have disabilities, and foreign children are among those who have difficulties in accessing the statutory care system. For the first group this is due to an almost total lack of appropriate programmes; in the others it has to do with lack of necessary knowledge and capacity. This indicator would help in monitoring improvements in this situation.	**Definition:** Groups of children who tend to be marginalised from the statutory service system include: i) children with disabilities, ii) children of foreign origin, iii) children who have experienced commercial sexual exploitation or trafficking. Data must be available for each province. **Measures:** 1. Evidence of measures introduced by government to capacitate existing service providers to care for these categories of children. 2. Number of programmes introduced to care specifically for children who have been extracted from commercial sexual exploitation and/or trafficking. 3. Numbers of children in the relevant categories in the statutory care system. **Source:** Not currently being collated. Proposed Register of Children in Care; quality audit to be developed for statutory care services. **Period:** Annual if the Register of Children in Care is established and disaggregate data by the three categories of child above; every 5 years for quality audits.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor children's movement through the statutory system.	**Type 5 Indicator: Service Quality** Children committed to statutory care, and their subsequent movement between different forms of care and out of care. **Reason for use:** To provide data regarding the length of time which children are spending in care, the effectiveness of permanency planning, and trends as regards movement while in care, for purposes of policy development, planning and resourcing.	**Definition:** For every child who enters statutory care a 'permanency plan' must be developed in which the reasons why placement is necessary are spelled out, and the desired outcomes and the necessary steps and services towards an ultimate long-term arrangement are specified. Preferred outcomes are permanent integration into the original family or a substitute family. Data must be available for each province. **Measures:** 1. The number of children in *ongoing statutory care* per year, in each form of care. 2. The number of children *leaving each form of care* per year, as well as their destination (alternative form of statutory care, biological family, adoption, independent living arrangement, etc.). 3. The average duration of the period spent in statutory care, inclusive of initial phase prior to finalisation of children's court enquiry (in months). 4. The following should also be captured in a checklist, for example as follows: • Any movement of the child. For example, i) move to own immediate family, extended family, an unrelated foster family, or an adoptive family; ii) transfer to residential care (specify type); iii) abscondment; iv) discharge from care/independent living; • Reason why the child is still in care; • Date of Care and Development Plan record; • Dates of reviews of the plan; • Child's and family's participation in planning; • Annual statement of preferred permanency outcome for child; • Annual statement of level of progress towards permanency. Statements should be summarised as: 'plan on track', 'plan partially on track', 'no progress', 'case inactive' or 'permanency already achieved' – where, for instance, the child is in long-term foster care with relatives and there is no prospect of changing this situation. The latter option should not apply to any form of institutional care. **Source:** Not currently being collated. Proposed Register of Children in Care or a quality audit to be developed for statutory care services. **Period:** Annual if the Register of Children in Care is established and disaggregate data by the elements mentioned above; every 5 years for audits.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure an adequate supply of statutory care vacancies for children in need thereof.	**Type 4 Indicator: Service Access** Placements for children who cannot safely remain where they are. **Reason for use:** Children remain for protracted periods in unsafe circumstances or inappropriate placements due to lack of provision for them. (Measures to address this problem must be balanced with measures to prevent the need for placement and measures to prevent children from becoming 'stuck in the system', so that more vacancies become available.)	**Definition:** Sufficient placement options should be available for all children who cannot safely remain in their own homes, even with support and linkage to needed services. **Measure:** Shortage of placement vacancies per category of placement in each province. **Source:** Provincial DoSD **Period:** Annual – recorded halfway through each financial year. The reason for recording in the middle of the financial year is that children in care who go back to their families often do so at the end of the school year so as not to disrupt their schooling. This means that vacancies are more likely to be available during the first term, and shortages are likely to peak towards the end of the year. A figure taken halfway through the financial year (September) is probably the most helpful. **Note:** Available but not currently captured. Departments should capture information from their own caseloads and from facilities and organisations providing foster care services, as well as court records of children in places of safety for whom long-tern placement vacancies are awaited.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve the capacity of the Department of Justice (DoJ) to monitor cases brought before the children's court.	**Type 5 Indicator: Service Quality** A standardised children's court register is in place. **Reason for use:** Currently there is no readily available administrative information system that shows the numbers of children served by, or permits description of the cases that come before the children's courts, or the types of decision made. The data could be used to assess social service needs and practices in each jurisdiction, as well as court staff needs.	**Definition:** The DoJ Court Information Directorate should institute a nationally standardised register which includes information on the situation of every child who is subject to a form 4 emergency order; and/or who is placed on a temporary order pending further investigation in terms of Section 11 or Section 14(3) of the Child Care Act (No. 74 of 1983); and/or who is found to be in need of care in terms of Section 14(4) of the Act. Every child must be listed, rather than every family, as is currently the case. The categories will change once the incoming Children's Act is in place. The register should also include: appropriate information on the child (date of birth, population group, gender, language, religious denomination, etc.); the reasons why the child has been brought to court; and the nature of the order made, if any. The information should be regularly submitted by each children's court to the relevant provincial structure, and then to the national office of the DoJ for collation and analysis by the Court Information Directorate (at provincial and magisterial district level). **Measure:** A decision is taken by the DoJ to implement the register, and roll it out to every children's court within 2 years of the decision being taken. **Source:** Not currently available; DoJ. **Period:** Annual once established.
Reduce the number of children living in poverty and who are thereby at risk for circumstantial neglect.	**Type 1 Indicator: Child Status** Child poverty **Reason for use:** Child poverty is associated with the widest range of insults to child survival, health and development. Appropriate for national and international reporting: State of the World's Children; Millennium Development Goals.	**Definition & Measure:** Proportion of children in households experiencing the following: • Living in a household that has a household equivalent income below R10 189 per annum (2006 value); • Living in a household without a refrigerator; • Living in a household with neither a TV nor a radio. **Sources:** Census and other household surveys (Stats SA); provincial poverty data. **Period:** Every 10 years **Notes:** This measure is used in the Provincial Indices of Multiple Deprivation (PIMD) developed by Noble, Babita et al. (2006). See Chapter 3 in this volume.[1] A PIMD for children (PIMDC) will be available once this volume is published and should be seriously considered for these purposes as it will permit description of areas below provincial level and will take into account a range of deprivations experienced by children in poverty.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor the situation of children in initial phases of care prior to the completion of a children's court enquiry, including those on emergency (form 4) orders or retention (Section 11 or 14(3)) orders.	**Type 1 Indicator: Child Status** Children in emergency placements. **Reason for use:** All these children are highly vulnerable and are likely to have experienced some form of maltreatment, and the placement process will often have been traumatic. They may remain in a state of uncertainty for long periods due to logjams in the court and social welfare systems. Children aged under three years are specifically vulnerable to trauma and the effects of institutionalisation.	**Definition:** The early stages of statutory intervention before a children's court enquiry has been completed, and a final order issued, must be handled with great care and without unnecessary delays. Thorough assessment must take place and long-term planning with and for the child and the family must be initiated. Children may be placed on emergency (form 4) orders, or retention orders in terms of Sections 11 or 14(3) of the Child Care Act, pending the finalisation of a children's court inquiry. Emergency (form 4) orders should only be used where there is an immediate threat to the safety of the child which cannot be addressed in any other way. The child and the caregivers concerned should be properly prepared for placement where at all possible. Data analysed should include: reasons for placement in care, for example: sexual abuse, physical abuse, neglect, abandonment, orphanhood, chronic or terminal illness in a caregiver, poverty, unemployment, homelessness, addiction in the child or a caregiver, domestic violence, trafficking, and child labour including commercial sexual exploitation. Type of preliminary placement must also be specified, as in: places of safety, children's homes, safe houses/emergency foster homes, etc. Data must be available for each province. **Measure:** The number of children in each form of emergency or retention order placement (stratified by gender, population group and age). Special attention to be paid to children under 3 years. **Sources:** DoJ. Much is available in the records but not currently captured. Proposed children's court register or a services audit. **Period:** Annual if the register is established; every 5 years for quality audits.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor the children's courts' decisions.	**Type 1 Indicator: Child Status** Outcomes of children's court inquiries. **Reason for use:** Monitoring provides numbers of children entering and remaining in the various forms of care for purposes of planning and resourcing. It also indicates the extent to which placement occurs for reasons of poverty rather than due to abuse or neglect, for policy reviews as to which cases should be handled through the social security system rather than the statutory care system.	**Definition:** The outcome of an inquiry is the placement decision made by the presiding officer. Data must be available for each province. **Measures:** • The number of cases closed with no finding being made; • The number of children placed back with caregiver under supervision; • The number of children placed in each available form of residential care; • The number of children placed in foster care with relatives (kinship care); • The number of children placed in foster care with non-relatives; • The number of these for whom poverty is the primary reason for placement; • The average duration of stay in temporary care. **Sources:** DoJ. Much is available in the records but not currently captured. Proposed children's court register or a services audit. **Period:** Annual if the register is established; every 5 years for audits. **Note:** The categories should be adjusted once the new Children's Act is in force (for example, to add placement in shared care, and placement in rehabilitation centres or other specialist facilities).

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure an adequate human resource base for care of and services to children in statutory care and their families.	**Type 5 Indicator: Service Quality** 1. Residential facility child and youth care staff qualifications and experience. 2. Social work caseloads. 3. Residential facility quality. **Reason for use:** All of these factors impact on the quality of care received by children in the statutory care and child protection system.	**Definitions:** 1. Residential facilities include all those defined in terms of the Child Care Act and the Children's Amendment Bill (No. 19 of 2006). Child and youth care staff are those who are responsible for the daily care of the child (excluding staff who are not hired as child and youth care workers). Data must be available for each province. 2. Staff qualifications and experience: refers to the Further Education and Training Certificate in Child and Youth Care and other relevant training or qualifications, as well as years of experience in the childcare and protection field. 3. Social work caseloads: refers to the number of active cases for which the worker is responsible. 4. Residential facility quality: refers to Inter-Ministerial Committee on Young People at Risk (IMC) Minimum Standards and Developmental Quality Assurance (DQA) processes. **Measures:** **Staff qualifications and experience** 1. Qualifications of residential facility staff: 1.1 Percentage of residential facility child and youth care staff with each qualification level. 2. Qualifications and years of experience of social work staff in child protective services: 2.1 Percentage of social workers in the employ of the DoSD, and in subsidised NGOs who have training in child protection and care work (in-service training, postgraduate training, certificate courses, etc.) 2.2 Percentage of social workers in the employ of the DoSD, and in subsidised NGOs with more than 5 years in the field of child protection. 3. In-service training, support and supervision of social work staff in child protective services: 3.1 Number of supervision sessions per month attended by social workers in child protective services. **Social work caseloads** Caseloads of social workers managing all types of care and protection cases, both acute and ongoing (to derive averages for each province and each district – based on DoSD and subsidised agency caseloads). **Residential facility quality** Percentage of facilities complying with IMC Minimum Standards derived from DQA data. **Source:** DoSD. Much information is available in the records but is not currently used for monitoring purposes. **Period:** Every 5 years (for all indicators) – audit conducted by the department (all data to be aggregated by province and for the country as a whole).

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure access to and effective functioning of the children's court system. Ensure effective, child-friendly children's courts in the DoJ system as provided for in the Child Care Act (No. 74 of 1983) and the incoming Children's Act and regulations.	**Type 4 & 5 Indicators: Service Access and Service Quality** Extent to which children's courts are accessible and adequately capacitated for children in need of care. **Reason for use:** Indicators as to whether children coming into care are likely to have their rights fully upheld and their interests fully taken into account, within processes which are sensitive to their special needs.	**Definition:** A network of children's courts is in place which is accessible, child-friendly and has the necessary capacity (in terms of the measures below) to serve children who enter the statutory care system appropriately. **Measures:** 1. Provincial children's court throughput rate for children's court inquiries: the number of days per month when courts sit divided by the numbers of children served per month for the departmental reporting year. 2. Average waiting period for a children's court inquiry (in days) for the departmental reporting year for each province. 3. Percentage of presiding officers who have attended any form of training on childcare and development and family matters for the departmental reporting year. 4. Length of experience in years of presiding officers in children's courts for the departmental reporting year. 5. Percentage of children's courts with appropriate interpretation services including signing facilities for the departmental reporting year. 6. Percentage of contested cases in which child is legally represented at state cost for the departmental reporting year. **Sources:** These data are not currently aggregated although the data will be available from the children's courts and magisterial districts. It is recommended that routine administrative data in the DoJ contain this information and that it is reported annually at provincial and magisterial district levels via the Court Information Directorate. The information should also be captured by social workers for new cases in the proposed Register of Children in Care, collated by district child protection social workers and aggregated by provincial head offices. →

Policy goal	Indicator and reason for use	Definition, measure, period and data source
→	**Type 4 & 5 Indicators: Service Access and Service Quality** Extent to which child-friendly courts are in place. **Reason for use:** Availability of the relevant services is likely to improve the quality of child testimony and reduce the trauma of court appearance. To comply with sections 10, 11, 14, 42(8), 60(3) and 61(2) of the Children's Act (No. 38 of 2005), with regard to the children's court environment.	**Definition:** A separate children's waiting area should be available for children at courts. Anatomical dolls as well as closed-circuit television or other appropriate facilities at all courts where children are required to give evidence. Intermediary services for child witnesses should be available at all courts. Facilities for disabled children should be available at all courts. The DoJ Policy on Court Services for Children specifies the services that should be provided, as does the Children's Act. The Criminal Procedures Act (No. 51 of 1977) makes provision for intermediary and other services at the presiding officer's discretion in the criminal courts, and the Children's Act provides for these same measures to be used in the children's courts if necessary. Hence children's courts as well as criminal courts must be equipped accordingly. The criterion is fulfilled if measures 1, 4 and 5 are met immediately. Other conditions should be progressively met over a specified period (recommended – 2 years). **Measures:** 1. Proportion of children's courts in each province with properly equipped waiting areas for children. 2. Proportion of children's courts in each province with facilities for disabled children. 3. Proportion of children's courts in each province with anatomical dolls available for child abuse cases. 4. Proportion of courts in each province with closed-circuit television or other equally appropriate facility. 5. Proportion of courts in each province with intermediaries. **Source:** DoJ **Period:** Service quality audit every 5 years.

Note:
1 See also <http://www.statssa.gov.za/census01/html/C2001Deprivation.asp>.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure that children ageing out of care are equipped for the future.	**Type 1 & 5 Indicators: Child Status and Service Quality** 1. Children ageing out of care. 2. Preparedness of children who are ageing out of care. **Reason for use:** The extent to which children are ageing out of care may indicate shortcomings in permanency planning and associated services, or could be due to other factors which need to be identified to facilitate planning. Such youth may face a very uncertain future if they are not adequately equipped to function independently. Children who age out of care without adequate, proper preparation and support could be at risk of repeating the cycle of deprivation and abuse.	**Definitions:** 1. A child who ages out of care leaves the statutory system on or soon after attaining the age of 18 years. 2. Preparedness of children refers to the preparation of a child for an independent life outside the care system. **Measures:** 1. The number of children who age out of care (in an audit year). 2. The proportions of these children who have remained in care due to i) lack of services and/or planning, ii) unavailability of suitable foster or adoptive parents, iii) severe behaviour problems, iv) own choice, v) coming into care when already in teens (in an audit year). 3. The education and training qualifications of children who age out of care in an audit year. 4. The proportion of children who age out of care and who have been through a structured Independent Living Skills programme (in an audit year). 5. The proportion of children who age out of care and have an adequate support system in place on leaving (in an audit year). **Source:** Not currently being collated. Proposed Register of Children in Care and a quality audit to be developed for statutory care services. **Period:** Annual if the Register of Children in Care is established; every 5 years for quality audits.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure the positive growth and development of children in care.	**Type 1 & 5 Indicators: Child Status and Service Quality** 1. Growth rates of children in care. 2. Developmental delay in children in care. 3. School performance of children in care. **Reason for use:** Improvements of this kind can be related to the quality of the child's care environment. Monitoring of growth and development is also useful in assessing well-being in the vulnerable early childhood phase.	**Definitions:** Children entering care are likely to show lags in growth, development or scholastic progress. The placement environment should be of a standard that helps to address these deficits. In each case the measures should be norm referenced for age. **Measures:** 1. Percentage of children <5 years showing improved growth rates relative to age-appropriate norms since placement. **Source:** Child's Road to Health Card. 2. Percentage of children <3 showing a reduction in developmental delay relative to age-appropriate norms since placement. **Source:** Assessment according to START programme results. 3. Percentage of school-going children showing improved progress at school since placement. **Source:** School reports. **Period:** Reporting subject to data availability. **Note:** These data are currently not available and would require specific research studies undertaken in placements.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure as far as possible that continuity is maintained in children's cultural, religious and linguistic environments.	**Type 5 Indicator: Service Quality** Statutory foster placements and adoptions are in keeping with children's cultural, religious and linguistic heritage. **Reason for use:** Placement possibilities are limited. This principle might be secondary to the need for family care for a very young child. This indicator should provide insight as to how far continuity is being achieved, and guide recruitment efforts for staff, foster families and adopters. In the case of inter-country adoption it is necessary to monitor the extent to which children are leaving the country under the Hague Convention on Inter-country Adoption in relation to the availability of local adopters.	**Definition:** Children are fostered or adopted locally or into foreign countries by persons who match the language and religion of the family of origin. **Measure:** Proportions of children for whom continuity is maintained in terms of culture, language and religion in foster and adoptive placements. **Sources:** Foster placements: not currently being collated. Proposed Register of Children in Care or a quality audit to be developed for statutory care services. Adoptions: Registrar of Adoptions, DoSD national office. **Period:** Adoptions: annual; foster placements: annual if the Register of Children in Care is established; every 5 years for quality audits.

