THE RIGHT TO BELONG AND PARTICIPATE
Support Services to Children with Disabilities

Strategy for the Integration of Services for Children with Disabilities
Strategy for the Integration of Services for Children with Disabilities

Revised Draft
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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>CDG</td>
<td>Care Dependency Grant</td>
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<tr>
<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<td>CwD</td>
<td>Children with Disability</td>
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<tr>
<td>DAC</td>
<td>Department of Art and Culture</td>
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<td>DBST</td>
<td>District-based Support Teams</td>
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<tr>
<td>DCS</td>
<td>Department of Correctional Services</td>
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<tr>
<td>DEAT</td>
<td>Department of Environmental Affairs and Tourism</td>
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<td>DHS</td>
<td>Department of Human Settlement</td>
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<td>DoA</td>
<td>Department of Agriculture</td>
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<td>DoBE</td>
<td>Department of Basic Education</td>
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<td>DoC</td>
<td>Department of Communication</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DoHA</td>
<td>Department of Home Affairs</td>
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<tr>
<td>DoHE</td>
<td>Department of Higher Education</td>
</tr>
<tr>
<td>DoJ&amp;CD</td>
<td>Department of Justice &amp; Constitutional Development</td>
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<tr>
<td>DoL</td>
<td>Department of Labour</td>
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<tr>
<td>DoT</td>
<td>Department of Transport</td>
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<tr>
<td>DCG&amp;TA</td>
<td>Department of Corporative Governance &amp; Traditional Affairs</td>
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<tr>
<td>DPW</td>
<td>Department of Public Works</td>
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<tr>
<td>DPO</td>
<td>Disabled People’s Organisation</td>
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<td>DSD</td>
<td>Department of Social Development</td>
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<td>DSS</td>
<td>Department of Safety and Security</td>
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<tr>
<td>DST</td>
<td>Department of Science &amp; Technology</td>
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<tr>
<td>DWCPwD</td>
<td>Department of Women, Children and People with Disabilities</td>
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<td>DSR</td>
<td>Department of Sport and Recreation</td>
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<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
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<tr>
<td>ICF</td>
<td>International Classification of Functions</td>
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<td>IDP</td>
<td>Integrated Development Plans</td>
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<td>INDS</td>
<td>Integrated National Disability Strategy</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organisation</td>
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<tr>
<td>NMF</td>
<td>Nelson Mandela Foundation</td>
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<tr>
<td>NPF</td>
<td>National Policy Framework</td>
</tr>
<tr>
<td>NPO</td>
<td>Non Profit Organisation</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>SAHRC</td>
<td>South African Human Rights Commission</td>
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<tr>
<td>SALGA</td>
<td>South African Local Government Association</td>
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<tr>
<td>SASSA</td>
<td>South African Social Security Agency</td>
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<tr>
<td>SIAS</td>
<td>Strategy on Screening, Identification, Assessment and Support</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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Conceptual Framework

Children with disabilities remain one of the most vulnerable groups in society because of historical neglect and the lack of commitment to honour their dignity and rights.

1.1 Putting children with disabilities on the agenda

1.1.1 Introduction

Since 1994 South Africa has placed the rights of children high up on the agenda of all government programmes. These rights are firmly entrenched in the Bill of Rights of the South African Constitution (Act no: 108 of 1996) which outlines how the best interests of every child should be protected and promoted. However, the situation of children with disabilities continues to be characterised by neglect, ignorance, marginalisation and institutional failure, despite the vision and policy imperatives being adopted within a developmental and rights-based framework. With a scarcity of resources across the service sector, children with disabilities have been shown to fall between the cracks, thus deserving our focussed attention, not only to illustrate the complexity of their situation, but to ensure that the playing field is equalised. The development of this strategy document heeds this call, with the Department of Social Development (DSD) mandated to facilitate the process of closing the gap between policy development and the implementation of support services for children with disabilities.

1.1.2. The social protection agenda

Comprehensive social protection includes both social transfers as well as social services for the most vulnerable and marginalised members of society. However, evidence suggests that in many countries, progress is often measured by the
extent of cash transfers to vulnerable households with little attention given to the provision of appropriate services across the different government sectors, NGOs, CBOs, FBOs and the private sector. There is a need to expand the conceptualization of social protection from social transfers towards a comprehensive, inclusive and integrated approach to accessible social services.

South Africa’s social protection programme includes social grants as well as social services, headed by the Department of Social Development. Grants are administered and regulated by the SASSA, with an estimated 25% of the population receiving some sort of social assistance. While social grants have significantly reduced the impact of poverty on families, it should not detract attention from developing and strengthening social services. If delivered in an integrated and coordinated manner, social services have the potential to further reduce the impact of poverty, reduce vulnerability and improve capabilities of individuals. Children with disabilities especially, depend on appropriate social services throughout their childhood to facilitate their development into adults as recognised and respected citizens.

1.1.3 Poverty reduction

The recognition of disability as a development issue, as both a cause and a consequence of poverty has facilitated a broadened understanding of disability, contributing towards social transformation. Disability increases vulnerability to poverty, while poverty creates the conditions for increased risk of disability. Furthermore, disability increases vulnerability to poverty because of the costs associated with living with a disability, discrimination in the labour market and difficulties related to access to education and assistive devices.1

Poverty is indeed a multi-dimensional concept and includes unacceptable social and economic deprivation, and lack of empowerment and security. As Amartya Sen suggests, poverty should also be understood in relation to human development and the ‘Capabilities’ necessary for maximising potential in the life of each and every individual, family and community. The OECD uses this approach to define five dimensions of deprivation: economic, human (health, education, clean water, etc), socio-cultural (valued participation in community life), political and protective capabilities for a good and productive life.4
Globally, as well as in South Africa, the group of disabled children who are most vulnerable to living in extreme poverty, are those with intellectual disability and those in rural areas\(^5\). Children with disabilities who are hidden are also not recorded by the system and consequently do not access any services. The link between poverty and disability has also not been systematically examined. Information therefore relies heavily on anecdotal evidence and case studies. Unless disability is specifically emphasised in all programmes related to poverty relief, South Africa will not be able to achieve the visions and targets by 2015 as set out in the Millennium Development Goals.

### 1.2 Historical perspective

#### 1.2.1. The ideological shift from welfarism to a developmental and rights based approach

In South Africa, as in various other countries, a medical model has been used to understand many aspects of child development in the context of special needs education and specialised health provision. Disability gets framed as an individual, rather than a societal problem, and one that can be prevented or ameliorated through medical, biological or genetic intervention or through therapy, rehabilitation services and technical supports aimed at the individual. This thinking led to the idea that ‘children with special needs’, need to receive services in segregated settings. The problem is that where these specialised services or settings are not available, many children do not have access to any services whatsoever.

A rights-based and social approach indicates that if society cannot cater for people with disabilities, it is society that must change. The goal must be the right of people with disabilities to play a full, participatory role in society\(^6\). Most policies in South Africa have therefore adopted a social model according to which the right of people with disabilities to play a full, participatory role in society is acknowledged \(^6\). All systems and services should be structured in such a way that they do not create barriers to participation, learning and development.
1.3. Current Situation

1.3.1 Status of services for children with disabilities after 14 years of democracy

The large scale policy reforms of the nineties emphasised access, equity and equality. Access to basic health and education services for all children became the main priorities and the language of equal opportunities and rights-based approaches became prevalent in all government and non-government initiatives.

In spite of large scale reform in government policies, systems and programmes, services to children with disabilities still remain fragmented and unequal. Government Departments still work in silos and services are not coordinated. The South African Human Rights Commission (SAHRC) reported that the implementation of the Integrated National Disability Strategy (INDS) by government is “disappointingly slow”. Specifically, the systems to identify learners with disabilities at birth or as soon as the health condition or impairment appears or is noticed, and track their progress through early childhood on to school going age are sadly deficient. Many children who grow up in poor socio-economic conditions are never assessed with a view to planning and designing early intervention and appropriate support for them in a structured and coordinated way. The only assessment that is carried out is to determine eligibility to receive social grants. Within a social model, it would therefore also be inappropriate and insufficient to merely assess and classify persons with disabilities according to the category and severity of their disability. The traditional medical diagnostic approaches can no longer be used in isolation to organise and fund support services for children with disabilities. The context in which a child lives and learns must also be taken into account.

The education system currently fails to provide sufficient access to basic education for learners with disabilities. A study conducted by the Nelson Mandela Foundation (NMF) on the educational status of children in rural communities points out that children with disabilities are a large group whose needs generally go unnoticed. Widespread biases and exclusionary practices affect the educational possibilities of boys and girls who have disabilities. A large percentage of children with severe and profound disabilities stay at home,
placing an additional burden on the family because of their need for full-time care and preventing the mother from going to work. Many families are forced to pay for day care and even school hostels from the social grants received by their children.

Sufficient and appropriate school placements are not available to disabled learners representing a failure to fulfil the Constitutional mandate that guarantees access to quality basic education for all children. The limited number and capacity of special schools in rural areas makes children with disabilities travel far from their families in order to access education. This leads to a failure to equip a substantial number of our children with skills to be fully integrated into society and contribute productively in the economy. It leads to considerable unnecessary burdens and economic pressures on parents and society.

1.3.2. Evidence informing the strategy

The generation of this strategy was informed by two direct research activities undertaken by the DSD:

(i) an audit report of national departments and Non-Profit Organizations on their roles and responsibilities in the delivery of services to children with disabilities

(ii) a desk top study on the Social Needs of People with Disabilities conducted during the period 1995-2006 in Gauteng, KwaZulu-Natal, Limpopo and Mpumalanga provinces

The results of these studies are used as a guideline for the national status of service provision for children with disabilities in South Africa. The main findings are summarised below:

1. Children living in poverty or disadvantaged areas are more at risk of having a disability.
2. Children between birth and 10 years of age born in rural areas are twice as likely to have multiple disabilities. The provinces of the Eastern Cape and
Kwa-Zulu Natal have a higher childhood disability prevalence rate than the other provinces.

3. Children with Disabilities continue to experience discrimination at all levels of society. They are excluded from mainstream services that are relatively more resourced, less costly and within reach. These services are not accessible due to physical structures, communication barriers, negative attitudes and inexperienced service providers and partly due to difficulties in obtaining a birth certificate and an identity document.

4. In Limpopo province, a situational analysis found that children with intellectual impairments, severe and multiple disabilities are the most marginalised and receive least support and access to services.

5. Currently only 1.36% of children with disabilities attend Early Childhood Development centres.

6. A high number of children with disabilities do not receive care dependency grants although they may be technically eligible through the financial means test. In Mpumalanga province, 43% and in Gauteng less than a half of children with disabilities do not receive a care dependency grant. Children with disabilities do not access services (mainly educational and rehabilitation) despite policies on their rights being in place, and the roles and responsibilities of departments.

7. Rehabilitation services are not integral to primary care programmes and remain largely a specialised service at tertiary level. The current service provision highlights deficiencies and gaps where, for example, free health services for children under 6 years of age, do not include provision of assistive devices.

8. There is no specific budget for children with disabilities. Each department is given a budget and this must include services for children with disabilities. Although this assists in the integration of children with disabilities into the mainstream services, it can also mean that these children with special needs are neglected as they do not have a specific focus or budget.

9. There is inadequate data on children with disabilities to inform programme planning.

10. There is poor collaboration between government departments to ensure, for example, that children with disabilities and their caregivers have access
to accessible transport that is also affordable and convenient. This was reported in studies in the Ingwavuma district of KwaZulu Natal and Orange farm, Gauteng as a major obstacle and was therefore needed in the district for accessing services.

1.3.3. Prevalence of childhood disability

Currently, there is little consensus on the prevalence of childhood disability. The prevalence rates for children with disabilities ranges from 2 to 6% of the population as indicated in the Table 1. The South African National Census Report of 2001 indicated that there were 4.9 million children in a total population of approximately 44 million. A community survey carried out by STATSSA in 2007 has data available on disability, but is not disaggregated for children, making it difficult to use the data. The few national sources of data currently available vary in the estimation of the number of children with disabilities as shown in Table 1 below\(^{13}\). The large variations between the national and local studies are generally as a result of a self-report versus confirmed methodology as well as different wording of questions.

<table>
<thead>
<tr>
<th>Area of study</th>
<th>Age of children</th>
<th>% of population (reported)</th>
<th>% of population (confirmed)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>0-9</td>
<td>2.1 (males=2.2, females=1.9)</td>
<td>-</td>
<td>Census 2001,(^{14}) Stats SA 2005</td>
</tr>
<tr>
<td>National</td>
<td>10-19</td>
<td>3.0 (males=3.2, females=2.9)</td>
<td>-</td>
<td>Census 2001 Stats SA 2005(^{14})</td>
</tr>
<tr>
<td>National</td>
<td>0-5</td>
<td>1.6</td>
<td>3.3</td>
<td>CA S E survey 1999(^{15})</td>
</tr>
<tr>
<td></td>
<td>6-10</td>
<td></td>
<td>4.5</td>
<td></td>
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<tr>
<td></td>
<td>11-15</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>16-20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kwa-Zulu Natal-Ntuze</td>
<td>2-19</td>
<td>3.8</td>
<td>3.3</td>
<td>James Irlam(^{16})</td>
</tr>
<tr>
<td>KwaZulu Natal-Manguzi</td>
<td>0.9</td>
<td>8.3</td>
<td>6.0</td>
<td>J Couper(^{17})</td>
</tr>
<tr>
<td>Bushbuckridge</td>
<td>2-9</td>
<td></td>
<td>6.4</td>
<td>Kromberg, Christianson(^{18})</td>
</tr>
</tbody>
</table>

The Census 2001 and other data suggested that there were more male children with disabilities\(^{14}\). The CASE study\(^{15}\) also established that disabled children living in rural areas were twice as likely to have more than one type of impairment as
those living in urban areas. Fifty nine percent (59%) of rural children had three or more disabilities compared to 24% of urban children. In addition, the disabilities of children living in rural areas were more severe than those in urban areas. However, there were more children with disabilities living in urban areas than in rural areas, which may be related to more known children with milder impairments in the urban areas. Of all the children with disabilities in the age range 0 – 5 years, 43% had 3 or more impairments, 26% had two impairments and 31% only one. This suggests that the children who were identified as disabled in the young age group (0-5 years) tended to have multiple impairments with greater severity. This is not surprising as reporting of disability is easier when a condition is visible and severe in its effects. Mild and moderate disabilities are more difficult to identify early. The prevalence of childhood disability increases with age as seen in Table 1.

Prevalence rates are available for children based on their different impairments, but more recent figures are not available. The report on the Situational Analysis of Children in South Africa (The Presidency, 2009) indicated that, for all children with disabilities, reported cases for visual impairment was the highest (36%), followed by hearing impairment (22%), physical impairment (16%), mental and multiple impairments (5%). South Africa has a high prevalence rate of children with cerebral palsy (10 per 1000), with birth related trauma (a preventable cause) being one of the main causes and intellectual impairments being the most common outcome (Couper, 2002). There was a prevalence rate of 15 per 1000 (Bushbuckridge) and 17 per 1000 (KwaZulu Natal-Manguzi) for mild intellectual impairment, and 7 per 1000 respectively for children with severe intellectual impairments under 9 years. Hearing impairment also had a high prevalence rate (39 per 1000) in the Manguzi study due mostly to chronic ear infections, which is a preventable cause of childhood disability.
Limited literature is available on the impact of HIV and AIDS on the prevalence of children with disabilities. Children with HIV and AIDS experience difficulties in their development, including learning abilities. This has a negative impact on increasing the prevalence of childhood disability with a consequent increase in the need and demand for services from the various sectors.

Planning for services without more current prevalence rates for disabilities in children is therefore a major challenge, compounded further by poor systems of data collection on the number of children receiving services. The development of effective data collection platforms should happen in tandem with the development of services as described in this strategy.

1.3.4. Causes of childhood disability

Causes of childhood disability are categorised as **before birth** (prenatal: e.g. genetic; infection, injury and abuse of alcohol or other substance during pregnancy), **during birth** (perinatal: e.g. birth trauma) and **after birth** (postnatal: e.g. malnutrition; illnesses; injury). In some cases no known causes can be found. Preventable causes of disability have been estimated to be up to 40% \(^{19}\), implying that preventable measures can reduce the incidence of childhood disability greatly, especially with regard to antenatal care; improving women’s health services; and addressing environmental and social circumstances (e.g. foetal alcohol syndrome of the Western and Northern Cape).

- Up to 40% of causes of childhood disability are preventable
- There is no policy on the prevention of childhood disability (to date) and therefore no coherent disability prevention programmes
- Children living in disadvantaged areas, are more likely to have a preventable disability

1.3.5. Silo approach to service delivery

The primary national and provincial departments who provide direct services to children with disabilities are DSD, DoH, DoBE, while DoT, DHS, DoJ&CD, DSS and DoHA (amongst others) have policies relating to disability, but depend on more local level public participation for implementation, coordination and monitoring of services through the various actors. However, figure 1 illustrates the main service departments for children with disabilities. Programmes within DoH and
DoBE are listed, while for DSD the **levels of intervention** are given with actual programmes bulleted below the levels. DSD has **PREVENTION** as a level of intervention with awareness and educational programmes falling under this level. Prevention within DOH is one pillar of the Primary Health Care (PHC) package including other services for integration within the e.g. genetic and mental health care services. This highlights the need to develop a common understanding of levels of intervention and programme development within and between the different government departments as a starting point.

Programmes, projects and activities which aim to improve the quality of life of children with disabilities are still found to dominate within the sectors that initiate them, with little integration across departments to make a meaningful impact. At best, there may be inter-referrals between professionals across the sectors, but the overall institutional context has not undergone any structural changes and does not facilitate integrated service delivery. The recent ECD strategy has been the most positive initiative to coordinate and integrate the specific educational and developmental needs of all children, but with little attention given to the needs of children with disabilities.
1.4. Rationale for an integrated strategy

In response to the abovementioned realities and in the absence of a coherent approach to the delivery of support services to children with disabilities as a group of children who have not enjoyed the same rights and opportunities as their counterparts, the call to develop an integrated national strategy becomes a crucial and probably the most urgent need in the life of any child with a disability in South Africa. The rationale for an integrated strategy is therefore to:

1. Serve as a guide for the development and implementation of all Government frameworks on Children with Disabilities
2. Serve as an inter-sectoral collaboration mechanism to mobilise resources for service provision
3. Integrate and align all budgets related to Children with Disabilities
4. Ensure the implementation of the Children’s Act (No. 35 of 2005), as amended
5. Implement the research findings on the needs of Children with Disabilities
6. Address barriers faced by children with disabilities in service delivery
7. Outline family and community based services without exclusion of alternative care where it is required in the best interest of the child
8. Create an enabling environment in order to prepare children with disabilities to become independent adults
9. Facilitate developmental programmes in order to support families and children who are vulnerable, including children with disabilities living in poor and rural areas and to reduce dependency on disability grants
10. Target age group is based on the Children’s Act (0-18 years)
LEGISLATIVE FRAMEWORK

The South African legislative framework for children with disabilities is one of the most enabling in the world.

