

REPORTING ON CHILDREN IN THE CONTEXT OF HIV/AIDS

A Journalist's Resource

About the research

This resource draws on media research conducted by the Children's Institute and the Centre for Social Science Research (both at the University of Cape Town), the Media Monitoring Project, and the HIV/AIDS and the Media Project, managed by the Journalism Programme and the Perinatal HIV Research Unit (at the University of the Witwatersrand).

For more detailed analysis, copies of related research publications are available from the Children's Institute, the Media Monitoring Project, and the HIV/AIDS and the Media Project.

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The media shapes public attitudes and actions towards children affected by HIV/AIDS. This makes it important for journalists and editors to be conscious of the perspectives and judgements that are implicit in their reporting.

This resource provides reference information to assist journalists in reporting on children in the context of HIV/AIDS.

	Part 1	Presents recent research and thinking around the ways in which children are affected by HIV/AIDS, including being orphaned.	1
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How children are affected by HIV/AIDS

Part 1 highlights the many ways children are affected by HIV/AIDS, and challenges the predominant focus in the media on “AIDS orphans”. Some of the statistics and stereotypes commonly associated with “AIDS orphans” are contextualised within the range of children rendered vulnerable by the combined impact of HIV/AIDS and poverty.

Children of all races, classes, and geographical areas are affected by HIV/AIDS.

Children are affected by HIV/AIDS in a number of different ways.

- **Being born to a mother who is HIV-positive.** Most children who are born to HIV-positive mothers are not HIV-positive themselves. Without prevention of mother-to-child transmission (PMTCT) interventions, 25 - 30% of children born to HIV-infected women are likely to be HIV-positive. Where available, current PMTCT interventions in South Africa reduce these figures to between 5% and 15%. See page 8 for more on PMTCT;
- **Being HIV-positive.** It is estimated that 1.8% of South African children under the age of 18 are HIV-positive¹. Research indicates that antiretroviral treatment (ART) reduces mortality rates in HIV-positive children by roughly 70%¹². See page 11 for more on ART;



What is the definition of a child?

In terms of section 28 of the South African Constitution, a child is defined as a person younger than 18 years old.

- **Living with sick parents, caregivers, or others who are sick.**

The times during which parents and caregivers are ill are often times of increased stress and difficulty for children. For example, children often take on additional domestic tasks or care for sick relatives or younger siblings. Children's school attendance can be compromised during this time;

- **The illness or death of someone who provides financial or other support** to children and their households (whether or not that person lives with the family).

As increasing numbers of people depend on limited or decreasing income and resources, children are at greater risk;

- **Living in communities with high rates of illness and death.**

Though it is not well documented, there is likely to be significant emotional impact on children who grow up surrounded by illness and death in their families, social networks, and neighbourhoods;

- **Being orphaned;** it is estimated that 802 000 – or 4.5 % of – children in South Africa would have lost a mother to HIV/AIDS by 2005¹⁴. See page 3 for more information on orphans.



OVC

As HIV/AIDS affects children in a variety of ways, the phrase “orphans and vulnerable children” (OVC) was coined. This phrase is an attempt to recognise that it is not only children orphaned by HIV/AIDS who are vulnerable as a result of the epidemic. The term OVC remains problematic, as it is frequently used as a replacement term for “AIDS orphans”, rather than as a reference to the much broader range of children (including orphans) who are affected by HIV/AIDS²¹.