Indicators for monitoring children in conflict with the law

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring the legislative and policy environment and for multiple stages of the justice system		
Progressively improve the country report to the Committee on the Rights of the Child in relation to reporting on child justice.	**Type 5 Indicator: Service Quality** The South African country report to the Convention on the Rights of the Child (CRC) is comprehensive and complies with reporting requirements regarding child justice. **Reason for use:** To monitor government's commitment to compliance with the CRC.	**Definition:** General Guidelines regarding the form and contents of country reports to be submitted by States Parties under Article 44, paragraph 1(b) of the convention. CRC/C/58. Adopted by the committee at its 343rd meeting (thirteenth session) on 11 October 1996. **Measures:** 1. Submission of South African country reports is on time, and in accordance with the General Guidelines. 2. A comparison between country and shadow reports is undertaken to ascertain points of agreement and difference. 3. Country reports address shortcomings made by the committee and by shadow reports on previous country reports as far as possible. 4. Country report complies with articles 37 and 40 of the CRC. The report must specify: 4.1. Available alternatives to the deprivation of liberty and the frequency with which they are used; 4.2. All data on children deprived of their liberty must be disaggregated to show the following: children detained unlawfully, arbitrarily and within the law together with the reasons for, and period of, deprivation of liberty; 4.3. Reports on children who have been deprived of their liberty, including the percentage in which legal or other assistance has been provided, and in which the legality of the deprivation of liberty has been challenged before an appropriate authority, together with the results of such challenges. **Sources:** Country reports; comments of the committee; shadow reports. **Period:** Every 5 years in line with the required reporting periods.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Integration of legislation affecting children in the justice system. Ensure specialised procedures for children appearing before the courts.	**Type 5 Indicator: Service Quality** 1. An integrated legislative framework for regulating children in the criminal justice system (following the CRC) is in place. 2. Specialised courts and procedures for children are in place. **Reason for use:** To monitor government's commitment to compliance with the CRC, and the transformation of the justice system to one that meets the needs of children. An integrated system is key to protecting the rights of children. To ensure effective justice services for children and to monitor progressive compliance with the CRC and the Child Justice Bill (CJB). Existence of specialised courts provides for the right of children to special protection (CRC and CJB).	**Definition:** Appropriate legislation has been passed and harmonised in terms of regulations, and the necessary procedures as noted below are in place. **Measures:** 1. Number of judgements and comments against the provisions of the CJB (once enacted). 2. Existence of specialised courts and procedures for children measured against departmental targets. 3. Compliance with specialised procedures. 4. The number of jurisdictions designated as one-stop child justice centres measured against departmental targets. 5. The existence of requirements in policy and legislation to ensure services are of acceptable quality. 6. Existence of specialised courts and procedures for children (CRC 40.2(b)): UNICEF Indicators for Juvenile Justice require that the availability of specialised staff be expressed as a per 1 000 ratio of arrested children for: judges, lawyers, prosecutors, police and social workers (probation officers). 7. The existence of a body or bodies responsible for overseeing judicial and correctional services to children. 8. Revision of the age of criminal capacity to 10 years with a rebuttable presumption of lack of capacity up to 14 years. 9. Constitutionality of retroactive legislation. 10. Use of the presumption of innocence by the courts. 11. Assessment of automatic review of custodial sentences for children under 16 years (in terms of CJB Section 80 if passed); until such time, periodic assessment of the extent to which decisions and sentences are reviewed. **Sources:** Department of Justice (DoJ) and National Prosecuting Authority (NPA): • Legislation; • Case law; • Departmental programme plans, progress reports, outputs, and annual reports; • Criminal, civil and constitutional court cases involving children's rights matters; • CRC country reports. **Period:** Periodic reviews of the legislative and policy environment for child justice; every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Prevent abuse of children in the justice and correctional systems and ensure compliance with the objectives of the Optional Protocol to the Convention Against Torture (2002) Article 1, and in terms of the Constitution and the CRC.	**Type 5 Indicator: Service Quality** Detention facilities for children are inspected at least once per annum. **Reason for use:** The Children's Act (No. 38 of 2005) and the associated Children's Amendment Bill (No. 19 of 2006), as well as the Correctional Services Act (CSA) (through the Judicial Inspectorate), make provision for unannounced visits to facilities where children are detained. The frequency, duration and timing of these visits are important indicators of the commitment of oversight bodies to detention conditions which comply with the legislative requirements.	**Definition:** All facilities where children are detained (awaiting trial and sentenced) are inspected unannounced by the Office of the Inspecting Judge (OIJ) at least twice per year. **Measure:** Proportion of facilities inspected twice per year. **Source:** OIJ **Period:** Annual

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Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 1 & 5 Indicators: Child Status and Service Quality** Children subject to torture and inhumane treatment while in the care of the state. **Reason for use:** Monitor safety and security of children in the criminal justice system and violations of the law.	**Definition:** Torture 'means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions' (CRC Article 1). **Measures:** 1. Number of allegations of torture, abuse, cruel and inhumane treatment of children in conflict with the law. 2. Number of cases investigated alleging torture, abuse, cruel and inhumane treatment of children in conflict with the law. 3. Number of convictions for torture, abuse, cruel and inhumane treatment of children in conflict with the law. **Sources:** NPA; Independent Complaints Directorate (ICD); OIJ; Department of Correctional Services (DoCS). **Period:** Every 5 years.
	Type 1 & 5 Indicators: Child Status and Service Quality Deaths in the child justice system. **Reason for use:** Key indicator of failure to protect children in the justice system.	**Definition:** Child deaths occurring in the criminal justice system. **Measure:** Proportion of children who die in state custody and in programmes or interventions sanctioned by the criminal justice system. **Sources:** ICD; OIJ; director-general of the Department of Social Development (DoSD). **Period:** Annual
	Type 1 & 5 Indicators: Child Status and Service Quality Children injured in state custody by those responsible for the child. **Reason for use:** Key indicator of failure to protect children in the justice system.	**Definition:** Injury sustained while in state custody and caused by those responsible for the child as an injury that necessitates hospitalisation. **Measure:** Proportion of children injured while in state custody. **Sources:** SAP 14 forms; ICD; OIJ; DoSD. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure that children in detention are held in conditions that comply with the CRC. Ensure that children are held in conditions appropriate to their age and in compliance with regulations – CSA 8.2, 12, 19; Constitution (sections 12, 35). Promote children's access to educational and social services while in custody during all phases of the justice process. Ensure the child's right to education and development while in custody.	**Type 4 Indicator: Service Access** Services provided to children in detention (sentenced and unsentenced) in terms of the relevant Acts and regulations. **Reason for use:** Monitor children's access to services which meet the psychological, educational, health, spiritual and recreational needs of children awaiting trial and serving custodial sentences.	**Definitions:** Services as defined in terms of the relevant Acts and which apply to all facilities where sentenced children may be detained. The regulations only apply to prisoners with a sentence exceeding 12 months and do not apply to children awaiting trial. However, detained children have a right to services which respond to their social, religious, recreational and psychological needs. In the absence of these services, as is often the case, children are deprived of their rights to development and protection. It is recommended that both awaiting trial and sentenced children be monitored. **Measures:** 1. Proportion of eligible sentenced and awaiting trial children (disaggregate) who are enrolled in formal education. 2. Proportion of eligible sentenced and awaiting trial children (disaggregate) (16–18) who are enrolled in education and training. 3. Proportion of children who have access to a social worker or other social services professional during each 6-month period of custody and while awaiting trial. 4. Average number of child prisoner–social worker interviews per annum. 5. Availability of recreational and spiritual guidance in all custodial facilities (based on registration of secure care facilities, and reports of the Inspecting Judge). **Sources:** DoCS; DoSD. **Period:** Annual
	Type 5 Indicator: Service Quality Capacity of secure and residential facilities to hold children apart from adults and to segregate genders. **Reason for use:** Regulations require children to be housed separately from adults and segregated by gender.	**Definition:** Accommodation separate from adults is provided to children and is provided for boys and girls and in all facilities in which children may be held prior to the preliminary hearing, awaiting trial and following sentence. **Measures:** 1. Proportion of facilities which have facilities for male and female children separate from those for adults. 2. Reports of children being held in contravention of the regulations. **Sources:** 1. DoSD: from facility registration applications and renewals (required every 2 years) in accordance with regulations of the relevant Acts. 2. Regular facility audits (reports of the OIJ). **Period:** Every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring arrest, including detention, release to appear, and assessment prior to first appearance		
Reduce the number of children in trouble with the law.	**Type 1 Indicator: Child Status** Children arrested (by offence category). **Reason for use:** Monitoring of numbers of children in trouble with the law. Monitor compliance with standards applicable to arrest procedures.	**Definition:** Persons under the age of 18 years arrested by the South African Police Services (SAPS), disaggregated by age (10 years & 11–17 years inclusive) and by offence category. **Measure:** Proportion of persons under the age of 18 years recorded as suspects on Case Administration System (CAS) (child population for the denominator), for each offence category. **Source:** SAPS (CAS) **Period:** Annual
Limit the child's exposure to the criminal justice system and use detention as a measure of last resort (CJB). Ensure compliance with regulations that protect children in the justice system.	**Type 1 Indicator: Child Status** 1. Children in detention in police cells for over 48 hours. 2. Children who are arrested but no further action is taken. **Reason for use:** Monitor compliance with SAPS regulations (SAP 14). Protect children from possible harm following arrest. Arbitrary detention and detention without being charged are serious rights violations.	**Definitions:** 1. Police release the child into the care of parents or guardians prior to first appearance. 2. Children who are arrested but no further action is taken (arrested children who are not assessed, do not appear in court, or appear before a prosecutor) (CJB Chapter 4). **Measures:** 1. Proportion of arrested children held in custody for more than 48 hours following arrest. The number of children in detention in a particular jurisdiction should be disaggregated in terms of i) the average number of children in detention per week/month/year, ii) date-specific counts, for example at month end or on Mondays, iii) new admissions to police custody, iv) number of children who have been in custody for less than 48 hours, and v) children in custody for more than one week. 2. Proportion of children who are arrested but no further action is taken. **Source:** SAPS **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
	Type 1 Indicator: Child Status Placements of children prior to first court appearance. **Reason for use:** Monitoring of children prior to first court appearance. Children are at risk in custody, and wherever possible should be released into the care of parents or guardians. The CJB makes provision for this.	**Definition:** Decision by the police to release the child into the care of parents or guardians prior to first appearance. **Measure:** Proportion of arrested children released into the care of a parent or guardian. **Source:** SAPS **Period:** Annual
Promote sound and comprehensive assessments of all children so as to inform judicial decisions.	**Type 5 Indicator: Service Quality** Children are assessed using a standard assessment system prior to the preliminary inquiry. **Reason for use:** The assessment process is key to all the steps that follow and is a vital component of a child justice process. Monitor utilisation of assessment tool in line with Diversion Minimum Standards.	**Definition:** The use of a standard national assessment tool by all probation officers, as defined by the Diversion Minimum Standards of the DoSD and the CJB. **Measure:** Proportion of arrested children assessed using the tool. **Sources:** Not available at present. DoSD; SAPS (CAS) for number of arrested children. **Period:** Annual (once available) **Note:** At the time of writing the standards had not been finalised by the department.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 1 Indicator: Child Status** Timely assessment of children prior to first court appearance. **Reason for use:** Monitor compliance with the relevant legislation. The difference between the numbers of arrested children and the numbers assessed, as well as the period taken for the child to be assessed, are indicators of the capacity of the DoSD to assess the number of children arrested.	**Definition:** Each child must be assessed within 48 hours and prior to first court appearance. **Measures:** 1. Proportion of arrested children assessed within 48 hours of arrest; 2. Proportion of arrested children assessed after 48 hours but in under 7 days from date of arrest; 3. Proportion of all arrested children assessed prior to first court appearance. **Sources:** DoSD; SAPS (CAS) for number of arrested children. **Period:** Annual
	Type 1 & 4 Indicators: Child Status and Service Access Children who at first appearance have legal representation. **Reason for use:** Promote the child's right to support during trial proceedings. Monitor progress in relation to the CJB.	**Definition:** The child is assigned legal representation at first appearance. **Measure:** Proportion of children at first appearance who have legal representation. **Sources:** DoJ; Legal Aid Board. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring children awaiting trial in custody post first court appearance		
Promote children's rights to a speedy trial.	**Type 1 & 5 Indicators: Child Status and Service Quality** 1. Average detention cycle time of children awaiting trial; 2. Children detained awaiting trial in excess of 180 days. **Reason for use:** To monitor children's access to a prompt legal process. Children remaining in custody longer than 6 months need to be identified and action needs to be taken as lengthy custody places the child at risk for abuse.	**Definitions:** 1. Average detention cycle time is the average duration of incarceration from when an accused person is admitted to custody for the first time until that matter is adjudicated. **Measure:** Average detention cycle time for persons under 18 years for each district and regional court. **Source:** DoJ (Directorate of Prosecutions biannual reports) – would have to be disaggregated by age. **Period:** Annual 2. Children awaiting trial in prison for a continuous period of more than 180 days. **Measure:** Proportion of awaiting trial children held in prison for more than 6 months. **Source:** DoJ (Directorate of Prosecutions biannual reports) **Period:** Twice per annum on release of the report to Parliament as required in Act 55 of 2004.
Ensure that children in detention are held in conditions that comply with the CRC. Ensure that children are held in conditions appropriate to their age and in compliance with the regulations.	**Type 1 Indicator: Child Status** 1. Placements of awaiting trial children. 2. Placements of sentenced children. **Reason for use:** Monitor orders for the placement of awaiting trial and sentenced children. Children are at risk in custody, and wherever possible should be released into the care of parents or guardians and/or diverted.	**Definition:** Judicial decisions regarding placement of children awaiting trial: awaiting trial children, and those awaiting deportation, may be ordered detained in places of safety, prisons, secure care facilities, immigration centres and police cells, or released into the care of parents or guardians (in terms of the applicable legislation – CJB Section 16(1)(a)(i)). **Measures:** 1. Awaiting trial: proportion of awaiting trial children in each category. **Period:** Monthly 2. Sentenced: proportion of awaiting sentenced children in each appropriate category. **Period:** Annual **Sources:** DoCS; Department of Home Affairs (DoHA); DoSD – Youth Care Centres and other facilities; SAPS.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring diversion and diversion programmes		
Reduce the number of children whose cases go to trial and increase the numbers of children who are diverted out of the justice system.	**Type 1 indicator: Child Status** Children diverted from the justice system (for each type). **Reason for use:** Monitor the extent to which diversion is being used as an alternative to trial by judicial officers in terms of the CJB.	**Definition:** Children may be diverted out of the justice system at the preliminary hearing (and thereafter). A range of options for diversion is contained in the CJB. **Measures:** Proportion of children diverted from the justice system stratified by diversion option. **Source:** DoJ **Period:** Annual
Indicators for monitoring the trial		
Increase the number of decisions to divert children and reduce the number in custody.	**Type 1 Indicator: Child Status** Preliminary inquiry outcomes. **Reason for use:** Wherever possible children should be diverted out of the justice system. This indicator monitors the extent to which this occurs.	**Definition:** Preliminary inquiry outcomes include: • Prosecution; • Diversion: arrested children who do not proceed to trial and who are diverted from the justice system; • Conversion: the matter is converted to a Children's Court Inquiry (CCI). **Measure:** Proportion of children who are prosecuted, diverted or converted to a CCI. **Source:** DoJ **Period:** Annual **Note:** Data should also be monitored for children who are diverted prior to appearing at the preliminary inquiry.
	Type 1 Indicator: Child Status Adjudication results of court cases. **Reason for use:** Monitor adjudications to track court decisions and the extent to which diversion is being used.	**Definition:** Outcome of tried cases for each category of offence: acquitted, convicted, converted to CCI, diverted. **Measure:** Proportion of cases acquitted, convicted, converted to CCI and diverted (by offence category). **Sources:** DoJ; NPA. **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Promote children's access to a fair trial that is in accordance with due process principles outlined in Article 40 of the CRC, and the South African Constitution, as articulated in the CJB.	**Type 1 Indicator: Child Status** Children appearing at trial with legal representation. **Reason for use:** Monitor children's access to legal representation during trial proceedings.	**Definition:** The child is assigned legal representation. **Measure:** Proportion of children appearing in court with a legal representative. **Sources:** DoJ; Legal Aid Board. **Period:** Annual
Indicators for monitoring sentencing and sentenced children		
Ensure that the state makes a range of non-custodial options available in terms of the CRC.	**Type 1 Indicator: Child Status** Sentencing practices in the child justice system. **Reason for use:** To monitor the use of custodial and non-custodial sentences for children.	**Definition:** Sentences imposed by the court stratified by type of sentence, offence category, sentence length, and conditions of sentence. **Measures:** Sentence profile of convicted children: • Proportion of sentenced children sentenced to life imprisonment; • Proportion of sentenced children receiving prison sentences of longer than 18 years; • Proportion of sentenced children sentenced to non-custodial options; • Proportion of children sentenced in terms of minimum sentences legislation (Criminal Law Amendment Act [No. 105 of 1997]). **Sources:** DoJ; DoCS based on the following data: new admissions; specific date count; average number of children serving custodial sentences. **Period:** Annual
Ensure that children are held in conditions appropriate to their age and in compliance with relevant law and regulations.	**Type 5 Indicator: Service Quality** Detention of children in prisons is in compliance with the provisions of the CSA and other relevant legislation. **Reason for use:** Monitor compliance with the CSA and regulations, and the CRC.	**Definition:** Inter alia, the provisions include the following: • Prisons comply with dietary requirements as set out in the CSA and the regulations; • The right to be held separately from persons over 18 years, for the shortest possible time, and in a manner appropriate for the child's age; • The right to education and other services (see elsewhere in this table); • For complaints to be laid by children against state care; • For notifications sent to parents and the relevant authorities informing them of the detention of the child. **Measure:** The number of prisons that comply with the above provisions based on documentary evidence held by each prison. **Source:** DoCS **Period:** Every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure adequate care for children in custody.	**Type 5 Indicator: Service Quality** Staff–child ratios in custodial facilities. **Reason for use:** Monitor the quality of care of children in custody. High staff care loads undermine service quality. Poor care violates the child's right to be held in humane conditions.	**Definition:** Guidelines for staff–child ratios would normally be set by the relevant department, and would differ according to type of custodial facility. Ratios should be expressed for each type of custodial facility. **Measures:** 1. The relevant departments have published staff–child ratios in place. 2. Ratio of children to care workers in each type of custodial facility (and compliance with norms once they are in place). **Sources:** DoSD; DoCS. **Period:** Annual
Ensure that children in detention are held in conditions that comply with the CRC, the UN Convention Against Torture (UNCAT) and other relevant bodies of law and regulations. Ensure that children are held in conditions appropriate to their age.	**Type 5 Indicator: Service Quality** References in UNCAT country report to alleged and confirmed cases of torture and ill-treatment where the victims were children serving custodial sentences. **Reason for use:** Monitor compliance with reporting requirements of UNCAT.	**Definition:** Children noted as victims in the UNCAT country report. **Measure:** Number of notations. **Source:** South Africa country report. **Period:** Every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring reintegration		
Improve the effectiveness of diversion programmes and the reintegration of children who have come into conflict with the law in terms of the CRC and the CJB.	**Type 5 Indicator: Service Quality** The effectiveness of all services in reintegrating children in conflict with the law. **Reason for use:** To monitor the effectiveness of custodial and non-custodial measures (e.g. diversion) for children in conflict with the law and different forms of diversion. Re-imprisonment of offenders aged between 18 and 20 years who have already served a term of imprisonment for an offence committed as a child provides a fairly robust indicator of the level of reintegration and rehabilitation attained as a result of a custodial sentence.	**Definition:** Effective reintegration is defined as: 1. A child who does not re-offend within 18 months of exiting a custodial facility or diversion programme (each to be measured separately). 2. A youth of 18–20 years who served a custodial sentence as a child and who has not been re-imprisoned for a different offence committed since leaving prison. **Measures:** 1. The proportion of children who are released from each form of sentence or diversion programme who do not re-offend within 18 months of release. 2. The proportion of persons aged 18–20 years who are not re-imprisoned and who served a custodial sentence for an offence committed as a child. **Sources:** SAPS; DoJ; Child and Youth Care Administration (CYCA) database (DoSD); DoCS. **Period:** Audit every 5 years.

