

Government-funded programmes and services for vulnerable children in South Africa



We look out for our children
SIZE
Sibhekelela izingane zethu



NEW YORK UNIVERSITY



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Human Sciences
Research Council

Commissioned by the Principal Investigators and Project Management group of SIZE:
The Wellbeing of South African Children – Linda Richter, Lawrence Aber, Vuyiswa Mathambo
and Erin Godfrey.

Published by Human Sciences Research Council
134 Pretorius Street
Pretoria 0002
South Africa
www.hsrc.ac.za

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First published 2010

Production by HSRC Press

Patricia Martin from Advocacy AID was commissioned to research and write the report.
Suggested citation: Martin P (2010) *Government-funded programmes and services for vulnerable children in South Africa*. Cape Town: HSRC Press

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ACKNOWLEDGEMENTS

The US National Institute of Child Health and Development, the Rockefeller Brothers Fund, the University of California at Los Angeles and UNICEF South Africa for financial support.

The Alliance for Children's Entitlement to Social Security (ACCESS) where, as Director, Patricia Martin acquired much of her knowledge of and expertise in socio-economic policies and laws affecting children.

Sonia Giese, Karen Kallmann and Laura Markowitz who, while working as researchers for ACCESS, tirelessly tracked and documented policies affecting children, laying a strong foundation for this project.

George Laryea-Adjei, Andries Viviers, Nkechi Obisie-Nmehielle and Bjorn Gelders from UNICEF South Africa for working towards a comprehensive and final product. UNICEF South Africa for the willingness to sponsor the publication and distribution of the report.

ACRONYMS AND ABBREVIATIONS

ACCESS	Alliance for Children's Entitlement to Social Security
ACRWC	African Charter on the Rights and Welfare of the Child
ART	antiretroviral therapy
ARV	antiretroviral
CASP	Comprehensive Agricultural Support Programme
CCMT	comprehensive HIV and AIDS care, management and treatment plan
CDG	care dependency grant
CSG	child support grant
CTX	Cotrimoxazole
DAFF	Department of Agriculture, Forestry and Fisheries
DHS	Department of Human Settlement
DoBE	Department of Basic Education
DoE	Department of Education
DoH	Department of Health
DoHA	Department of Home Affairs
DoJCD	Department of Justice and Constitutional Development
DoL	Department of Labour
DoME	Department of Minerals and Energy
DoP	Department of Police
DoSD	Department of Social Development
DWA	Department of Water Affairs
ECD	early childhood development
EPWP ECD	expanded public works ECD programme
FCG	foster child grant
FCS	family violence, child protection and sexual offences
HCBC	Home- and community-based care
IMCI	Integrated management of childhood illnesses
INP	Integrated Nutrition Programme
MAFISA	Micro-Agricultural Finance Initiative of South Africa
NCLPA	National Child Labour Programme of Action
NGO	non-governmental organisation
NIP for ECD	National Integrated Plan for Early Childhood Development in South Africa, 2005–2010
NPA	National Prosecuting Authority
NPO	non-profit organisation
NPR	National Population Register
NSNP	National School Nutrition Programme
NSP	HIV and AIDS and STI National Strategic Plan, 2007–2011 Nutrition Supplementation Programme
NVP	Nevirapine
OAP	old-age pension
OVC	orphaned and vulnerable children

PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission
SAPS	South African Police Services
SASSA	South African Social Security Agency
TB	tuberculosis
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund

Introduction

Families under stress vary in their access to government-funded social protection, such as grants and quality services, as well as to different kinds of community support. This variability in access has implications for their well-being and that of their children. Grants are social cash transfers like the old-age pension (OAP) and the child support grant (CSG). Other social protection mechanisms include government-provided schooling, healthcare and social welfare services. Community support includes assistance provided by civil society organisations, community groups, neighbours and families.

This review was undertaken as one of the preparatory activities for a study that aims to describe how children, families and communities cope with the combined challenges of poverty and HIV/AIDS; how and why families and children affected by HIV/AIDS and poverty vary in their access to grants, services and community support; the links between poverty and HIV/AIDS and children's well-being; and the influence of grants and services on families and children, and what families need from the state, civil society and their communities to assist them to support children's well-being in conditions of poverty and HIV/AIDS.

South Africa is a middle-income country, yet two-thirds of all children live in households with incomes below the poverty line. In addition, many of these poor children do not have access to good-quality education, health and social services. Since the advent of the South African democratic state in 1994, a number of policies and programmes have been put in place to support children and families. Despite this, most South African children still live in very difficult circumstances.