Being orphaned

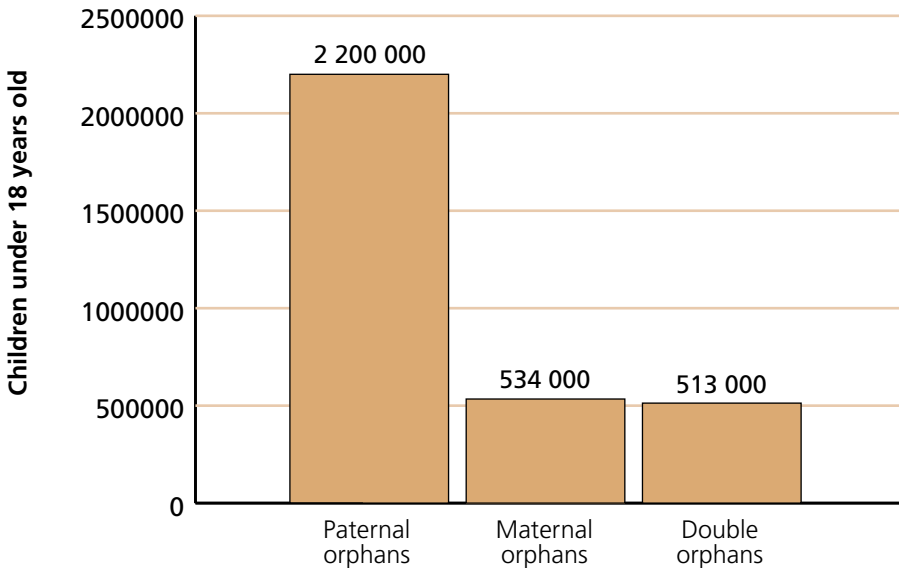
Many “orphans” still have one living parent.

In South Africa there are more than 3.4 million children under the age of 18 who have lost either a mother or a father, or both parents.

- The Actuarial Society of South Africa model (ASSA2002) estimates a total of 3.4 million orphans as of July 2005;
- The General Household Survey (GHS) indicated that in June 2004, this figure totalled 3.3 million.

Almost 70% of all orphans in the GHS 2004 were “paternal orphans”: children whose fathers had died but whose mothers were alive.

Orphans in South Africa, June 2004 (GHS 2004)



AIDS is not the only cause of orphanhood

It is estimated that 62% of all maternal orphans have lost their mothers due to HIV/AIDS¹⁴. The proportion of children who have lost their father to HIV/AIDS will be lower, because of lower AIDS mortality rates in men. A large proportion of children lose their parents to violence, motor vehicle accidents, and illnesses other than HIV.

This makes it difficult to identify the numbers of children orphaned by AIDS, rather than by other causes, and mistakes are easily made by those who give estimates of “AIDS orphan” numbers.

Most children orphaned by HIV/AIDS are not HIV-positive.

HIV is not transmitted to most children born to HIV-positive parents. Most children orphaned by AIDS are born many years before their parents die. At the time of their birth, their parents are either not yet infected with HIV, or are in the early stages of HIV, and so at a low risk of transmitting the virus from mother to child.

Most orphans are not very young children.

According to the 2004 General Household Survey, 70% of orphans are 9 years and older.

Orphan statistics can be confusing:

The term “orphan” is frequently applied differently by modellers, statisticians, and researchers. Some statistics refer to children up to the age of 15 rather than 18. Sometimes when the term “maternal orphan” is used, it applies to children whose mothers have died, but whose fathers are alive. At other times, it applies to all children whose mothers have died, i.e., the figure might include children whose fathers have also died. The same frequently applies to the term “paternal orphans”.



Few children live in child-headed households.

The General Household Survey data suggests that 0.6% of children (orphaned or otherwise) in South Africa were living in child-headed households in June 2004. This is equal to roughly 107 000 children⁶. This figure should, however, be treated with caution as child-headed households formed only a small sub-sample of the survey.

Research shows that child-headed households are frequently temporary households^{10, 21}. In other words, many child-headed households may exist for a limited period after the death of an adult, prior to other arrangements being made to care for the children. These include adults moving in or the children moving to another household to live with relatives.

In other words, the vast majority of children who have been orphaned in South Africa are growing up in households where adults are also resident. While this does not necessarily guarantee the children a supportive living environment, it provides them with adult socialisation and the potential for adult care and support.

Existing evidence about whether orphans are at special risk is contradictory.

Studies that compare the experiences of children who have lost one or both parents to children whose parents are alive provide inconsistent results. There is a range of contradictory evidence as to whether the following factors are in fact adversely affected by the death of one or both parents²¹:

- Schooling access or achievement;
- Poverty level and living standards;
- Health outcomes, including nutritional status, weight-for-height/age measures, and mortality and morbidity.



Considering the existing evidence, predictions about increasing numbers of orphans resulting in “hordes of criminal children” are unlikely to be fulfilled³.