Additional indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring the legislative and policy environment and for multiple stages of the justice system		
Promote the development of child-centred policy and legislation. Ensure children's rights to participation.	**Type 5 Indicator: Service Quality** Children contribute to the development of legislation and policy. **Reason for use:** Ensure the child's right to participation in decisions affecting him or her.	**Definition:** Recorded inputs by children on each new legislative and policy framework. **Measure:** Number and scope of inputs. **Source:** Not available. Will depend on provisions to record such processes. **Period:** Review periodically following the introduction of new law and policy.
Ensure equal access to services.	**Type 4 Indicator: Service Access** Discriminatory treatment of children in the justice system. **Reason for use:** To monitor fair and equitable treatment of all children in the justice system (in terms of the Constitution and the CRC).	**Definition:** Cases reported to Public Protector, Commission on Gender Equality, South African Human Rights Commission, OIJ and any other body resulting from alleged discrimination in the criminal justice system against a child. **Measure:** Number of cases reported and investigated by these bodies. **Sources:** The above bodies. **Period:** Audit every 5 years.
Indicators for monitoring arrest, including detention, release to appear, and assessment prior to first appearance		
Ensure that children in detention are not held illegally (compliance with the CRC). Promote the participation of children in the justice system in evaluating police and justice services.	**Type 1 Indicator: Child Status** Illegal detentions of children. **Reason for use:** Monitor illegal detention of children.	**Definition:** Any detention that is found upon review or inspection to be in contravention of any law, including children under the age of 14 years awaiting trial in prison and police cells. **Measure:** Number of children illegally detained by the DoSD, SAPS, DoHA or DoCS. **Sources:** DoSD; SAPS; DoHA (for illegal immigrants); DoCS; other oversight structures. **Period:** Audit every 5 years.

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Policy goal	Indicator and reason for use	Definition, measure, period and data source
➔	**Type 5 Indicator: Service Quality** Children's experience of their treatment by the police and private security agents. **Reason for use:** Monitor the child's experience of police treatment.	**Definition & Measure:** Children's satisfaction with the treatment they received from police and private security agents during the pre-trial period. Exit polls to be developed in specific studies. **Source:** None **Period:** Audit every 5 years.
Promote support of parents and guardians for children appearing in court (in terms of the CRC).	**Type 1 Indicator: Child Status** Children accompanied by parent/guardian at first court appearance. **Reason for use:** The police must inform the parent/guardian of a child's arrest and court appearance. The absence of a parent/guardian can result in the child being remanded in custody.	**Definition & Measure:** Child at first appearance is accompanied by a parent/guardian. To be developed in specific studies. **Source:** DoJ **Period:** Audit every 5 years.
Promote sound record keeping in compliance with the UN Standard Minimum Rules (UNSMR) for the Treatment of Prisoners (in Rule 7.1 and Rule 7.2), and South African regulations.	**Type 5 Indicator: Service Quality** Record keeping of arrests and detention of children. **Reason for use:** Poor quality record keeping contributes to children 'getting lost' in the system. To monitor compliance with Rule 7.1 of the UNSMR and South African regulations.	**Definition & Measure:** SAPS are obliged to keep records on all persons in their custody in the SAP 14 form. Rule 7.1 states that, 'In every place where persons are imprisoned there shall be kept a bound registration book with numbered pages in which shall be entered in respect of each prisoner received: (a) Information concerning his identity; (b) The reasons for his commitment and the authority therefore; (c) The day and hour of his admission and release. (2) No person shall be received in an institution without a valid commitment order of which the details shall have been previously entered in the register.' **Source:** SAPS (SAP 14 forms) **Period:** Audit every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Promote sound and comprehensive assessments of all children so as to inform judicial decisions.	**Type 5 Indicator: Service Quality** Judicial decisions are informed by assessments of arrested children. **Reason for use:** Monitor compliance with the recommendations of the CJB.	**Definition:** Judicial decisions are informed by assessment reports that include the wishes of children (in terms of the CRC). **Measure:** Proportion of completed assessments of arrested children that are used to inform judicial decisions. **Sources:** DoSD; NPA. **Period:** Every 5 years.
Promote quality services to children in the justice system.	**Type 1, 4 & 5 Indicators: Child Status, Service Access and Service Quality** Cases appearing before a magistrate at the preliminary inquiry. **Reason for use:** Monitor compliance with the CJB.	**Definition:** Magistrates hear all preliminary inquiries. **Measure:** Proportion of children who are arrested and who appear before a magistrate at the preliminary inquiry. **Source:** DoJ **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring children awaiting trial in custody post first court appearance		
Promote compliance with Article 37 of the CRC.	**Type 5 Indicator: Service Quality** 1. Use of non-custodial measures for children awaiting trial. 2. Effectiveness of non-custodial measures in securing children's attendance at trial. 3. Children under the age of 14 years awaiting trial in prison and police cells. **Reason for use:** Detention poses significant risks for the rights of children, particularly in the awaiting trial or unsentenced phase, and should therefore be avoided as far as possible. It is important to monitor the effectiveness of non-custodial measures for policy monitoring purposes.	**Definition & Measures:** Range and utilisation of non-custodial means to secure attendance of suspect at trial with regard to: • Proportion of arrested children released into care of parents (CRC 37.1(b)); • Proportion of arrested children released on bail (CRC 37.1(b)) and bail amounts for children (CRC 40.2(b)); • Proportion of arrested children placed under house arrest (CRC 37.1(b)); • Proportion of arrested children placed under Section 62(f) of the CSA (CRC 37.1(b)); • Children under the age of 14 years awaiting trial in prison and police cells. **Source:** DoJ **Period:** Annual

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring diversion and diversion programmes		
Promote sound and comprehensive assessments of all children so as to inform judicial decisions.	**Type 5 Indicator: Service Quality** Recommendations for diversion in assessments are accepted by the prosecution service. **Reason for use:** To monitor changes in prosecutor practice in respect of diversion recommendations.	**Definition:** Cases recommended through assessment for diversion which are accepted by the prosecution as suitable to be diverted. **Measure:** Proportion of cases recommended through assessment for diversion that are accepted by the prosecution service. **Sources:** None at present. Developed for specific studies. DoSD; NPA. **Period:** Audit every 5 years.
Ensure fair and equal treatment of all children in the justice system and equal access to diversion opportunities.	**Type 4 Indicator: Service Access** Equity in the diversion system. **Reason for use:** Ensure that diversion is accessible to all arrested children without discrimination.	**Definition:** Diverted children should reflect the population of arrested children (gender and population group) in the same offence category. **Measure:** Profile of diverted cases disaggregated by population group and gender for each offence category. **Sources:** DoSD; NPA. **Period:** Audit every 5 years.
	Type 4 Indicator: Service Access Geographical accessibility and type of diversion services. **Reason for use:** Monitor the availability of diversion services in each jurisdiction.	**Definition:** Diversion services are defined by the CJB and Diversion Minimum Standards (of the DoSD). **Measure:** Types of service available in each magisterial district. **Sources:** DoJ; NPA; the National Institute for Crime Prevention and the Reintegration of Offenders. **Period:** Audit every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Promote effective diversion services that comply with standards and within which children comply with the order and complete the programme.	**Type 1 Indicator: Child Status** Compliance of children with diversion conditions. **Reason for use:** Monitor effectiveness of diversion programmes as well as the suitability of the match between the child and the programme.	**Definition & Measure:** Children who do not comply are those who violate their diversion conditions as set by the prosecutor. **Sources:** None at present. Developed for specific studies. DoSD; NPA. **Period:** Audit every 5 years.
	Type 5 Indicator: Service Quality Compliance with Diversion Minimum Standards in terms of service providers' requirements and programme outcomes. **Reason for use:** To monitor the quality and improvement of diversion services.	**Definition:** Level of compliance with the Diversion Minimum Standards as defined by the DoSD. **Measure:** Proportion of diversion service providers who meet all the minimum standards. **Source:** None at present. Awaiting finalisation of the standards by the DoSD. **Period:** At application for and renewal of accreditation.
Indicators for monitoring the trial		
Promotion of a fair judicial process that promotes the participation of the child and is in accordance with due process.	**Type 5 Indicator: Service Quality** Decisions overturned due to non-compliance. **Reason for use:** To monitor compliance with provisions as required by the South African Constitution as outlined in Section 35(3)(a)–(o), 4 and 5.	**Definition:** Compliance with provisions as required by the Constitution. **Measure:** Proportion of decisions and judgements overturned as a result of non-compliance. **Sources:** Constitutional Court; Supreme Court of Appeal; Supreme Court. **Period:** Every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Roll out effective child-friendly courts in the justice system as provided for in various bodies of law and regulations.	**Type 4 & 5 Indicators: Service Access and Service Quality** Child-friendly courts in place. **Reason for use:** Availability of these facilities' services is likely to improve the quality of child testimony, reduce the trauma of court appearance, and improve the conviction rate. To monitor compliance with regulations and to assess progress in transformation of the justice system.	**Definition:** The child's identity is protected during legal proceedings through provision of in-camera hearings; the trial is accessible to the child through the provision of interpreters and through legal aid. **Measures:** 1. Proportion of children receiving requested interpretation services. 2. Proportion of children who receive legal representation. 3. Proportion of children whose hearings are held in camera. **Source:** DoJ **Period:** Service quality audit every 5 years.
Promote compliance of the justice system with Article 40 of the CRC and relevant South African provisions. Reduce prosecutions of children within the rebuttable age margins.	**Type 1 Indicator: Child Status** Children prosecuted in the rebuttable age margins. **Reason for use:** Monitor prosecutions of children in this age group where there is the risk that they may not have criminal capacity.	**Definition:** The rebuttable margin covers children aged between 10 and 14 years and carries a rebuttable presumption of lack of criminal capacity for the period. **Measure:** Proportion of prosecutions of children where children are aged between 10 and 14 years. **Sources:** NPA; DoJ. **Period:** Service quality audit every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Indicators for monitoring sentencing and sentenced children		
Ensure that children in detention are held in conditions that comply with articles 37 and 40 of the CRC. Ensure that children are held in conditions appropriate to their age and in compliance with regulations.	**Type 1 Indicator: Child Status** Number of children held in solitary confinement. **Reason for use:** Isolation is a cruel form of punishment and can be psychologically damaging to children in custody when used for excessive periods. The Child Care Act Regulations specify that children may only be isolated when they are a danger to self or others for a period not exceeding 2 hours.	**Definition:** Children serving custodial sentences who are held in solitary confinement for longer than 2 hours as reported to the OIJ. **Measure:** Number of sentenced children held in solitary confinement in prisons. **Source:** Reports of the Inspecting Judge **Period:** Annual
	Type 5 Indicator: Service Quality Parents/guardians are informed of detention and transfers. **Reason for use:** To monitor compliance with the CSA.	**Definition:** Notification to parent/guardian from DoCS regarding detention and/or transfer of a child. **Measure:** Number of notifications sent to relevant authorities by the commissioner informing them of the detention and/or transfer of a child. **Source:** DoCS **Period:** Service quality audit every 5 years.
Increase the use of non-custodial sentences and the use of the review process in terms of Chapter 30 of the Criminal Procedure Act.	**Type 5 Indicator: Service Quality** Custodial sentences overturned upon review. **Reason for use:** The results of this review mechanism need to be monitored, as well as its consequences for children.	**Definition:** Custodial sentences that are converted to non-custodial sentences upon review or appeal. This applies particularly to children under 16 where the CJB will require that all receiving sentences of imprisonment will be subject to automatic review before a judge of the high court. **Measure:** Proportion of custodial sentences converted to non-custodial sentences in children under 16 and 16–17 (inclusive). **Sources:** DoJ; law reports. **Period:** Every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Only use custodial sentences for first offenders if no other option is possible. Reduce the proportion of children serving full sentences.	**Type 1 Indicator: Child Status** First-time offenders receiving custodial sentences. **Reason for use:** Monitor application of Beijing Rule 17c and the CRC.	**Definition:** Children with no prior convictions sentenced to serve a custodial sentence. **Measure:** Proportion of first-time offenders receiving a custodial sentence. **Source:** DoJ **Period:** Every 5 years.
Custodial sentences should be for the shortest possible period.	**Type 1 Indicator: Child Status** Children serving full sentences in custody. **Reason for use:** Custody places children at risk in a number of ways, and wherever possible children should not be required to serve a full sentence.	**Definition:** Children who serve their full sentence in prisons and are not released on parole or correctional supervision. **Measure:** Proportion of children serving their full sentence in custody. **Source:** DoCS **Period:** Every 5 years.
	Type 1 Indicator: Child Status Children released early on parole/correctional supervision. **Reason for use:** Children should be held in custody for as short a time as possible.	**Definition:** Children who are released on parole or correctional supervision to complete the remainder of their sentence outside of prison. **Measure:** Proportion of children not serving their full sentences in prison. **Source:** DoCS **Period:** Every 5 years.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Promote children's access to educational and social services while in custody during all phases of the justice process. Ensure the child's right to education and development while in custody (CRC and Constitution).	**Type 1 Indicator: Child Status** Educational qualification attainment of children in custody. **Reason for use:** Measure of success of educational programmes for children in detention.	**Definition:** Children who receive an educational qualification while in custody. **Measure:** Proportion of children in custody who attend education programmes and who graduate with a certificate. **Sources:** DoCS; DoSD; Department of Education. **Period:** Every 5 years.
Indicators for monitoring reintegration		
Improve reintegration and reduce re-offending by children.	**Type 1 Indicator: Child Status** Compliance of children with non-custodial sentencing options. **Reason for use:** To monitor compliance with such measures.	**Definition:** The child fails to comply with the sentence and is returned to court. **Measure:** Proportion of children in non-custodial sentence options who do not comply. **Sources:** DoCS; DoJ; NPA. **Period:** Every 5 years.
	Type 5 Indicator: Service Quality Child criminal record expungements. **Reason for use:** Expungements are subject to the offender not being convicted of a further offence and provide an indication of re-conviction rates.	**Definition:** Criminal record expungements effected in terms of the legislation. **Measure:** The number of expungements executed by the SA Criminal Bureau and the director-general of the DoSD in terms of Section 82(5) and Section 82(6) of the CJB respectively per year. **Sources:** SA Criminal Bureau; DoSD. **Period:** Annual