2.1 International context

International actors in the field of development work, human rights and child protection have influenced states to adopt the rights-based approach in framing policy content aimed at improving the lives of all children. The adoption of the United Nations Convention on the Rights of the Child in 1989 introduced a new era for all children globally, recognising that children also have rights. The four core principles of the Convention are:

- non-discrimination
- devotion to the best interests of the child
- the right to life, survival and development
- to participate fully in family, cultural and social life

The Convention goes further by specifically emphasizing that children with disabilities should enjoy a full and decent life in conditions which ensure dignity; promote self reliance and active participation in society.

In 2006, the rights of the disabled child were further recognised through the ratification of the UN Convention on the Rights of Persons with Disabilities, which replaces the ‘Standard Rules on the Equalization of Opportunities for Person’s with Disabilities’ of 1993. The 2006 Convention contains a number of articles outlining the rights of children with disabilities. Mainstreaming of disability issues is
emphasized in Article 4.1.(c) of the Convention which states that: ‘Parties undertake to take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes’. According to the Convention, mainstreaming of disability issues is recommended to cover a wide institutional framework ranging from Human Rights Councils to Census data and sectoral policies.

2.2. National policy and legislative framework

While South Africa ratified the Convention on the Rights of the Child (CRC) as well as the Convention on the Rights of Persons with Disabilities (CRPD) more recently, the Constitution of RSA (Act No. 108 of 1996) and the White Paper on an Integrated National Disability Strategy (INDS) of 1997, represents two historical milestones for people with disabilities immediately post 1994. In response to the INDS, various government departments reviewed their policies towards a more inclusive approach for people with disabilities. Currently, South Africa is reported to have developed the most progressive and comprehensive policies towards an enabling, rights-based framework for people with disabilities. Children with disabilities are regarded as a particularly vulnerable group in South African society, and therefore targeted specifically for social protection measures. One of the most enabling policy instruments for all children, specifically the most vulnerable, is the recent Children’s Act (No. 35 of 2005), as amended which replaced the Child Care Act of 1983.

The planning and development of all strategies and programmes for children with disabilities are required to be aligned to the basic principles entrenched in both the international conventions: CRC and CRPD. The Children’s Act (No. 35 of 2005), as amended and the Promotion of Equality and Prevention of Discrimination Act have led the way giving effect to the rights of children as contained in the Constitution, mandating various government sectors to fulfil the obligation in meeting these rights. Following these developments, the mission of South Africa’s National Programme of Action for Children is clear in its intentions for all children as well as for children with disabilities, namely:

- To advance the best interests of children in all matters affecting them
- To promote and enable the realisation of children’s rights to survival development, protection, and participation
To mobilise resources at all levels

The Social Assistance Act (No 13 of 2004), has enabled children with disabilities to receive social transfers, thus equally acting as an important social protection measure. Section seven of this act, together with the Social Assistance Regulations of 2008 makes provision for a child with a disability through the Care Dependency Grant (CDG) under the criteria below. If a child with a disability is not eligible for a CDG, they do remain eligible for foster care grants and the child support grant. A disabled child is only eligible to receive one of these grants at a time.

Criteria for eligibility to the CDG:

- The applicant and child must be resident in South Africa at the time of application for the grant
- The applicant must submit a medical/assessment report confirming that the child due to his or her disability requires and receives permanent care or support services
- The care-dependent child/children must not be cared for on a 24 hour basis for a period exceeding 6 months in an institution that is funded by the State

Several other legislations also impact on this strategy, since they make direct or indirect reference to the rights of all children, which would include children with disabilities. These are listed below:

- Sexual Offences and Related Matters Amendment Act (Act No. 32 of 2007)
- Film and Publication Act, 1996 (Act No. 65 of 1996)
- Child Justice Act 2008 (Act No. 75 of 2008)
- SA Schools Act, 1996 (Act No. 84 of 1996)
- Criminal Procedure Act, 1977 (Act No. 51 of 1977)
2.3. Applying the legislative framework to children with disabilities

In applying the international and national legislative framework to children, a number of critical shifts are required in how services to children with disabilities are to be contextualised, namely:

- An emphasis on their rights – their right to protection, development and participation in society
- The equalization of opportunities for children with disabilities through the provision of additional support so that they can realise their full potential; to enjoy a full and decent life in conditions which ensure dignity, promote self-reliance and active participation in society
- The acknowledgement that disabled children should, as far as possible, have a say in decisions which affect their lives and should no longer be seen as passive recipients of welfare

Table 2: Understanding the shift towards a rights-based approach for children and specifically children with disabilities

<table>
<thead>
<tr>
<th>Other Approaches</th>
<th>Rights-based Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action is voluntary or optional</td>
<td>Action is mandatory</td>
</tr>
<tr>
<td>People have needs which should be met, and these needs can be prioritised</td>
<td>People have legally established claims and entitlements</td>
</tr>
<tr>
<td>Poor people deserve help as the object of charity</td>
<td>Poor people are entitled to help as the subject of rights</td>
</tr>
<tr>
<td>Some people may have to be left out (i.e. a target can be less than 100%)</td>
<td>All people have the same right to fulfil their potential and should be assisted to do so (i.e. the target is 100%)</td>
</tr>
<tr>
<td>People affected by development work are passive beneficiaries; they can be invited to participate in order to improve the effectiveness of programmes or projects</td>
<td>People affected by development work are active participants by right</td>
</tr>
<tr>
<td>Some needs may not be recognised in some cultures</td>
<td>Rights are universal and inalienable, they cannot be diluted or taken away</td>
</tr>
<tr>
<td>Power structures are too difficult to change and pragmatic ways need to be found to work within them</td>
<td>Power structures that block progress in realising human rights must be effectively changed</td>
</tr>
<tr>
<td>Development is a technocratic process and should be led by technical ‘experts’ who know best</td>
<td>Development actors must empower rights holders to claim their rights and be involved in public decision-making</td>
</tr>
<tr>
<td>There is a ‘hierarchy’ of needs and some needs are nearly always more important than others</td>
<td>Rights are indivisible and interdependent, though in any situation some practical prioritisation may be required</td>
</tr>
</tbody>
</table>
2.4. Impact of legislative process on definitions and terminology

The use of terminology often reflects the attitude of service providers towards children with disabilities. To depart from the medical deficit views of disability, it is critical that inappropriate terminology should be abolished and replaced with terminology that reflects a social rights position (see Terminology Appendix).

The Broad Definition of Disability as approved by Cabinet in 2005 underlines this approach:

“Disability is the loss or elimination of opportunities to take part in the life of the community, equitably with others that is encountered by persons having physical, sensory, psychological, developmental, learning, neurological or other impairments, which may be permanent, temporary or episodic in nature, thereby causing activity limitations and participation restrictions within the mainstream society. These barriers may be due to economic, physical, social, attitudinal and / or cultural factors”

The narrower definition of disability given below was approved by Cabinet in 2005 for the specific purpose of determining eligibility for the Disability Grant and Free Health Care at hospital level:

“Disability means a moderate to severe limitation in a person’s ability to function or ability to perform daily life activities as a result of a physical, sensory, communication, intellectual or mental impairment”

The Convention on the Rights of Persons with Disability (CRPD, 2006) takes the terminology debate one step forward by standardising the terminology to be used. Article 1 defines persons with disabilities as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

2.5 Applying the Children’s Act to children with disabilities

This Act provides the primary legal framework for the realisation of every child’s right to social services, parental care, family care and appropriate alternative
care and protection from abuse and neglect. Following the amendments, it specifically recognises the special needs of children with disabilities. The provisions made in the Children’s Act (No. 35 of 2005) as amended, impact on several key service provision areas, requiring an intersectoral approach for successful implementation. Specific sections of the Act are referred to in appendix C. While all children have the right to survival, protection, development and participation in society, children with disabilities require additional support, services and technical expertise in order to realise these rights and utilise the opportunities provided to fully participate in all family and community life.

**Right to life.**

The right to life is to be recognised and promoted especially within the context of the high infant mortality and the under five mortality rates in South Africa. While this applies to all children, some children are found to be particularly at risk. These include children infected and affected by HIV & AIDS as well as children with disabilities, compounded further by spatial factors, where children from rural or poorly resourced areas are more vulnerable. These contextual factors emphasize the fact that for vulnerable children, the basic right to survival needs to be addressed before considering interventions in reaching their full potential, as the Act states.

**Right to standard of living and to benefit from social security**

One of the specific purposes outlined in the Act is “to develop appropriate parenting skills and the capacity of parents and care-givers to safeguard the best interests of children with disability” (Clause 144 1 (c)). Children with disabilities are often found to be neglected, malnourished or not able to participate fully in family and community life. Stating the right to a decent standard of living for children with disabilities implies adequate access for the child to food, clothing, shelter, safety and health through income that parents or caregivers obtain, either through work or through social assistance in the form of cash grants from the government.

**Protection from abuse.**

Children with disabilities become helpless and are the most vulnerable when faced with violence and sexual abuse. Although there is a lack of data for South
Africa, the patterns in other countries are that children with disabilities are abused more than those without disabilities. Children with disabilities in South Africa may be treated with equal protection but there is limited access for children with disabilities to the courts. Legal professionals are less likely to consider a child with a disability as a reliable witness. Abuse has been reported both within families as well as within institutional facilities. Children who are deaf and those with intellectual disability are reported to be most vulnerable.

**Right to education**

The Children’s Act (No. 35 of 2005) as amended, indicates that funding must be prioritised to make ECD programmes available to children with disabilities (clause 93(4)(b)). National norms and standards stress that programmes must be appropriate for all children, including those with disabilities (clause 94(3)). The Inclusive Education Policy has made great strides in improving access to education and the provision of educational services. However, there are still a significant number of children with disabilities who do not attend both mainstream ECD centres and schools or specialised schools. They remain undetected by the education sector, which stipulates that all children from the age of 7 years are legally bound to attend a school. The right to education can only be realised with accurate data on school enrolment and on the prevalence of childhood disability.

**Right to healthcare**

The National Health Act (No: 61 of 2003) provides for the conditions under which vulnerable groups such as pregnant women, children under 6 years of age, older persons and people with disabilities are eligible for free health care services, at all three levels of health care provision, i.e. primary (clinics and health centres), secondary (district hospitals) and tertiary levels (specialist hospitals). Appropriate health care services depend on the level of care including preventative, curative and rehabilitative services with access to assistive devices. There are several administrative measures required to ensure that all vulnerable groups have access to these services.

A mother replied to a health care worker when asked about her malnourished child with a disability, “If you only had food for one child, which child would you feed, the one with or without a disability?”
THE STRATEGY OUTLINED

The commitment of Government to increase momentum and ensure appropriate service delivery to children with disabilities will be strengthened through integration, alignment and coordination of all current strategies.

3.1 Vision and principles of the strategy

This strategy sets in motion the combined efforts of all those service providers in the care, protection and well being of children with disabilities, to move from policy statements towards an integrated, coordinated and efficient system of service delivery within the short, medium and long term, in order to develop all children with disabilities to become active and respected members of an inclusive society.

The principles of the strategy are:

- Children with disabilities have inherent dignity and have a right to survival and development to their maximum ability like their non-disabled counterparts
- In all interventions and any services planned and implemented for children with disabilities, the best interests of the child will be ensured
- Children with disabilities should enjoy on an equal basis with other children their human rights, fundamental freedoms and full participation in their communities
- Children with disabilities should be respected for being different and accepted as part of human diversity and humanity. The acceptance should be promoted among their non-disabled counterparts
- There is a need for ongoing promotion of self representation and participation of children with disabilities, parents and care givers in all
decision making processes affecting them. They have a right to have their views heard and taken seriously

- Respect for the evolving capacity of children with disabilities and respect for the right of children with disabilities to preserve their identity
- Children with disabilities have a right to be part of their families, and the society into which they were born and are entitled to parent care. They should receive alternative care when the family environment is not conducive
- Children with disabilities should have access to basic education and developmental opportunities
- Children with disabilities should enjoy civil rights such as identity including nationality and name, freedom of association and expression
- Equitable allocation of resources: All resources available to other children should be equally and equitably available to children with disabilities

3.2. Aim and objectives

3.2.1. Aim

This strategy aims to improve the quality of life of all children with disabilities in the South African context by creating an enabling environment within which they can have access to equitable, affordable and quality services as a prerequisite, achieve independent functioning, enjoy a full and decent quality of life in conditions which ensure dignity, promote self reliance and active participation in society.

3.2.2. Objectives

- To strengthen inter-sectoral collaboration between government departments for effective and efficient use of resources in the provision of services to children with disabilities
- To ensure that the legislative mandates which have intersectoral implications are realised
- To ensure alignment and integration of key legislative provisions, national policies and services for children with disabilities
- To ensure that the strategy serves as a guide for the implementation of all Government frameworks regarding children with disabilities
• To facilitate service responses to the research findings on the needs of children with disabilities
• To increase access to services and opportunities for development by addressing the barriers faced by children with disabilities in all spheres of life

3.3 Scope of the strategy

The target group for the strategy is children with disabilities between the ages of 0 to 18 years as stipulated in the Children’s Act (No. 35 of 2005), as amended. While the chronological age of 18 years has been stipulated in the Act as 18 years, consideration must be given to children with disabilities who are older but who function at a lower age. In this regard, the majority age of children with disabilities who can benefit from this strategy is recommended to be 21 years.

The main focus of the strategy will be to:

• Address the needs of children in need of special care and support
• Address the needs of children in especially difficult circumstances
• Mainstream and integrate issues related to children with disabilities in all government programmes and service delivery
• Address gaps and barriers experienced by children with all types of disabilities and those with disabling chronic illnesses in accessing government and other services
• Explore areas for service specialisation for children who need special care and support and who are not able to access mainstream services due to their disability
• Propose poverty alleviation measures which will improve future sustainable livelihoods for children with disabilities
• Increase access for disabled children to the care dependency grants
• Improve service delivery in rural and under developed areas
• Outline community based services that will enhance integration of children with disabilities

3.4 Components of the strategy

There are five components or thematic areas, which are directly related to the international and national legislative guides and areas of service delivery. These
five components, which become the strategic areas of focus of this strategy document, are outlined below:

i. Survival and well-being
ii. Childhood Development
iii. Protection
iv. Participation
v. Mobilisation of resources

3.4.1 Strategic area 1:

| Ensuring the right to survival and well-being of all children with disabilities and promoting their best interests in order to reach their full potential within the family, community and society |

Prevention of childhood disability

In ensuring the right to survival and well-being of children who are at risk for childhood disability, a specific understanding of causes of impairment and disability prevention programmes is required. A distinction between impairment and disability is made in appendix A under “Terminology”, which influences the approach and types of services provided. The planning and provision of appropriate services has the potential to reduce the risk and ultimately the incidence of childhood disability. Programmes designed specifically for the prevention of impairments and disabilities should be prioritised in service delivery. The DoH for example, through its Expanded Programme on Immunisation (EPI) has been integral in preventing disabling conditions and reducing the risk of disability for all vulnerable children. At all levels of prevention, the public must be made aware of both social and medical causes of childhood disability.

The lack of coherent policy on the prevention of disability however, demonstrates that the focus is more curative rather than preventative. The prevention of childhood disability is not necessarily the absence of impairment but the well being and promotion of health of all children. As was noted in the previous chapter, poor information and national data on the prevalence of childhood disability demonstrates the need to identify population groups who are at risk or
have higher childhood prevalence rates of disability in order to develop integrated programmes across all sectors, based on need.

Research is recommended on the causes of childhood disability to inform prevention programmes. Some causes of childhood disability may be related to the mental and physical well being of mothers during pregnancy, ante natal care, and infectious diseases. Genetic abnormalities in children are also one of the causes of childhood disability. Social causes of childhood disability are not to be ignored; substance and alcohol abuse in pregnant mothers is a social cause of intellectual disability in children (Foetal Alcohol Syndrome); child abuse and violence lead to trauma and mental health conditions. Road traffic accidents are another major cause of death and disability, compounded by substance abuse. There is a need for collaboration between the different sectors to focus on prevention and awareness programmes in reducing the risk and incidence of childhood disability.

The goal of prevention services is:

- To identify the primary causes of disability, using both a medical and social approach.
- To prevent secondary disability through early identification, treatment and intervention services. This includes the prevention of discrimination and negative attitudes towards children with disabilities.

**Promotion of general well being of children with disabilities**

The promotion of general well-being of children with disabilities has many dimensions, with emotional, intellectual, mental, physical and social well-being at the core. Activities which encompass these dimensions of well-being again cut across all sectors in the provision of services. DoH, DSD and DoBE are the primary service providers, while other national departments, for example, Transport, Sport and Recreation, Arts and Culture, as well as services at Local Government level and the NGO’s contribute towards the promotion and well being of children with disabilities. At all levels, and within all sectors, intervention depends on the early identification of children with disabilities. Together with preventative measures, health promotion, advocacy to reduce levels of stigmatization, access to basic
health and education and a safe living environment are regarded as primary factors to promote general well-being.

Direct or indirect discrimination against children with disabilities in society has an impact on children reaching their full potential. The active participation of children with disabilities in mainstream awareness programmes forms part of the role and responsibility of each government department. An incremental approach is used to identify a sufficient budget allocation for these awareness programmes, thus ensuring that children with disabilities access mainstream services. Physical barriers (inaccessible buildings), lack of information (unavailability of Braille) and other barriers (negative attitudes, unavailability of assistive devices, inaccessible curricula) limit the full participation of children in mainstream activities, however if identified they can be solved using an integrated approach.

Children with disabilities are encouraged to represent themselves on issues that affect them, for example, information on the management of their own disability. All children including children with disabilities should have access to age appropriate information on issues of:
- sexual and health education
- abuse (physical, sexual and emotional)
- domestic violence
- substance abuse
- HIV and AIDS

Children with disabilities need encouragement and continuous capacity building to ensure confidence in self representation and understanding their rights, which ultimately will assist them to interact with mainstream society and enhance their independence.
3.4.2 Strategic area 2:

Facilitating and ensuring optimal development of all children with disabilities through the provision of mainstream services as well as specialised services within an inclusive society

**Early identification and intervention**

The benefits of early identification of children with disabilities have been well documented. All service providers are obligated to plan and design programmes that are able to screen children for developmental delay and implement appropriate interventions. Early intervention programmes are hugely beneficial to the young child and reduce the complications of disability.

Within the health sector, early identification of developmental delays are signs of impairment in children between 0-4 years of age, which could lead to a disability. Developmental delays should be detected at PHC level, alongside immunizations and well baby programmes. Many children with impairments are not identified at primary level, or if identified, get lost in the system due to poor referrals and follow-up at the secondary and tertiary levels of health care.