Common experiences of many South African children

Many children in South Africa share experiences often associated specifically with orphans²¹, such as:

- **Poverty:** Using national survey data from 2000, it was estimated that 75% of South Africa's children were living in poverty, where the poverty line is based on a per capita income of R430 per month (similar to the US\$2 a day line). This translates to over 13 million South African children living in poverty.

54% of South Africa's children were living in deep poverty, where the poverty line is based on a monthly per capita poverty line of R215 (almost equivalent to US\$1 per day). In other words, even when extreme poverty measures are used, more than half of South Africa's children are poor.²²

Using national survey data from 2004, it was estimated that 65% of South Africa's children are living below the poverty line, as defined by the South African government for its cash grant poverty alleviation programme. In other words, in terms of the government's own definition, two-thirds of South Africa's children are living in families that are so poor that they cannot afford to fulfil their children's basic needs.⁴

- **Living with people other than their biological parents:** 16% of South African children whose parents were alive in June 2004 were not living with either of their parents⁶.
- **Rights not realised:** South African children, whether they are orphans or not, frequently go hungry, struggle to attend school, and experience violence, abuse, and exploitation in a number of forms.



I go and sleep and
forget.



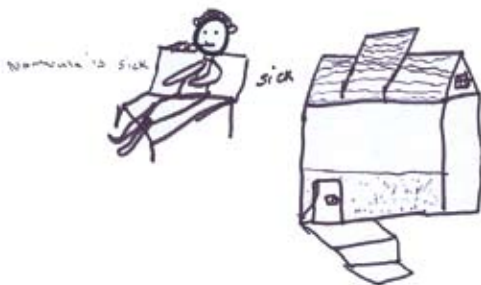
Responses to children affected by HIV/AIDS

With children affected in a multitude of ways, part 2 presents just ten of the many critical issues at stake in a national response to children experiencing the impact of the epidemic. Key issues related to the implementation of clinical interventions to prevent and treat HIV in children are presented first. Urgent attention is also called to the delay in formalising programmes and policies, and the appropriateness of some existing responses, such as the building of more orphanages, the reliance on volunteers, and the ways government grants are being implemented. Lastly, the limitations of media prevention campaigns and poor health services for youth are noted.

Important policy and programme debates are being held within government and civil society about the best ways to assist children in the context of the HIV/AIDS epidemic. Studies on the impact of different service and support responses on children's lives are underway. Such research plays a crucial role in identifying appropriate interventions for children (see part 5 for a list of research organisations to contact for updated information).

What we already know is that there is no single solution. A range of complementary strategies is needed to address the impact of the epidemic, some of which focus directly on children, while others focus on families and communities.

The media can play a vital role in ensuring appropriate responses to HIV/AIDS. How? By engaging in the debates, tracking implementation, and highlighting areas where government does not live up to its promises.



Prevention of mother-to-child transmission (PMTCT) programmes must not be sidelined in the urgent rollout of antiretroviral treatment.

Prevention of vertical HIV infection of children is simple, readily achievable in the South African context, and is much more cost-effective than treating infected children. It is crucial that attention be paid to making PMTCT programmes effective.

Public sector PMTCT programmes in South Africa currently involve:

- Voluntary counselling and testing (VCT) for HIV for mothers;
- Single-dose Nevirapine for mothers and babies;
- Counselling on infant feeding options and free formula for six months if needed;
- Access to support groups where disclosure, practising safe sex, and family planning are discussed;
- Infant follow-up and testing.

With this intervention, transmission from mother to child can be reduced by about 50% to between 13% and 15%.

Slightly more complex PMTCT regimens, which use more than one ARV drug, do exist. These could bring vertical transmission of HIV down to between 2% and 5%⁷. Unfortunately, these are not currently available in public sector clinics in South Africa, with the exception of the Western Cape. There is minimal reporting in the South African media on PMTCT.

What is vertical / horizontal transmission of HIV?

Vertical transmission of HIV refers to when a mother transmits HIV to her child while in-utero, during birth, or through breast-feeding. Horizontal transmission of HIV refers to transmission through sex, contaminated needles, etc.