Indicators for monitoring orphans and children made vulnerable by HIV/AIDS

Core indicators

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor the numbers of orphans.	**Type 1 Indicator: Child Status** Children who are orphans. **Reason for use:** To monitor the levels of orphanhood.	**Definition:** Children under 18 whose mother, father or both parents have died (stratify for each, and by gender and age: 0–4, 5–9, 10–14 and 15–17). **Measure:** Proportion of children under 18 whose mother, father or both parents have died. **Sources:** Census; actuarial predictions where available. **Period:** Every 10 years for the Census; every 5 years from actuarial projections. **Note:** As stated by UNICEF (2005b), this is a *proxy* indicator for children orphaned by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high.
Monitor the number of vulnerable children.	**Type 1 Indicator: Child Status** Children made vulnerable by HIV and AIDS. **Reason for use:** To monitor the proportion of children who are made vulnerable by HIV/AIDS.	**Definition:** A child made vulnerable by HIV/AIDS is below the age of 18 and: • Has lost one or both parents; or • Has a chronically ill parent (regardless of whether the parent lives in the same household as the child); or • Lives in a household where in the past 12 months at least one adult died and was sick for three of the 12 months before he/she died; or • Lives in a household where at least one adult was seriously ill for at least three months in the past 12 months; or • Lives outside of family care (i.e. child-headed households, lives in an institution or on the streets). **Measure:** Proportion of children under 18 who are vulnerable according to the definition. Source: Specific surveys **Period:** At time of survey **Note:** As stated by UNICEF (2005b), this is a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor the numbers of children outside of family care, and attend to the needs of these children.	**Type 1 Indicator: Child Status** Children outside of family care. **Reason for use:** To obtain estimates of child-headed households, and children living on the streets and in institutions.	**Definition:** Children living outside of traditional households include child-headed households, homeless children and children living in institutions. Institutions include: facilities used for statutory care (e.g. children's homes), homes for children who are disabled, street shelters, juvenile justice facilities, etc. **Measure:** The proportion of all children aged 0–17 living outside of family care (child-headed households, on the streets and in institutions) divided by the estimated number of children aged 0–17. **Sources:** Data on child-headed households can be gleaned from the Census, the Demographic and Health Survey and other household surveys (households with no person over age 18 years) (see Bray, 2003b). Other sources include special surveys of children living on the streets, and surveys of children living in institutions. Alternatives include statutory care placement data obtained from children's court inquiries (Department of Justice). Data could be obtained from subsidised street shelters – information is collected from shelters by provincial Departments of Social Development (DoSDs). **Period:** Every 5 years if feasible. **Notes:** Children living in institutions – a census of institutions that take care of children will need to be conducted. Once the institutions have been identified, all orphaned and vulnerable children living in them are enumerated. These data should be stratified by the type of institution (orphanage, home for the physically disabled, juvenile justice facility, etc.). Homeless children on the streets need to be sampled using the concept of *time-location sites*. Sampling of street children should be confined to children who actually slept on the streets the night before the survey.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Strengthen the capacity of families to protect and care for orphans and vulnerable children (OVCs).	**Type 2 Indicator: Family & Household Environment** Children aged 5–17 with three unmet basic material needs. **Reason for use:** The indicator estimates whether the overall levels of basic personal needs for children are being met. Furthermore, when calculated as a ratio of OVC to non-OVC, it assesses progress in preventing relative disadvantages for orphaned and vulnerable children.	**Definition:** This indicator assesses the capacity of families to provide children with minimum basic material needs (food, education and medical care are covered by other indicators). Suggested items are availability of a blanket, shoes and two sets of clothes. These three items can be modified if other basic needs are considered more important (school books, etc.). **Measure:** Ratio of OVC versus non-OVC who have three unmet basic material needs for personal care. The ratio of (1) proportion of OVC who have three unmet basic material needs to (2) proportion of non-OVC who have three minimum basic material needs. 1. Proportion of OVC who have three unmet basic material needs for personal care. Numerator 1: Number of OVC aged 5–17 surveyed with a minimum set of three unmet basic personal material needs. Denominator 1: Number of OVC aged 5–17 surveyed. 2. Proportion of non-OVC who have three unmet basic material needs for personal care. Numerator 2: Number of non-OVC aged 5–17 surveyed with a minimum set of three unmet basic personal material needs. Denominator 2: Number of non-OVC aged 5–17 surveyed. **Source:** Specific surveys **Period:** Where survey is available. **Note:** As stated by UNICEF (2005b), the definition of OVC has been developed to define a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high. This is the only context in which a ratio of the kind used here might be meaningful.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Improve OVC's food security.	**Type 1 Indicator: Child Status** Malnutrition/underweight prevalence 0–4. **Reason for use:** To assess progress in preventing relative disparity in malnutrition among orphaned and vulnerable children compared with other children.	**Definition:** OVC aged 0–4 years who are malnourished (below 2 standard deviations from the median weight-for-age of World Health Organisation/National Centre for Health Statistics reference population). Weight-for-age reflects a combination of acute and chronic malnutrition for the child. **Measure:** Ratio of the proportion of OVC compared to non-OVC who are malnourished (underweight). Orphan malnutrition ratio: The ratio of (1) OVC malnutrition rate to (2) non-OVC malnutrition rate. 1. Malnutrition rate among OVC (%) Numerator 1: Number of malnourished OVC aged 0–4 years. Denominator 1: Number of OVC aged 0–4 years. 2. Malnutrition rate among non-OVC (%) Numerator 2: Number of non-OVC aged 0–4 years who are malnourished. Denominator 2: Number of non-OVC aged 0–4 years. **Source:** Specific surveys of target areas would be required; primary health clinics; Early Childhood Development facilities (from Road to Health Cards). **Period:** Where survey is available. **Notes:** 1. Typically, household surveys have only measured malnutrition for children below the age of 5; pilot surveys with this measure show that as children get older, the variations in underweight are small and thus comparing children aged 5–8 is not useful (UNICEF, 2005b). 2. As stated by UNICEF, this is a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high. This is the only context in which a ratio of the kind used here might be meaningful.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Prevent early-age exposure to sexually transmitted infections/HIV/ teenage pregnancies among OVC.	**Type 1 Indicator: Child Status** Sex before age 15 in OVCs. **Reason for use:** Monitors whether the behaviour of OVC is different from that of non-OVC. Teenage orphans and other vulnerable adolescents can be at especially high risk because of a lack of adult guidance to help them protect themselves, and are additionally at risk for violent assault.	**Definition:** An OVC (see definitions) aged 15–17 who had sex before age 15. **Measures:** Ratio of OVC to non-OVC who had sex before age 15: The ratio of (1) the proportion of OVC ages 15–17 who had sex before age 15 to (2) the proportion of non-OVC ages 15–17 who had sex before age 15. 1. Proportion of OVC who had sex before age 15. Numerator 1: Number of OVC who report their age at first sex as under age 15. Denominator 1: Number of OVC aged 15–17. 2. Proportion of non-OVC who had sex before age 15. Numerator 2: Number of non-OVC who report their age at first sex as under age 15. Denominator 2: Number of non-OVC aged 15–17. **Source:** Human Sciences Research Council (HSRC) HIV/AIDS behavioural risks, sero-status and media impact surveys (SABSSM) and Youth Risk Behaviour surveys provide data for the population as a whole, but cannot discriminate between OVC and non-OVC. Therefore, special studies would be required. Specific surveys of target areas would be required. **Period:** Where survey is available. **Note:** As stated by UNICEF (2005b), the definition of OVC has been developed to define a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high. This is the only context in which a ratio of the kind used here might be meaningful.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Ensure external support to OVC.	**Type 4 Indicator: Service Access** External support for OVC. **Reason for use:** To assess the support provided to households that are caring for OVC.	**Definition:** External support for OVC may fall into any of the following categories: • Medical (medical care, medical care supplies); • Emotional/psychological (counselling from a trained counsellor, emotional or spiritual support or companionship); • School fees/school-related assistance (waiver of fees); • Social support including socio-economic (clothing, extra food, financial support [including grants]), • Shelter and instrumental (help with household work, training for caregiver, childcare, legal services). **Measure:** Proportion of OVC who live in households that received at least one of the following services for the child: • Medical support within the past 12 months; • School-related assistance within the past 12 months; • Emotional support within the past 3 months; • Other social support, including material support, within the past 3 months. **Source:** Special survey of high prevalence area (Department of Education [DoE] for school fee waiver data). **Period:** Where survey is available. **Notes:** Apart from school fee waivers for which administrative data are available, this indicator should only be monitored in settings with high HIV prevalence in which household rosters are used to identify all eligible OVC. As stated by UNICEF (2005b), the definition of OVC has been developed to define a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high.
Ensure registration of all OVC so that their right to access services is supported.	**Type 1 Indicator: Child Status** Birth registration **Reason for use:** To determine whether children are registered. Orphans without proof of birth lack the essential protection that stems from this legal form of identity, for inheritance, and for access to services.	**Definition:** This indicator assesses the extent of registration of OVC. It is derived from responses by caretakers of children to a question about the registration status of the child (based on physical evidence if the document exists). **Measure:** Proportion of OVC whose births are reported registered (stratify by age: 0–4; 5–9; 10–17). **Source:** Specific surveys of target areas would be required. **Period:** Annual **Note:** As stated by UNICEF (2005b), the definition of OVC has been developed to define a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Monitor and improve the government's policy for OVC.	**Type 4 & 5 Indicators: Service Access and Service Quality** OVC Policy and Planning Effort Index **Reason for use:** To measure the government's response to provision of supports and services to OVC. It identifies strengths, weaknesses, and gaps in policy and planning efforts.	**Definition & Measure:** National Policy and Planning Effort Index score for OVC. Note that a departmental definition of OVC is needed for this purpose. The OVC Policy and Planning Effort Index is a self-assessment by key stakeholders made by completing a country assessment questionnaire with 100 questions. The indicator is based on a score of 1–100, with 100 being the best score and 1 the lowest. The index reflects the national OVC task force's opinion on how well the country is doing in eight areas of response to OVC. Stakeholders are asked to rate the programme on a list of important items. The effort index is intended to measure policy and planning effort independent of programme outputs. The components covered in the tool are: 1. National situation analysis: whether the country has investigated the situation of orphans and other children made vulnerable by HIV/AIDS and, if so, the nature of that research. 2. Consultative process: the extent to which key stakeholders are involved in planning interventions for orphans and other children made vulnerable by HIV/AIDS. 3. Co-ordinating mechanism: whether action for orphans and other children made vulnerable by HIV/AIDS is being co-ordinated and the nature of that co-ordination. 4. National action plans: whether the country has a national plan of action for orphans and other children made vulnerable by HIV/AIDS, and the nature of that plan. 5. Policy: whether the country has a policy on orphans and other children made vulnerable by HIV/AIDS and the nature of that policy. 6. Legislative review: whether the country has reviewed and updated the legal framework relating to orphans and other children made vulnerable by HIV/AIDS. 7. Monitoring and evaluation (M&E): whether M&E is being conducted nationally of the situation of orphans and other children made vulnerable by HIV/AIDS, and of programmes addressing their needs. 8. Resources: the availability of resources to meet the needs of orphans and other children made vulnerable by HIV/AIDS. **Source:** DoSD **Period:** Every 5 years if feasible.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase the numbers of orphans attending school and provide support for schools with affected children.	**Type 1 & 4 Indicators: Child Status and Service Access** Orphan school attendance ratio **Reason for use:** This indicator assesses progress in preventing relative disadvantage in school attendance among orphans versus non-orphans.	**Definition:** Orphan school attendance ratio is: The ratio of (1) orphans' school attendance to (2) non-orphans' school attendance. **Measure:** The ratio of orphaned children aged 10–14 compared to non-orphaned children aged 10–14 who are currently attending school. 1. Orphans' school attendance (%) Numerator 1: Number of children who have lost one or both parents and are attending school. Denominator 1: Number of children who have lost one or both parents. Alternatively, vulnerable children (children whose parents are chronically ill or whose households have experienced the death of an adult, or whose households contain a chronically ill adult) can be included in the numerator of the ratio. 2. Non-orphans' school attendance (%) Numerator 2: Number of children who are not orphans (according to the above definition) who live with at least one parent and who are attending school. Denominator 2: Number of children whose parents are both still alive and who live with at least one parent. **Source:** DoE (Education Management Information System) **Period:** Annual **Note:** As stated by UNICEF (2005b), the definition of OVC has been developed to define a *proxy* indicator for children made vulnerable by AIDS and *should only be used* in purposive studies conducted in contexts within which the prevalence of HIV is high. This is the only context in which a ratio of the kind used here might be meaningful.
Improve access to treatment for HIV-infected carers and children.	**Type 4 & 5 Indicators: Service Access and Service Quality** Treatment and medical services for infected children and their primary caregivers. **Reason for use:** To assess children and their caregivers' access to treatment.	**Definition & Measure:** Treatment and medical services for infected children and their primary caregivers: • Provision of treatment to prevent mother-to-child transmission; • Provision of antiretrovirals (ARVs) to eligible caregivers; • Provision of ARVs in appropriate form (e.g. suspensions rather than large pills, etc.) to eligible children; • Provision of palliative care for terminally ill children; • Ensure access to clinical services for children affected by HIV and AIDS, particularly for orphans and children who attend the clinics unaccompanied by an adult. **Source:** Department of Health **Period:** Every 5 years if feasible.

Policy goal	Indicator and reason for use	Definition, measure, period and data source
Increase children's HIV knowledge with a view to reducing unsafe sexual behaviour in young people.	**Type 1 indicator: Child Status** Knowledge of HIV risk behaviour and prevention. **Reason for use:** To determine children's knowledge of risk behaviours (in accordance with the UNICEF State of the World's Children indicator reports).	**Definition:** HIV knowledge **Measure:** • Comprehensive knowledge of HIV (in 15–17 year olds); • Knowledge that condom use can prevent HIV transmission (in 15–17 year olds). **Source:** HSRC SABSSM surveys **Period:** Every 5 years data are available.

APPENDIX 1

Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989. Entry into force 2 September 1990, in accordance with article 49.

Preamble

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, 'the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth',

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules); and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict,

Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child,

Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,

Have agreed as follows:

PART I

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards

established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 6

1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.
2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.
2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.

2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.
3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.
4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Article 10

1. In accordance with the obligation of States Parties under article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.
2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances, personal relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order (ordre public), public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

Article 11

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.
2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either

directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.
2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
   (a) For respect of the rights or reputations of others; or
   (b) For the protection of national security or of public order (*ordre public*), or of public health or morals.

Article 14

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.
2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.
3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 15

1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.
2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (*ordre public*), the protection of public health or morals or the protection of the rights and freedoms of others.

Article 16

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.
2. The child has the right to the protection of the law against such interference or attacks.