Children with disabilities as well as those children who are at risk (e.g. through injury, disease, poverty) between 5-15 years of age, should also be able to access services as early as possible in order to reduce the impact of secondary disabilities. The DSD is responsible for ECD centres and thus can identify early learning and other difficulties. The DoBE, through its foundation, intermediate and senior phases at the basic level of education, becomes the primary role-player in early identification and intervention for difficulties of a school going child, together with supporting services from Health and Social Development.

Early identification does not only refer to young children but also to the identification of problems that occur or manifest later in a child’s life. It is critical that systems are in place to identify symptoms of mental health problems as early as possible so as to take preventative measures. Young children and adolescents are extremely vulnerable to depression and other mental health disorders, which if identified early can be treated. All children who have been victims of abuse,
substance abuse and other forms of emotional trauma need to have access to counselling services, life skills programmes and peer counselling. Measures must be taken to ensure equal access to these services for children with disabilities who cannot represent themselves. The Mental Health Care Act (No 17 of 2002) emphasises a holistic, integrated and community-based approach at primary, secondary and tertiary levels.

Successful early identification programmes therefore depend on an integrated and efficient referral system across the different sectors. Rehabilitation services form an integral part of early identification and intervention but if these services continue to be viewed and delivered as a specialised service as evidence-based research demonstrates, they compromise the goal of equitable and efficient service delivery. In addition, these services then remain only accessible to a few, impacting negatively on service delivery where scarce public resources are wasted, fragmented or duplicated.

**Parenting skills, parent mobilisation and empowerment**

Children with disabilities and their families need access to community programmes of empowerment and life skills training that will enable them to function optimally within society. Parents of deaf children should be supported in attaining skills in Sign Language; parents of children with severe and profound disabilities should be linked to community based poverty alleviation programmes and other forms of support such as respite care services or support from other families. There is a continuous need for parental programmes in order to assist the families to handle the challenges they face. Psychosocial intervention is aimed at an individual, family or a group of people who experience trauma or any serious change in their life situation. Without such ongoing support, families may run the risk of breaking down or remaining maladjusted.

**Habilitation and rehabilitation**

Rehabilitation (including habilitation) offers support to a child with a disability with the ultimate aim of “attaining and maintaining maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life”. To this end government should “organise, strengthen and extend comprehensive habilitation and rehabilitation services and programmes.
particularly in the areas of health, employment, education and social services.” (Refer to appendix C)

The ‘medical’ and ‘social’ rehabilitation models should not be seen as separate approaches. Combining both these approaches is evident when viewing the child with a disability as a whole and managing all his/her needs, to ensure inclusion into a family and community. Habilitation and rehabilitation involve several processes - assessment, intervention and reassessment. It is most beneficial if delivered through multidisciplinary teams that can assess individual needs and strengths as early as possible and take the necessary steps to enhance participation and inclusion in the community and all aspects of society. The role of midlevel workers in extending coverage of habilitation and rehabilitation services has been a positive experience in many resource-constrained areas. These services must be available to children with disabilities as close as possible to their own communities, including in rural areas.

All relevant departments must promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services. They must also promote the availability, knowledge and use of assistive devices and technologies, designed for children with disabilities, as they relate to habilitation and rehabilitation. While the training of midlevel workers has been included in many policy documents for disability and rehabilitation, there is a need for consensus on the way forward to facilitate integrated services with a focus on the primary or local levels of service delivery.

**Appropriate assessment of individual needs and strengths**

The main aim of any assessment is to obtain information in order to intervene appropriately. Assessing children with a disability involves understanding and measuring each child’s ability, potential, attitude, opinion, interest, knowledge and personality. The assessment not only focuses on a child’s ability to care for him/herself, move, see, hear and learn but to participate in play with other children and in the community. The process of assessment should be guided by sound principles with the child and the parents being central and having the right to all information about the process.
Historically in South Africa, people with disabilities have been given labels or categorized into ‘boxes’, due to the method of assessment. This has resulted in discrimination and negative attitudes towards people with disabilities making it difficult for them to reach their full potential. Assessment also did not go hand in hand with the planning and provisioning of support, but more often led to exclusion and segregation.

Assessment for support must be seen separately from assessment for planning of resources and funding of services. Within the DOH, the International Classification of Functioning, Disability and Health introduced a biopsychosocial model of assessment which took into consideration not only the extent to which the impairment limits functioning, but the impact of contextual factors and how these need to be taken into consideration when determining levels and nature of support needs. The assessment and classification system directly informs decisions on the type of intervention programme to implement in order to minimise the barriers to participation in family and community life. The assessment protocol introduced by the Department of Social Development to determine eligibility to receive social grants, has also been aligned to the ICF approach.

The National Strategy on Screening, Identification, Assessment and Support which has been developed by the DoBE for piloting in 2008 – 2009, is also in alignment with the ICF. The strategy is aimed at guiding the entire process of screening, identifying, assessing and supporting learners who experience barriers to learning, including those with disabilities. The strategy provides an approach that will guide role players to achieve a comprehensive support programme for learners and educators in order to ensure integration of children with barriers to learning at school. As indicated in the SIAS, there is a need for the ECD Centres, social workers or other social service providers to work closely with the District Based Support Teams giving special attention to the rural areas to facilitate proper assessments and referrals.

It is critical that all educators, social workers and health practitioners follow the same approach and protocols in the assessment of children to determine what would be the most appropriate support to provide. In the DoBE, the approach is to determine the level and nature of support needed rather than to classify the
severity of the disability for the purpose of making decisions about placement. In view of the fact that access to special schools should eventually be restricted only to learners with high and very high needs, the assessment is mainly aimed at determining eligibility for admission. That does not imply that children with high support needs must go to special schools. They can also be supported in their ordinary neighbourhood or full-service schools. Parents and teachers are seen to be central to the assessment and decision making process. Contextual factors such as family situation, transport, socio-economic status, etc. are all taken into account when planning appropriate support for learners. The emphasis is always towards support in a mainstream environment as first option. Table 3 is an example of assessing children with disabilities to determine the level and nature of support services (See full table in Appendix B).

Table 3  Assessment of children with disabilities

<table>
<thead>
<tr>
<th>Domain of activity</th>
<th>Severity of difficulty</th>
<th>Educational needs</th>
<th>Social and Health service needs (Care needs)</th>
<th>Physical / environmenta l needs</th>
<th>Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual functioning</td>
<td>Mild / moderate / severe</td>
<td>Support provided in a continuum of educational settings – ECD, inclusive, specialised and partial care</td>
<td>Early intervention, rehabilitation, parent advisory and respite care services, community awareness raising</td>
<td>Safe transport with supervision</td>
<td>Intellectual disability, including certain syndromes, autism, ADDH,</td>
</tr>
<tr>
<td>Lower body</td>
<td>Mild / moderate / severe</td>
<td>Support provided mostly in inclusive settings except in cases where full-time care is needed</td>
<td>Early intervention Rehabilitation appropriate mobility devices, Social services to families and children</td>
<td>Accessibility of buildings; home and public Accessible transport</td>
<td>Physical disability, Cerebral palsy, Quadriplegia Muscle weakness</td>
</tr>
<tr>
<td>Arm and hand use, dexterity</td>
<td>Mild / moderate / severe</td>
<td>Availability of educational devices and teachers trained in early intervention and support in inclusive settings</td>
<td>Early intervention and therapeutic services, social services to families and children, assistive devices</td>
<td>Environments compliant with principles of universal access</td>
<td>Physical disability, cerebral palsy, quadriplegia, syndromes with poor eye hand coordination</td>
</tr>
<tr>
<td>Social skills- communication</td>
<td>Mild / moderate /</td>
<td>Teacher support, alternative</td>
<td>Early intervention,</td>
<td>Inclusive signage,</td>
<td>Cerebral palsy, hearing</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>Communication skills and devices, translator (sign language)</td>
<td>Rehabilitation, assistive devices, translator assistance,</td>
<td>Impairment,</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------</td>
<td>-------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td><strong>Self care</strong></td>
<td>Mild / moderate / severe</td>
<td>Support for independence</td>
<td>Early intervention, Rehabilitation, Family support, Assistive devices</td>
<td>Cerebral palsy, Visual and Intellectual impairment</td>
<td></td>
</tr>
<tr>
<td><strong>Social skills - communication</strong></td>
<td>Mild / moderate / severe</td>
<td>Teachers skills and support, inclusive environment</td>
<td>Family support, social and life skills development, Assisted living</td>
<td>Safe, secure environment</td>
<td></td>
</tr>
<tr>
<td><strong>Community skills</strong></td>
<td>Mild / moderate / severe</td>
<td>Teachers skills and support, inclusive environment</td>
<td>Family support, social and life skills development, Assisted living</td>
<td>Safe, secure environment</td>
<td></td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Mild / moderate / severe</td>
<td>Teacher skills, access to assistive devices and adaptive technology, Braille materials, orientation and mobility training</td>
<td>Early detection, rehabilitation, assistive devices</td>
<td>Adapted roads and buildings</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td>Mild / moderate / severe</td>
<td>Teacher skills, hearing aids, assistive and adaptive technology, Sign Language interpretation</td>
<td>Early detection, rehabilitation, assistive devices, included in social activities</td>
<td>Visual signage cues</td>
<td></td>
</tr>
</tbody>
</table>

An overall score must be given to determine the intensity or extent to which the child has a **functional or activity limitation** across all domains (the category of disability can never be the sole determining factor). This score must always be considered in combination with the outcome of the assessment of **contextual factors** when decisions are made about the support that is required.

**Formal compulsory education in ordinary schools, in special schools and in ECD sites**

In order to meet the constitutional right to basic education, the inclusive education policy provides for children with disabilities of compulsory school going age, to have support in local mainstream schools. Only learners with very high needs will be admitted to special schools. The limited number and capacity of special schools in rural areas forces children with disabilities to travel far from their families in order to access educational services. Those who have multiple
disabilities experience more barriers. The education sector acknowledges the fact that barriers to learning need to be detected as early as possible so that they can be effectively addressed in order to avoid learning breakdown. Learners with permanent disabilities should have access to early intervention to ensure them optimal opportunity to develop their full potential.

Within DSD, emphasis has been placed on the early identification of children with disabilities through the legislative requirement of promoting ECD. According to the Children’s Act (No. 35 of 2005) as amended, ECD centres are aimed at promoting emotional, cognitive and physical development of children from 0 – 4 years (Tswaragano Kabane Programme) and also up to school going age. It is further indicated in the Act that ECD programmes must meet the needs of children with disabilities or chronic illness. Steps must be taken to train more ECD practitioners in skills to support and accommodate children with disabilities.

**Informal education – day care and stimulation centres**

Due to past discrimination in the mainstream, children with disabilities were taken care of in separate and informal facilities, called day care centres. The centres admitted children over a wide range of abilities. Even children with mild and moderate disabilities who could not cope well in mainstream facilities were admitted to these informal centres. In terms of the Children’s Amendment Act (No. 35 of 2005) as amended, these centres should be registered and funded as partial care facilities, provided they comply with certain standards. Many are however left without funding due to the absence of a comprehensive database. These centres must therefore be registered and funded according to the provisions of the Act. Admission to these centres must also be strictly controlled by the DSD and DoBE. No child attending an ordinary or special school should be refused admission and referred to a partial care facility without approval by the Head of the Provincial DoBE (South African Schools Act, 1996, Chapter 2, Section 4). A register must be kept of all children exempted from schooling.

Children with profound and multiple disabilities are eligible to be admitted to special care or stimulation centres. These centres are currently administered by both the DoH and DSD. There is currently no synergy between provinces regarding the provision of services in stimulation centres. In terms of the Children’s
Act (No. 35 of 2005) as amended (Section 79), these centres should be registered and funded, and stimulation and/or education programmes need to be jointly provided by the DoH, DSD and DoBE. Proposals that the centres should be linked to existing special schools as satellite centres, should be further explored so that children have access to structured curricula.

Children with mental health problems and intellectual disabilities also need to be identified early so that early intervention and prevention programmes can be made available. All children of school going age, including those that are identified at a later stage, should have access to education programmes even if these need to be delivered at psychiatric institutions. The DoH and DoBE should coordinate processes around the implementation of the Mental Health Care Act and its regulations.

**Special needs and services**

The special needs of children with disabilities should be met within mainstream services and in specialised facilities depending on the nature of the disability. The needs of children with disabilities are heterogeneous and diverse. For any effective mainstreaming to take place, the individual needs of children with disabilities should be understood. Special services can be indicated to meet the individual needs of children with disabilities if this is not possible within mainstream programmes. In some instances the specialised services are informed by the assessment criterion that is based on the classification of disabilities. Specialised services are therefore sometimes provided in groups for children who have similar disabilities.

**3.4.3 Strategic area 3:**

**Protecting the rights of all children with disabilities by ensuring that statutory and legal protection services are provided without discrimination**

**Social security**

Evidence based on research studies in Gauteng and Mpumalanga have estimated that more than 50% of children with disabilities are eligible, but do not receive a care dependency grant. This finding is specific to children with
disabilities, but is also supported on a broader level by findings from the Children’s Institute where studies were conducted on the child support grant.

Using the Dutyini Model which was piloted by the DSD, there is a need to expand efforts to establish a comprehensive database of children with disabilities who are beneficiaries of disability grants. Many children with disabilities receive a care dependency grant but do not access health, rehabilitation and educational services. Further recommendations include linking the database with access to services in order to monitor, the participation and progress of a children with disabilities.

**Community development and reintegration**

Social Security grants are not sustainable without linking them to the reintegration into family life and community development activities. The security of employment amongst adults who care for children is one of the factors associated with a sustainable reduction in childhood poverty and wellbeing. One of the recommendations is for parents of children with disabilities to be employed by ECD or day care centres where they can be both employed, as well as be with their disabled child. The DoL, DoH, DSD and DoBE should identify common employment projects in rural or target areas as an effort to improve the situation of poverty and reduce the dependency on social grants.

**Child protection: court services**

The NPF and Strategic Plan for the Prevention and Management of Child Abuse, Neglect and Exploitation indicate that Children with Disabilities are vulnerable to abuse and violence. Children with disabilities are not sufficiently accommodated in the child protection system. There is currently no profile or statistics for children with disabilities in the child protection system. Services in this system include court proceedings, implementing court orders for children in need of care and protection, which should include disability. The existing protocols should take into account investigation procedures and approaches when assessing children with disabilities to ensure that the court systems are friendly to these children. There is a need for information in this area to plan and design systems that include the protection of children with disabilities from abuse, and the successful conviction of perpetrators and listing of those who are unsuitable to work with children, as
stipulated in the Act under part B of the National Register. Children with disabilities are often unable or afraid to report abuse which can lead to them becoming victims of repeated abuse. Children with intellectual, communication and visual impairments have difficulty reporting the perpetrator and therefore require support from their family and community. In addition, service providers in this field such as probation officers, social workers, magistrates, commissioners including judges should be exposed to disability sensitivity training.

**Alternative care**

Children with disabilities who are vulnerable to abuse and neglect within the family setting and by primary caregivers themselves, need protection through statutory intervention and alternative care. There are a number of alternative care options for abused children with disabilities, namely:

- foster care
- group foster care
- child and youth care centres
- respite care
- partial care

These alternative care placements are also used for children with severe disabilities when the family are not able to cope and require temporary relief. Caring for a child with a disability requires additional support and resources to ensure optimal growth and development. Respite care services are provided by Child and Youth Care Centres, registered and funded according to the Children’s Act (No. 35 of 2005) as amended. Respite care services are another form of supporting parents of children with severe and profound disabilities by providing temporary relief for parents and care givers.

**Partial care**

Children with disabilities who do not have the support of their families are placed in the partial care programme. In terms of the Children’s Act (No. 35 of 2005) as amended partial care is a service provided through day or night care to more than six children, including those with disabilities, on behalf of their parents with or without any reward, for a temporary period. Children with disabilities who function independently should be integrated in the mainstream partial care
facilities. All the norms and standards for partial care facilities should take into account the needs of children with disabilities, for example, children with a communication or hearing disability require staff members to understand basic sign language. The service providers should be provided with training that will enable them to take care of and integrate children with disabilities into the stimulation programmes.

3.4.4 Strategic area 4:

Promoting the rights of all children with disabilities to participate within the family, community and society without discrimination

Integration and reintegration into family and community life

Article 23 of the CRPD outlines rights with regard to home and family. Families are a social institution and the building blocks of communities and societies. However, integration of children born with or who later acquire an impairment, into family and community life is complex. Efforts for integration and reintegration require planning, coordination and participation at the most local levels of society.

Firstly, young people with disabilities should have equal opportunities in all matters relating to relationships and should therefore have access to age-appropriate information such as sex education. Children and youth with disabilities should retain their fertility on an equal basis with others. In line with the Sterilization Act of 1998, no person with a disability may be sterilized without consent. Sterilisation should only be done on medical grounds and not for menstrual management purposes. Institutions should not make sterilisation a condition for admission to the facility.

The state should further ensure that children with disabilities have equal rights with respect to family life. With a view to realizing these rights, and to preventing concealment, abandonment, neglect and segregation of children with disabilities, government shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families. A child should also not be separated from his or her parents against his or her will, except when competent authorities, subject to judicial review, determine in
accordance with applicable laws and procedures, that such separation is necessary in the best interests of the child. In no case shall a child be separated from his or her parents on the basis of a disability.

Government should, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

Community workers, whether employed by DSD, DoH, DoBE, DCG&TA (Local Government), the NGO or private sector, in partnership with parents and family members all have the responsibility of facilitating and monitoring the process of integrating children into **mainstream community activities**.

SALGA, through its Disability Framework for Local Government (2009-2014), recognises its important role in this endeavour. Their framework sets out clear basic service delivery objectives of providing sustainable, accessible and affordable community services to people with disabilities. However, defining what these services are, apart from the basic services of access to all public facilities, may differ from community to community. This depends on access to information and the active participation of adults with disabilities, parents of children with disabilities and concerned citizens to make their voices heard in the provided spaces for public participation to improve service delivery, namely the Integrated Development Plans of Local Government.

**Prevocational skills, work training skills and life skills development**

In preparation for economic and social independence, children between the ages of 16 and 18 years should receive age appropriate life skills and be involved in programmes that will prepare and encourage their integration into the community. The curriculum offered to children with disabilities must have high expectations and support for attainment of the National Senior Certificate or the National Senior Certificate with Endorsement so that higher education levels can be pursued.

For children with moderate and severe intellectual disability or those who find it difficult to attain the National Senior Certificate or Grade 9, the curriculum should be adapted to emphasise transition-to-work content. Schools should in all cases
support learners to develop their full potential so that they eventually have the opportunity to work in the open labour market or become economically and socially independent by working in protective or sheltered employment.

The DoBE should develop assessment procedures which will lead to certification for learners who leave school at the end of the general education band. All youth with disabilities should be skilled in life skills, economic and labour rights and be able to relate to their contemporaries. Peer education programmes must be introduced to break down barriers between children and youth and dispel myths about disability.