Large numbers of South African children are being adversely affected by poverty and the HIV/AIDS epidemic. South Africa has the largest number of HIV infections in the world. In 2009 alone, 310 000 people are estimated to have died of AIDS-related illnesses. Approximately 11 per cent of South African adults are estimated to be living with HIV, more than half of whom are resident in the provinces of KwaZulu-Natal and Gauteng. The prevalence rises to nearly 40 per cent among women attending public antenatal services in the worst affected areas. The most recent estimates are that 12.9 per cent of all children aged 2–18 years have lost one or both parents, and that close to half of all parental deaths are due to AIDS-related mortality.

When adults get sick, become unable to work, do household chores or care for children, and perhaps even die, children may lose not only the care provided by parents but also income and livelihood security, as well as their prospects of remaining in school and in their home.

It is agreed at the international level that social protection, particularly income support paid to the poorest families in communities affected by HIV/AIDS, is a strong policy option for mitigating the combined effects of poverty and HIV/AIDS on children. In budget and beneficiary terms, the CSG is one of the largest programmes targeted at children in low- and middle-income countries. More than 8 million children benefit from the CSG, with eligible (income means-tested) caregivers receiving R240 per month for children 16 years and younger. Although access to the CSG is improving, available research indicates that approximately 20 per cent of eligible families, mostly the poorest, are not yet receiving grants for which they are eligible.

Enrolment in education, at least until the compulsory age of 15 years, is estimated to be over 85 per cent and most South Africans now live within five kilometres of a health service. But the poorest families, some labour constrained by age and/or disability, socially isolated and in other ways disadvantaged, continue to fall between the cracks and do not receive grants such as the OAP and the CSG, which help children to enrol and attend school, or receive the preventive health services prescribed for young children, such as immunisations and nutritional supplements.

SIZE,¹ a study of the well-being of children, aims to provide some answers to these very important questions. SIZE is a longitudinal study that follows children and their families for two and a half years. Children are enrolled in the study in the first few years of school, when they are between 7 and 10 years of age.

The study is being undertaken by a team of researchers at the Human Sciences Research Council (HSRC) in South Africa, New York University (NYU) in the United States and collaborators locally and internationally.

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1 SIZE is an acronym for *sibhekelela izingane zethu*, Zulu for 'we look out for our children'.

Children's rights in South Africa

Children's rights in South Africa are protected by international, continental and national law. Three of the primary sources of law are the 1990 United Nations Convention on the Rights of the Child (UNCRC), the 1990 African Charter on the Rights and Welfare of the Child (ACRWC) and the Constitution of the Republic of South Africa (Act No. 108 of 1996).

These instruments guarantee the following rights for children and their families, which are essential to the health, well-being and optimal development of all children:

- a name and a nationality from birth;²
- basic nutrition, shelter, basic healthcare services, and social services;
- family care, parental care or appropriate alternative care;
- protection from maltreatment, neglect, abuse or degradation;
- protection from work practices that undermine child well-being;
- appropriate treatment when in conflict with the law;
- to have their best interests taken into account in every matter concerning the child;
- adequate housing;
- social security, including appropriate social assistance;
- basic education.

Who is a child?

The Children's Act, No. 38 of 2005 as amended takes its lead from the Constitution (section 28(3)), the UNCRC (Article 1) and the ACRWC (Article 2) in its definition of a child as a person under the age of 18 years.

Vulnerable children

All children are vulnerable due to their inherent characteristics.

Their vulnerability arises from their physical characteristics, special emotional and developmental needs, their dependence on adult care and guidance, lack of legal capacity and inability to access many government services without adult assistance. (Liebenberg 2010: 229)

However, the government has recognised that some children are made more vulnerable than others due to the social and economic realities within which they live. Policy and law have prioritised the realisation of the rights of those children made more vulnerable by 'additional circumstances which aggravate their exposure to risk' (Liebenberg 2010: 230).

Which children are vulnerable?