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health. To this end, States Parties shall:

(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;
(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;
(c) Encourage the production and dissemination of children's books;
(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;
(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

Article 18

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.
2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.
3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
2. States Parties shall in accordance with their national laws ensure alternative care for such a child.
3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of

children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;
(b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;
(c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;
(d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;
(e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

Article 22

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.
2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or nongovernmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason, as set forth in the present Convention.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.
3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development
4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognize 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. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
   (a) To diminish infant and child mortality;
   (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
   (d) To ensure appropriate pre-natal and post-natal health care for mothers;
   (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
   (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.
2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.
3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.
4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:
   (a) Make primary education compulsory and available free to all;
   (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the

introduction of free education and offering financial assistance in case of need;
(c) Make higher education accessible to all on the basis of capacity by every appropriate means;
(d) Make educational and vocational information and guidance available and accessible to all children;
(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.
3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States Parties agree that the education of the child shall be directed to:
   (a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;
   (b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;
   (c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;
   (d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;
   (e) The development of respect for the natural environment.
2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 30

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

Article 31

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.
2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.
2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:
   (a) Provide for a minimum age or minimum ages for admission to employment;
   (b) Provide for appropriate regulation of the hours and conditions of employment;
   (c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;
(b) The exploitative use of children in prostitution or other unlawful sexual practices;
(c) The exploitative use of children in pornographic performances and materials.

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 37

States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;
(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;
(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;
(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 38

1. States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.
2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.
3. States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.
4. In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Article 40

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.
2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:
   (a) No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;
   (b) Every child alleged as or accused of having infringed the penal law has at least the following guarantees:
      (i) To be presumed innocent until proven guilty according to law;
      (ii) To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;
      (iii) To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;
      (iv) Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;
      (v) If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;
      (vi) To have the free assistance of an interpreter if the child cannot understand or speak the language used;
      (vii) To have his or her privacy fully respected at all stages of the proceedings.
3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:
   (a) The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;
   (b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected.
4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

Article 41

Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:

(a) The law of a State Party; or
(b) International law in force for that State.

PART II

Article 42

States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Article 43

1. For the purpose of examining the progress made by States Parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.
2. The Committee shall consist of ten experts of high moral standing and recognized competence in the field covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.
3. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.
4. The initial election to the Committee shall be held no later than six months after the date of the entry into force of the present Convention and thereafter every second year. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to States Parties inviting them to submit their nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating States Parties which have nominated them, and shall submit it to the States Parties to the present Convention.
5. The elections shall be held at meetings of States Parties convened by the Secretary-General at United Nations Headquarters. At those meetings, for which two-thirds of States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.
6. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. The term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the Chairman of the meeting.
7. If a member of the Committee dies or resigns or declares that for any other cause he or she can no longer perform the duties of the Committee, the State Party

which nominated the member shall appoint another expert from among its nationals to serve for the remainder of the term, subject to the approval of the Committee.

8. The Committee shall establish its own rules of procedure.
9. The Committee shall elect its officers for a period of two years.
10. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee. The Committee shall normally meet annually. The duration of the meetings of the Committee shall be determined, and reviewed, if necessary, by a meeting of the States Parties to the present Convention, subject to the approval of the General Assembly.
11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.
12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide.

Article 44

1. States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights:
   (a) Within two years of the entry into force of the Convention for the State Party concerned;
   (b) Thereafter every five years.
2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfilment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.
3. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1 (b) of the present article, repeat basic information previously provided.
4. The Committee may request from States Parties further information relevant to the implementation of the Convention.
5. The Committee shall submit to the General Assembly, through the Economic and Social Council, every two years, reports on its activities.
6. States Parties shall make their reports widely available to the public in their own countries.

Article 45

In order to foster the effective implementation of the Convention and to encourage international cooperation in the field covered by the Convention:

(a) The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the

implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

(b) The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;

(c) The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;

(d) The Committee may make suggestions and general recommendations based on information received pursuant to articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from States Parties.

PART III

Article 46

The present Convention shall be open for signature by all States.

Article 47

The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 48

The present Convention shall remain open for accession by any State. The instruments of accession shall be deposited with the Secretary-General of the United Nations.

Article 49

1. The present Convention shall enter into force on the thirtieth day following the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.
2. For each State ratifying or acceding to the Convention after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the deposit by such State of its instrument of ratification or accession.

Article 50

1. Any State Party may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon

communicate the proposed amendment to States Parties, with a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that, within four months from the date of such communication, at least one-third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of States Parties present and voting at the conference shall be submitted to the General Assembly for approval.

2. An amendment adopted in accordance with paragraph 1 of the present article shall enter into force when it has been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of States Parties.
3. When an amendment enters into force, it shall be binding on those States Parties which have accepted it, other States Parties still being bound by the provisions of the present Convention and any earlier amendments which they have accepted.

Article 51

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.
2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.
3. Reservations may be withdrawn at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall then inform all States. Such notification shall take effect on the date on which it is received by the Secretary-General.

Article 52

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

Article 53

The Secretary-General of the United Nations is designated as the depositary of the present Convention.

Article 54

The original of the present Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations. IN WITNESS THEREOF the undersigned plenipotentiaries, being duly authorized thereto by their respective governments, have signed the present Convention.

APPENDIX 2

South African Constitution: the Bill of Rights

Rights

7. (1) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.
   (2) The state must respect, protect, promote and fulfil the rights in the Bill of Rights.
   (3) The rights in the Bill of Rights are subject to the limitations contained or referred to in section 36, or elsewhere in the Bill.

Application

8. (1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.
   (2) A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.
   (3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court –
      (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
      (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1).
   (4) A juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of the rights and the nature of that juristic person.

Equality

9. (1) Everyone is equal before the law and has the right to equal protection and benefit of the law.
   (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
   (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
   (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
   (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

Human dignity

10. Everyone has inherent dignity and the right to have their dignity respected and protected.

Life

11. Everyone has the right to life.

Freedom and security of the person

12. (1) Everyone has the right to freedom and security of the person, which includes the right –
    (a) not to be deprived of freedom arbitrarily or without just cause;
    (b) not to be detained without trial;
    (c) to be free from all forms of violence from either public or private sources;
    (d) not to be tortured in any way; and
    (e) not to be treated or punished in a cruel, inhuman or degrading way.
    (2) Everyone has the right to bodily and psychological integrity, which includes the right –
    (a) to make decisions concerning reproduction;
    (b) to security in and control over their body; and
    (c) not to be subjected to medical or scientific experiments without their informed consent.

Slavery, servitude and forced labour

13. No one may be subjected to slavery, servitude or forced labour.

Privacy

14. Everyone has the right to privacy, which includes the right not to have –
    (a) their person or home searched;
    (b) their property searched;
    (c) their possessions seized; or
    (d) the privacy of their communications infringed.

Freedom of religion, belief and opinion

15. (1) Everyone has the right to freedom of conscience, religion, thought, belief and opinion.
    (2) Religious observances may be conducted at state or state-aided institutions, provided that –
    (a) those observances follow rules made by the appropriate public authorities;
    (b) they are conducted on an equitable basis; and
    (c) attendance at them is free and voluntary.
    (3) (a) This section does not prevent legislation recognising –
    (i) marriages concluded under any tradition, or a system of religious, personal or family law; or
    (ii) systems of personal and family law under any tradition, or adhered to by persons professing a particular religion.
    (b) Recognition in terms of paragraph (a) must be consistent with this section and the other provisions of the Constitution.

Freedom of expression

16. (1) Everyone has the right to freedom of expression, which includes –
    (a) freedom of the press and other media;
    (b) freedom to receive or impart information or ideas;
    (c) freedom of artistic creativity; and
    (d) academic freedom and freedom of scientific research.
    (2) The right in subsection (1) does not extend to –
    (a) propaganda for war;
    (b) incitement of imminent violence; or
    (c) advocacy of hatred that is based on race, ethnicity, gender or religion, and that constitutes incitement to cause harm.

Assembly, demonstration, picket and petition

17. Everyone has the right, peacefully and unarmed, to assemble, to demonstrate, to picket and to present petitions.

Freedom of association

18. Everyone has the right to freedom of association.

Political rights

19. (1) Every citizen is free to make political choices, which includes the right –
    (a) to form a political party;
    (b) to participate in the activities of, or recruit members for, a political party; and
    (c) to campaign for a political party or cause.
    (2) Every citizen has the right to free, fair and regular elections for any legislative body established in terms of the Constitution.
    (3) Every adult citizen has the right –
    (a) to vote in elections for any legislative body established in terms of the Constitution, and to do so in secret; and
    (b) to stand for public office and, if elected, to hold office.

Citizenship

20. No citizen may be deprived of citizenship.

Freedom of movement and residence

21. (1) Everyone has the right to freedom of movement.
    (2) Everyone has the right to leave the Republic.
    (3) Every citizen has the right to enter, to remain in and to reside anywhere in the Republic.
    (4) Every citizen has the right to a passport.

Freedom of trade, occupation and profession

22. Every citizen has the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law.

Labour relations

23. (1) Everyone has the right to fair labour practices.
    (2) Every worker has the right –
        (a) to form and join a trade union;
        (b) to participate in the activities and programmes of a trade union; and
        (c) to strike.
    (3) Every employer has the right –
        (a) to form and join an employers' organisation; and
        (b) to participate in the activities and programmes of an employers' organisation.
    (4) Every trade union and every employers' organisation has the right –
        (a) to determine its own administration, programmes and activities;
        (b) to organise; and
        (c) to form and join a federation.
    (5) Every trade union, employers' organisation and employer has the right to engage in collective bargaining. National legislation may be enacted to regulate collective bargaining. To the extent that the legislation may limit a right in this Chapter, the limitation must comply with section 36(1).
    (6) National legislation may recognise union security arrangements contained in collective agreements. To the extent that the legislation may limit a right in this Chapter, the limitation must comply with section 36(1).

Environment

24. Everyone has the right –
    (a) to an environment that is not harmful to their health or well-being; and
    (b) to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that –
        (i) prevent pollution and ecological degradation;
        (ii) promote conservation; and
        (iii) secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

Property

25. (1) No one may be deprived of property except in terms of law of general application, and no law may permit arbitrary deprivation of property.
    (2) Property may be expropriated only in terms of law of general application –
        (a) for a public purpose or in the public interest; and
        (b) subject to compensation, the amount of which and the time and manner of payment of which have either been agreed to by those affected or decided or approved by a court.
    (3) The amount of the compensation and the time and manner of payment must be just and equitable, reflecting an equitable balance between the public interest and the interests of those affected, having regard to all relevant circumstances, including –
        (a) the current use of the property;
        (b) the history of the acquisition and use of the property;
        (c) the market value of the property;

(d) the extent of direct state investment and subsidy in the acquisition and beneficial capital improvement of the property; and
(e) the purpose of the expropriation.

(4) For the purposes of this section –
(a) the public interest includes the nation's commitment to land reform, and to reforms to bring about equitable access to all South Africa's natural resources; and
(b) property is not limited to land.

(5) The state must take reasonable legislative and other measures, within its available resources, to foster conditions which enable citizens to gain access to land on an equitable basis.

(6) A person or community whose tenure of land is legally insecure as a result of past racially discriminatory laws or practices is entitled, to the extent provided by an Act of Parliament, either to tenure which is legally secure or to comparable redress.

(7) A person or community dispossessed of property after 19 June 1913 as a result of past racially discriminatory laws or practices is entitled, to the extent provided by an Act of Parliament, either to restitution of that property or to equitable redress.

(8) No provision of this section may impede the state from taking legislative and other measures to achieve land, water and related reform, in order to redress the results of past racial discrimination, provided that any departure from the provisions of this section is in accordance with the provisions of section 36(1).

(9) Parliament must enact the legislation referred to in subsection (6).

Housing

26. (1) Everyone has the right to have access to adequate housing.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

(3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

Health care, food, water and social security

27. (1) Everyone has the right to have access to –
(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.

Children

28. (1) Every child has the right –
(a) to a name and a nationality from birth;

(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;
(c) to basic nutrition, shelter, basic health care services and social services;
(d) to be protected from maltreatment, neglect, abuse or degradation;
(e) to be protected from exploitative labour practices;
(f) not to be required or permitted to perform work or provide services that –
(i) are inappropriate for a person of that child's age; or
(ii) place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development;
(g) not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be –
(i) kept separately from detained persons over the age of 18 years; and
(ii) treated in a manner, and kept in conditions, that take account of the child's age;
(h) to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and
(i) not to be used directly in armed conflict, and to be protected in times of armed conflict.

(2) A child's best interests are of paramount importance in every matter concerning the child.
(3) In this section 'child' means a person under the age of 18 years.

Education

29. (1) Everyone has the right –
(a) to a basic education, including adult basic education; and
(b) to further education, which the state, through reasonable measures, must make progressively available and accessible.

(2) Everyone has the right to receive education in the official language or languages of their choice in public educational institutions where that education is reasonably practicable. In order to ensure the effective access to, and implementation of, this right, the state must consider all reasonable educational alternatives, including single medium institutions, taking into account –
(a) equity;
(b) practicability; and
(c) the need to redress the results of past racially discriminatory laws and practices.

(3) Everyone has the right to establish and maintain, at their own expense, independent educational institutions that –
(a) do not discriminate on the basis of race;
(b) are registered with the state; and
(c) maintain standards that are not inferior to standards at comparable public educational institutions.

(4) Subsection (3) does not preclude state subsidies for independent educational institutions.

Language and culture

30. Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights.

Cultural, religious and linguistic communities

31. (1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community –
    (a) to enjoy their culture, practise their religion and use their language; and
    (b) to form, join and maintain cultural, religious and linguistic associations and other organs of civil society.
    (2) The rights in subsection (1) may not be exercised in a manner inconsistent with any provision of the Bill of Rights.

Access to information

32. (1) Everyone has the right of access to –
    (a) any information held by the state; and
    (b) any information that is held by another person and that is required for the exercise or protection of any rights.
    (2) National legislation must be enacted to give effect to this right, and may provide for reasonable measures to alleviate the administrative and financial burden on the state.

Just administrative action

33. (1) Everyone has the right to administrative action that is lawful, reasonable and procedurally fair.
    (2) Everyone whose rights have been adversely affected by administrative action has the right to be given written reasons.
    (3) National legislation must be enacted to give effect to these rights, and must –
    (a) provide for the review of administrative action by a court or, where appropriate, an independent and impartial tribunal;
    (b) impose a duty on the state to give effect to the rights in subsections (1) and (2); and
    (c) promote an efficient administration.

Access to courts

34. Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.

Arrested, detained and accused persons

35. (1) Everyone who is arrested for allegedly committing an offence has the right –
    (a) to remain silent;
    (b) to be informed promptly –
    (i) of the right to remain silent; and
    (ii) of the consequences of not remaining silent;

(c) not to be compelled to make any confession or admission that could be used in evidence against that person;
(d) to be brought before a court as soon as reasonably possible, but not later than –
(i) 48 hours after the arrest; or
(ii) the end of the first court day after the expiry of the 48 hours, if the 48 hours expire outside ordinary court hours or on a day which is not an ordinary court day;
(e) at the first court appearance after being arrested, to be charged or to be informed of the reason for the detention to continue, or to be released; and
(f) to be released from detention if the interests of justice permit, subject to reasonable conditions.

(2) Everyone who is detained, including every sentenced prisoner, has the right –
(a) to be informed promptly of the reason for being detained;
(b) to choose, and to consult with, a legal practitioner, and to be informed of this right promptly;
(c) to have a legal practitioner assigned to the detained person by the state and at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly;
(d) to challenge the lawfulness of the detention in person before a court and, if the detention is unlawful, to be released;
(e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment; and
(f) to communicate with, and be visited by, that person's –
(i) spouse or partner;
(ii) next of kin;
(iii) chosen religious counsellor; and
(iv) chosen medical practitioner.

(3) Every accused person has a right to a fair trial, which includes the right –
(a) to be informed of the charge with sufficient detail to answer it;
(b) to have adequate time and facilities to prepare a defence;
(c) to a public trial before an ordinary court;
(d) to have their trial begin and conclude without unreasonable delay;
(e) to be present when being tried;
(f) to choose, and be represented by, a legal practitioner, and to be informed of this right promptly;
(g) to have a legal practitioner assigned to the accused person by the state and at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly;
(h) to be presumed innocent, to remain silent, and not to testify during the proceedings;
(i) to adduce and challenge evidence;
(j) not to be compelled to give self-incriminating evidence;
(k) to be tried in a language that the accused person understands or, if that is not practicable, to have the proceedings interpreted in that language;

(l) not to be convicted for an act or omission that was not an offence under either national or international law at the time it was committed or omitted;
(m) not to be tried for an offence in respect of an act or omission for which that person has previously been either acquitted or convicted;
(n) to the benefit of the least severe of the prescribed punishments if the prescribed punishment for the offence has been changed between the time that the offence was committed and the time of sentencing; and
(o) of appeal to, or review by, a higher court.