**Assistive devices and technology**

For people with disabilities, participation in social life depends on the opportunities provided to function within the norms set by society. One of the ways this is possible is through the provision of appropriate assistive devices, which emphasize the person’s abilities rather than the disability. Children with disabilities require assistive devices, which are monitored throughout childhood as needs change, to facilitate optimal functioning and provide opportunities to interact on a social level. The current reality is that more than 50% of children do not have access to appropriate assistive devices to fully integrate into school and community activities. This situation can be improved if there are clear policies which regulate the budgets, procedures and supply of assistive devices and technology between the relevant departments, namely Health and Education.

a. Education related devices

One of the key prerequisites for reasonable accommodation of children in inclusive educational settings (as outlined in Article 24 of the CRPD) is to make available the devices which will facilitate their full and equal participation in all educational activities. Assistive devices and technology provide powerful mechanisms to overcome barriers to effectively access education.

The process of ensuring that children in both ordinary and special schools have access to the required assistive technology and specialised equipment, involves the following:
• Assessment procedures to assess which are the appropriate devices needed by individual learners and in classrooms
• Enough skilled professionals to oversee the assessment process – whether they are appointed in education, district offices, special schools or by DoH
• Clear procedures for procurement of affordable and appropriate devices
• Measures for the maintenance and repair of devices
• Guidelines for the effective use of devices in the education process, e.g. orientation and mobility training, use of assistive technology in curriculum planning, etc.
• Budgets for the ongoing supply of devices which are robust for local conditions and cost-effective – also looking at the development of locally produced equipment (Braille materials, Perkins Braillers, Braille production equipment, low vision equipment, alternative and augmentative devices, fine motor control equipment, classroom devices to maximise access for children with hearing loss, etc.)

b. Devices to support personal mobility and daily living

The CRPD (Article 20) further outlines the obligation of government to “take effective measures to ensure personal mobility with the greatest possible independence for persons/children with disabilities.”

These measures would include facilitating access to quality mobility aids, devices, and assistive technologies at affordable cost; training in mobility skills for children with disabilities and to specialist staff working with children with disabilities; encouraging the production of mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

Participation in leisure, arts, culture and sport activities

This is a grossly neglected area in service delivery for children with disabilities and deserves to be given individual attention. It is an expansion of the section on integration and reintegration into community life. The family, school, religious and cultural organisations operating within the communities need to review their policies and programmes to ensure all leisure, arts, culture and sport activities are inclusive of children with disabilities. Municipalities should support this by making facilities and amenities accessible to children with disabilities.
Article 30 of the CRPD not only emphasises the right of participating in mainstream arts, culture, sports and recreation but also the opportunity to organise, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources. The DoBE, DCA and Sport and Recreation should jointly be responsible for this area of service.

Awareness-raising

Government departments, local government and NPOs all have a role to play in awareness raising throughout society to foster respect for the rights and dignity of children with disabilities; to combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life and to promote awareness of the capabilities and contributions of children with disabilities.

3.4.5 Strategic area 5:

| Mobilising resources at all levels and from all sources both within and outside of government, to ensure that all children with disabilities can reach their full potential, given the support and protection they need |

Production, supply and utilisation of human resources

Professionals providing expertise in the assessment, care, treatment, and integration of the disabled child are collectively providing a rehabilitation service. Several professions thus contribute to the process of rehabilitation, the availability of which differs from province to province and facility to facility. The core rehabilitation team consists of the audiologist, community based facilitator, occupational therapist, physiotherapist, speech therapist, nurse and social worker, while doctors, psychologists, orthotists & prosthetists, remedial teachers, dieticians and individual medium therapists enhance the team to provide a more comprehensive rehabilitation service. An effective rehabilitation service depends on the availability and coordination of all the rehabilitation professionals.

These service providers are reported to be a scarce human resource within South Africa, and where available, are concentrated in urban areas. They continue to
work predominantly within the health sector, with some employed in education, despite the INDS stipulating the need to establish services within all service sectors. The establishment of posts within all sector departments should take priority if there is to be alignment of legislative frameworks and national policies with service delivery to people with disabilities. These posts should include opportunities for career mobility to attract and retain these scarce human resources. However, recruitment and retention of human resources is only feasible if the training of sufficient numbers of workers is also given due attention. In this regard, the DoH acknowledges the need for proper planning and setting of targets in the production of human resources for health through the National Human Resource Plan for Health, 2006. Within this context of human resources for the delivery of services to children with disabilities, the role of all categories of workers: managers, rehabilitation professionals, and community rehabilitation workers needs to be reviewed in line with the establishment of the mid-level worker, which is primarily aimed at improving coverage to all people in need of support services.

In providing strategic direction, together with the establishment of new roles and responsibilities and the broadened understanding of disability as a development issue, all service providers ranging from professionals, to administrators and community development workers need to undergo a reorientation in the field of disability. A sustainable approach is to review the current training curricula of all categories of workers and bring them into alignment with the needs of the majority of the South African population, especially in this case the needs of adults and children with disabilities.

**Financial Resources**

Dedicated financial resources to key service delivery functions for children with disabilities should be reflected in all targeted programmes both horizontally across the different sectors as well as vertically between all three spheres of government. Departments should be able to indicate the cost of delivering adequate and appropriate services to children with disabilities, based on need and prevalence of disability. Costing for the new objectives identified in this Strategy is recommended. Departments working together will identify objectives that
overlap, and therefore can look for ways to reduce or share costs. A cost-benefit analysis of moving rehabilitation services to the primary or community level, with suitably trained workers, is recommended as the starting point to approach decision makers, as compared to the present system of hospital based services with specialised rehabilitation. Consideration must be given to the long term benefits of disability prevention and early intervention programmes to reduce the prevalence and severity of disabilities in children.

Information

The lack of adequate and disaggregated data for children with disabilities has been a common thread in many areas of service delivery, leading to poor planning and social exclusion. There is a need to develop a national database on children with disabilities. This will assist in the ongoing monitoring and evaluation of programmes for children with disabilities. Information is routinely gathered by various government departments for the purposes of planning and monitoring of services. The DSD gathers information with regard to those children with disabilities receiving a care dependency grant as well as services received at household and community levels, while DoH have routine data available at facility level on the different diagnoses reflecting causes of disability. The DoBE has information on the number of children with disabilities receiving educational services. However, the assimilation of this information towards a comprehensive data base and an interface between the various sectors is absent. In other situations, disaggregated data is not available for disability for the purposes of planning and coordination. The database must include for example, the number of children with disabilities per geographical area, the access and availability of services (including NPOs and support groups), the number of assistive devices required, issued and repaired etc. Current legislation in the Children’s Act (No. 35 of 2005), as amended, provides for children with disability who may be abused or deliberately neglected through the establishment of the National Child Protection Register (see appendix C).

Physical resources

Physical resources required in the delivery of appropriate and effective services to children with disabilities range from more basic to highly advanced materials,
equipment and technologies in the screening, assessment and intervention of services. These include the ongoing supply and maintenance of assistive devices needed for children throughout their childhood. Procurement of these resources should be the function of all provincial government departments and needs to be reflected in all budgetary allocations. A coordinated system of monitoring and evaluating ongoing needs should also be in place.
IMPLEMENTATION OF THE STRATEGY

The committed and integrated implementation of service delivery by government to children who have disabilities can be seen as a key to developing their potential and eventual full participation in society as young adults.

4.1. Integration of services

The Children’s Act (No. 35 of 2005), as amended outlines specific considerations in the implementation of the Act, noting that successful implementation depends on several sectors working together. Section 4 (1)(2) states that:

“This Act must be implemented by organs of state in the national, provincial and where applicable, local spheres of government subject to any specific sections of the Act and regulations allocating roles and responsibilities, in an integrated, coordinated and uniform manner.

Specific mention is made of inter-sectoral implementation of the Act in section 5:

“...all organs of state...involved in the care, protection and well-being of children must co-operate in the development of a uniform approach aimed at coordinating and integrating the services delivered to children”.

Integration of services and policy coherence has thus emerged as crucial issues in the implementation of this strategy. Other key issues are coordination and a uniform approach for successful implementation.

The adoption of the cluster approach in the South African context was an attempt to improve coordination between line functions and mitigate the silo-approach to service delivery. For children with disabilities, the social cluster was required to coordinate the services provided by the various government departments as demonstrated. Generation of this strategy document attempts to
deepen efforts in the integration of service delivery between the different actors outlined in the previous chapter.

The provision of care, protection and ensuring the child’s well-being should be conceptualized in terms of the functions and activities when implementing service integration. Implementation of this strategy focuses on the systems/sector-based approach as opposed to integration at a more micro level of client-based service coordination which occurs inter-professionally. The systems/sector-based approach ensures the availability and accessibility of services across agencies or service sectors in a geographical area. This strategy thus provides the first national instrument in South Africa to facilitate intersectoral planning within and between the various actors in the delivery of the entire spectrum of support services to children with disabilities.

4.2. Availability of resources and capacity for implementation

4.2.1. Government departments and non profit organisations

Despite all government departments and NPOs having clear objectives relating to children with disabilities, several gaps in service provision still exist. These include:

- Poor coordination of services between departments and NPOs is mentioned frequently as a challenge to developing integrated services for children with disabilities. This fragmentation of services for children with disabilities contributes to poor access to services by the ‘consumers’
- NPOs working with children with disabilities receive limited support from government departments and there is poor collaboration.

4.2.2. Human resource capacity

Both government departments and NPOs expressed a serious lack of staff to fulfil their roles and carry out the services of the various departments. Not only are there too few trained professionals (psychologists, therapists, social workers) in the country, but their distribution is unequal with the majority working in urban and
metropolitan areas. Even when posts are created in rural areas, few applications are received because of various factors. Due to inappropriate service delivery models, the utilisation of available staff is also not always effective.

Although community health workers provide primary level care, many are not trained to work with children with disabilities. There is no agreement or coordination between government departments on the category of workers who would be able to provide adequate coverage for services to children as well as adults with disabilities. There is no consensus within and between government agencies; professional groups; and disability activists on the international experience of adopting the concept of community rehabilitation facilitators/workers, in line with the other categories of midlevel workers amongst medical doctors, pharmacists, and dentists.

4.2.3. Physical, material and financial resources

Poor geographical access, professional expertise and financial resources were specified in the DSD report as the main obstacles to delivering services for children with disabilities. Transport that is affordable and convenient was identified as a major obstacle to accessing services in different areas, for example Orange farm, Gauteng province and Ingwavuma district, KwaZuluNatal province.

4.2.4. Societal Attitudes

Over the years there has been a gradual, but very slow change the in the attitude of society towards people with disabilities. However, children with disabilities remain the most marginalised and particularly vulnerable to negative social attitudes. Rejection of young children in the formative years has a significant role to play in the exclusion of a child from normal development and lack of participation in family and community life. Children with disabilities are excluded from mainstream services and cannot function optimally, not only because of their disabilities, but also due to inaccessible buildings, attitudes of service providers and the community. Children with disabilities, as a result, are particularly vulnerable to abuse and violence.
4.3. National Policy Framework for the implementation of the Children’s Act

The purpose of the National Policy Framework (NPF) is

• To guide and ensure the implementation of the Children’s Act (No. 35 of 2005) as amended, by all role players.
• To promote corporation and collaboration between government and civil society to work together in the care and protection of children in South Africa
• To implement a comprehensive child protection system and identify children at risk and develop appropriate programmes.

One of the objectives of the Children’s Act (No. 35 of 2005) as amended, is to recognise needs that children with disabilities may have. The NPF therefore becomes an important instrument in the implementation of this strategy.

4.4. Institutional arrangements

Rules and procedures are required to guide government operations and public officials in the day-to-day functioning of service delivery. It is during implementation of policies that fundamental conflicts between different policies and institutional structures are likely to become apparent. Avoiding these conflicts may be difficult, but the risk can be minimised with adequate information, open communication channels and capacity building. The Government-wide Monitoring and Evaluation System developed by the Presidency, together with other planning instruments like the Medium Term Expenditure Framework (MTEF) for national and provincial departments and the Integrated Development Plans (IDP’s) at local government level have served as a guide and basis for multi-year and multi-sectoral planning.

Planning should be guided by strategy generation, in this case, the strategy on the integration of services rendered to children with disabilities. While there are various systems for gathering information, it is also recognised that many gaps still exist, most notably the poor prevalence of data for children with disabilities. Figure 4.1 below demonstrates the basic planning cycle as outlined by National Treasury. The institutional context includes national and provincial departments across all sectors. All government departments mandated to provide support services to children with disabilities are therefore urged to use this strategy as a
guide and begin filling these gaps, while constantly communicating and providing feedback through the appropriate established channels.

Figure 4.1. The planning, budgeting and reporting cycle

4.4.1. National Departments

The primary role and responsibility of national departments is to develop legislation, national policies, and monitoring and evaluation of service delivery. National departments are also responsible for providing funding, streamlining services and capacity building to provincial departments and national NPOs. The secondary responsibility of national departments is to create a platform for networking at national level.
4.4.2. Provincial Departments

The role and responsibility of provincial departments is to develop provincial policies that are aligned to national legislation and policies, provide direct services, capacity building and funding of provincial NPOs. Provincial departments are responsible for developing operational policies and guidelines, establishing provincial networks and contracting with identified private providers through formalizing Public Private Partnerships.

4.4.3. Local Government

At the local level, support services to children with disabilities range from family care services and intervention to housing, police services as well as health and education. The coordination of various sectors and actors in the delivery of these services is therefore crucial. For the child with a disability, DSD, through the social worker, is usually the first point of entry into the system. Local government specifically, through the development of Integrated Development Plans, facilitates the inclusion of disability as a policy issue through public participation of people with disabilities at the community level. The role of the local government is to make provision and allocate facilities of care and protection to children with disabilities, provide accessible public infrastructure and amenities, including public transport. Facilities should be compliant with local government legislation. Drop in centres are the responsibility of local government (chapter 14 of Children’s Act (No. 35 of 2005), as amended and should offer programmes which includes primary health care, in collaboration with the local health clinic and prevention and early intervention programmes.

4.5. Infrastructure Development

The development of infrastructure is essential for the smooth running of services with special focus in rural areas. This process is about ensuring that the services are streamlined in all provinces and that there is uniformity in the provision of services. Findings from the audit report on the National Departments and the National Organisations has determined the need for development of new infrastructure for improvement of services. At an operational level, the
development of one-stop service centres has been identified, especially in areas where there are shared responsibilities in order to strengthen referrals and reduce movement of clients from one centre to another.

Departments should also identify areas where a single tool or a multi disciplinary tool can be developed for the benefit of key departments that are sharing responsibilities rather than each department developing their own individual tools. The DSD has initiated the Individual Development Plan for adults with a disability, to identify needs within a residential care facility to inform service delivery.

4.6. Non-profit organizations

Non-Profit Organisations provide services on the ground on behalf of government. Government must acknowledge that effective provision of services requires human and financial support. Organisations should also maximize resources by avoiding duplication as much as possible. All the same policies and principles outlined in this document apply to service delivery by those NPOs who are subsidized by DSD.

4.6.1. Disabled Peoples’ Organisations

Parent groups are active members or affiliates of DPO’s in that they represent the voice of their children with disabilities. It is the role of DPOs to provide capacity building to the parents on legislation and policy advocacy. DPOs also have the responsibility of providing capacity building to children with disabilities through leadership, mentorship and training programmes in schools, institutions of higher learning, protective workshops, residential and other facilities.

4.6.2. Faith based organisations

The faith based organisations, for example churches have a significant role to play in providing spiritual growth and development to children with disabilities. Churches have the responsibility of removing the burden of stigma carried by children with disabilities in society. This can be overcome by churches moving away from the need to heal and cure, but rather facilitate acceptance, love and support of people with disabilities.
4.7. Community based organizations

4.7.1. Support Groups

Support groups are voluntary social, community networks where people come together to share common experiences. Support groups usually form out of tragic experiences of individuals who have overcome catastrophic events. Specialised needs of children with disabilities can best be addressed by support groups that are initiated by parents. The support groups are facilitated and managed by ordinary people who have personal experience on how to take care of children with disabilities. Parents who have developed best practice family models to survive challenges are in a better position to share experiences and knowledge with other parents. Support groups provide peer counselling and information, and can be therapeutic to families.

Children and young people should also be encouraged to manage their own support groups in schools. The support groups can assist young people with disabilities to accept themselves and help to build resilience to cope with the challenges of life. Issues of sexuality and HIV and AIDS can easily be discussed in support groups. Specific efforts should be made to develop support groups for children between the ages of 13-18 years.

4.7.2. Parent Organisations

The parents are the primary care givers and play an advocacy and self representation role on behalf children who are unable to speak for themselves. They should participate in all decision making processes that affect their children. Self representation of parents of children with disabilities is pertinent to the development of legislation, policy and programme development. Parents should participate in the multi disciplinary professional teams where decisions are taken about rehabilitation of their children.

Parents who provide care to their own children should also receive support and the children should be taken to respite care in order to give parents a chance to attend to other responsibilities.
4.7.3. Children with Disabilities

Children with disabilities are direct beneficiaries of services and therefore they should also be empowered to participate in decision making processes. This is possible through research programmes where they are able to articulate their needs at their own level in terms of age and disabilities. Adults can interact with children and gather information about their needs both formally and informally. Children with disabilities should and can participate in mainstream programmes such as Children’s Parliament where they can voice their political, educational and social issues. There are experts who are trained to interpret the actions and words of children with various disabilities (including those with mental disabilities) so that they can make sense to the adult world and vice versa.

4.7.4. Forums

Forums can be formal or informal, permanent, ad hoc or voluntary structures that are established to facilitate networking, collaboration, exchange and sharing of information and resources, and enhance partnership between government and civil society. Forums are established to address common issues that affect a sector of society for effective management of particular problems.

4.8. Roles and responsibilities

The scope of work in the field of disability extends to every sector that provides a service to improve the quality of life of an individual or groups of individuals. The first step is in identifying which sector has a role to play in the delivery of support services to children with disabilities. The role of the different sectors in the development of indicators and meeting the objectives outlined within this strategy is provided in the implementation matrix. Roles may overlap, thus requiring role clarification amongst the various actors in implementing this strategy. The strategic focus given should, however steer all in the same direction.
4.9. Issues for consideration in the implementation of the strategy

- DSD in its mandate to develop this strategy, should plan, design and implement a communication strategy for disseminating this document to all the actors identified to initiate dialogue.

- A critical factor in implementation is to assess the capacity to implement in terms of knowledge, skills and resources.

- Implementation should be done in accordance with the agreed plan, and resources made available in order to facilitate an integrated approach. Budget priorities need to be determined by National Treasury and allocations prioritised and monitored by managers at the level of provincial government to wipe out backlogs as well as to ensure expansion of services.

- Establishment of partnerships and project teams across the sectors are critical for implementation.

- All government departments should take the responsibility to make provisions for costing the services for children with disabilities, based on the mandate from the Children’s Act (No. 35 of 2005), as amended.