Definitive HIV tests for children are not available in the public sector until they are 18 months old, even though alternatives exist.

A key component of PMTCT is the follow-up and testing of children. Most provinces use antibody tests, which only confirm positive diagnoses when a child is 18 months old. More expensive tests (PCR tests) are available and effective from six weeks, but these are only used in the Western Cape.

There are many disadvantages to a late diagnosis of children's HIV status:

- The longer the time lapse, the higher the proportion of children who do not return to clinics for follow-up care;
- Delays in children's treatment can lead to illness and death;
- Most children who have gone through the PMTCT programme should ultimately test HIV-negative. Late testing places unnecessary loads on public health services to follow up children who could have been released from monitoring at a much younger age.



Safe infant feeding is a challenge for HIV-positive women.

Although formula feeding removes the risk of post-natal transmission of HIV, there is concern that it could lead to an increase in diarrhoeal disease, due to contamination of bottles. There are, however, many areas where formula feeding can be safely promoted.

If women decide to breastfeed their infants, there is evidence to suggest that exclusive breastfeeding is safer than mixed feeding.

HIV-positive women are, therefore, advised to bottle-feed or to breastfeed exclusively for four months and then abruptly wean their babies. Many complex factors need to be taken into account before one or the other can be recommended. Context is key and the following need to be taken into consideration:

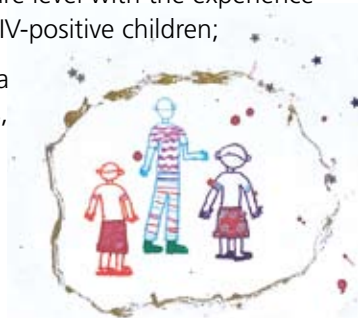
- Access to clean, safe water in sufficient quantities;
- Stigma associated with bottle-feeding;
- Costs of bottle-feeding or access to free formula milk;
- Customary feeding practices;
- The support of family and the baby's caregivers.



The challenges in providing antiretroviral treatment (ART) to children can be different to those involved in treating adults.

The number of children in need of ART far exceeds the current availability of the drugs. In early 2005, estimates based on the ASSA model suggest that less than one in five children who were in need of ART were actually receiving the treatment¹. Hopefully this proportion will change rapidly, as treatment is rolled out nationally. Some of the barriers to providing antiretrovirals to children include:

- A shortage of trained staff at primary care level with the experience and confidence to diagnose and treat HIV-positive children;
- Antiretroviral treatment regimens need a minimum of three different medications, often in the form of syrups, some of which taste unpleasant and require refrigeration;
- Few combined formulations (more than one drug in a single tablet/syrup/suspension) are available for children;
- Paediatric syrups are more expensive than adult medication. Global activism to make treatment affordable has focused on adults;
- Current medicine formulations can be difficult for children or their caregivers to manage. This can put adherence to treatment at risk;
- Research and drug development of paediatric antiretroviral medication lags behind that available for adults. This is because there is a relatively small market for paediatric antiretroviral treatment in the developed world, due to the successful implementation of prevention of mother-to-child transmission programmes.



Government grants to support poor children are insufficient, especially considering the impact of HIV/AIDS on household economic status.

The child support grant (CSG) is a cash grant provided by the government to caregivers of poor children under the age of 14. In 2005, the grant is equal to R180 per month per eligible child, up to a maximum of six children. This means that there is no income support for poor children over the age of 14; an age at which children are especially prone to dropping out of school if there are insufficient resources to support them and their households.

It is well documented that HIV/AIDS can have a significant effect on household financial resources, as money is diverted to health care and funerals, and income is lost when breadwinners are too ill to work. In the context of HIV/AIDS, therefore, it is especially crucial that the government pay attention to providing adequate poverty relief.

Research undertaken in KwaZulu-Natal⁵ suggests that CSGs are making a difference to children (including those affected by HIV/AIDS) by increasing, for example, their chances of regular school attendance. While there is much discussion in the media about abuse of grants, there is no evidence that this is a widespread practice.

Government grants and other poverty alleviation programmes are not as accessible as they should be.

Children and families frequently experience difficulties in accessing the government services and support for which they are eligible^{4, 10}.