(4) Whenever this section requires information to be given to a person, that information must be given in a language that the person understands.

(5) Evidence obtained in a manner that violates any right in the Bill of Rights must be excluded if the admission of that evidence would render the trial unfair or otherwise be detrimental to the administration of justice.

Limitation of rights

36. (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including –
(a) the nature of the right;
(b) the importance of the purpose of the limitation;
(c) the nature and extent of the limitation;
(d) the relation between the limitation and its purpose; and
(e) less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

States of emergency

37. (1) A state of emergency may be declared only in terms of an Act of Parliament, and only when –
(a) the life of the nation is threatened by war, invasion, general insurrection, disorder, natural disaster or other public emergency; and
(b) the declaration is necessary to restore peace and order.

(2) A declaration of a state of emergency, and any legislation enacted or other action taken in consequence of that declaration, may be effective only –
(a) prospectively; and
(b) for no more than 21 days from the date of the declaration, unless the National Assembly resolves to extend the declaration. The Assembly may extend a declaration of a state of emergency for no more than three months at a time. The first extension of the state of emergency must be by a resolution adopted with a supporting vote of a majority of the members of the Assembly. Any subsequent extension must be by a resolution adopted with a supporting vote of at least 60 per cent of the members of the Assembly. A resolution in terms of this paragraph may be adopted only following a public debate in the Assembly.

(3) Any competent court may decide on the validity of –
(a) a declaration of a state of emergency;

(b) any extension of a declaration of a state of emergency; or
(c) any legislation enacted, or other action taken, in consequence of a declaration of a state of emergency.

(4) Any legislation enacted in consequence of a declaration of a state of emergency may derogate from the Bill of Rights only to the extent that –
(a) the derogation is strictly required by the emergency; and
(b) the legislation –
(i) is consistent with the Republic's obligations under international law applicable to states of emergency;
(ii) conforms to subsection (5); and
(iii) is published in the national Government Gazette as soon as reasonably possible after being enacted.

(5) No Act of Parliament that authorises a declaration of a state of emergency, and no legislation enacted or other action taken in consequence of a declaration, may permit or authorise –
(a) indemnifying the state, or any person, in respect of any unlawful act;
(b) any derogation from this section; or
(c) any derogation from a section mentioned in column 1 of the Table of Non-Derogable Rights, to the extent indicated opposite that section in column 3 of the Table.

Table of Non-Derogable Rights

Section Number	**Section Title**	**Extent to which the right is protected**
9	Equality	With respect to unfair discrimination solely on the grounds of race, colour, ethnic or social origin, sex, religion or language.
10	Human dignity	Entirely
11	Life	Entirely
12	Freedom and security of the person	With respect to subsections (1)(d) and (e) and (2)(c).
13	Slavery, servitude and forced labour	With respect to slavery and servitude.
28	Children	With respect to: – subsection (1)(d) and (e); – the rights in subparagraphs (i) and (ii) of subsection (1)(g); and – subsection 1(i) in respect of children of 15 years and younger.
35	Arrested, detained and accused persons	With respect to: – subsections (1)(a), (b) and (c) and (2)(d); – the rights in paragraphs (a) to (o) of subsection (3), excluding paragraph (d); – subsection (4); and – subsection (5) with respect to the exclusion of evidence if the admission of that evidence would render the trial unfair.

(6) Whenever anyone is detained without trial in consequence of a derogation of rights resulting from a declaration of a state of emergency, the following conditions must be observed:
(a) An adult family member or friend of the detainee must be contacted as soon as reasonably possible, and informed that the person has been detained.
(b) A notice must be published in the national Government Gazette within five days of the person being detained, stating the detainee's name and place of detention and referring to the emergency measure in terms of which that person has been detained.
(c) The detainee must be allowed to choose, and be visited at any reasonable time by, a medical practitioner.
(d) The detainee must be allowed to choose, and be visited at any reasonable time by, a legal representative.
(e) A court must review the detention as soon as reasonably possible, but no later than 10 days after the date the person was detained, and the court must release the detainee unless it is necessary to continue the detention to restore peace and order.
(f) A detainee who is not released in terms of a review under paragraph (e), or who is not released in terms of a review under this paragraph, may apply to a court for a further review of the detention at any time after 10 days have passed since the previous review, and the court must release the detainee unless it is still necessary to continue the detention to restore peace and order.
(g) The detainee must be allowed to appear in person before any court considering the detention, to be represented by a legal practitioner at those hearings, and to make representations against continued detention.
(h) The state must present written reasons to the court to justify the continued detention of the detainee, and must give a copy of those reasons to the detainee at least two days before the court reviews the detention.
(7) If a court releases a detainee, that person may not be detained again on the same grounds unless the state first shows a court good cause for re-detaining that person.
(8) Subsections (6) and (7) do not apply to persons who are not South African citizens and who are detained in consequence of an international armed conflict. Instead, the state must comply with the standards binding on the Republic under international humanitarian law in respect of the detention of such persons.

Enforcement of rights

38. Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights. The persons who may approach a court are –
(a) anyone acting in their own interest;
(b) anyone acting on behalf of another person who cannot act in their own name;

(c) anyone acting as a member of, or in the interest of, a group or class of persons;
(d) anyone acting in the public interest; and
(e) an association acting in the interest of its members.

Interpretation of Bill of Rights

39. (1) When interpreting the Bill of Rights, a court, tribunal or forum –
(a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
(b) must consider international law; and
(c) may consider foreign law.
(2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.
(3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.

APPENDIX 3

African Charter on the Rights and Welfare of the Child

OAU Doc. CAB/LEG/24.9/49 (1990), *entered into force* Nov. 29, 1999.

Preamble

The African Member States of the Organization of African Unity, Parties to the present Charter entitled 'African Charter on the Rights and Welfare of the Child',

CONSIDERING that the Charter of the Organization of African Unity recognizes the paramount of Human Rights and the African Charter on Human and People's Rights proclaimed and agreed that everyone is entitled to all the rights and freedoms recognized and guaranteed therein, without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status,

RECALLING the Declaration on the Rights and Welfare of the African Child (AHG/ST.4 Rev.l) adopted by the Assembly of Heads of State and Government of the Organization of African Unity, at its Sixteenth Ordinary Session in Monrovia, Liberia, from 17 to 20 July 1979, recognized the need to take appropriate measures to promote and protect the rights and welfare of the African Child,

NOTING WITH CONCERN that the situation of most African children remains critical due to the unique factors of their socio-economic, cultural, traditional and developmental circumstances, natural disasters, armed conflicts, exploitation and hunger, and on account of the child's physical and mental immaturity he/she needs special safeguards and care,

RECOGNIZING that the child occupies a unique and privileged position in the African society and that for the full and harmonious development of his personality, the child should grow up in a family environment in an atmosphere of happiness, love and understanding,

RECOGNIZING that the child, due to the needs of his physical and mental development requires particular care with regard to health, physical, mental, moral and social development, and requires legal protection in conditions of freedom, dignity and security,

TAKING INTO CONSIDERATION the virtues of their cultural heritage, historical background and the values of the African civilization which should inspire and characterize their reflection on the concept of the rights and welfare of the child,

CONSIDERING that the promotion and protection of the rights and welfare of the child also implies the performance of duties on the part of everyone,

REAFFIRMING ADHERENCE to the principles of the rights and welfare of the child contained in the declaration, conventions and other instruments of the Organization of African Unity and in the United Nations and in particular the United Nations Convention on the Rights of the Child; and the OAU Heads of State and Government's Declaration on the Rights and Welfare of the African Child.

Have agreed as follows:

Part 1: Rights and duties

Chapter one: rights and welfare of the child

Article 1: Obligation of State's Parties

1. Member States of the Organization of African Unity Parties to the present Charter shall recognize the rights, freedoms and duties enshrined in this Charter and shall undertake the necessary steps, in accordance with their Constitutional processes and with the provisions of the present Charter, to adopt such legislative or other measures as may be necessary to give effect to the provisions of this Charter.
2. Nothing in this Charter shall affect any provisions that are more conductive to the realization of the rights and welfare of the child contained in the law of a State Party or in any other international Convention or agreement in force in that State.
3. Any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations contained in the present Charter shall to the extent of such inconsistency be discouraged.

Article 2: Definition of a Child

For the purposes of this Charter, a child means every human being below the age of 18 years.

Article 3: Non-Discrimination

Every child shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in this Charter irrespective of the child's or his/her parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.

Article 4: Best Interests of the Child

1. In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.
2. In all judicial or administrative proceedings affecting a child who is capable of communicating his/her own views, an opportunity shall be provided for the views of the child to be heard either directly or through an impartial representative as a party to the proceedings, and those views shall be taken into consideration by the relevant authority in accordance with the provisions of appropriate law.

Article 5: Survival and Development

1. Every child has an inherent right to life. This right shall be protected by law.
2. States Parties to the present Charter shall ensure, to the maximum extent possible, the survival, protection and development of the child.
3. Death sentence shall not be pronounced for crimes committed by children.

Article 6: Name and Nationality

1. Every child shall have the right from his birth to a name.
2. Every child shall be registered immediately after birth.
3. Every child has the right to acquire a nationality.
4. States Parties to the present Charter shall undertake to ensure that their Constitutional legislation recognize the principles according to which a child shall acquire the nationality of the State in the territory of which he has been born if, at the time of the child's birth, he is not granted nationality by any other State in accordance with its laws.

Article 7: Freedom of Expression

Every child who is capable of communicating his or her own views shall be assured the rights to express his opinions freely in all matters and to disseminate his opinions subject to such restrictions as are prescribed by laws.

Article 8: Freedom of Association

Every child shall have the right to free association and freedom of peaceful assembly in conformity with the law.

Article 9: Freedom of Thought, Conscience and Religion

1. Every child shall have the right to freedom of thought conscience and religion.
2. Parents, and where applicable, legal guardians shall have a duty to provide guidance and direction in the exercise of these rights having regard to the evolving capacities, and best interests of the child.
3. States Parties shall respect the duty of parents and where applicable, legal guardians to provide guidance and direction in the enjoyment of these rights subject to the national laws and policies.

Article 10: Protection of Privacy

No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks.

Article 11: Education

1. Every child shall have the right to an education.
2. The education of the child shall be directed to:
   (a) the promotion and development of the child's personality, talents and mental and physical abilities to their fullest potential;
   (b) fostering respect for human rights and fundamental freedoms with particular reference to those set out in the provisions of various African instruments on human and people's rights and international human rights declarations and conventions;
   (c) the preservation and strengthening of positive African morals, traditional values and cultures;

(d) the preparation of the child for responsible life in a free society, in the spirit of understanding, tolerance, dialogue, mutual respect and friendship among all people's ethnic, tribal and religious groups;
(e) the preservation of national independence and territorial integrity;
(f) the promotion and achievements of African Unity and Solidarity;
(g) the development of respect for the environment and natural resources;
(h) the promotion of the child's understanding of primary health care.

3. States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realization of this right and shall in particular:
(a) provide free and compulsory basic education;
(b) encourage the development of secondary education in its different forms and to progressively make it free and accessible to all;
(c) make higher education accessible to all on the basis of capacity and ability by every appropriate means;
(d) take measures to encourage regular attendance at schools and the reduction of drop-out rates;
(e) take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.
4. States Parties to the present Charter shall respect the rights and duties of parents, and where applicable, of legal guardians to choose their children's schools, other than those established by public authorities, which conform to such minimum standards as may be approved by the State, to ensure the religious and moral education of the child in a manner consistent with with the evolving capacities of the child.
5. States Parties to the present Charter shall take all appropriate measures to ensure that a child who is subjected to schools or parental discipline shall be treated with humanity and with respect for the inherent dignity of the child and in conformity with the present Charter.
6. States Parties to the present Charter shall have all appropriate measures to ensure that children who become pregnant before completing their education shall have an opportunity to continue with their education on the basis of their individual ability.
7. No part of this Article shall be construed as to interfere with the liberty of individuals and bodies to establish and direct educational institutions subject to the observance of the principles set out in paragraph 1 of this Article and the requirement that the education given in such institutions shall conform to such minimum standards as may be laid down by the States.

Article 12: Leisure, Recreation and Cultural Activities

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.
2. States Parties shall respect and promote the right of the child to fully participate in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 13: Handicapped Children

1. Every child who is mentally or physically disabled shall have the right to special measures of protection in keeping with his physical and moral needs and under

conditions which ensure his dignity, promote his self-reliance and active participation in the community.
2. States Parties to the present Charter shall ensure, subject to available resources, to a disabled child and to those responsible for his care, assistance for which application is made and which is appropriate to the child's condition and in particular shall ensure that the disabled child has effective access to training, preparation for employment and recreation opportunities in a manner conducive to the child achieving the fullest possible social integration, individual development and his cultural and moral development.
3. The States Parties to the present Charter shall use their available resources with a view to achieving progressively the full convenience of the mentally and physically disabled person to movement and access to public highways, buildings and other places to which the disabled may legitimately want to have access.

Article 14: Health and Health Services

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
   (a) to reduce infant and child morality rate;
   (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   (c) to ensure the provision of adequate nutrition and safe drinking water;
   (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
   (e) to ensure appropriate health care for expectant and nursing mothers;
   (f) to develop preventive health care and family life education and provision of service;
   (g) to integrate basic health service programmes in national development plans;
   (h) to ensure that all sectors of the society, in particular parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;
   (i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children;
   (j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

Article 15: Child Labour

1. Every child shall be protected from all forms of economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's physical, mental, spiritual, moral, or social development.
2. States Parties to the present Charter take all appropriate legislative and administrative measures to ensure the full implementation of this Article which covers both the formal and informal sectors of employment and having regard to

the relevant provisions of the International Labour Organization's instruments relating to children, States Parties shall in particular:
(a) provide through legislation, minimum wages for admission to every employment;
(b) provide for appropriate regulation of hours and conditions of employment;
(c) provide for appropriate penalties or other sanctions to ensure the effective enforcement of this Article;
(d) promote the dissemination of information on the hazards of child labour to all sectors of the community.

Article 16: Protection Against Child Abuse and Torture

1. States Parties to the present Charter shall take specific legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse, while in the care of the child.
2. Protective measures under this Article shall include effective procedures for the establishment of special monitoring units to provide necessary support for the child and for those who have the care of the child, as well as other forms of prevention and for identification, reporting, referral, investigation, treatment, and follow-up of instances of child abuse and neglect.

Article 17: Administration of Juvenile Justice

1. Every child accused or found guilty of having infringed penal law shall have the right to special treatment in a manner consistent with the child's sense of dignity and worth and which reinforces the child's respect for human rights and fundamental freedoms of others.
2. States Parties to the present Charter shall in particular:
   (a) ensure that no child who is detained or imprisoned or otherwise deprived of his/her liberty is subjected to torture, inhuman or degrading treatment or punishment;
   (b) ensure that children are separated from adults in their place of detention or imprisonment;
   (c) ensure that every child accused in infringing the penal law:
      (i) shall be presumed innocent until duly recognized guilty;
      (ii) shall be informed promptly in a language that he understands and in detail of the charge against him, and shall be entitled to the assistance of an interpreter if he or she cannot understand the language used;
      (iii) shall be afforded legal and other appropriate assistance in the preparation and presentation of his defence;
      (iv) shall have the matter determined as speedily as possible by an impartial tribunal and if found guilty, be entitled to an appeal by a higher tribunal;
   (d) prohibit the press and the public from trial.
3. The essential aim of treatment of every child during the trial and also if found guilty of infringing the penal law shall be his or her reformation, re-integration into his or her family and social rehabilitation.
4. There shall be a minimum age below which children shall be presumed not to have the capacity to infringe the penal law.

Article 18: Protection of the Family

1. The family shall be the natural unit and basis of society. It shall enjoy the protection and support of the State for its establishment and development.
2. States Parties to the present Charter shall take appropriate steps to ensure equality of rights and responsibilities of spouses with regard to children during marriage and in the event of its dissolution. In case of the dissolution, provision shall be made for the necessary protection of the child.
3. No child shall be deprived of maintenance by reference to the parents' marital status.

Article 19: Parent Care and Protection

1. Every child shall be entitled to the enjoyment of parental care and protection and shall, whenever possible, have the right to reside with his or her parents. No child shall be separated from his parents against his will, except when a judicial authority determines in accordance with the appropriate law, that such separation is in the best interest of the child.
2. Every child who is separated from one or both parents shall have the right to maintain personal relations and direct contact with both parents on a regular basis.
3. Where separation results from the action of a State Party, the State Party shall provide the child, or if appropriate, another member of the family with essential information concerning the whereabouts of the absent member or members of the family. States Parties shall also ensure that the submission of such a request shall not entail any adverse consequences for the person or persons in whose respect it is made.
4. Where a child is apprehended by a State Party, his parents or guardians shall, as soon as possible, be notified of such apprehension by that State Party.