4.10 The Implementation matrix

An implementation strategy model has been outlined below. The purpose of this strategy is to initiate a developmental approach towards service delivery for children with disabilities. The inclusion of indicators in this matrix is guided by several references as discussed in section five (5.3.) These indicators are to be monitored over a five year period and further divided into short term (1-2 years), medium term (3-5 year) and long term (more than 5 years) time frames. This strategy is the start of the process of policy implementation for children with disability and would more appropriately need to be aligned and included in the broader implementation strategy of the Children’s Act (No. 35 of 2005) as amended.
## STRATEGIC AREA 1

Ensuring the right to survival and well-being of all children with disabilities and promoting their best interests in order to reach their full potential within the family, community and society.

<table>
<thead>
<tr>
<th>Thematic areas</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Time Frame</th>
<th>Output</th>
<th>Lead departments and NPO’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of childhood disability</td>
<td>To identify and intervene for medical and social causes of childhood disability</td>
<td>1. Disaggregated data available on incidence of childhood disability</td>
<td>Short term</td>
<td>Causes of childhood disability inform strategies on prevention and planning of services</td>
<td>DoH DoBE Stats SA DSD DoT</td>
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<td>2. Increased rates of immunization in all areas especially in poor areas</td>
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<td>3. Reduced levels of maternal mortality</td>
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<td></td>
<td>To develop an integrated national prevention programme for identifiable and other causes of childhood disability</td>
<td>4. Reduce the number of children (presently up to 40%) with preventable causes of disability</td>
<td>Medium term</td>
<td>Improve management of preventable and other causes of childhood disability</td>
<td>DoH, DSD, DoT</td>
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<td>To identify target areas with a higher prevalence of childhood disability</td>
<td>5. Decrease the prevalence rate of disabilities in children in under-resourced areas</td>
<td>Long term</td>
<td>Develop resources and programmes in disadvantaged and poor areas Promote general wellbeing of children in under-resourced areas</td>
<td>DoH DSD DoBE DWCPwD</td>
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<td>To increase awareness programmes on disability prevention</td>
<td>6. Decrease prevalence of childhood disability through public participation</td>
<td>Medium term</td>
<td>Improve public knowledge on preventable causes of childhood disability</td>
<td>DoH DSD</td>
</tr>
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</table>
## STRATEGIC AREA 1
Ensuring the right to survival and well-being of all children with disabilities and promoting their best interests in order to reach their full potential within the family, community and society.

<table>
<thead>
<tr>
<th>Thematic areas</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Time Frame</th>
<th>Output</th>
<th>Lead departments and NPO’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion of physical, mental and social well being of children with disabilities</td>
<td>To promote the physical, mental, and social well being of children with disabilities</td>
<td>7. Decrease the infant and under five mortality rate amongst children with disability</td>
<td>Medium term</td>
<td>Improve access to services: antenatal care, genetic counselling, developmental screening; improve awareness and attitudes towards disability issues</td>
<td>DoH DSD DoBE</td>
</tr>
<tr>
<td></td>
<td>To combat stigma surrounding children with disabilities</td>
<td>8. Increase in number of children with disabilities in mainstream activities by ensuring self representation</td>
<td>Short term</td>
<td>Develop awareness and advocacy programmes; rights of children with disabilities and community development programmes focusing on social inclusion; involve FBOs and NPOs in attitudinal change programmes</td>
<td>DSD DoBE DWCPwD</td>
</tr>
</tbody>
</table>
# STRATEGIC AREA 2

**Facilitating and ensuring optimal development of all children with disabilities through the provision of mainstream services as well as specialised services within an inclusive society**

<table>
<thead>
<tr>
<th>Thematic areas</th>
<th>Objectives</th>
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<th>Time Frame</th>
<th>Output</th>
<th>Lead departments/ NPO’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early identification (0-4 years) and intervention</td>
<td>To identify all children with a disability or impairment early</td>
<td>9. Screening protocols and procedures in place in all primary health care facilities, and registered day-care centres  10. Caregivers, community health workers and community development workers trained to administer screening protocols</td>
<td>Medium term</td>
<td>To identify disability in children as early as possible through screening at primary level</td>
<td>DoH  DSD  DoBE  DWCPwD</td>
</tr>
<tr>
<td></td>
<td>To support families with a child with a disability</td>
<td>11. Increase outreach programmes for parents and families  12. All approaches to screening to involve parents and families especially in decision making</td>
<td>Medium term</td>
<td>To develop a family centred approach to the management of children with disabilities</td>
<td>DSD  DoH  DoBE</td>
</tr>
<tr>
<td></td>
<td>To develop ‘one stop’ screening for children with disabilities to receive care dependency grants</td>
<td>13. Increase in percentage of children with disabilities on the population register  14. Standardized and viable criteria for eligibility developed  15. Alignment of departmental assessment protocols and procedures</td>
<td>Short term</td>
<td>Better efficiency for CDG applications to increase percentage of children who receive grants</td>
<td>DSD  DoH  DoBE</td>
</tr>
<tr>
<td></td>
<td>To track learners that have been assessed between Health and Education</td>
<td>16. Align learner tracking systems of departments  17. Capture screening information on Road to Health Card and Learner Profile</td>
<td>Short term</td>
<td>Learners who have been identified through early screening systems are ensured of accessing support when they enter ECD sites</td>
<td>DoH  DoBE</td>
</tr>
</tbody>
</table>
### STRATEGIC AREA 2
**Facilitating and ensuring optimal development of all children with disabilities through the provision of mainstream services as well as specialised services within an inclusive society**

<table>
<thead>
<tr>
<th>Thematic areas</th>
<th>Objectives</th>
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<th>Lead departments/ NPO’s</th>
</tr>
</thead>
</table>
| **Parent mobilisation and empowerment of families** | To equip parents with disabled children with better coping and handling skills  | 18. All ECD practitioners trained in early screening, identification and intervention methods  
19. Early intervention programmes for children with disabilities in place at all local service centres | Short – medium term | Increase number of trained primary and secondary providers on skills in early intervention. Increase the number of learners who receive early intervention services | DoBE, DSD, DPO’s, Parent organisations, NPO’s |
| **Habilitation and rehabilitation services** | To develop minimum standards                                               | 20. Decrease abuse (sexual and violent) of children with disabilities  
21. Increase no. of children receiving early intervention and stimulation.  
22. Increase parental involvement in education of children | Medium term  
Medium term  
Short term | Parent training programmes  
Support groups  
Peer counselling  
Group therapy  
Outreach by special schools and inclusive schools | DWCPwD, DSD, DoH, DoBE, NPO’s |
| To ensure all children                | 23. Increase the number/percentage of rehabilitation services meeting minimum standards | Short term | Train appropriate mid-level workers and health professionals so as to ensure quality service provision | DoH, NPO’s, DoBE, All other depts |
|                                       | 24. Increase the number of children                                         | Medium | Establish rehabilitation services | DoH |
STRATEGIC AREA 2
Facilitating and ensuring optimal development of all children with disabilities through the provision of mainstream services as well as specialised services within an inclusive society

<table>
<thead>
<tr>
<th>Thematic areas</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>have equal access to rehabilitation services</td>
<td>with disabilities attending rehabilitation services to above 40%</td>
<td>term</td>
<td>that are accessible to all children on an ongoing basis</td>
<td>DoBE  DSD</td>
</tr>
<tr>
<td></td>
<td>To improve rehabilitation services at community and primary level</td>
<td>25. Increase rehabilitation services at clinics and in the community</td>
<td>Medium term</td>
<td>Develop a strategy for community rehabilitation that is appropriate and accessible</td>
<td>DoH  DSD Professional therapy bodies</td>
</tr>
<tr>
<td></td>
<td>To ensure all children with disabilities have access to assistive devices (see below under Strategy 4)</td>
<td>26. Develop and align departmental policies on the supply of assistive devices</td>
<td>Short term</td>
<td>Clear inter-departmental policies on assistive devices</td>
<td>DoH  DoBE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27. Increase assistive device coverage above 50%</td>
<td>Medium term</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate assessment of individual needs and strengths</td>
<td>To align all assessment processes to international standards as outlined in the ICF</td>
<td>28. Develop and utilize a common assessment tool for primary service providers in health, education and social development</td>
<td>Short term</td>
<td>Train all service providers to understand and utilize a common assessment approach for the benefit of the individual child with a disability</td>
<td>DoH  DoBE  DSD</td>
</tr>
<tr>
<td></td>
<td>Assessment as a tool to provide access to services rather than as a placement tool</td>
<td>29. Access to appropriate services for children with disabilities for care, protection and individual development</td>
<td>Long term</td>
<td>Assessment tools are used to monitor growth and development of children with disabilities</td>
<td>DoBE  DoH  DSD</td>
</tr>
<tr>
<td>Formal compulsory education in ordinary and education</td>
<td>To improve access to ECD by children with disabilities</td>
<td>30. Increase attendance of children with disabilities at ECD centres to above 1,36%</td>
<td>Medium term</td>
<td>Develop support and training for ECD facilitators to teach Children with disabilities, Disability awareness</td>
<td>DSD  DoBE</td>
</tr>
</tbody>
</table>
## STRATEGIC AREA 2
Facilitating and ensuring optimal development of all children with disabilities through the provision of mainstream services as well as specialised services within an inclusive society

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>special schools and ECD (5-18 years)</td>
<td>To ensure all children with disabilities have access to education, support and foundation phase (grade R)</td>
<td>31. Increase school attendance for all children with disabilities, specifically in rural and poor areas above 60%</td>
<td>Long term</td>
<td>• Equip education practitioners to teach children with disabilities • Strengthen district support services through increasing capacity and promoting inter-sectoral collaboration</td>
<td>DoBE</td>
</tr>
<tr>
<td>Informal education – day care and stimulation centres</td>
<td>Exemption of compulsory schooling is given in accordance with regulations as outlined in SA Schools Act</td>
<td>32. Decrease number of children with disabilities at age 7 years not in an educational facility 33. Increase no. of children with disabilities in unregistered and registered day care facilities / stimulation centres</td>
<td>Long term</td>
<td>Identify all children with disabilities who are 7 years in order to meet the legislative requirement of educational placement</td>
<td>DoBE  DSD  NPO’s</td>
</tr>
<tr>
<td>Identify special needs and related support services</td>
<td>To develop support services for mainstreaming and the capacity development of specialized services in targeted areas</td>
<td>34. Individualize a plan for each child with a disability for growth and development</td>
<td>Medium term</td>
<td>Develop a balance between mainstream and specialized services for children with disabilities</td>
<td>DSD  DoBE  DoH</td>
</tr>
</tbody>
</table>
### STRATEGIC AREA 3
Protecting the rights of all children with disabilities by ensuring that statutory and legal protection services are provided without discrimination

<table>
<thead>
<tr>
<th>Thematic areas</th>
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<th>Time Frame</th>
<th>Output</th>
<th>Lead department/ NPOs</th>
</tr>
</thead>
</table>
| Protection              | • To ensure that all children with disabilities are protected from abuse, violence, exploitation, neglect and child trafficking  
• To provide children with disabilities appropriate support when utilizing court services  
• To provide disability sensitive training to all those service providers in the police and judicial dept who deal with children with disabilities  | 35. Legislative measures to protect children against any form of abuse and violence  
36. Profile of children with disabilities in child protection system  
37. No. of convictions of perpetrators involved in cases against children with disabilities  
38. Increase level and type of reasonable accommodation provided to children with disabilities who utilize court services  
39. No. of probation officers, clerks, magistrates, judges etc who undergo disability sensitive training and basic sign language | Medium term  
Short term  
Medium term  
Short term  
Short term | Strengthen implementation of protective measures, specifically relating to children with disabilities, as outlined in Children’s Act (No. 35 of 2005), as amended  
Increase no. of cases on abuse and neglect of children with disabilities.  
Provision of alternative accommodation, rehabilitation and access to due legal recourse for abused children with disabilities. | DSD  
DoJ&CD |
| Optimisation of social grants for children with disabilities | To improve access to CDG for children with disabilities  | 40. Comprehensive data base of children with disabilities as beneficiaries of grants  
41. Comprehensive data base linked | Short term  
Medium | All eligible children with disabilities have access to grants.  
Encourage independent living | DSD  
DoBE  
DoHA  
DoH |
## STRATEGIC AREA 3
Protecting the rights of all children with disabilities by ensuring that statutory and legal protection services are provided without discrimination

<table>
<thead>
<tr>
<th>Thematic areas</th>
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<th>Lead department/ NPOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>disabilities</td>
<td>To utilize rates of services.</td>
<td>Gradual increase of eligible children with disabilities receiving CDG from 50% to 80% within MTEF</td>
<td>term</td>
<td>and not dependency on grants</td>
<td>DSD DCG&amp;TA/ Municipalities DPW – EPWP NPO’s</td>
</tr>
<tr>
<td>Community development</td>
<td>To reduce the levels of poverty amongst families who have children with disabilities through employment opportunities especially in rural areas</td>
<td>Increase no: of parents of children with disabilities who are employed</td>
<td>Long term</td>
<td>Community mobilization, active participation and empowerment of families who have a child with a disability through community development projects</td>
<td>DoL DCG&amp;TA/ Municipalities DPW – EPWP DSD NPO’s</td>
</tr>
<tr>
<td>Accessible alternative care for children with disabilities</td>
<td>To improve alternative care options viz. foster care, group foster care, residential care, respite care and partial care making them available and accessible for children with disabilities, according to the Children’s Act</td>
<td>Update regularly the no. of children with disabilities requiring alternative care</td>
<td>Short term</td>
<td>Alternative care protects and promotes the development of children with disabilities who are vulnerable to abuse, neglect, or who simply require additional support</td>
<td>DSD DCG&amp;TA/ Municipalities DSS NPO’s</td>
</tr>
</tbody>
</table>
## Strategic Area 4
Promoting the rights of all children with disabilities to participate within the family, community and society without discrimination

<table>
<thead>
<tr>
<th>Thematic areas</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Time Frame</th>
<th>Output</th>
<th>Lead department/ NPO’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration and reintegration of children</td>
<td>To plan, implement, coordinate and monitor appropriate support services to all children with disabilities at a community level</td>
<td>49. Develop and maintain a register of the different types of services available for children with disabilities per district e.g. health, counselling rehabilitation, remedial etc</td>
<td>Medium term</td>
<td>Local level services at schools, clinics, municipalities, DSD offices as an entry point for identification of children with disabilities, as well as for integration of services</td>
<td>DSD, DoH, DoBE, DCG&amp;TA/ Municipalities</td>
</tr>
<tr>
<td>with disabilities into family and community life</td>
<td>50. Develop an inter-referral system between all service providers (schools, clinics, social development etc) per district</td>
<td>51. Increase no: of inter-referrals per district</td>
<td>Short term</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>52. Increase no: of children with disabilities fully integrated into community life</td>
<td></td>
<td>Medium term</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>53. Ensure all national buildings comply with requirements of universal design and norms</td>
<td></td>
<td>Medium term</td>
<td>Put in place monitoring mechanisms to ensure that building regulations are adhered to in all public buildings (including all schools)</td>
<td>DPW, DoH, DoBE</td>
</tr>
<tr>
<td></td>
<td>54. Maintain a register of children with disabilities in need of assistive devices per district</td>
<td></td>
<td>Short term</td>
<td>Develop and align departmental policies, national and local systems for the supply, management and</td>
<td>DoH, DoBE, DSD</td>
</tr>
<tr>
<td></td>
<td>55. Ensure (40%) children with disabilities have access to assistive devices</td>
<td></td>
<td>Medium</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Thematic areas</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Time Frame</th>
<th>Output</th>
<th>Lead department/ NPO’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIC AREA 4</td>
<td>Promoting the rights of all children with disabilities to participate within the family, community and society without discrimination</td>
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</tr>
<tr>
<td><strong>Integration and reintegration of children with disabilities into family and community life</strong></td>
<td>To ensure accessible transport for children with disabilities</td>
<td>devices</td>
<td>disabilities (including rural areas) have access to mobility, communication and other assistive devices as required</td>
<td>Medium term</td>
<td>maintenance of assistive devices</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>56. Develop a monitoring and follow up system of children with assistive devices</td>
<td></td>
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<tr>
<td></td>
<td>To ensure access to information and communication services</td>
<td></td>
<td></td>
<td>Long term</td>
<td>Accessible transport for all community and social activities for children including transport to and from educational facilities</td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preparation for economic and social independen ce</strong></td>
<td>To develop transition to work and prevocational skills training for children with disabilities between the ages 15-18 years</td>
<td></td>
<td></td>
<td>Medium term</td>
<td>Children with disabilities are trained and empowered to access and utilize information according to their abilities</td>
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<td></td>
<td>Long term</td>
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</tbody>
</table>
## STRATEGIC AREA 4
Promoting the rights of all children with disabilities to participate within the family, community and society without discrimination

<table>
<thead>
<tr>
<th>Thematic areas</th>
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<th>Time Frame</th>
<th>Output</th>
<th>Lead department/ NPO’s</th>
</tr>
</thead>
</table>
| Participation in leisure and sport | To ensure that children with disabilities have equal access to art, culture, sport and recreation activities | 62. Increase no. of children with disabilities participating in local activities  
63. Number of opportunities for participation in local sport, culture and recreational activities at the local level / per district.  
64. No: of children/youth with disabilities who have self representation in media film and entertainment industry | Medium term  
Short term           | Acceptance of children with disabilities to participate in local activities, amongst peers, siblings and friends within all social networks | DCG&TA/ Municipalities Sport and Recreation’  
DAC  
DoBE  
NPO’s |
| Awareness Raising              | To raise the awareness of the community and social circles of children with disabilities of their human right to have access to leisure, sport and recreational activities | 65. No. of awareness campaigns run at schools and in communities  
66. Level of inclusion of children with disabilities in local activities | Short term  
Long term        |                                                                       |                                                             |
### STRATEGIC AREA 5

Mobilizing resources at all levels and from all sources both within and outside of government to ensure that all children with disabilities can reach their full potential, given the support and protection they need.