The use of foster care grants (FCGs) to provide orphans with poverty relief threatens the functioning of the child protection system.

The foster care system is a cornerstone of the child protection system, which is designed to assist children who have been abused and neglected.

However with encouragement from the South African government, increasing numbers of families that care for orphans are relying on foster care placement and FCGs as a means to access financial support. This approach on the part of the government is questionable for a number of reasons, including²⁰:

- The number of foster care applications in many parts of South Africa already far exceeds social workers' and courts' capacity to process them. As a result, vast numbers of orphans are already unable to access FCGs;
- Continued use of the administratively complex foster care system to provide basic financial support to orphans will bring the child protection system to its knees, and render it even less able to provide protection to children who really need it;
- Children's poverty-related vulnerability is neither synonymous with nor exclusive to orphanhood. A social security system that provides grants to orphans younger than 18, without providing adequate and equal support to the many other impoverished children whose parents are alive, is discriminatory. It fails to make provision for the multitude of other children made vulnerable by growing up in the time of the AIDS epidemic.



Prevention of sexual transmission of HIV to children and teenagers is complex and has shown little improvement.

The prevention of sexual transmission of HIV is especially challenging because it requires complex changes in behaviour and social norms. Media campaigns in partnership with the Department of Health, such as Khomanani, loveLife, and Soul City, specifically target the youth with prevention messages around safe sex, and try to encourage confidence, particularly amongst young women, around negotiating sexual practices.

Many public clinics are not child- or youth-friendly.

Research has repeatedly documented children's and adolescents' negative experiences when attempting to access reproductive health-related services and support.



Orphanages continue to mushroom, despite expert advice that they should only be a small aspect of an appropriate response to the epidemic.

Their limitations include very high running costs, the fact that children are separated from their families and communities, and well-documented difficulties that older children experience when they leave the institutions.

Targeting orphans with support programmes that are not accessible to other poor children is a widespread response.

There is evidence that this strategy can have negative consequences for orphans, and that it does not adequately respond to the much larger numbers of needy children who live in the same communities. Orphan recipients of aid can become exploited, while those who do not fit the definition "orphan" remain at huge risk^{10, 21}.



Many government and civil society programmes to support children affected by HIV/AIDS rely on volunteers.

Community-based care (in the form of home-based care services, community child-care forums, and others) plays a vital role in supporting children and families affected by HIV/AIDS. There is scope for further strengthening of community-based support through better use of existing institutions, such as schools.

However, the heavy reliance of many of these programmes on volunteer labour – usually of poor women – raises questions of appropriateness, equity, and sustainability¹⁰.

Key policies and laws to address the needs of children affected by HIV/AIDS remain incomplete and unimplemented.

The Department of Social Development's orphans and vulnerable children (OVC) policy framework and the Children's Bill are two key pieces of policy and legislation that have not yet been implemented:

- The OVC policy framework is important for South Africa's fulfilment of the commitments that arose during the UN Special Session on HIV/AIDS held in 2001;
- The first part of the Children's Bill (the Section 75 Bill) was passed by the National Assembly in June 2005. Once the Section 75 Bill has been passed by parliament and signed by the president, the second Bill, the Section 76 Bill, will be tabled in parliament. Once the second Bill has been passed, the two Bills will be merged into a single Children's Act. The Children's Act will replace the Child Care Act of 1983.



Misleading messages

With the huge potential to impact on responses and policy debates, part 3 uses recent research studies to describe some of the media's limitations in its representation of children and HIV/AIDS. Some of the misleading messages commonly perpetuated are listed and trends in the ways in which stories are reported are outlined.

Do any of the quotations on this page sound familiar?

“Scientists, researchers and welfare agencies warn that without ‘determined and dramatic’ intervention, the soaring AIDS deaths, particularly of young mothers, will turn our city streets into dangerous ‘no go’ areas. They paint a grim, nightmarish picture of bands of lawless children, armed to the teeth and rampaging for food and shelter; waging a war of survival against each other and society at large, much like a page from Lord of the Flies”

(Independent on Saturday, 11/05/2002)

“A Cape Town-born banker ... who gave up a successful financial career in London to help raise funds for AIDS orphans in South Africa”

(The Star, 30/05/2002)

“There can be no more pathetic a group of children than the growing legion of AIDS orphans, who daily face a desperate fight for survival in a society which largely continues to close its collective eyes to their plight”

(Daily News, 03/05/2003).