Regionally, vulnerable children are defined as:

Children who are deprived or likely to be deprived or harmed as a result of their physical condition or social, cultural, economic, political circumstances and environment, and require external support because their immediate care and support system can no longer cope. Examples are children living in a household whose parent/s is infected with HIV, lives in a child headed or

2 UNCRC, Article 7 and ACRWC, Article 6

elderly household, who is disabled or the parents are disabled, who is HIV positive, who has been traumatised by war, living on the street, neglected by her/his parents, who is undocumented in other countries and is involved as a child labourer, among others. (SADC 2008: 6)

Although there are a number of laws and policies which provide care and support to vulnerable children, such as the Children's Act of 2005 as amended, only the Policy Framework on Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2005, provides a definition of a vulnerable child. In this Framework, vulnerable children are defined as 'children whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance that prevents fulfilment of his or her rights' (DoSD 2005: 5).

Children that are recognised as vulnerable in accordance with this national definition include:

- young children (0–9);³
- children living in poverty;⁴
- children who have a disability or are living with a chronic illness;⁵
- children in conflict with the law;⁶
- children living or working on the streets;⁷
- children in need of care and protection because of risk of harm or because they have been abandoned;⁸
- children who are undocumented minors and/or refugees;
- children who are orphaned;⁹
- children who are affected by HIV/AIDS, which includes children:¹⁰
 - who are vulnerable to infection, including those who are HIV exposed, e.g. perinatal exposure, sexual abuse, sexually active or engaged in transactional sex;
 - in households where there are sick persons and where children, due to ignorance, do not practise universal precautions;
 - who are infected with HIV;
 - whose parent or primary caregiver is terminally ill;
 - with no surviving parent or alternative caregiver to care for him or her;
 - who are abandoned;
 - who are in households that care for orphans and/or abandoned children and which often experience increased poverty as a result;
 - who experience high levels of mobility between households;
 - who experience multiple bereavements and trauma of death;
 - in households where they face significant physical, mental, social and emotional harm and neglect;
 - in need of legal protection and alternative family care.

3 National Integrated Plan for Early Childhood Development in South Africa, 2005–2010

4 South African Constitution; National Integrated Plan for Early Childhood Development in South Africa, 2005–2010; Policy Framework (DoSD 2005); HIV & AIDS and STI National Strategic Plan, 2007–2011

5 Children's Act, No. 38 of 2005 as amended by Act No. 41 of 2007 and No. 75 of 2008

6 Child Justice Act, No. 75 of 2008

7 Children's Act as amended by Act No. 41 of 2007

8 Children's Act as amended by Act No. 41 of 2007

9 Children's Act as amended by Act No. 41 of 2007; Policy Framework (DoSD 2005); HIV & AIDS and STI National Strategic Plan, 2007–2011

10 Policy Framework (DoSD 2005)

National policy frameworks guiding the development and implementation of policies

There are a number of national policy frameworks that have been developed 'to provide an overarching framework to support stakeholders in the development of comprehensive, age appropriate, integrated and quality responses' to the different vulnerabilities that children face in South Africa (DoSD 2005: 8). The frameworks in question are multidisciplinary. They all recognise that vulnerable children require complex and comprehensive responses which protect and nurture their full complement of rights. For this reason, the overarching frameworks do not fall within one single department, but embrace the full departmental spectrum that is responsible for the continuum of services and benefits to ensure the holistic well-being and development of vulnerable children.

These policy frameworks include:

- The National Integrated Plan for Children and Youth Infected and Affected by HIV/AIDS, 2000 (NIP)
- HIV & AIDS and STI National Strategic Plan, 2007–2011
- Policy Framework on Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2009–2012
- The National Integrated Plan for Early Childhood Development in South Africa, 2005–2010

Departmental interpretation of roles and responsibilities

Each department has interpreted the role assigned to it in terms of the overarching frameworks in a series of departmental policy documents and legislative instruments. These documents and laws make provision for the delivery of programmes and services to vulnerable children and their families. It must be noted that the approach adopted by all of the departments is primarily to provide programmes and services for all poor children and/or their families, rather than targeting specific vulnerable groups of children. In addition, many of the departmental responses do not target children specifically, but are aimed at either the broader family or the caregiver. This review will include these responses in so far as they benefit vulnerable children.

The objective of this review

The objective of this review is to identify and document the programmes and services provided by the different departments for vulnerable children as defined thus far. Specifically, the review aims, first, to identify within each relevant department what the available government-funded statutory services and programmes are that are offered to vulnerable children, or which have a beneficial impact on vulnerable children. The second aim is to identify, through a review of existing literature, any overt policy/legislative gaps and any gaps in the delivery of the programmes and services to vulnerable children and their families.