<table>
<thead>
<tr>
<th>Thematic areas</th>
<th>Objectives</th>
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<th>Time Frame</th>
<th>Output</th>
<th>Lead departments/ NPO’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human: production, supply and utilization of human resources</strong></td>
<td>To clearly identify the human resources necessary for delivering services to children with disabilities in all sectors To train and retain these human resources</td>
<td>67. Ratio of rehabilitation professionals: social workers, physiotherapists, OT’s, speech therapists, medical orthotists etc to number of people per district with disabilities (disaggregated for children) 68. No. of posts for professional services for children with disabilities in the public sector (education; health; social development; labour; transport) 69. Increase coverage of support social services for children with disabilities</td>
<td>Short term</td>
<td>Adequate number of human resources providing appropriate and effective services to children with disabilities in all areas of need.</td>
<td>DoH, DoBE, DSD, DoT, Training institutions, NGO’s</td>
</tr>
<tr>
<td><strong>Financial Information for planning, statistics, dedicated budgeting</strong></td>
<td>To dedicate financial resources for services for children with disabilities within all sectors that provide services to children with disabilities.</td>
<td>70. Target programmes for children with disabilities within all service sectors 71. Develop a costing analysis of disability prevention, rehabilitation, early</td>
<td>Medium term</td>
<td>Adequate financial resources available for integrated service delivery within all programmes, targeted as well as mainstream for children with disabilities at local level.</td>
<td>Provincial depts: DoH, DoBE, DSD, DoT</td>
</tr>
</tbody>
</table>
Mobilizing resources at all levels and from all sources both within and outside of government to ensure that all children with disabilities can reach their full potential, given the support and protection they need

<table>
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<tr>
<th>Thematic areas</th>
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<th>Output</th>
<th>Lead department/ NPO’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring of implementation</td>
<td>disabilities</td>
<td>identification and intervention programmes</td>
<td>Medium to long term</td>
<td>Integrated services for children with disability are coordinated and cost effective</td>
<td>As above</td>
</tr>
<tr>
<td></td>
<td>To integrate services for efficient use of resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systems development for improved information resources</td>
<td>To disaggregate baseline data collection at facility/organizational levels, provincial and national spheres of government</td>
<td>74. Data-base of no. of children with disabilities utilizing mainstream support services from government, NPO’s and NGO’s</td>
<td>Short term</td>
<td>Improved designing, planning and monitoring of programmes for children with disabilities at local, provincial and national spheres of government</td>
<td>Stats SA</td>
</tr>
<tr>
<td>Disaggregate disability data collection</td>
<td>75. Integrated early intervention services at the local level</td>
<td></td>
<td>Medium to long term</td>
<td></td>
<td>DoH DoBE DSD DoT DCG&amp;TA/ Municipalities Private sector NPO’s</td>
</tr>
<tr>
<td></td>
<td>76. Institutional restructuring to facilitate registration, licensing and programme development for: Residential facilities, partial care services &amp; Early Childhood Development; Rehabilitation; and Community development</td>
<td></td>
<td>Long term</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STRATEGIC AREA 5
Mobilizing resources at all levels and from all sources both within and outside of government to ensure that all children with disabilities can reach their full potential, given the support and protection they need

<table>
<thead>
<tr>
<th>Thematic areas</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Formalisation of Public Private partnerships (PPP)</td>
<td>Improve partnerships between various service providers in the delivery of services for children with disabilities</td>
<td>77. Develop contractual agreements of PPP established in service delivery for children with disabilities</td>
<td>Medium term</td>
<td>Efficient use of all resources in an integrated approach to delivering a service for children with disabilities.</td>
<td>NPO’s NGO’s FBO’s Govt depts</td>
</tr>
<tr>
<td>Availability of physical resources</td>
<td>To plan, utilize, monitor and evaluate all physical resources required in the delivery of services for children with disabilities</td>
<td>78. Facility audits on the no., type and function of existing physical resources for the provision of services for children with disabilities at provincial and district levels</td>
<td>Medium term</td>
<td>Adequate physical resources available for the rendering of appropriate, efficient and effective services to children with disabilities</td>
<td>All service providers</td>
</tr>
</tbody>
</table>
MONITORING AND EVALUATION

5.1 Monitoring and Evaluation

5.1.1. Overall process

Monitoring and evaluation (M & E) of services is an ongoing process and is the responsibility of all service providers within all tiers of government and NPOs. However, this strategy should undergo a five year review, taking into account contextual factors that may influence the outputs and outcomes. Engagement of the service recipients is critical during both the implementation and evaluation stages and should also be done within the rights-based framework. M & E activities should take place horizontally and vertically. Horizontal monitoring and evaluation is when government departments and NGO’s put a collaboration mechanism in place for evaluation of each other in order to identify gaps and challenges in service delivery as mandated by the INDS. Vertical monitoring and evaluation is where the responsibility of monitoring and evaluation occurs between national, provincial and local levels both within government and NGOs.

Previously the Office on the Status of Disabled Persons (OSDP) in the Presidency was responsible for the overall monitoring of the implementation of programmes for persons with disabilities (including children with disabilities). Since the fourth democratic elections occurred, the restructuring of OSDP into a separate ministry: Department of Women, Children and People with Disability has created a new dynamic in institutional capacity. While this new Ministry would naturally be expected to continue this implementation and monitoring process in partnership with sectoral departments, NPO’s and the private sector, the new administration still has to indicate how this function will in future be fulfilled. Higher level coordination is needed within the new Planning Commission, where institutional
efficiency and effectiveness can be monitored and evaluated in the delivery of integrated services.

5.1.2. Monitoring of the Strategy

At an immediate level, monitoring of this strategy should be carried out by senior officials or representatives from the key government departments. This is to integrate this strategy into the broader implementation plan of the Children’s Act (No. 35 of 2005) as amended, taking into account the delegation of powers as contained in the enforcement and administration of the Act. All national and provincial government departments have an obligation to report on an annual basis on progress made regarding implementation of disability related programmes.

Consultative workshops, conducted by DSD to identify comprehensive objectives that should be implemented in collaboration with key departments have been included in the implementation matrix of the previous chapter. There is a need to identify priority areas of collaboration which will be translated into achievable strategic and operational objectives towards a comprehensive plan that can be implemented over a period of five years. The implementation plan should reflect time frames, elaborate further on key departmental roles and responsibility, and should be costed. NPOs also have the responsibility to develop monitoring and evaluation systems and tools to ensure effective service delivery.

5.2. Information management

Information management leads to statistics and a database that serves to determine the trends and the needs on the ground. This information if well managed will facilitate policy, and programme formulation and planning. There are information management systems in place both within the DSD and other Departments. Children with Disabilities are not sufficiently reflected in some of the systems in place.

There is also need for a separate tool for statistics which focuses on organizations that provide services to Children with Disabilities. The information can be
managed from local, provincial and national organizations of and for People with Disabilities. Children with Disabilities should be included in the register for information management and statistics regarding the prevalence of abuse of Children.

5.3. The development of indicators

With evidence of the severe lack of information and disaggregated data on children with disabilities, the development of indicators becomes the most urgent priority for all national and provincial departments. In the implementation of the Children’s Act (No. 35 of 2005), as amended, DSD has developed a range of indicators for key elements of the legislation as part of the Monitoring & Evaluation strategy. Indicators developed in this strategy need to be reflected within this overall M & E framework. This is to avoid isolating the issue of childhood disability from the mainstream of those indicators developed, whilst also ensuring that disability specific aspects are not neglected.

However, there is also caution in the development of appropriate indicators that will be useful for decision makers to evaluate policies, programmes and services and allocate resources. Guidance on the development of core indicators demonstrates five areas based on children’s rights as well as addressing the needs of vulnerable groups: (i) child status; (ii) family and household environment; (iii) neighbourhood and surrounding environment; (iv) service access; and (v) service quality. While some indicators in section four are based on available data, many have to be generated through the development of systems of data collection which are sensitive to disability. National and provincial departments therefore have the responsibility of coordinating this task as a project on its own.
### Terminology

| **IMPAIRMENT vs DISABILITY** | ‘Impairment’ and ‘disability’ are terminology used to promote the understanding of the medical and social models of disability, where ‘impairment’ refers to structural changes in the body when a physical and/or psychiatric problem disturbs how the body or mind works requiring medical intervention to improve function. ‘Disability is related to social restrictions, requiring structural or attitudinal changes within society. |
| **HABILITATION AND REHABILITATION** | Habilitation refers to a process of supplying a child with means to develop maximum independence in activities of daily living through treatment. The implication for children is that the impairment sets in before the child had learnt any basic skills (such as walking, talking or writing). Rehabilitation, on the other hand is the more common term used after the loss of a certain function (i.e. a skill that had already been learnt). Rehabilitation is defined by the United Nations as the process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. |
| **HEALTH CONDITION** | A health condition is the state of a person’s health and tells us whether or not a disease, illness, disorder, injury or trauma is present. Some health conditions make people feel sick (e.g. a chest infection), others do not make them feel sick. Children are not always able to tell us what is wrong with them, and so an adult may be unaware of the problem until a comparison is made with other children (e.g. the child does not crawl even although he is nearly two years old); or something unusual occurs (e.g. the child won’t eat or has blood in their urine). Some health conditions may require medical treatment but not lead to any enduring complications (e.g. a fractured arm). In this assessment we are concerned about enduring health conditions and/or which require the ongoing help and attention of a carer. |
| **REASONABLE ACCOMMODATION** | Reasonable accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure for persons with disabilities the enjoyment or exercise on an equal basis with others, of all human rights and fundamental freedoms. |
| **UNIVERSAL DESIGN** | Refers to the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design. “Universal design” shall not exclude assistive devices for particular groups of |
persons with disabilities where these are needed.

**MID-LEVEL WORKER**
These are substitute health workers, falling in several categories of specialisation such as nursing assistants, dental therapists, oral hygienists, occupational therapy, physiotherapy and speech and hearing therapy assistants, radiographer assistants, pharmacy assistants, mid-level worker for psychology, called a registered counsellor and community speech and hearing workers. Community rehabilitation workers are multi-skilled mid-level workers working in the cross field between physio, speech and occupational therapy. In 2003 training of this category of workers was abolished by the Department of Health in favour of occupation specific therapy mid-level worker training. All categories of mid-level workers are integral to health systems and intended at extending health services especially to peri-urban and rural communities. Specific training and registration are required to ensure standards of practice and compliance with ethical codes of practice.

**ATTENTION DEFICIT DISORDER WITH/WITHOUT HYPERACTIVITY (ADHD)**
ADHD refers to a chronic disorder that initially manifests in childhood and is characterized by hyperactivity, impulsivity and/or inattention. Not all of those affected by ADHD manifest all three behavioural categories. Can lead to difficulty in academic, emotional, and social functioning. May be associated with other neurological, significant behavioural, and/or developmental/learning disabilities.

**AUTISTIC SPECTRUM DISORDERS**
Autistic spectrum disorders impact the normal development of the brain in the areas of social interaction and communication skills. Children typically have difficulties in verbal and non-verbal communication, social interactions, and leisure or play activities, find it hard to communicate with others and relate to the outside world. A medical practitioner, preferably a specialist (paediatrician or psychiatrist) must diagnose learners.

**BEHAVIOURAL / CONDUCT DISORDER (INCLUDING SEVERE BEHAVIOURAL PROBLEMS)**
Learners with behaviour / conduct disorder usually have little concern for others and repeatedly violate the basic rights of others and the rules of society. Children and adolescents act out their feelings or impulses in destructive ways. Offences often grow more serious over time. Such offences may include lying, theft, aggression, truancy, the setting of fires and vandalism.

**BLINDNESS**
Loss of useful sight. Blindness can be temporary or permanent. Damage to any portion of the eye, the optic nerve, or the area of the brain responsible for vision can lead to blindness. Blindness is classified as <3/60 in the better eye, after maximum correction.

**CEREBRAL PALSY**
Cerebral palsy describes a group of chronic conditions affecting body movements and muscle coordination. Caused by damage
to one or more specific areas of the brain, either traumatic, infectious, or developmental. Major types include spastic, dystonic, athetoid and ataxic and they can be quadriplegic, diplegic or hemiplegic. A medical practitioner must make the diagnosis.

<p>| DEAFNESS | Learners who experience a severe hearing impairment and who depend on specialised educational support. Hearing must be assessed through an auditory test and the hearing loss should be more than 61 dB at 0.5; 1; 2 and 4KHz in the better ear |
| DEAF-BLINDNESS | Deaf-blindness means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs, they differ from children with deafness or children with blindness. |
| EPILEPSY | Disorder caused by the sudden overactivity of brain cells and characterized by repetitive seizures of a diverse nature. Seizures (or convulsions) occur when there is abnormal electrical discharge in the brain. This may be triggered by chemical imbalance or a structural abnormality. Seizures differ in cause, nature, severity, management and long term effect. |
| HARD OF HEARING | Learners who experience a moderate hearing impairment and who are in need of additional specialised support. Hearing must be assessed through an auditory test and the decibel loss must be more than 31dB for persons under the age of 15 and more than 41dB for persons 15 years and older |
| MILD TO MODERATE INTELLECTUAL DISABILITY | Learners with an intellectual disability have significantly lower than average intellectual ability and deficits in social and adaptive functioning, that is, limitations in such areas as communication, social, daily living or movement skills. Learners with mild to moderate intellectual disability are functioning academically on a level below 75% of that of their peers. (See moderate to severe intellectual disability below) |
| MODERATE TO SEVERE/PROFOUND INTELLECTUAL DISABILITY | Learners with moderate to severe/profound intellectual disability are functioning academically on a level below 50% of that of their peers. Some identifiable causes include: hereditary factors; chromosome abnormalities, such as in Down Syndrome; brain damage before or at birth; brain damage after birth due to illness or accident; malnutrition or other deprivation in early childhood. |</p>
<table>
<thead>
<tr>
<th>MULTIPLE DISABILITY</th>
<th>Learners who experience more than one of the disabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARTIAL SIGHTEDNESS / LOW VISION</td>
<td>Low vision is impairment of visual functioning even after treatment, for example an operation and/or standard refractive correction (has been given glasses or lenses) and has a visual acuity of less than 6/18 to light perception, or a visual field of less than 10° from the point of fixation (i.e. 20° across) but who uses, or is potentially able to use, vision for the planning and/or execution of a task</td>
</tr>
<tr>
<td>PHYSICAL DISABILITY</td>
<td>Learners with a significant physical disability that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying.</td>
</tr>
<tr>
<td>SPECIFIC LEARNING DISABILITY</td>
<td>A specific learning disability is a disorder in one or more of the central nervous system processes involved in perceiving, understanding and/or using concepts through verbal (spoken or written) language or nonverbal means. This disorder manifests itself with a deficit in one or more of the following areas: attention, reasoning, processing, memory, communication, reading, writing, spelling, calculation, coordination, social competence and emotional maturity.</td>
</tr>
<tr>
<td>PSYCHIATRIC DISORDER</td>
<td>These disorders must be diagnosed by a psychiatrist or psychologist and could include:</td>
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<tr>
<td></td>
<td>• <strong>Personality disorders</strong>: Mental illnesses that share several unique qualities. While many disorders vacillate in terms of symptom presence and intensity, personality disorders typically remain relatively constant.</td>
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<td></td>
<td>• <strong>Adjustment disorders</strong>: Disorders in this category relate to a significantly more difficult adjustment to a life situation than would normally be expected considering the circumstances.</td>
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<td></td>
<td>• <strong>Mood disorders</strong>: Those disorders where the primary symptom is a disturbance in mood i.e. inappropriate, exaggerated, or limited range of feelings e.g. bipolar disorder, major depression.</td>
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<td></td>
<td>• <strong>Anxiety disorders</strong>: The primary feature is abnormal or inappropriate anxiety such as Acute Stress Disorder, Obsessive-Compulsive disorder, Phobias, Posttraumatic Stress Disorder.</td>
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<td></td>
<td>• <strong>Psychotic disorders</strong>: The major symptom of these disorders is psychosis, or delusions and hallucinations. Delusions are false beliefs that significantly hinder a person’s ability to function, e.g. schizophrenia</td>
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<tr>
<td>UNACCEPTABLE TERMINOLOGY</td>
<td>TERMINOLOGY THAT IS ACCEPTABLE WITHIN THE NEW FRAMEWORK OF THINKING</td>
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<tr>
<td>Learners with “Special” Education Needs</td>
<td>Learners who experience barriers to learning</td>
</tr>
<tr>
<td></td>
<td>‘Special needs’ is replaced with the concept of ‘Reasonable Accommodation’</td>
</tr>
<tr>
<td>Learners with barriers to learning</td>
<td>Learners who experience barriers to learning Describe the barrier rather than the person, e.g. Deafness, Blindness, Visual Impairment</td>
</tr>
<tr>
<td>Remedial</td>
<td>Teaching and Learning Support</td>
</tr>
<tr>
<td>The Deaf, the Blind, the Physically Disabled, the Mentally Retarded</td>
<td>People first terminology: People who are Blind, Children with hearing loss, intellectual disability, Down Syndrome, Autism, Physical Disability</td>
</tr>
<tr>
<td></td>
<td>People living with or affected by HIV and AIDS</td>
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<tr>
<td></td>
<td>Wheel-chair users</td>
</tr>
<tr>
<td>SMH – Severely Mentally Handicapped/ Mentally Challenged/ Cognitively Challenged</td>
<td>Children with Intellectual Disability</td>
</tr>
<tr>
<td>Slow learners</td>
<td>Learners with learning difficulties</td>
</tr>
<tr>
<td>Uneducable</td>
<td>Children with Severe or Profound Disability</td>
</tr>
<tr>
<td>Sufferers</td>
<td>People with disabilities are not ill and do not necessarily suffer from their disability</td>
</tr>
</tbody>
</table>
Classification of Functioning in Relation to Services

There is some debate about classifying children with disabilities. The traditional classification used a scale of mild to profound impairment; however, this has been criticized as following the medical model without considering the social aspects of disability. Activity limitations and related needs in a child with a disability combine both the medical and social models and an example is given in the table below. Each domain is scored and then totalled giving an overall indication of the needs of the child. Emphasis is on determining support and where this can be obtained rather than on placement. All Departments involved in assessment to determine support needs, should use the same procedures and tools.