Article 20: Parental Responsibilities

1. Parents or other persons responsible for the child shall have the primary responsibility of the upbringing and development of the child and shall have the duty:
   (a) to ensure that the best interests of the child are their basic concern at all times;
   (b) to secure, within their abilities and financial capacities, conditions of living necessary to the child's development; and
   (c) to ensure that domestic discipline is administered with humanity and in a manner consistent with the inherent dignity of the child.
2. States Parties to the present Charter shall in accordance with their means and national conditions take all appropriate measures:
   (a) to assist parents and other persons responsible for the child and in case of need provide material assistance and support programmes particularly with regard to nutrition, health, education, clothing and housing;
   (b) to assist parents and others responsible for the child in the performance of child-rearing and ensure the development of institutions responsible for providing care of children; and
   (c) to ensure that the children of working parents are provided with care services and facilities.

Article 21: Protection against Harmful Social and Cultural Practices

1. States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:
   (a) those customs and practices prejudicial to the health or life of the child; and
   (b) those customs and practices discriminatory to the child on the grounds of sex or other status.
2. Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.

Article 22: Armed Conflicts

1. States Parties to this Charter shall undertake to respect and ensure respect for rules of international humanitarian law applicable in armed conflicts which affect the child.
2. States Parties to the present Charter shall take all necessary measures to ensure that no child shall take a direct part in hostilities and refrain in particular from recruiting any child.
3. States Parties to the present Charter shall, in accordance with their obligations under international humanitarian law, protect the civilian population in armed conflicts and shall take all feasible measures to ensure the protection and care of children who are affected by armed conflicts. Such rules shall also apply to children in situations of internal armed conflicts, tension and strife.

Article 23: Refugee Children

1. States Parties to the present Charter shall take all appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law shall, whether unaccompanied or accompanied by parents, legal guardians or close relatives, receive appropriate protection and humanitarian assistance in the enjoyment of the rights set out in this Charter and other international human rights and humanitarian instruments to which the States are Parties.
2. States Parties shall undertake to cooperate with existing international organizations which protect and assist refugees in their efforts to protect and assist such a child and to trace the parents or other close relatives of an unaccompanied refugee child in order to obtain information necessary for reunification with the family.
3. Where no parents, legal guardians or close relatives can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his family environment for any reason.
4. The provisions of this Article apply mutatis mutandis to internally displaced children whether through natural disaster, internal armed conflicts, civil strife, breakdown of economic and social order or howsoever caused.

Article 24: Adoption

States Parties which recognize the system of adoption shall ensure that the best interest of the child shall be the paramount consideration and they shall:

(a) establish competent authorities to determine matters of adoption and ensure that the adoption is carried out in conformity with applicable laws and procedures and on the basis of all relevant and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and guardians and that, if necessary, the appropriate persons concerned have given their informed consent to the adoption on the basis of appropriate counselling;
(b) recognize that inter-country adoption in those States who have ratified or adhered to the International Convention on the Rights of the Child or this Charter, may, as the last resort, be considered as an alternative means of a child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;
(c) ensure that the child affected by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;
(d) take all appropriate measures to ensure that in inter-country adoption, the placement does not result in trafficking or improper financial gain for those who try to adopt a child;
(e) promote, where appropriate, the objectives of this Article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs;
(f) establish a machinery to monitor the well-being of the adopted child.

Article 25: Separation from Parents

1. Any child who is permanently or temporarily deprived of his family environment for any reason shall be entitled to special protection and assistance.
2. States Parties to the present Charter:
   (a) shall ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include, among others, foster placement, or placement in suitable institutions for the care of children;
   (b) shall take all necessary measures to trace and re-unite children with parents or relatives where separation is caused by internal and external displacement arising from armed conflicts or natural disasters.
3. When considering alternative family care of the child and the best interests of the child, due regard shall be paid to the desirability of continuity in a child's up-bringing and to the child's ethnic, religious or linguistic background.

Article 26: Protection Against Apartheid and Discrimination

1. States Parties to the present Charter shall individually and collectively undertake to accord the highest priority to the special needs of children living under Apartheid and in States subject to military destabilization by the Apartheid regime.
2. States Parties to the present Charter shall individually and collectively undertake to accord the highest priority to the special needs of children living under

regimes practising racial, ethnic, religious or other forms of discrimination as well as in States subject to military destabilization.
3. States Parties shall undertake to provide, whenever possible, material assistance to such children and to direct their efforts towards the elimination of all forms of discrimination and Apartheid on the African Continent.

Article 27: Sexual Exploitation

1. States Parties to the present Charter shall undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:
   (a) the inducement, coercion or encouragement of a child to engage in any sexual activity;
   (b) the use of children in prostitution or other sexual practices;
   (c) the use of children in pornographic activities, performances and materials.

Article 28: Drug Abuse

States Parties to the present Charter shall take all appropriate measures to protect the child from the use of narcotics and illicit use of psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the production and trafficking of such substances.

Article 29: Sale, Trafficking and Abduction

States Parties to the present Charter shall take appropriate measures to prevent:

(a) the abduction, the sale of, or traffick of children for any purpose or in any form, by any person including parents or legal guardians of the child;
(b) the use of children in all forms of begging.

Article 30: Children of Imprisoned Mothers

1. States Parties to the present Charter shall undertake to provide special treatment to expectant mothers and to mothers of infants and young children who have been accused or found guilty of infringing the penal law and shall in particular:
   (a) ensure that a non-custodial sentence will always be first considered when sentencing such mothers;
   (b) establish and promote measures alternative to institutional confinement for the treatment of such mothers;
   (c) establish special alternative institutions for holding such mothers;
   (d) ensure that a mother shall not be imprisoned with her child;
   (e) ensure that a death sentence shall not be imposed on such mothers;
   (f) the essential aim of the penitentiary system will be the reformation, the integration of the mother to the family and social rehabilitation.

Article 31: Responsibility of the Child

Every child shall have responsibilities towards his family and society, the State and other legally recognized communities and the international community. The child, subject to his age and ability, and such limitations as may be contained in the present Charter, shall have the duty:

(a) to work for the cohesion of the family, to respect his parents, superiors and elders at all times and to assist them in case of need;
(b) to serve his national community by placing his physical and intellectual abilities at its service;
(c) to preserve and strengthen social and national solidarity;
(d) to preserve and strengthen African cultural values in his relations with other members of the society, in the spirit of tolerance, dialogue and consultation and to contribute to the moral well-being of society;
(e) to preserve and strengthen the independence and the integrity of his country;
(f) to contribute to the best of his abilities, at all times and at all levels, to the promotion and achievement of African Unity.

Part II

Chapter two: establishment and organization of the committee on the rights and welfare of the child

Article 32: The Committee

An African Committee of Experts on the Rights and Welfare of the Child hereinafter called 'the Committee' shall be established within the Organization of African Unity to promote and protect the rights and welfare of the child.

Article 33: Composition

1. The Committee shall consist of 11 members of high moral standing, integrity, impartiality and competence in matters of the rights and welfare of the child.
2. The members of the Committee shall serve in their personal capacity.
3. The Committee shall not include more than one national of the same State.

Article 34: Election

As soon as this Charter shall enter into force the members of the Committee shall be elected by secret ballot by the Assembly of Heads of State and Government from a list of persons nominated by the States Parties to the present Charter.

Article 35: Candidates

Each State Party to the present Charter may nominate not more than two candidates. The candidates must have one of the nationalities of the States Parties to the present Charter. When two candidates are nominated by a State, one of them shall not be a national of that State.

Article 36:

1. The Secretary-General of the Organization of African Unity shall invite States Parties to the present Charter to nominate candidates at least six months before the elections.
2. The Secretary-General of the Organization of African Unity shall draw up in alphabetical order a list of persons nominated and communicate it to the Heads of State and Government at least two months before the elections.

Article 37: Term of Office

1. The members of the Committee shall be elected for a term of five years and may not be re-elected. However, the term of four of the members elected at the first election shall expire after two years and the term of six others, after four years.
2. Immediately after the first election, the Chairman of the Assembly of Heads of State and Government of the Organization of African Unity shall draw lots to determine the names of those members referred to in sub-paragraph 1 of this Article.
3. The Secretary-General of the Organization of African Unity shall convene the first meeting of Committee at the Headquarters of the Organization within six months of the election of the members of the Committee, and thereafter the Committee shall be convened by its Chairman whenever necessary, at least once a year.

Article 38: Bureau

1. The Committee shall establish its own Rules of Procedure.
2. The Committee shall elect its officers for a period of two years.
3. Seven Committee members shall form the quorum.
4. In case of an equality of votes, the Chairman shall have a casting vote.
5. The working languages of the Committee shall be the official languages of the OAU.

Article 39: Vacancy

If a member of the Committee vacates his office for any reason other than the normal expiration of a term, the State which nominated that member shall appoint another member from among its nationals to serve for the remainder of the term – subject to the approval of the Assembly.

Article 40: Secretariat

The Secretary-General of the Organization of African Unity shall appoint a Secretary for the Committee.

Article 41: Privileges and Immunities

In discharging their duties, members of the Committee shall enjoy the privileges and immunities provided for in the General Convention on the Privileges and Immunities of the Organization of African Unity.

Chapter three: mandate and procedure of the committee

Article 42: Mandate

The functions of the Committee shall be:

(a) To promote and protect the rights enshrined in this Charter and in particular to:
   (i) collect and document information, commission inter-disciplinary assessment of situations on African problems in the fields of the rights and welfare of the child, organize meetings, encourage national and local institutions concerned with the rights and welfare of the child, and where necessary give its views and make recommendations to Governments;

(ii) formulate and lay down principles and rules aimed at protecting the rights and welfare of children in Africa;
(iii) cooperate with other African, international and regional institutions and organizations concerned with the promotion and protection of the rights and welfare of the child.

(b) To monitor the implementation and ensure protection of the rights enshrined in this Charter.

(c) To interpret the provisions of the present Charter at the request of a State Party, an Institution of the Organization of African Unity or any other person or Institution recognized by the Organization of African Unity, or any State Party.

(d) Perform such other task as may be entrusted to it by the Assembly of Heads of State and Government, Secretary-General of the OAU and any other organs of the OAU or the United Nations.

Article 43: Reporting Procedure

1. Every State Party to the present Charter shall undertake to submit to the Committee through the Secretary-General of the Organization of African Unity, reports on the measures they have adopted which give effect to the provisions of this Charter and on the progress made in the enjoyment of these rights:
   (a) within two years of the entry into force of the Charter for the State Party concerned; and
   (b) thereafter, *every three years*.
2. Every report made under this Article shall:
   (a) contain sufficient information on the implementation of the present Charter to provide the Committee with comprehensive understanding of the implementation of the Charter in the relevant country; and
   (b) shall indicate factors and difficulties, if any, affecting the fulfillment of the obligations contained in the Charter.
3. A State Party which has submitted a comprehensive first report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1(b) of this Article, repeat the basic information previously provided.

Article 44: Communications

1. The Committee may receive communication, from any person, group or nongovernmental organization recognized by the Organization of African Unity, by a Member State, or the United Nations relating to any matter covered by this Charter.
2. Every communication to the Committee shall contain the name and address of the author and shall be treated in confidence.

Article 45: Investigations by the Committee

1. The Committee may resort to any appropriate method of investigating any matter falling within the ambit of the present Charter, request from the States Parties any information relevant to the implementation of the Charter and may also resort to any appropriate method of investigating the measures the State Party has adopted to implement the Charter.

2. The Committee shall submit to each Ordinary Session of the Assembly of Heads of State and Government every two years, a report on its activities and on any communication made under Article [44] of this Charter.
3. The Committee shall publish its report after it has been considered by the Assembly of Heads of State and Government.
4. States Parties shall make the Committee's reports widely available to the public in their own countries.

Chapter four: miscellaneous provisions

Article 46: Sources of Inspiration

The Committee shall draw inspiration from International Law on Human Rights, particularly from the provisions of the African Charter on Human and People's Rights, the Charter of the Organization of African Unity, the Universal Declaration on Human Rights, the International Convention on the Rights of the Child, and other instruments adopted by the United Nations and by African countries in the field of human rights, and from African values and traditions.

Article 47: Signature, Ratification or Adherence

1. The present Charter shall be open to signature by all the Member States of the Organization of African Unity.
2. The present Charter shall be subject to ratification or adherence by Member States of the Organization of African Unity. The instruments of ratification or adherence to the present Charter shall be deposited with the Secretary-General of the Organization of African Unity.
3. The present Charter shall come into force 30 days after the reception by the Secretary-General of the Organization of African Unity of the instruments of ratification or adherence of 15 Member States of the Organization of African Unity.

Article 48: Amendment and Revision of the Charter

1. The present Charter may be amended or revised if any State Party makes a written request to that effect to the Secretary-General of the Organization of African Unity, provided that the proposed amendment is not submitted to the Assembly of Heads of State and Government for consideration until all the States Parties have been duly notified of it and the Committee has given its opinion on the amendment.
2. An amendment shall be approved by a simple majority of the States Parties.

APPENDIX 4

Key terms associated with indicators and monitoring

Term	Definition
Child well-being	The economic, physical, social and psychological 'wellness' of all children under the age of 18 years (age of a child according to the CRC).
Indicator	Indicators are normally quantitative measures of observable features of the child's status or situation. When measured across time, they point to changes (or consistencies).
Measure	Indicators are derived from one or more measures. A measure operationalises an indicator. It is a defined piece of information able to accurately assess and represent a specific phenomenon or outcome (e.g. <5MR). A measure may be direct or indirect. (A direct measure of girls' school attendance is obtained through a count of girls in school; an indirect measure would be obtained from a head of household report.)
Proxy indicator	Technically referred to as a Reference Measure, a proxy indicator is related to the phenomenon of interest. For example, child literacy could be a proxy for school readiness.
Composite indicator	Assessment of child well-being or rights based on a limited number of measures selected for their ability to capture fundamental aspects of child well-being, and for their ability (when used in combination) to generate a summary picture of the status of children.
Sectors and clusters	Sector: Area of policy and action responsible for a particular aspect of child well-being (e.g. the health sector). Cluster: In South Africa, the term 'cluster' is used to identify government ministries that work together for policy purposes. An example is the national Social Cluster (Health, Social Development and Education).
Indicator domain	An indicator domain is a grouping of indicators that are classified by sector or area of concern (e.g. health, education, safety).
Child outcome (or child status)	Measurable end result in terms of child well-being or child rights.
Child-centred statistic	Child-centred statistics are measures for which the unit of analysis is the child. Such statistics are not usually generated through usual statutory processes, although it is often possible to re-analyse existing household data to produce child-centred measures. It is essential to review existing data sources for their potential to produce child-centred statistics when measures are being assigned to the chosen set of indicators (Saporiti, 1999).
Indicator levels	Core indicators are 'must haves' or priority indicators. They are aggregated from provincial administrative data or based on representative surveys. They are needed for annual high-level provincial and national reporting. They measure child outcomes and service parameters of national and international importance (must include those required by international conventions). They should be collected regularly and →

➔	frequently (normally annually) by all provinces (unless national surveys), and aggregated to national level for internal and external reporting purposes (e.g. to the Committee on the Rights of the Child). They are based on quantitative information and are usually fairly coarse descriptions of the situation. Additional indicators add depth to the core indicators. They are more intensive and are useful for planning purposes and for targeting interventions for children and communities. They require more effort to obtain, and commonly this data would be collected in specific research studies to answer particular questions. The data should also be collected regularly, but usually less frequently than core indicators. This level of data may be appropriate for monitoring social programmes provided the measures are appropriate to the intervention. They may include both qualitative and quantitative indicators.

APPENDIX 5

Characteristics of effective indicators for child rights and well-being

Child rights and well-being indicators should:

- Be valid in terms of face validity (the indicator's ability to measure what it says it measures); content validity (the indicator takes into account the qualities that its definition implies); construct validity (that the indicator demonstrates an expected empirical relationship with other related indicators);
- Be clearly defined (both the indicator and the measures);
- Be consistent, that is, the measures must be reliable;
- Use the same valid, reliable, sensitive and robust measures over time;
- Be feasible, that is, measures should be accessible, and the data should be relatively easy to collect;
- Strive for comprehensive coverage of child outcomes and child development contexts;
- Assess both positive and negative outcomes for children and their situations;
- Offer comprehensive baseline data for tracking future trends, that is, of relevance to the diversity of the population;
- Be age-appropriate and consistent with developmental theory;
- Be comprehensible to lay people, useable at community level and cost-efficient to collect;
- Be collected at regular intervals and at the most appropriate geographical level possible (e.g. census tracts);
- Reflect population demographics of importance, and account for spatial differences, for example geopolitical differences between urban, peri-urban, rural and deep-rural settings;
- Include both direct and indirect measures. Child mortality is a direct measure of child well-being, while child poverty is an indirect measure because it assesses known risks to child well-being.