Department of Home Affairs

Introduction

The Constitution of the Republic of South Africa provides that 'Every child has the right to a name and nationality from birth' (section 28(1)(a)). This protection echoes the protection afforded by both the UNCRC (Article 7.1) and the ACRWC (Articles 6(1)(2) (3)). The latter two instruments both guarantee a child's right to a name and nationality. Moreover, all of the instruments recognise the complementary right to registration of the birth of the child from birth.

In South Africa, as in other countries, the key process to the realisation of the rights to a name and nationality is registration of the birth of a baby and the issuing of identification documents when the child reaches the age of 16. 'When the birth of a South African is registered, that child's name and birth date is linked to an identity number and a record is created on the National Population Register (NPR). This gives the child the identity of a South African citizen, with all the Constitutional rights and obligations that go with that status' (DoHA 2010: 3).

Linked to this is the issuing of identity documents, marriage certificates and death certificates for the caregivers of children. All of these documents are necessary for the registration of the birth of a child.

Key responsibilities related to vulnerable children and their families

The Department of Home Affairs (DoHA) is responsible for the registration of births, deaths, marriages and the issuing of identification documents for all people in South Africa. 'The Department is in essence the custodian of identity and citizenship' (DoHA 2010: 3). These documents are collectively referred to as 'enabling documents'.

The importance of birth registration and other enabling documents

Enabling documents are the cornerstone of the realisation of the right of every child to a name and a nationality from birth.

In addition, enabling documents are essential in order to benefit from most of the programmes that have been developed and implemented by government to realise the socio-economic rights guaranteed by the Constitution, whether for vulnerable children or their adult family members. Without access to enabling documents it is not possible to access income support, and without income support poor families struggle to access enabling documents. Enabling documents are required, however, not only to access social assistance (grants), but also healthcare, subsidised early childhood development (ECD), schooling, housing, free basic services such as water and electricity, and other services and benefits.

Furthermore, enabling documents are essential to enjoy inheritance rights and to access social insurance death and disability benefits upon the death or injury of a spouse or caregiver. Adults (and older children) who do not have enabling documents cannot engage in trade and employment activities. These documents are essential for getting a job, for purchasing a cell phone, for opening a bank account, for applying for credit, etc.,

all of which are critical tools for gainful employment and engaging in commercial life, both for children once they leave school and for their families.

Overarching policy responses to the importance of enabling documents

The fundamental importance of enabling documents, especially birth certificates, for vulnerable children is recognised in three of the most important overarching policy frameworks designed to address the needs of vulnerable children in South Africa.

HIV and AIDS and STI National Strategic Plan, 2007–2011 (NSP)

The NSP recognises enabling documents as critical to ‘mitigate the impact of HIV/AIDS and create an enabling environment for care, treatment and support’ (Goal 8), specifically in the context of orphaned and vulnerable children (OVCs). Goal 8.1 of the NSP is to strengthen the implementation of OVC policy and programmes, and it identifies a core intervention in this regard as the need to ‘increase the proportion of children obtaining vital documents such as birth and death registration’. Not surprisingly, this intervention is complemented by the need to ‘increase the proportion of vulnerable children accessing social grants (child support, foster care and care dependency), benefits and services’ (DoH 2007a: 83).

Policy Framework on Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2005

The OVC policy framework recognises the DoHA as one of the many critical role-players that must work as part of a coordinated effort to realise the rights of orphans and other children made vulnerable by HIV/AIDS, their caregivers, families and communities through the promotion, facilitation and provision of birth, death, marriage and identity documents and by providing mobile units to ensure greater accessibility of these services to targeted vulnerable communities.

National Integrated Plan for Early Childhood Development in South Africa, 2005–2010 (‘the NIP for ECD’)

The NIP for ECD, like the previous two frameworks, provides guidance as to the essential services that are necessary to ensure the holistic well-being of young children. It recognises that the well-being and optimal development of young children depends on early and easy access to birth registration and birth certificates.