“Children who have been left to fend for themselves, having been forgotten by those responsible for them”

(The Citizen, 02/05/2003).

“Relatives abandoned them because they had the disease”

(Daily News, 02/12/2002).

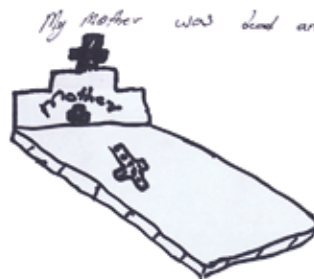
“Helpless victims of a social and medical nightmare...”

(Sowetan Sunday World, 24/7/2002)

A recent study that addressed the content of articles published in the South African print media found that some reports convey misleading messages about children affected by HIV/AIDS¹⁹. These can, and should, be replaced by accurate information.

Common examples of misleading messages include:

- There are only two categories of children affected by HIV/AIDS: “AIDS orphans” and HIV-positive children;
- Children affected by HIV/AIDS are helpless, pitiful victims of their own circumstances;
- Where children are affected by HIV/AIDS, mothers or other family members desert their children. Parents and families are not fulfilling their responsibilities towards children;
- Fathers are often left out of the picture where the focus is on “errant” and “bad” mothers;
- Orphans live without adult caregivers, as part of child-headed households, or on the streets;
- (White) middle-class people tend to come to the rescue of (black) children affected by HIV/AIDS in South Africa;
- Increasing numbers of “AIDS orphans” will result in gangs of uncivilised and criminal children, who threaten society, and put the South African public’s safety at risk;
- South African society is experiencing a loss of morality. According to some media, there is a need for widespread social and moral regeneration in order to ensure an adequate response to the HIV/AIDS epidemic.



Missing the whole picture: Media trends in reporting on HIV/AIDS

Studies highlight a number of tendencies in media coverage of HIV/AIDS:

- Children are used to highlight the tragedy of the HIV/AIDS epidemic. They are portrayed as “innocent” victims, which implies not only that others are guilty, but also that the effects of the epidemic are the worst for children. This skewed portrayal prevents a balanced discussion of how children and adults experience and respond to the epidemic;
- The complicated and extensive duties that government has towards children are rarely explained or challenged;
- In the absence of key conflict events (such as the landmark Constitutional Court case in 2002) and/or key personalities (like the minister of health) the frequency and prominence of media coverage on HIV/AIDS drops⁹;
- An assumption that readers are unaffected by HIV/AIDS prevails in the media. They are presented as “outsiders” to the relevant issues, except in coming to the rescue.

While many media reports present facts, they risk distorting the overall picture by presenting only a particular set of facts. Often the context is not present in the articles, or the stories are too narrow in their focus.



What's at stake for children?

The media have the potential to compound the vulnerability of children affected by HIV/AIDS:

- **Children could be stigmatised and experience added pressures** following news stories that target or identify them;
- **Children's rights to dignity and privacy can be violated;**
- **Stereotypes and untruths can be unintentionally reinforced** by a careless choice of words;
- **Children and families cannot easily challenge** the ways in which they are represented by the media.

The media have the power to inform and promote appropriate responses to the range of children affected by HIV/AIDS. The media can and should:

- **Hold service providers accountable** to their commitments to children;
- **Ensure decision-makers do not ignore critical issues** for children. Sustained coverage of issues in news stories will pressurise decision-makers to explain their efforts and address them;
- **Influence public opinion** against behaviour that helps to spread and stigmatise HIV/AIDS.



Every little bit counts toward an appropriate response: it is the cumulative effect of stereotypical, partial, or inaccurate reporting that threatens South Africa's ability to respond effectively to children's needs. If the majority of reporting is sensitive and informed, there are huge potential benefits for children, families, and society.

Guiding principles for reporting on children and HIV/AIDS

Following up on the challenge for absolute rigour and sensitivity in reporting on children, part 4 provides five guiding principles to both safe-guard children and enhance reporting.