APPENDIX 6

Summary of South African data on child health indicators

Indicator	Age group (years)	Year	Statistic	Source
Mortality				
Infant mortality rate	0–1	2005	43.0 per 1 000 live births	Stats SA Mid-year Estimates (2005)
Under 5 mortality rate	0–5	2005	72.1 per 1 000 live births	Stats SA Mid-year Estimates (2005)
Perinatal mortality rate		2000–02	34.0 per 1 000 births	Pattinson (2003b)
Cause-specific mortality	0–14	1997–2001	Intestinal infectious diseases leading cause of death 15.4% of male deaths 16.1% of female deaths	Stats SA (2002)
Neonatal mortality rate	0–28 days	1998	19.8	Pattinson (2003b)
Child mortality rate (1–4 year)	1–4	2003	15.8 per 1 000	DoH, Measure DHS and ORC Macro (2004)
Post-neonatal mortality rate	29–365 days	2003	27.5 per 1 000 live births	DoH, Measure DHS and ORC Macro (2004)
Stillbirth rate	28 weeks gestation – day 7 of life	2003	3.1 to 6.2 at different levels of hospitals	DHIS (2004)
Case fatality rate (%)		2004	Measles – 7/786 (0.9) Tetanus – 2/14 (14.3)	DoH Notification System (2005)
Morbidity: Incidence/Prevalence				
Polio	All	2005	No confirmed cases of polio	DoH Notification System (2006)
Measles (serology confirmed)	All	2005	616	DoH Notification System (2006)
Congenital syphilis notified		2005	1	DoH Notification System (2006)
Diarrhoea incidence in under-5 year olds (number seeking treatment at PHC facilities)	0–5	2005	268 per 1 000 children	DHIS (2006)

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Indicator	Age group (years)	Year	Statistic	Source
Pneumonia incidence in under-5 year olds (number seeking treatment at PHC facilities)	0–5	2002	241.0 per 1 000 children	DHIS (2003)
Tuberculosis		2002	Proportion children 0–14 years dying due to this cause approximately 2.0% Cure rate (in adults) 53.8% Multiple drug resistance TB rate estimated to be 1.6%	DoH (2004)
HIV/AIDS				
HIV incidence rate – perinatal (births) %		2002	6.0	Dorrington et al. (2002)
HIV prevalence %	2–14	2002	5.6	Shisana and Simbayi (2002)
AIDS orphans	0–17	2003	1 100 000	UNAIDS et al. (2004)
Nutrition				
Underweight %	1–9	1999	10.3	Labadarios (2000)
Stunting %	1–9	1999	21.6	Labadarios (2000)
Wasting %	1–9	1999	3.7	Labadarios (2000)
Overweight %	1–9	1999	6.0	Labadarios (2000)
Breastfeeding %		1998	Initiation – no data Exclusive – <3 months 10.4% 4–6 months 1.2% At 12 months – no data	DoH et al. (2002)
Anaemia (Iron)	0.5–6	1994	Anaemia (Haemoglobin <11g/dl) in children less than 6 years of age – 21.4% Iron depletion or deficiency – 9.8% Iron deficiency anaemia – 5.0%	SAVACG (1996)
Vitamin A	0.5–6	1994	Marginal vitamin A status – 33.3%	SAVACG (1996)
Iodine		1998	10% of school pupils nationally with low median iodine concentrations	SAIMR (2000)

Indicator	Age group (years)	Year	Statistic	Source
Iodised salt consumption (<10mg/kg)		1998	25.5%	SAIMR (2000)
Maternal/Neonatal				
Adolescent pregnancy (%)	15–19	1998	16.8	DoH et al. (2002)
Low birth weight rate (%)		2002	19.6%, 16.5% and 13.0% in metropolitan, town and rural hospitals respectively	Pattinson (2003b)
Antenatal HIV seroprevalence (%)		2005	30.2	DoH (2006a)
Antenatal syphilis prevalence (%)		2005	2.7	DoH (2006a)
Maternal mortality ratio (per 100 000 live births)		2000	230	WHO (2004)
Immunisation				
Immunisation coverage of children <1 year (%)	0–1	2005	90.2	DHIS (2006)
Measles first dose coverage (annualised) (%)	0–1	2005	92.0	DHIS (2006)
Immunisation dropout rate (Measles 1 to 2) (%)		2005	20.0	DHIS (2006)
Health services/Systems (Programmes)				
Primary Health Care (PHC) facilities with ≥60% professional nurses trained in the Integrated Management of Childhood Illness strategy (%)		2005	48	Saloojee and Bamford (2006)
Baby-friendly hospitals		2003	178 of the 480 facilities that deliver babies (37%)	Saloojee and Bamford (2006)
Clinics with antenatal services every weekday (%)		2000	59.3	Viljoen et al. (2000)

Indicator	Age group (years)	Year	Statistic	Source
Clinics with Expanded Programme on Immunisation services every weekday (%)		2000	73.7	Viljoen et al. (2000)
Family planning services every weekday (%)		2000	87.1	Viljoen et al. (2000)
Sexually transmitted infections services every weekday (%)		2000	94.9	Viljoen et al. (2000)
Tuberculosis services every weekday (%)		2000	84.1	Viljoen et al. (2000)
Facilities that are prevention of mother-to-child transmission (PMTCT) programme sites		2004	PMTCT services available in 204 public hospitals and 1 055 community health centres	DoH (2004)
PHC facilities offering voluntary counselling and testing (%)		2002	67.0	Ramkissoon et al. (2004)

APPENDIX 7

South African EMIS indicator domains

South African EMIS indicators: Learner characteristics

- Number of learners enrolled according to grade and gender;
- Number of learners according to race, gender and grade;
- Number of learners who experience barriers to learning according to race, gender and disability;
- Number of learners who benefit from the Primary School Nutrition Project by age;
- Number of learners according to grade and age including Education for Learners with Special Needs (ELSEN) and Special Needs Education (SNE) for males and females;
- Learners (excluding LSEN/SNE* units) according to home language and grade for males and females;
- LSEN/SNE learners according to home language and disability for males and females;
- Learners (excluding LSEN/SNE units) according to language of teaching and learning and grade for males and females;
- Learners (excluding LSEN/SNE units) according to home language and disability for males and females;
- Preferred language of teaching and learning for learners by language and grade (excluding LSEN/SNE) for males and females;
- Preferred language of teaching and learning for learners in LSEN/SNE classes by language and disability for males and females;
- LSEN/SNE learners in mainstream classes per disability and grade for males and females;
- LSEN/SNE learners in mainstream classes according to learning barriers;
- Number of female learners who fell pregnant during the previous academic year;
- Number of transfers to and from the school;
- Number of learners who dropped out (stopped attending school), were not promoted last year and are repeating a grade;
- Grade 1 first time enrolments;
- Number of Grade 1 learners who have attended pre-primary programmes;
- Mortality statistics for learners during the previous academic year;
- Number of learners whose parents are deceased;
- Number of learners registered for a social grant.

* Note: for learners to be classified as LSEN/SNE, they must be assessed with the permission of the parent/s by a registered and professional assessor or by an educator.

South African EMIS indicators: Contextual dimension

- How policy is formulated at the school;
- Which stakeholders are involved in formulation of vision and mission of the school;

- Codes of conduct situation at the school;
- Learners' code of conduct;
- School's learners' code of conduct in alignment with South African Schools Act (SASA) or not;
- Educators' code of conduct;
- Educators' code of conduct in alignment with provincial and SASA policy;
- Public servants' code of conduct in the school;
- Alignment of school's public servants' code of conduct with Public Servants' Act.
- Does language policy conform to Constitution?
- Does school have policies to deal with issues of staff equity and discrimination?
- Is there a need for staff training in diversity and conflict resolution?
- Does the school have clear plans to integrate learners?
- Does the school have clear plans to integrate staff?
- Assess the school development plan.
- Does the school have a year plan for the current academic year?
- Does the school have appropriate policies and procedures to enable it to function effectively?
- Do they help the school to attain its aims?
- Is the implementation of policies and procedures being monitored?
- Community and parent support, use of school services and facilities;
- Safety and security of school.

South African EMIS indicators: Teaching and learning dimension

- Registered school specialisation at Further Education and Training (FET) level;
- Teaching hours at General Education and Training (GET) and FET levels;
- Languages in GET band: number of learners according to languages as subjects and phase;
- Number of learners who participated in school-based extramural activities (sports, arts and culture) during the previous year in both GET and FET bands for male and female learners;
- Number of learners (grades 10–12) taking secondary subjects according to grade, gender, race and subject grade;
- Approval of school curriculum by School Governing Body (SGB);
- Availability of curriculum policy documents and circulars to staff;
- Time allocated at school for curriculum planning;
- Means of monitoring curriculum for each phase or subject;
- School's timetable covers the entire curriculum or not;
- Existence of a curriculum plan for each subject and learning area;
- Tests and assessments grow naturally from the curriculum and are used to aid planning;
- School subject heads have a well-defined system to monitor the implementation of the curriculum for the current academic year;
- School is making a concerted effort to broaden access to and improve quality of mathematics;
- School is making a concerted effort to broaden access to and improve quality of science;

- School is beginning to integrate information and communication technology into the teaching and learning programme;
- Educators experiencing difficulty with Curriculum 2005 have access to assistance from the provincial office.
- Number of hours per week a Foundation Phase learner spends in a reading programme.

South African EMIS indicators: Enabling inputs dimension

- Mortality statistics for educators during the previous academic year;
- Lowest and highest grades in the school;
- Total number of multigrade classes;
- Existence of double shifts;
- Number of classes for each grade;
- Number of staff remunerated by the state/remunerated by the SGB;
- Total number of full-time educators;
- SGB:
  - level of members' education,
  - assessment by principal of frequency with which structures meet,
  - effectiveness,
  - tasks undertaken,
  - current status with respect to several areas,
  - existence in school of a School Management Team (SMT),
  - frequency with which such structures meet,
  - effectiveness of the SMT,
  - relationship between SGB and SMT;
- Management:
  - which senior staff observe educator and learner performance in the classroom?
  - are learner, educator and public servants' performance monitored regularly at the appropriate meetings?
  - do principal and appropriate staff offer induction, support and guidance to new staff members?
  - are selection criteria for new appointments known to the staff?
  - does the school have a duly elected representative council of learners?
  - does the school have a duly elected education liaison officer?
  - has the developmental appraisal system been implemented at the school or not?
  - number of cases of sexual harassment against learners and educators by learners and educators;
- Effectiveness of school procedures;
- Positive or negative contribution made by SGB, educators, public servants, parents' body and learners;
- Functional record keeping and filing system; manual or computerised system;
- Preparations for start of school year completed or not; completion and verification of learner and admission documentation;
- Leave register in place;
- Attendance registers in place;

- Mail received regularly or not;
- Use of email for administrative communication purposes;
- Discussion of relevant departmental circulars with staff;
- Availability of the following to provincial offices:
  - minutes of meetings,
  - audited financial statements,
  - budgets for current year,
  - promotion records for previous academic year,
  - textbook control schedule for previous academic year,
  - quarterly summary of learner attendance,
  - register of educators' attendance,
  - year plan and staff planning files,
  - assessment files;
- Textbooks:
  - school has an adequate supply of textbooks to support the curriculum,
  - rating of the school's textbook recovery system,
  - sufficiency of stationery and learning support materials (LSMs)to support the curriculum,
  - amount of money allocated per learner for prescribed textbooks for primary and secondary learners,
  - did every learner receive at least one textbook in each learning area/subject at the beginning of the current academic year? If not, why not?
  - when did the school receive books/LSMs from the department for the academic year?
- Availability of resources and equipment – facilities, classrooms, computers, specialised equipment for ELSEN/SNE learners;
- Efficient and transparent internal financial systems and controls;
- School fees:
  - annual school fees for last year and current year,
  - number of exemptions granted,
  - process by which fees were agreed on,
  - number of parents present at meeting,
  - which additional costs parents are required to contribute to,
  - actions taken to ensure school fees are paid;
- Income for previous academic year; expenditure for previous academic year;
- Bookkeeping and accounting practices; availability of financial records for scrutiny by staff and parents; auditing of financial reports; does school have a bank account?
- School uniforms:
  - does school have one (winter and summer)?
  - available from,
  - type of clothing required,
  - cost;
- Provincial support;
- Physical infrastructure:
  - who owns land?
  - access roads,
  - boundary walls,

  - distance from nearest tarred road,
  - type and condition of school construction,
  - sanitation,
  - hostel,
  - offices,
  - non-instructional and instructional areas on school premises,
  - sports facilities;
- Educator information:
  - disability,
  - race,
  - gender,
  - nature of appointment,
  - qualifications,
  - subject/learning area,
  - hours taught per week,
  - subjects taught,
  - number of educators,
  - experience in subject,
  - number of years formal training.

South African EMIS indicators: Outcomes dimension (learner performance)

Percentage of learners reaching the expected outcomes for their age for each phase of the education system (literacy, numeracy and life skills are assessed for this purpose below Junior Secondary Phase). Note that children's ages do not correspond neatly to phases, in many cases due to starting school late. As a consequence, many children will not meet this criterion.

APPENDIX 8

Indicators for juvenile justice as developed by UNICEF

1. *Children in detention:* Total number of children in detention; proportion of children in detention in the pre-trial stage, over the total number of children in detention.
2. *Duration of detention:* The number of children sentenced to detention for: less than one year; one to five years; five to ten years; more than ten years; life imprisonment. The average length of pre-sentence detention.
3. *Children coming into contact with the juvenile justice system:* Number of children: arrested; referred to pre-trial diversion measures; tried (dismissed, acquitted, convicted and sentenced to custodial measures and non-custodial measures).
4. *Existence of a juvenile justice system:* Existence of specialised courts and/or procedures and/or dispositions or measures applicable to children; ratio per 1 000 arrested children of trained specialised professionals among: judges, lawyers, prosecutors, police, social workers/probation officers.
5. *Separation from adults:* Proportion of children in detention who are not separated from adults: in police cells, in detention facilities/prisons.
6. *Conditions for control of quality of services for children in detention:* Existence of a system guaranteeing mandatory visits by magistrates/judges; existence of a system guaranteeing regular visits by external, independent persons and bodies; proportion of children not being visited by parents or relatives over the last six months.
7. *Protection from torture, violence, abuse and exploitation:* Existence of legal provisions prohibiting torture, inhuman and degrading treatment or punishment; existence of safe, accessible and child-sensitive complaint mechanisms for children; the number of reported cases of violations; proportion of reported cases followed by penal or administrative sanctions
8. *Prevention:* Existence of a national programme for the prevention of juvenile offending that has at least 3/5 of the following components: Family support services; community-based programmes for vulnerable groups; programmes for prevention of drugs, alcohol abuse; educational support programmes; involvement of mass media in prevention.
9. *Aftercare:* Proportion of children in detention benefiting from an aftercare programme lasting at least six months following release.

Source: Developed by UNICEF in November 2003 in New York (Skelton, 2004)

APPENDIX 9

UNICEF recommended indicators for orphans and other children made vulnerable by HIV/AIDS

Strategic approach	Age	Key domain	Measurement tool
Strengthening the capacity of families and care for children			
Core indicators			
1. Basic material needs	5–17	Family capacity	Population-based survey
2. Malnutrition/underweight prevalence	0–4	Food security and nutrition	Population-based survey
3. Sex before 15	15–17	Health	Population-based survey
Additional indicators			
A1. Food security	NA	Food security and nutrition	Household survey
A2. Psychological health	12–17	Psychosocial	Population-based survey
A3. Connection with an adult caregiver	12–17	Psychosocial	Population-based survey
A4. Succession planning	NA	Protection	Household survey
Mobilising and strengthening community-based responses			
Core indicators			
4. Children outside of family care	0–17	Institutional care and shelter	Street children survey and institutional survey
5. External support for orphaned and vulnerable children	0–17	Community capacity	Household survey
Additional indicator			
A5. Orphans living with siblings	0-17	Community and family capacity	Population-based survey
Ensuring access to essential services			
Core indicators			
6. Orphan school attendance ratio	10–14	Education	Population-based survey
7. Birth registration	0–4	Protection	Population-based survey
Ensuring that governments protect the most vulnerable children			
Core indicator			
8. Orphaned and Vulnerable Children Policy and Planning Effort Index	N/A	Policies/strategies, sources and resource mobilisation	Key informant interviews
Additional indicator			
A6. Property dispossession	15–49	Protection	Household survey

➔ Raising awareness to create a supportive environment			
Core indicators			
9. Percentage of children who are orphans	0–17	Policies/strategies	Population-based survey
10. Percentage of children who are vulnerable	0–17	Policies/strategies	Population-based survey
Additional indicator			
A7. Stigma and discrimination	15–49	Protection	Population-based survey

Source: UNICEF (2005b)

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