Key policies

- Policy Framework on Orphans and other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS, 2009–2012
- The National Integrated Plan for Early Childhood Development in South Africa, 2005–2010
- The HIV and AIDS and STI National Strategic Plan, 2007–2011
- Department of Home Affairs Strategic Plan 2010–2013

Key legislation

- The Births and Deaths Registration Act¹¹ (No. 51 of 1992), amended by Act No. 67 of 1997 and Act No. 43 of 1998 and Regulations promulgated in terms of the Act
- The Marriage Act (No. 25 of 1961) and Regulations promulgated in terms of the Act
- Recognition of Customary Marriages Act (No. 120 of 1998) and Regulations promulgated in terms of the Act
- Identification Amendment Act (No. 47 of 1995) and accompanying Regulations
- The South African Citizenship Act¹² (No. 88 of 1995) as amended and accompanying Regulations
- The Refugees Act (No. 130 of 1998) and accompanying Regulations
- The Immigration Act (No. 13 of 2002) and accompanying Regulations

Programmes and services provided

- Birth registration and birth certificates
- Issuing of identity documents
- Registering deaths and issuing death certificates
- Registering marriages and issuing marriage certificates
- Processing applications for refugee status

11 The minister of home affairs tabled a Births and Deaths Registration Amendment Bill, B18–2010 before Parliament in July 2010. This Bill seeks to amend certain provisions relating to the registration of the birth of a child. The proposed revisions are discussed in more detail later in this chapter.

12 The minister of home affairs tabled a South African Citizenship Amendment Bill, B17–2010 before Parliament in July 2010. This Bill seeks to amend certain provisions relating to the acquisition of citizenship by birth and descent. The proposed revisions are discussed in more detail later in this chapter.

Table 2.1 Programme/service map: Department of Home Affairs

Programme/ service	Description of the programme/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Birth registrationⁱ	<p>The birth of every child that is born alive in South Africa must be registered with the DoHA within 30 days of the birth.</p> <p>Upon the registration of the birth, a birth certificate is issued.</p> <p>The first unabridged birth certificate is free.</p>	<p>Targeted beneficiaries All children</p> <p>Documents required</p> <ul style="list-style-type: none"> • Proof of birth of the child (either a birth notification certificate from the hospital where the baby was born or the Road to Health Card) • The mother's identity document • The father's identity document and the presence of the father himself at the registration service delivery point if the mother and father are not married and the baby is to be registered in the father's name • The mother and father's marriage certificate • The applicant will take these documents to Home Affairs and complete a B1-24 Application for Birth form. 	<p>The parents of the child must register the birth of the baby at any DoHA office or service point.</p> <p>Birth registration is done at all five tiers of service delivery. The five tiers are:</p> <ul style="list-style-type: none"> • regional offices; • district offices; • permanent service points and Thusong centres; • mobile units; • hospital registration sites.



→	Late registration of births for a child older than 1 but younger than 15 years	If a baby's birth is not registered before the child's first birthday, but before the age of 15 years, the birth registration process requires the parents to provide all the prescribed documents, plus they will have to complete an affidavit provided by Home Affairs (B1-288) confirming the child's identity. ⁱⁱ	<p>Targeted beneficiaries Children between the ages of 1 and 15 whose births have not been registered</p> <p>Documents required</p> <ul style="list-style-type: none"> • The same documents as listed for a birth registration above • Confirmation of the child's name, sex, age and other details taken from the school register of the first school attended by the child • The child's baptismal certificate if he or she has one • School reports 	<p>Late birth registrations are processed at regional and district level DoHA offices.</p> <p>Application may be made at any of the other tiers, for example a Thusong centre, but the application will be sent to the district or regional office for processing.</p>
	Issuing identity documents	<p>Any citizen or permanent resident who is 15 years or older must apply for an ID from the DoHA.</p> <p>It is free when you apply for an ID. The applicant will only have to pay for the photos.</p>	<p>Targeted beneficiaries All citizens and permanent residents older than 15</p> <p>Documents required</p> <ul style="list-style-type: none"> • A birth certificate • A marriage certificate if married • Four identity photographs 	<p>All five tiers of service delivery</p>
	Registering deaths and issuing death certificates	<p>A death certificate is issued by the DoHA when someone dies.</p>	<p>Targeted beneficiaries Living relatives of a deceased parent/caregiver</p> <p>How to obtain a death certificate</p> <ul style="list-style-type: none"> • A doctor examines the deceased's body and completes a certificate of death. • The certificate of death is given to the closest relative. 	<p>The medical practitioner, undertakerⁱⁱⁱ and Home Affairs are together responsible for the delivery of the death certificate.</p>