Ethical guidelines for journalists:

Children are afforded special protection by a number of international conventions and national laws (see the Resources section on page 24 for more information). Journalists have a responsibility to be constantly aware of the need to protect children and to enhance their rights, and in practice, adhere to the highest ethical principles. These are:

- Seek truth and report it as fully as possible;
- Act independently;
- Minimise harm.

Below are five guiding principles for reporting on children affected by HIV/AIDS:

1. The best interests of the child

“The child’s best interests are of paramount importance in every matter concerning the child”

(Section 28(2) of the South African Constitution).

All media coverage of children should be assessed to check that reports do not contribute to children’s vulnerability and are in the best interests of the children concerned.

2. Highest ethical standards

“In reporting on children, journalists must maintain the highest standards of ethical conduct, excellence, and sensitivity. In particular, children’s rights to privacy and dignity should be afforded even greater protection”¹³.

This includes:

- Accurate reporting that does not fuel the myths and misconceptions around the epidemic;

- Avoiding stereotypes and words that carry value judgements, such as “sufferer” or “victim”;
- Avoiding sensationalising children affected by the epidemic, such as “innocent” babies;
- Using a variety of reliable and authoritative sources.

3. Confidentiality

A child’s HIV status must remain confidential, unless the child wants to reveal her/his status, and through informed consent, is made aware of the potential consequences. Even if the child’s caregivers give consent, unless it is demonstrably in the best interests of the child, and unless the child him/herself consents, the child’s HIV status should not be revealed. Great care needs to be exercised in preventing the indirect identification of a child through the naming or photographing of a child’s school, home, place of care, or through naming the child and/or the child’s caregivers or parents.



If in doubt, leave it out.

Only in cases where there is an overwhelming and demonstrable public interest, should a child’s HIV status be revealed.

4. Consider the consequences

Be mindful of the consequences of your story. The children whom you use as sources have to live with the story long after you have moved on²³.

5. Children have the right to be seen and heard

Children have the right to participate in matters that affect them. Where possible, journalists should give children the opportunity to express their views and opinions on HIV/AIDS and related matters. When working with children, children’s ages and developmental stages need to be taken into account.

Why should journalists consult children?

- Children bring fresh perspectives to HIV/AIDS stories;
- Children reveal a range of different and unique stories, which contest many of the widely held stereotypes about children;
- Children reflect and highlight varied experiences and views from different economic and cultural backgrounds;
- Children can tell you how they would like to be referenced and identified in news stories (informed consent and ethical practice is critical);
- Children have the right to participate in matters that concern them. As they too are affected by HIV/AIDS, they should be consulted for their views or experiences.

Child #1: I think this child is HIV-positive. He is going to die. If people don't understand his situation they may laugh at him [because he is HIV-positive], but when they know about HIV/AIDS they will give him support and love. He must be open so he can get help.

Child #2: You mean people who are HIV-positive should talk about it?

Child #1: I am not going to get support easily if I am not open about being HIV-positive. They need to be open so people can help them to cope with the stress.

Child #3: I don't like it. I think they shouldn't show the face. Other people will know now and laugh at him at school.

Child #1: I agree. Why did they decide to take this photo when he was taking the medicine? Why did they decide to take a photo that makes him look so bad? Why must they show this child with the tube in his nose and the medicine? He looks sick and very bad. I really don't like it. They should have taken the tube out and then taken the photo.

(Children commenting on a photograph published in a local newspaper; Empowering Children & the Media project, 2003)

For up-to-date statistics, estimates, and projections:

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www.childrencount.ci.org.za

Centre for Actuarial Research

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For social, clinical, and legal research on children affected by HIV/AIDS and related interventions:

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www.hsrc.ac.za/research/programmes/CYFD/

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Centre for HIV/AIDS Networking (HIVAN)

University of KwaZulu-Natal

+27 31 260 3334

www.hivan.org.za

Centre for AIDS Development, Research, and Evaluation (CADRE)

Durban: +27 31 242 5413

Gauteng: +27 11 339 2611

Grahamstown: +27 46 603 8553

www.cadre.org.za

African Network for the Care of Children Affected by AIDS (ANECCA)