<table>
<thead>
<tr>
<th>Domain of functioning</th>
<th>Severity of functional limitation</th>
<th>Educational support needs</th>
<th>Social and Health services and support needs (Care needs)</th>
<th>Physical environmental needs</th>
<th>Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual functioning (concentration, learning new tasks, remembering, applying knowledge)</td>
<td>Mild (1) Can master academic skills, vocational skills and is self supporting</td>
<td>Inclusive setting with low level of adaptation and support</td>
<td>Requires guidance and support in unfamiliar environment</td>
<td>Nothing specific</td>
<td>- Intellectual impairments such as Down’s Syndrome, etc. Attention Deficit Disorder (ADD/ADHD) –which may or may not present with learning difficulties; autism, fetal alcohol syndrome, etc.</td>
</tr>
<tr>
<td></td>
<td>Moderate (2) Has difficulty mastering more than basic academic skills</td>
<td>Inclusive or specialised setting with moderate level of adaptation and specialised support</td>
<td>Social support and therapeutic intervention needed</td>
<td>Transport with supervision</td>
<td></td>
</tr>
<tr>
<td>Severe (3) Cannot master any skills beyond systematic habits; responds to stimulation</td>
<td>Eligible to receive support in a special setting such as special school or stimulation</td>
<td>Eligible to receive 24 hour care in highly supported environment, respite</td>
<td>Transport with supervision and care facility with stimulation centre</td>
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<tr>
<td>Domain of functioning</td>
<td>Severity of functional limitation</td>
<td>Educational support needs</td>
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<tr>
<td></td>
<td>and training</td>
<td>centre</td>
<td>care for family</td>
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<tr>
<td>Mobility</td>
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<tr>
<td>Lower body</td>
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</tr>
<tr>
<td>(walking, maintaining a body position, transfer from one surface to another)</td>
<td>Mild (1)</td>
<td>Inclusive setting with access to mobility aids</td>
<td>Access to therapeutic, rehabilitation services and mobility aids needed</td>
<td>Assistance to use public transport, accessible built environment e.g. ramps, lifts, accessible toilets)</td>
<td>Physical disability, cerebral palsy, quadriplegia</td>
</tr>
<tr>
<td></td>
<td>No difficulty, or may need help occasionally</td>
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<tr>
<td></td>
<td>Moderate (2)</td>
<td>Inclusive setting with access to specialised/individual support and mobility devices – environmental access</td>
<td>More frequent access to therapeutic, rehabilitation services and mobility aids needed</td>
<td>Accessible bus, assistance to use public transport, accessible built environment at home and public facilities</td>
<td>Physical disability, cerebral palsy, quadriplegia</td>
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<tr>
<td></td>
<td>Can move, but must be assisted, is slow, or gets very tired</td>
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<td>Severe (3)</td>
<td>Access to individual and specialised support in special or full-service school that is environmentally accessible</td>
<td>Full-time assistance, individually fitted wheelchair, frequent therapeutic intervention, rehabilitation programmes</td>
<td>Assistance to use public transport, accessible built environment</td>
<td>Physical disability, cerebral palsy, quadriplegia and some syndromes that present with low muscle tone and poor eye hand coordination</td>
</tr>
<tr>
<td></td>
<td>Unable to move alone</td>
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<tr>
<td>Arm and hand use and dexterity</td>
<td>Mild (1)</td>
<td>Early identification and intervention and teacher support in inclusive setting – adaptation and additional time needed</td>
<td>Low frequency therapy needed</td>
<td>No adaptations needed – physical and built environment complies with principles of universal design</td>
<td>Physical disability, cerebral palsy, quadriplegia and some syndromes that present with low muscle tone and poor eye hand coordination</td>
</tr>
<tr>
<td>(use of both arms, use of fingers and hand to pick up small objects, tie shoelaces and buttons, etc.)</td>
<td>If given enough time, ties a knot; ties shoe laces or a bow; cuts on a line and around a curve</td>
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<tr>
<td></td>
<td>Moderate (2)</td>
<td>Inclusive setting with access to specialised/individual support and assistive</td>
<td>Moderate frequency therapy needed</td>
<td>Moderate adaptations needed – physical and built environment</td>
<td>Physical disability, cerebral palsy, quadriplegia and some syndromes that present with low muscle tone and poor eye hand coordination</td>
</tr>
<tr>
<td></td>
<td>Can do most of these activities, but slow and does not do them well</td>
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<tr>
<td>Domain of functioning</td>
<td>Severity of functional limitation</td>
<td>Educational support needs</td>
<td>Social and Health services and support needs (Care needs)</td>
<td>Physical environmental needs</td>
<td>Impairment</td>
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<tr>
<td></td>
<td></td>
<td>devices that support hand control as well as ITC support</td>
<td>High frequency therapy and family support needed</td>
<td>complies with principles of universal design</td>
<td></td>
</tr>
<tr>
<td><strong>Severe (3)</strong></td>
<td>Great difficulty, or unable to do these activities</td>
<td>Access to individual and specialised support in special or full-service school equipped with trained teachers, support staff and assistive devices that support hand control as well as ITC support</td>
<td>Extensive adaptations needed – physical and built environment complies with principles of universal design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Receptive and expressive</td>
<td>Availability of support in inclusive settings – curriculum differentiation, access to AAC devices, speech therapy</td>
<td>Early identification and intervention, therapeutic services, assistive devices</td>
<td>Safe transport</td>
<td>Communication disorders such as aphasia, apraxia, dyspraxia</td>
</tr>
<tr>
<td></td>
<td>communication)</td>
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<tr>
<td><strong>Mild (1)</strong></td>
<td>Understands everything that is said or misses just a few meanings</td>
<td>Inclusive setting with access to specialised/individual support and communication devices, trained support staff, speech therapists (on a part time basis), itinerant learning support teachers</td>
<td>Early identification and intervention, therapeutic services, assistive devices</td>
<td>Safe transport</td>
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<tr>
<td></td>
<td>Can converse/sign with a stranger, making conversation</td>
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<td></td>
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<tr>
<td><strong>Moderate (2)</strong></td>
<td>Able to understand basic, simple sentences</td>
<td>Access to individual and specialised support in special or full-service school that</td>
<td>Early identification and intervention, therapeutic services, assistive devices</td>
<td>Safe transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Able to produce basic, simple sentences</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Severe (3)</strong></td>
<td>Unable to understand any meaningful language</td>
<td>Access to individual and specialised support in special or full-service school that</td>
<td>Early identification and intervention, therapeutic services, assistive devices, family</td>
<td>Safe transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty due to severe</td>
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<tr>
<td>Domain of functioning</td>
<td>Severity of functional limitation</td>
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<tr>
<td></td>
<td>disturbance or no voluntary control of speech muscles Has no voice due to structural impairment</td>
<td>is equipped with communication devices, trained support staff, speech therapists</td>
<td>support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self care (feeding, hygiene, dressing, toileting)</td>
<td>Mild (1) Eats in a socially acceptable way, bathes/washes and cares for hair when reminded, manages toileting independently, needs occasional help</td>
<td>Availability of support such as early developmental programmes, individual support, health care and curriculum support provided in an inclusive setting</td>
<td>Primary health interventions, parental guidance</td>
<td>Accessible school nutrition centres' incontinence facilities' child friendly facilities that enhance health, dignity and inclusion' accessible transport</td>
<td>Intellectual disabilities, conditions which entail incontinence such as spina bifida, visual impairment needing daily living skills training, physical disabilities</td>
</tr>
<tr>
<td></td>
<td>Moderate (2) Can do activities but not well; or cannot do one or two of the activities Loses control occasionally; bowel control; no bladder control or vice-versa; uses aids; social embarrassment</td>
<td>Availability of support such as early developmental programmes, individual support, health care and curriculum support, teacher assistant provided in inclusive settings – ordinary or full-service schools with support from district services</td>
<td>Secondary and tertiary medical interventions to prevent deterioration of conditions (e.g. renal failure)</td>
<td>Accessible school nutrition centres' incontinence facilities' child friendly facilities that enhance health, dignity and inclusion, accessible transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe (3) Unable to do oral hygiene, hair and nails Needs to be reminded regularly; or incontinent</td>
<td>Availability of support such as early developmental programmes, individual support, health care and curriculum support</td>
<td>Secondary and tertiary medical interventions to prevent deterioration of conditions (e.g. renal failure); access to partial care centres</td>
<td>Accessible school nutrition centres, incontinence facilities; child friendly facilities that enhance health, dignity and inclusion,</td>
<td></td>
</tr>
<tr>
<td>Domain of functioning</td>
<td>Severity of functional limitation</td>
<td>Educational support needs</td>
<td>Social and Health services and support needs (Care needs)</td>
<td>Physical environmental needs</td>
<td>Impairment</td>
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<tr>
<td>Vision</td>
<td><strong>Mild</strong> (1)</td>
<td>Support available in inclusive schools – curriculum differentiation and assistive technology</td>
<td>Psycho-social support services, primary medical facilities, regular eye tests, visual aids</td>
<td>Accessible transport and accessible public buildings with appropriate signage</td>
<td>Blind and low vision – Astigmatism Bardet Biedl Syndrome Cataract Chorioretinal Atrophy Cortical Visual Impairment Glaucoma Lazy Eye Macular dystrophy Myopia Nystagmus Optic Atrophy Optic Nerve Hypoplasia Retinal detachment Retinitis Pigmentosa Strabismus, etc.</td>
</tr>
<tr>
<td>Vision</td>
<td><strong>Moderate</strong> (2)</td>
<td>Support available in inclusive schools – curriculum differentiation, assistive technology, trained teachers</td>
<td></td>
<td>Accessible transport and accessible public buildings with appropriate signage</td>
<td></td>
</tr>
<tr>
<td><strong>Classification of Visual impairment after maximum correction: 6/24 – 6/36 - moderate</strong></td>
<td><strong>Severe</strong> (3)</td>
<td>Support available in full-service or special schools, access to Braille textbooks and Perkins Braille for blind learners and assistive technology for low vision learners – training for teachers, orientation and mobility training, parental guidance</td>
<td></td>
<td>Accessible transport and accessible public buildings with appropriate signage</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td><strong>Mild</strong> (1)</td>
<td>Hears sounds and can usually identify them</td>
<td></td>
<td></td>
<td>Deafness Hearing loss Cochlear Implant</td>
</tr>
<tr>
<td>Domain of functioning</td>
<td>Severity of functional limitation</td>
<td>Educational support needs</td>
<td>Social and Health services and support needs (Care needs)</td>
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<td>Impairment</td>
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<td></td>
<td></td>
<td>Fluctuating hearing loss Otitis media Otosclerosis Sudden hearing loss</td>
</tr>
</tbody>
</table>
| Moderate impairment:   | *Person under 15 years: >31dB threshold for pure tones (0.5, 1, 2, 4 and 8 KHz) or Speech awareness threshold  
*Person 15 years or older: >41dB threshold for pure tones (0.5, 1, 2, 4 and 8 KHz) in better ear | Moderate (2) Cannot always localise sounds or hear warnings e.g. alarm ringing; traffic | Children must have right to make informed choices to learn orally or through SASL, teachers have specialised training sign language interpreters must be available, hearing aids must be maintained and sound amplification devices must be available, early screening, identification and intervention must be available in inclusive as well as special schools and ECD centres | Availability of social and therapeutic services as well as access to audiology services and assistive devices, e.g. hearing aids | Accessible transport and built environment that comply with norms for environmental access, e.g. light arrangements and electricity to accommodate devices |
<p>| Severe impairment:     | &gt;61dB threshold for pure tones (0.5, 1, 2, and 4 KHz) in better ear | Severe (3) Severe difficulty or complete inability to hear warning sounds | Children must have right to make informed choices to learn orally or through SASL, teachers have specialised training sign language interpreters must be available, hearing aids must be maintained and sound amplification devices must be available, early screening, identification and | Availability of social and therapeutic services as well as access to audiology services and assistive devices, e.g. hearing aids | Accessible transport and built environment that comply with norms for environmental access, e.g. light arrangements and electricity to accommodate devices |</p>
<table>
<thead>
<tr>
<th>Domain of functioning</th>
<th>Severity of functional limitation</th>
<th>Educational support needs</th>
<th>Social and Health services and support needs (Care needs)</th>
<th>Physical environmental needs</th>
<th>Impairment</th>
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<tr>
<td>Behaviour</td>
<td>(Ranging from transient coping difficulties and occasional disruptive behaviour in class or with siblings and parents to extreme anti-social behaviour)</td>
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<tr>
<td>Mild (1)</td>
<td>Minimally disturbing to others and not considered deviant by those who know them</td>
<td>Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health, prevention programmes delivered in ordinary schools as well as child and youth care centres, psychiatric hospitals, drop in centres</td>
<td>Psycho-social support services, access to child and youth care centres, diversion programmes, etc.</td>
<td>Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards</td>
<td>Oppositional defiant disorder, etc.</td>
</tr>
<tr>
<td>Moderate (2)</td>
<td>Poor or inappropriate social skills, like frequent episodes of aggression, or other antisocial behaviour, with some preservation of meaningful social relationships</td>
<td>Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health, prevention programmes delivered in ordinary schools psychiatric hospitals, drop in centres</td>
<td>Psycho-social support services, access to child and youth care centres, diversion programmes, etc.</td>
<td>Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards</td>
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<tr>
<td>Severe (3)</td>
<td>Persistent aggression</td>
<td>Availability of support from classroom teachers, school</td>
<td>Psycho-social support services, access to child and youth care</td>
<td>Safe and accessible sites of learning In case of hostels,</td>
<td></td>
</tr>
<tr>
<td>Domain of functioning</td>
<td>Severity of functional limitation</td>
<td>Educational support needs</td>
<td>Social and Health services and support needs (Care needs)</td>
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<td>without clear instigation; Severe anti-social and injurious behaviour</td>
<td>counsellors and psycho-social support staff – including peer support, mental health, prevention programmes delivered in ordinary schools as well as child and youth care centres</td>
<td>centres, diversion programmes etc.</td>
<td>complying with minimum health and safety standards</td>
<td></td>
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<tr>
<td>Mental-Psychiatric Condition</td>
<td><strong>Mild (1)</strong> Some disturbance of behaviour or emotional distress in response to life changing events e.g. separation of parents; deaths; birth of a sibling; these are brief and interface with functioning is transient</td>
<td>Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health prevention programmes delivered in ordinary schools</td>
<td>Psycho-social support services.</td>
<td>Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards</td>
<td>These disorders must be diagnosed by a psychiatrist or psychologist and could include: Personality disorders; Adjustment disorders; Mood disorders; Anxiety disorders; Psychotic disorders</td>
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<td></td>
<td><strong>Moderate (2)</strong> Suicidal preoccupations and ruminations; school anxiety and other forms of anxiety, obsessive rituals’ major conversion symptoms frequent anxiety attacks</td>
<td>Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health prevention programmes delivered in ordinary schools</td>
<td>Psycho-social support services</td>
<td>Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards</td>
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<td><strong>Severe (3)</strong> Unable to function in one of these areas e.g. disturbed at home, at</td>
<td>Psychiatric care facilities with part time educational support programmes delivered</td>
<td>Psycho-social support services, psychiatric hospitals, etc</td>
<td>Safe and accessible sites of learning In case of hostels, complying with</td>
<td></td>
</tr>
<tr>
<td>Domain of functioning</td>
<td>Severity of functional limitation</td>
<td>Educational support needs</td>
<td>Social and Health services and support needs (Care needs)</td>
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<td>school, with peers or in society at large’ suicidal attempts with clear lethal intent’ markedly withdrawn and isolated due either mood or thought disorder</td>
<td>from ordinary or special schools</td>
<td></td>
<td>minimum health and safety standards</td>
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Appendix C

Summary of Relevant Legislation, Policies and Research

Research Reports

- The research report on the needs of people with disabilities - DSD
- Audit report on services to children with disabilities

Policies and Legislation:

- UN Convention on the Rights of Persons with Disabilities
- UN Convention on the Rights of the Child
- The Constitution; of the Republic of South Africa
- Integrated National Disability Strategy (INDS 1997)
- Children’s Act (No: 38 of 2005) as amended
- DSD - Disability Policy
- Policy on Community Based Services for Persons with Disabilities;
- Mental Health Care Act (No 17 of 2002)
- Social Assistance Amendment Act (No 6: of 2008)
<table>
<thead>
<tr>
<th>Document</th>
<th>Year</th>
<th>Data Extract</th>
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<tbody>
<tr>
<td>Audit report</td>
<td>2008</td>
<td>Detail incorporated into Situational Analysis (Section 2)</td>
</tr>
<tr>
<td>DSD research report</td>
<td>June 2006</td>
<td><strong>Findings for children with disabilities:</strong></td>
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<tr>
<td></td>
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<td><strong>Service Provision:</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Little research on prevention reflecting the lack of priority given to prevention. An attempt to develop a policy on prevention by DoH has not been finalized.</td>
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<td>• All research on ‘early identification’ focussed on specific impairment types.</td>
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<td></td>
<td>• Research on prevention of specific impairment types is located within a more medical framework.</td>
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<td>• Significantly limited research on play and recreation</td>
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<td>• One study to evaluate the impact of Community Based Rehabilitation</td>
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<td>• No research on violence in relation to children with disabilities or as victims of abuse.</td>
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<td>• Poor working relations between government and NGO service providers.</td>
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<td></td>
<td></td>
<td>• Lack of policy guidelines and action plans on particular aspects of service provision – e.g. Assistive devices; CBR; prevention of HIV and AIDS, special and inclusive education, skills development and accessibility to public buildings</td>
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<tr>
<td></td>
<td></td>
<td>• Regional and more local research outputs available:</td>
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<td></td>
<td></td>
<td>Gauteng – Orange Farm (Anderson &amp; Phohole, 2001)</td>
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<td></td>
<td></td>
<td>KZN – Ingwavuma (O’ Brien, 2007)</td>
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<td></td>
<td></td>
<td>Limpopo – Mohlanatsi (Anderson &amp; Pholole, 2001)</td>
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<td>Mpumalanga – Dept of Social Development, undated.</td>
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</table>

Summary of findings of local research:
1. More than 50% of children with disabilities are not at school
2. Less than 33% of them are receiving rehabilitation
3. Less than 50% of those who qualify for Care Dependency grants are receiving them.
4. Absence of data regarding the prevalence of disability
5. Only 40% of disabled children who require rehabilitation actually receive it.
6. Lack of strong networks and partnerships between all these role-players in dealing with the issue of childhood disability
7. 86% of disabled people identified in Mpumalanga are children
8. 67% of children with disabilities do not have the assistive devices they need
9. Access to foster care grants for children with disabilities should be promoted
Needs of children who experience poverty

• Only one study on the impact of any kind of social security arrangements for children with disabilities – no research on impact of Foster Care Grants / Care Dependency Grants

Education

• Most research conducted was prior to the White Paper 6 – several other pilot projects were conducted but not yet in the public domain.
• Available research:
  ii. Inclusion and needs of learners with specific impairments
  iii. Skills for employment – do special schools adequately equip school leavers?

Psychological

• No research on the voices of children with disabilities in relation to their experience of social service provision or the impact of non-provision.

Recommendations for Department of Social Development:

a. More research on prevention and outcomes of early intervention.
b. Review the impact of current services for disabled people
c. Set up systems for monitoring and evaluation.
d. Ascertain the impact of community based rehabilitation
e. Inclusion of disability in all HIV / AIDS programmes
f. Review and improve service delivery:
   i. The need for a formal intersectoral district structure to plan disability and rehabilitation services (IDPs/DHS)

Conclusions

✓ To make social disability research more available
✓ To develop information systems
✓ To use research as a tool to improve service provision

INTERNATIONAL CONTEXT

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<tr>
<th>Document</th>
<th>Year</th>
<th>Data Extract</th>
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<tbody>
<tr>
<td>3. Convention on the Rights of Persons with</td>
<td>2006</td>
<td>The Convention on the Rights of Persons with Disabilities and its Optional Protocol was adopted on 13 December 2006 and came into force in May 2008 when it was ratified by the 20\textsuperscript{th} country. South Africa has ratified both the Convention and its Optional Protocol. Therefore the convention has legal binding power and the Government of South Africa has an obligation to report on progress made with the implementation of the convention by the end of 2010. The Convention marks a “paradigm shift” in attitudes and approaches to persons with disabilities. It takes to a new height the approach of viewing persons with disabilities as “objects” of charity, medical treatment and social protection towards viewing</td>
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persons with disabilities as “subjects” with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.

The Convention is unique in as far as it is both a development and a human rights instrument. It is a policy instrument which is cross-disability and cross-sectoral

Article 1 outlines the purpose of the Convention, namely to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The Convention does not explicitly define disability. It states that ‘Disability is an evolving concept, and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder full and effective participation in society on an equal basis with others’

Furthermore it states that ‘Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’.