→	<p>A death certificate is important because it allows vulnerable children to claim their inheritance rights, to prove their right to benefits that the deceased was entitled to leave the child and because it allows the caregiver of a child whose parent(s) are deceased to claim a CSG to care for the child.</p>	<ul style="list-style-type: none"> • The relative takes the certificate of death to the funeral undertaker, who will complete the relevant sections of the form and send it to Home Affairs. • Home Affairs will issue a death certificate to the undertaker who will give it to the relative. • Once a death is registered at Home Affairs, a copy of the death certificate can be obtained from Home Affairs at any time. 	
<p>Registering marriages and issuing marriage certificates</p>	<p>When a couple get married in a civil marriage, they will receive a marriage certificate from the marriage officer, free of charge.</p> <p>The marriage is registered by the DoHA.</p> <p>Marriage certificates are important for children in the family as they will be required when registering the birth of a child, when applying for a CSG and when applying for death benefits in the event of the death of a married caregiver.</p>	<p>Targeted beneficiaries All married couples</p> <p>Documents required to obtain a marriage certificate</p> <ul style="list-style-type: none"> • IDs of the husband and wife • If either party is under 18, written permission from their parents • If either is divorced, a copy of the divorce order • If either is widowed, a copy of their deceased spouse's death certificate 	<p>The marriage officer issues the marriage certificate.</p>



→	<p>Applications for status as a refugee and permanent residence</p>	<p>A refugee is defined in the Refugee Act as anyone who has fled their country of origin because of a well-founded fear of persecution, or anyone who has been forced to leave their country of origin because of external aggression or armed conflict.</p> <p>The application for refugee status is called an application for asylum, which is made to the DoHA. If successful, the refugee will receive an 'Asylum seeker permit' or a section 22 permit.</p> <p>Once an applicant has a section 22 permit, they must attend a status determination interview. If the interview is successful, the applicant will be granted refugee status and be issued with a section 24 permit.</p> <p>After five years of receiving a section 24 permit, the refugee may apply to Home Affairs for permanent residence status.</p> <p>Children of refugees are entitled to certain benefits, such as attending school, provided they are able to prove their lawful presence in the country, which is proved by producing these and related documents.</p>	<p>Targeted beneficiaries</p> <p>Refugees and their dependents</p> <p>Rights of a lawful registered refugee</p> <ul style="list-style-type: none"> • A refugee is entitled to all the rights in the South African Constitution, except those reserved exclusively for citizens. • In practice, this means that a refugee and his or her dependents may not vote in elections or claim social assistance such as the CSG. • However, they are entitled to an education, healthcare, to apply for a FCG and the social relief of distress benefit. 	<p>Specified refugee centres set up within Home Affairs</p>
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Notes:

(i) *Births and Deaths Registration Act (51/1992), amended in Act 67/1997 and in Act 43/1998, as well as Regulations to the Act, No. 4908*

(ii) This process is likely to be changed to become more onerous once the Births and Deaths Registration Amendment Bill becomes law and the relevant Regulations relating to the application procedures for registration are promulgated. See discussion later in this chapter with regards to the proposed Bill.

(iii) The Births and Deaths Registration Amendment Bill makes provision for the designation of undertakers running funeral parlours, upon application, for the purpose of registering deaths and requires that the Director-General of Home Affairs keeps a register of all designated undertakers (Article 8).

Some key policy and service delivery gaps

It is a well-established fact that vulnerable children are particularly at risk of not being able to access their enabling documents. This aggravates their vulnerability. This review will explore some of the policy and service delivery disjunctures contributing to this risk for three particularly vulnerable groups of children: children living in poverty, very young children, and children affected by HIV/AIDS.

Children living in poverty

Over the past eight years there has been a general increase in the number of birth registrations in South Africa. In 2009, the births of 85 per cent of children were registered in the year of their birth (Stats SA 2010b: 2). This was an increase from 25 per cent in 1998. However, these improvements conceal pockets of poor registration in impoverished, especially rural, communities. Those who are poorest continue to have the poorest access to enabling documents.

There is a provincial and local variability in the proportion of children whose births are not registered, with a strong correlation between poverty and poor birth registration rates. The provinces with the greatest proportion of poor children have the lowest proportion of births registered in the year of birth. The situation is particularly severe in predominantly rural provinces. For example, in KwaZulu-Natal in 2005, only 62 per cent of births were registered in the year of birth, compared with 97 per cent in the Western Cape (Giese & Smith 2007; Stats SA 2006).

In KwaZulu-Natal, the birth registration rate is worst in the more rural areas. A survey conducted in 2005 in the rural Umkhanyakude district showed that between 10 per cent and 45 per cent of children attending primary school did not have a birth certificate and between 10 per cent and 15 per cent of children at high school did not have birth certificates. In 2003, a survey conducted by the Media in Education Trust of 35 schools in the rural areas of Mt Ayliff, Dudumeni and Flagstaff in the Eastern Cape revealed that 51 per cent of learners did not have birth certificates (in Giese & Smith 2007: 28).