+27 21 658 5111

Community Law Centre Children's Rights Project

University of the Western Cape

+27 21 959 2950 / 959 3701

www.communitylawcentre.org.za

Harriet Shezi Children's HIV Clinic

University of the Witwatersrand

+27 11 933 9629/9630/9845

Perinatal HIV Research Unit

University of the Witwatersrand

+27 11 989 9700

www.hivsa.com

Red Cross Hospital: Infectious Diseases Unit

University of Cape Town

+27 21 658 5111

Children's Infectious Diseases Clinical Research Unit (KID-CRU)

Tygerberg Hospital

+27 21 938 4219

For information and support on reporting on children and HIV/AIDS:

Media Monitoring Project

+27 11 788 1278
www.mediamonitoring.org.za

HIV/AIDS and the Media Project

University of the Witwatersrand
+27 11 717 4086
www.journ-aids.org

Soul City and Soul Buddyz

Children's Rights and the Media
+27 11 643 5852
www.soulcity.org.za

For information on organisations that work directly with children and their families:

AIDS Consortium

+27 11 403 0265
www.aidsconsortium.org.za

Children's Rights Centre (CRC)

+27 31 307 6075
www.childrensrightscentre.co.za

ChildLine

Eastern Cape: +27 41 487 1997
Gauteng: +27 11 484 1070
KwaZulu-Natal: +27 31 312 0904
North West: +27 18 299 1940
www.childline.org.za

Children's HIV/AIDS Network (CHAiN)

+27 21 461 7348
www.wc-nacosa.co.za/chain

Children in Distress Network (C I N D I)

+27 33 345 7994
www.cindi.org.za

South African Professional Society on the Abuse of Children (SAPSAC)

+27 12 804 5052
www.sapsac.org.za

South African Society for the Prevention of Child Abuse and Neglect (SASPCAN)

+27 11 339 5741
www.saspcan.org.za

National bodies:

National Children's Rights Committee

+27 11 339 1919
www.crin.org

Office on the Rights of the Child in the Presidency

+27 21 464 2122 / 2100
www.info.gov.za/aboutgovt/contacts/min/presidency.htm

For information on special laws and regulations for the protection of children in the media:

World Health Organisation

www.who.int/children/

United Nations Convention on the Rights of the Child

www.unhchr.ch/html/menu3/b/k2crc.htm

For specific South African laws:

Media Monitoring Project

www.mediamonitoring.org.za/ecm_2005/pdf/journos_handbook.pdf

For specific South African law updates:

www.pims.org.za
www.gcis.gov.za



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List of media monitored

Print media

Afrikaner
Beeld
Business Day
Business Times
Cape Argus
Cape Talk
Cape Times
City Press
Daily Dispatch
Daily News
Diamond Fields Advertiser
Die Burger
Die Volksblad
Enterprise
EP Herald
Financial Mail
Finansies en Tegniek
Ilanga
Impak
Independent on Saturday
Leader
Mail & Guardian
Natal Witness
New Era
Newsweek
Pretoria News
Rapport
Saturday Star
Saturday Weekend Argus
Sowetan

Sunday World
Sunday Independent
Sunday Sun
Sunday Times
Sunday Tribune
The Citizen
The Star
The Teacher
Weekend Argus

Radio media

East Coast Radio
Jozi Fm (Soweto Community Radio)
Lesedi Fm
Motsweding Fm
Radio P4
Radio PMB
Radio Sonder Grense
SAfm
Ukhozi Fm
Y-Fm
Zibonele Fm

Television media

e-tv
SABC 1
SABC 2 (Afrikaans)
SABC 2 (Sotho)
SABC 3



"I know that children who have been abused need their names and faces protected. Journalists do not have a right to show that. I did not know that before the Empowering Children & Media project"

ECM child participant, 2003.





In the context of widespread HIV/AIDS and poverty, this booklet provides reference information about children affected by HIV/AIDS and related policy issues, all of which need urgent and in-depth coverage by the South African media. With the imperative to “put children first”, this resource challenges some of the limitations and misleading messages in current coverage and offers a resource list to help shape an appropriate national response to children affected by the epidemic.