The principles of the Convention relevant to children are:

- Respect for the inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- Equality of opportunity
- Accessibility
- Equality between men/boys and women/girls;
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Most articles of the convention have implications for children such as:

- Equality before the law without discrimination (article 5)
- Right to life, liberty and security of the person (articles 10 & 14)
- Freedom from torture (article 15)
- Freedom from exploitation, violence and abuse (article 16)
- Right to respect physical and mental integrity (article 17)
- Freedom of movement and nationality (article 18)
• Right to live in the community (article 19)
• Respect for privacy (article 22)
• Respect for home and the family (article 23)
• Right to adequate standard of living (article 28)
• Right to participation in cultural life (article 30)

Articles that specifically impact on lives of children with disabilities are discussed below:

Article 7 outlines the Rights of Children and states that ‘Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children; In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration; Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.’

Article 24 on Education is of central importance to introduce a new educational dispensation for children:

• It requires all signatories to ensure all disabled children and young people can fully participate in the state education system and that this should be an ‘inclusive education system at all levels’
• The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to reach their fullest potential.
• This right is to be delivered within an inclusive primary and secondary education system, from which disabled people should not be excluded.
• Support should be provided
• Reasonable accommodations should be provided for individual requirements and support provided in individualized programmes to facilitate their effective social and academic education.

Article 25 on Health:

Guarantees the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. Children with disabilities should have the same range, quality and standard of free or affordable health care and programmes as provided to other persons; specialised health services, including early identification and intervention as appropriate to minimise and prevent further disabilities; as close as possible to their own communities, including in rural areas;

Health professionals must provide care of the same quality to persons with disabilities as to others, including on the basis of
free and informed consent and there may not be discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 26 on Habilitation and Rehabilitation is also critical for children as it makes provision for comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, which begin at the earliest possible stage, are based on the multidisciplinary assessment of individual needs and strengths and support participation and inclusion in the community and all aspects of society. It also emphasizes access to assistive devices and technologies.


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 recognised in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular articles 23 and 24), in the International Convention on Economic, Social and Cultural Rights (in particular article 10) and in the statutes and relevant instruments of specialised agencies and international organizations concerned with the welfare of children. The Declaration of the Rights of the Child indicates that “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”. The child should be fully prepared to live an individual life in society and be 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. The family as the fundamental group of society and the natural environment for the growth and well being of children should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.

Articles 23 and 24 are relevant to children with disabilities.

Article 23 states:
1. Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in condition which ensure dignity, promote self reliance and facilitate the child’s active participation in the community.
2. Parties should recognise the right of the disabled child to special care
3. Recognizing the special needs of a disabled child, assistance extended should be provided free of charge whenever possible, and ensure effective access to education, training, health care services, rehabilitation services, preparation for employment and recreation to achieve the child’s fullest possible social integration and individual development.
Article 24 states:
1. Parties recognise the right of the child to enjoyment of the highest attainable standard of health and rehabilitation.
2. The implementation of this right includes the following:
   a. To diminish infant and child mortality
   b. To ensure the provision of health care to all children with the emphasis on primary health care
   c. To ensure appropriate pre-natal and post natal health care for mothers
   d. To develop preventative health care

Article 1: Refers to any human being below the age of eighteen years.
Article 6: Every child has the inherent right to life, survival and development
Article 25: Every child has the right to care and protection
Article 27: Every child has a right to a standard of living adequate for physical, mental, spiritual and social development.
Article 28: Every child has a right to education
Article 29 and 31: Every child has a right to rest and leisure, play, recreational, cultural life and art activities
Article 32: Every child has a right to be protected from economic exploitation
Article 34: Every child has a right to protection from sexual abuse

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<th>Document</th>
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| 5. South African Constitution (Act no: 108 of 1996) | 1996 | **Chapter 1: Founding Provisions.** One of the key values upon which our democratic state is founded is that of human dignity, the achievement of equality and the advancement of human rights and freedoms. **Bill of Rights** – the following sections are relevant to children with disabilities:  
**9. The Equality Clause**  
(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.  
**10. Human dignity**  
Everyone has inherent dignity and the right to have their dignity respected and protected.  
**11. Everyone has the right to life.**  
**12. Freedom and security of the person**  
1. Everyone has the right to freedom and security of the person  
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.  
**13. No one may be subjected to slavery, servitude or forced labour.** |
| 14. | Everyone has a right to privacy |
| 27. Health care, food, water and social security |
| 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. |
| 28. Children |
| 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. |
| 29. Education |
| 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. |
| | 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. |

| 6. Integrated National 1997 | Policy guidelines that pertain directly to children with disabilities: |
| 1. | Prevention |
Primary prevention means trying to prevent the diseases and accidents which may cause impairments and disabilities. Policy objectives: Healthy lifestyle promotion; protective measures.
- Secondary prevention means early identification of impairments and disabilities followed by prompt treatment (or early intervention). Secondary prevention results in a cure; slower rate of progression of impairment; prevention of complications.
- Strategies:
  - Decrease in poverty; avoidance of conflict; improved health services.

ii. Public education and awareness
- Objectives: awareness raising; decreasing discrimination; putting a value on diversity.

iii. Health care
- The development of a comprehensive universal health care system, at primary, secondary and tertiary level, that is sensitive to the general and specific health care needs of people with disabilities.
- Strategies: elimination of discrimination; national data base; child health care; computer technology; barrier free access; communication; training in the delivery of the social model.

iv. Rehabilitation 1: Original INDS:
- Access to appropriate rehabilitation services...must be reflected in policy on rehabilitation:
  - To reach and maintain the child’s optimal physical, sensory, intellectual, psychiatric and or social functioning.
  - To provide them with tools to change their lives and to give them a greater degree of independence.
  - To prevent secondary disabilities
  - To take into account specific needs of different disability groupings.
- Strategies: personnel training; intersectoral collaboration; role of DPO's / parent organizations
- Components: medical; psychological; educational; vocational; social rehabilitation; assistive devices

Rehabilitation 2: New revised version has the following: “National disability policy framework”

10 General policy guidelines...
- Health care (Dept of Health)
  - “Health care includes medical, nursing, rehabilitation, psychiatric and other specialist services which are available on an in-patient, out-patient as well as at a community and on a home care basis
- Habilitation and rehabilitation (Depts of Health, Labour, Social Services, Education)
  - “Policies relating to key departments must therefore organize, strengthen and extend comprehensive habilitation and rehabilitation services...”
  - Policy objectives: “Establish an integrated strategy for Community Based Habilitation and Rehabilitation”
  - “Promote the development of initial and ongoing training of professionals and staff working in habilitation and rehabilitation services”
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| v. **Barrier free access**  
To create a barrier free society that accommodates the diversity of needs and enables the entire population to move around the environment freely and unhindered. | vi. **Transport**  
To develop an accessible, affordable multi-modal public transport system that will meet the largest needs...and planning for those higher cost features for greater mobility needs. | vii. **Communication**  
To develop strategies that will provide people with communication disabilities with equal opportunities to access information. |
| viii. **Education**  
Transformation of the education system as a whole to facilitate equal access to education.  
- **Components:**  
  - Early Childhood Development  
  - General and further education  
  - Higher education  
  - Education Support Services | ix. **Social welfare and community development**  
Policy objectives include:  
- Developing social welfare services that aim to integrate people with disabilities within all activities in their communities  
- Developing social welfare services that recognise the differing specific needs of people with disabilities.  
- Facilitating the reorientation and training of social welfare workers.  
- **Components:**  
  - Community development  
  - Social welfare services which include a range of strategies designed to facilitate access by people with disabilities and parents of disabled children to mechanisms which enhance their ability to live independently. These include:  
    - Residential care facilities  
    - Institutions for people with severe disabilities  
    - Personal assistance services  
    - Activity centres | x. **Social security**  
To provide for a co-ordinated and equitable system of social security to meet basic needs and develop capacity for independent living, self-sufficiency and integration.  
- **Components** include state grants. |
| xi. **Housing**  
To provide people with disabilities and their families with safe shelter and dwellings through equitable access to a range of |   |   |
options in the housing subsidy scheme.

xii. **Sport and recreation**
   To develop and extend sporting activities for people with disabilities in both mainstream and special facilities so that they can participate in sport for both recreational and competitive purposes.

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<tr>
<th>7. Children’s Act (No. 35 of 2005) as amended</th>
<th>2008</th>
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<td>“To give effect to certain rights of children as contained in the constitution; to set out principles relating to the care and protection of children; to define parental responsibilities and rights; to make further provision regarding children’s courts; to provide partial care of children; to provide early childhood development; to provide for the issuing of contribution orders; to provide for prevention and early intervention; to provide for child and youth care centres and drop in centres; to make provision for the adoption of children; to provide for inter-country adoption; to give effect to the Hague convention on Inter-country Adoption; to prohibit child abduction and to give affect to the Hague convention on International Child Abduction; to provide for surrogate motherhood; and to prevent certain new offences relating to children; and to provide for matters connected therewith.”</td>
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**Chapter 5.**

1) Early childhood development means the process of emotional, cognitive, sensory, spiritual, moral, physical, social and communication development of children from birth to school going age.

2) Early childhood development services mean services -
   a) intended to promote early childhood development; and
   b) provided by a person, other than a child’s parent or caregiver, on a regular basis to children up to school going age.

3) An early childhood development programme means a programme structured within an early childhood development service to provide learning and support appropriate to the child’s developmental age and stage.

Departments of Education, Finance, Health, provincial and local government, and Transport must include in the departmental strategy a comprehensive national strategy aimed at securing a properly resourced, co-ordinated and managed early childhood development system.

The MEC for social development must maintain a record of all early childhood development programmes. The MEC for social development must also compile a provincial profile at prescribed intervals. The MEC for social development may provide and fund early childhood development programmes for that province.

**Chapter 7 – PROTECTION OF CHILDREN**

**National Child Protection Register**

111 (1) The Director-General must keep and maintain a register to be called the National Child Protection Register.

113. The purpose of Part A:
   (a) to have a record of abuse or deliberate neglect inflicted on specific children;
(b) record of the circumstances surrounding the abuse or deliberate neglect;...
(c) to use the information...to protect these children from further abuse or neglect;
(d) to monitor cases and services to such children;

Contents of Register
114 (a) Part A of the register must reflect:
(iii) whether the child has a disability and if so, the nature of the disability;
114 (b) in the case of a conviction referred to ...
(iii) whether the child has a disability and if so, the nature of the disability;
114 (c) in the case of a finding by a children's court ...
(iii) whether the child has a disability and if so, the nature of the disability;

118. Purpose of Part B:
...is to have a record of persons who are unsuitable to work with children and to use the information in the Register in order to protect children in general against abuse from these persons.

Chapter 8: Prevention and early intervention (143)

Prevention and early intervention programmes must focus on
a) Preserving a child’s family structure, developing parenting skills, promoting appropriate interpersonal relationships within the family, etc.
b) Providing psychological, rehabilitation and therapeutic programmes for children.

Habilitation programmes are neglected.

Prevention and early intervention programmes may include:
Assisting and empowering families to obtain basic necessities. Promoting the well being of the child and the realisation of their full potential.

Chapter 14: Drop in centres. (213)

A drop in centre is a facility providing basic services aimed at meeting the emotional, physical and social development needs of vulnerable children.

A drop in centre may offer any programme, which includes primary health care in collaboration with the local health clinic, referral to social workers and prevention and early intervention programmes.

Strategy concerning drop in centres [214. 1]
The Minister after consultation with interested persons and the Ministers of Finance, Health, provincial and local government
and Transport must include in the departmental strategy a strategy aimed at ensuring an appropriate spread of drop in centres throughout the Republic, giving due consideration as provided in section 11, to children with disability and chronic illnesses.

8. **Mental Health Care Act, Act 17 of 2002**

The intention of this Act is to promote and protect the rights of people with mental disorders through a number of legal requirements and safeguards that dictate the procedural flow and clinical management of mental health service users. It requires the establishment of Mental Health Review Boards that are to function as appropriately skilled and resourced bodies, and able to act independently and autonomously in ensuring the proper implementation of the Act and its regulations.

- Specifically provides for the assessment and determination of educational support needed and where it must be provided for users in the compulsory age groups.

### SECTORAL POLICIES

**Department of Social Development**

9. **Disability Policy – Dept of Social Development**

**Aim:**
- Guide and inform the mainstreaming of disability through developing and implementing departmental policies, strategies and integrated service delivery programmes.
- Facilitate the provision of integrated social services to people with disabilities
- Provide guidance to the development in terms of addressing social barriers that exclude people with disabilities which impede full and equitable integration and inclusion into mainstream society.

Focuses on the provision of integrated developmental social services through 3 programme areas:

1. **Social Security**
   - Management and oversight of financial grants to the poor, the vulnerable and those with special needs.

2. **Social Welfare**
   - Provision of developmental social welfare services in partnership with other role-players such as state funded institutions, NGO’s, DPO’s etc.

3. **Community Development**
   - To enhance and increase the capacity of communities to respond to their needs and improve their capacity for development.

**Levels of intervention:**
- **Prevention** – aimed at strengthening and building the capacity and self-reliance of service recipients; e.g. awareness raising, advocacy programmes, education and counselling services, addressing attitudes and misconceptions.
- **Early Intervention (non-Statutory)** – level of intervention is developmental and therapeutic in addition to above, includes
social protection programmes, care and support services, promoting sustainable livelihoods, provision of social security services, family support services, community-based rehabilitation programmes.

Statutory Intervention / residential / alternative care – for individuals who are unable to function in the community and require removal to alternative care or a residential facility as a temporary measure. Includes: rehabilitation services, security services, mediation services, assisted living and independent living programmes, day care and community-based care.

Reconstruction and after care – efforts to reintegrate the person back into their families and communities. Includes: rehabilitation services, HIV AND AIDS services, victim empowerment.

10. Social Assistance Act (No 13 of 2004).

Objects of the Act:
(a) Provide for the administration of social assistance and payment of social grants;
(b) Make provision for social assistance and to determine the qualification requirements in respect thereof;
(c) Ensure that minimum norms and standards are prescribed for the delivery of social assistance; and
(d) Provide for the establishment of an inspectorate for social assistance.

Eligibility for social assistance:
5 (1) (c) is a SA citizen or is a member of a group or category of persons prescribed by the Minister, with the concurrence of the Minister of Finance, by notice in the Gazette;
5 (2) The Minister may prescribe additional requirements or conditions in respect of -
(a) income thresholds;
(b) means testing;
(c) age limits, disabilities and care dependency;
(d) proof of and measures to establish or verify identity, gender, age, citizenship, family relationships, care dependency, disabilities, foster child and war veterans' status.

Care dependency grant
7 (a) A person is ... eligible for a care dependency grant if he or she is a parent, primary care giver or foster parent of a child who requires and receives permanent care or support services due to his or her physical or mental disability.

7 (b) A person ... is not eligible for such a grant if the child is cared for on a 24 hour basis for a period exceeding six months in an institution that is funded by the State.

Foster child grant
8 A foster parent is, subject to section 5, eligible for a foster child grant for a child for as long as that child needs such care if-
(a) the foster child is in need of care
### Abuse of social grants

19 (1) Where the Agency (SASSA) has reasonable grounds to suspect that a beneficiary, parent, procurator, or a primary care giver is abusing the social grant, the Agency may appoint a person to investigate such suspected abuse.

19 (3) (a) The Agency may suspend payment of a child support grant, foster child grant or a care dependency grant to a parent, primary care giver, foster parent or procurator where the parent, primary care giver, foster parent or procurator –

- (i) is convicted of abuse or neglect...
- (ii) is found ... to be incapable of using a grant for the benefit of the child in respect of whom he or she received it.

### 11. Policy on the Provision of social rehabilitation services to people with disabilities

This policy reflects internationally accepted approaches as found in Article 26 of the adopted UN convention on the Rights of People with Disabilities and states that “Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental and vocational ability and full inclusion and participation in all aspects of life.”

This policy incorporates national and international directives, and best practice methods to ensure that DSD provides combined and integrated social rehabilitation services that equally address the cause and consequences of disability.

Health, employment, education and social services are organized and strengthened to enable services and programmes to:

- Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths.
- Support participation and inclusion in the community and all aspects of society that are voluntary and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

Rehabilitation services are comprised of three key areas, namely: psychosocial support, skills development and environmental modification.

This policy supports and promotes social, vocational, educational and community based rehabilitation (CBR) through the following services and programmes: prevention, early intervention, statutory and rehabilitation.

An Individual Rehabilitation Plan (IRP) is developed for all persons with a disability at different levels; institution, community or integrated, which is integrated in the Individual Development Plan (IDP).

### Department of Health


GOAL: “...to improve accessibility to all rehabilitation services in order to facilitate the realisation of every citizen’s constitutional right to have access to health care services...”

OBJECTIVES:

1. “accessibility... mechanisms for intersectoral collaboration... facilitate appropriate allocation and utilisation of...”
resources...human resource development...monitoring and evaluation strategies for rehabilitation programmes...participation of persons with disabilities...research in rehabilitation”

HUMAN RESOURCES COMPONENT:
(2) Planning:
  o “The skills, experience and expertise of all health personnel should be used optimally to ensure maximum coverage and cost effectiveness
  o “That rehabilitation personnel should form part of the Primary Health Care Team…”

(3) Changing the nature of management:
  o “Management of programmes should be decentralized to the provincial and district levels…”
  o “Health service managers should be supported in acquiring the skills needed to manage a decentralized health service”
  o “Effective evaluation techniques and procedures should be introduced to assess management efficiency at all levels of the health service”

(4) Building capacity:
  o “Management skills at all levels should be developed if substantive health reform is to be sustained”
  o “Institutional capacity to support human resource planning and management should be developed”
  o “There should be a portfolio for disability prevention and rehabilitation services at provincial level to ensure development and coordination of services”

10 GUIDELINES FOR ESTABLISHING A REHABILITATION PROGRAMME:
(1) Services that are affordable, equitable and accessible to all
(2) Accountability of service providers and users
(3) Social reintegration
(4) Comprehensive service which covers all components of rehabilitation – needs a clearly defined referral system
(5) Balance between institution based and community based services
(6) Participation of persons with disabilities
(7) Optimal use of all resources – services coordinated between various levels
(8) Physical, social and economic independence and reintegration into society
(9) Inter-sectoral collaboration
(10) Minimum norms and standards and indicators for different components of rehabilitation should be the basis of service evaluation and monitoring

Department of Education

The policy aims to:
Inclusive Education and Training involves:

1. Changing general education and training so that they facilitate learning of all learners and that barriers to learning can be identified early and get appropriate support;
2. Improving and enhancing skills and knowledge of educators in ordinary schools, and establishing full-service schools so that learners who have mild to moderate disabilities can be adequately accommodated in these schools through appropriate support from district-based support teams; and
3. Upgrading the quality of special schools so that they, together with district-based support teams, can function as resource centres that provide quality service for learners who need high levels of support, as well as support full-service and ordinary schools.
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