Reasons for poor access to enabling documents

- A tendency by local community members and caregivers not to recognise the intrinsic importance of birth registration and enabling documents.¹³
- The multiplicity of supporting documents that are required to effect a late birth registration (after the age of one), the difficulty of obtaining these documents and the complexity of the types of documents that are required inhibit birth registrations (Giese & Smith 2007).
- The cost of transport to travel to Home Affairs (which is aggravated by the need for multiple visits), the cost of obtaining supporting documents, the cost of photocopies for certification purposes and the cost of photographs (Giese & Smith 2007).

¹³ This finding is supported by three separate research reports: Giese and Smith (2007), Peters and Williams (2009) and Save the Children UK (2006).

- There is a lack of accessible sites of service delivery in rural areas. In addition, both permanent and mobile service delivery sites in rural areas lack essential and basic resources. Both the Save the Children UK (2006) and the Peters and Williams (2009) reports document the lack of basic equipment in rural service centres, such as computers and photocopying equipment.
- Poorly trained and supervised staff, especially at Home Affairs service points in rural areas, create an obstacle to speedy and efficient processing of registrations and applications for certificates (Giese & Smith 2007; Peters & Williams 2009).
- Fraud and corruption by Home Affairs staff who extort money from already impoverished clients is a further obstacle to poor and vulnerable people obtaining their documentation.
- At present, there is only half the number of recommended sites of delivery required to meet demand in South Africa.¹⁴ The existing sites do not all offer a full complement of Home Affairs' services. Services are currently available through a five-tier service delivery structure:
 - 1 Regional offices (42 across the country)
 - 2 District offices (120 across the country)
 - 3 Permanent service points and Thusong centres (99 across the country)
 - 4 Mobile units (109 across the country)
 - 5 Hospital registration sites (101 across the country)

Birth registration is the only service that is available at all five tiers. Late birth registrations are only available at regional and district levels.¹⁵

Services in rural areas

The Thusong centres, mobile units and hospitals are intended to address the reach of services into rural, impoverished areas.

Thusong centres

Previously known as Multi-Purpose Community Centres, the Thusong centres were established in terms of the Thusong Service Centre Programme in 1999. The objective of the centres is to extend government services, in an integrated manner, into rural and outlying underserved communities. The services offered at the centres include accessing birth certificates and identity documents, grants and housing applications.¹⁶

However, there are not enough Thusong centres in the targeted communities. As a result, the travelling distance and cost involved remain barriers in some of the communities serviced by these centres. In addition, the centres are insufficiently resourced. For example, the study conducted by Peters and Williams (2009) in the Ratlou district in the North West province found that there was only one Thusong centre in the district. It was at least 10 kilometres from the closest villages. The cost of transport for those closest to the centre is R7, which is a significant sum of money for the impoverished community members of Ratlou. Furthermore, there is only one staff member staffing the centre and the centre has no computer facilities, so all applications have to be sent to district offices to be processed.

14 The Council for Scientific and Industrial Research (CSIR) was commissioned by the DoHA to review its 'footprint'. The working assumption was that people should not have to travel more than 30 minutes to their closest service point and mobile units should serve communities of less than 20 000 (in Giese & Smith 2007).

15 Acting Deputy Director-General: Civic Services, 2008; available at <http://www.pmg.org.za/report/20080801-access-education-children-special-needs-birth-certificates-and-id-doc>

16 Thusong Service Centres, Business Plan 2006–2014; available at http://www.thusong.gov.za/documents/establish_rollout/business_plan/reports/thusongbusplan.pdf

Mobile units

These were established in 2006 to reach into impoverished and marginalised rural communities. They have proven to be very useful in filling the rural service delivery gap. However, there are a number of problems in accessing the mobile units and the services they offer. These include:

- insufficient consultation with communities about where mobile services should be sent and a lack of accessible and accurate information about where and when mobile service delivery units will be available in rural areas. For example, in the Ratlou district, reliance is placed on a social network for the distribution of information about the days on which mobile trucks will visit a particular area. The social network is made up of community development workers, ward councillors, ward committees, tribal authorities, chiefs and local pension committees. Social networks of this kind cannot be relied on to convey the information (Peters & Williams 2009);
- insufficient numbers of mobile units;
- no dedicated staff for the mobile units;
- equipment in the units is often out of order and this means that documents cannot be issued. All that they can do is take the application and the applicant must still travel to the nearest fixed service point to collect the documents, defeating the objective of the mobile units (Giese & Smith 2007).

Hospital birth registrations

The DoHA has provided equipment and staff to 110 hospitals across South Africa with maternity and obstetric units to process immediate birth registration for newborn babies.¹⁷

Young children

A 2005 study in KwaZulu-Natal found that birth registration was poorest among very young babies (Dove & Naude 2005). In the research sample, 38 per cent of children between the ages of 0–3 months did not have birth certificates, 19 per cent of children between 3–12 months were not registered, 16 per cent of children 1–15 years did not have birth certificates and 13 per cent of children over the age of 15 years had not been registered.

These findings regarding young babies in poor rural communities were confirmed in a study conducted in 2009 in the rural communities of Mbizana in the Eastern Cape and Ratlou in the North West province (Peters & Williams 2009). The areas were chosen because of their predominantly rural character and high poverty levels. The take-up of the CSG in these areas is very low. Only 56 per cent of children that qualify for the CSG in Mbizana receive it, and this figure is even lower in Ratlou, where only 37 per cent of children receive it. Generally, there is a delay in accessing the CSG for children from birth to three years. The primary reason for the low levels of access to the grant is lack of enabling documents.

Reasons for very young children's poor access to enabling documents

The reasons for especially young children not having birth certificates are diverse. However, a common theme is the difficulty their mothers and caregivers experience in obtaining the supporting documents necessary to register the birth of the baby. This is

¹⁷ Acting Deputy Director-General: Civic Services, 2008; available at <http://www.pmg.org.za/report/20080801-access-education-children-special-needs-birth-certificates-and-id-doc>

often complicated by the lateness of the registration of the birth, which requires additional supporting documents. Unlike in predominantly urban areas, many of the births are not hospital or clinic births, but home births. As such, there is no formal hospital-issued birth notification certificate, which would suffice as proof of the birth of the baby for the purpose of registering the birth. In the absence of a birth notification certificate, the application for birth registration must be supported by a Road to Health/Clinic Card. Getting a Road to Health Card is a barrier. Some of the clinics will not, for a variety of reasons, give the child/caregiver a Clinic Card until the child is due for its first immunisation (at six weeks). This introduces delays into the registration process. Some clinic staff do not see the intrinsic and valuable link between birth registration (and subsequent access to grants and other services) and child well-being, which is precisely what the Road to Health Card is designed to facilitate and monitor. In addition, because the Road to Health Card is regarded by the DoHA as a legal document, any mistake made by the clinic staff on the Card will invalidate it for use as a registration supporting document (Giese & Smith 2007).

The need for proof of paternal identity for the registration of the birth is another aggravating factor. If the parents wish to register the baby with the name of the father, but the mother and father are not married, then the father must be present at Home Affairs when the birth is registered. This introduces delays in the registration process, especially when the father lives away from home, for example as a migrant labourer.

Traditional/cultural naming practices and processes in rural areas, which delay the naming of the baby, contribute to delayed registrations and the resultant documentation complications.

If mothers do not have an identity document, the registration of the birth of their baby is delayed. The birth registration Regulations require proof of maternal identity to register a baby's birth. In the case of mothers (often those that are younger than 16) who have not yet obtained their identity documents, the registration of the birth is delayed until the mother has done so. In some cases the grandmother registers the baby, identifying herself as the mother (Giese & Smith 2007). The latter practice is unlawful and itself causes further complications and delays further down the road when the mother does obtain an identity document and wishes to register the baby with her name.

The DoHA is recognised as a key partner in the integrated model of service delivery that is contained in the NIP for ECD. However, a review of coordinating structures set up by government to address the comprehensive needs of vulnerable children revealed that the DoHA was not, at the time of the review, represented on the National Interdepartmental Committee for ECD, which is responsible for the planning and implementation of the NIP for ECD (Giese & Sanders 2008). This represents a missed opportunity to address the gap in the early registration of babies within the context of an integrated service delivery plan.

Children affected by HIV/AIDS

Many of the difficulties associated with birth registrations and accessing enabling documents are aggravated in the context of HIV/AIDS. Poverty levels, maternal illness, death and increased child mobility in AIDS-affected communities leaves many children without supporting documents and/or the adults required to register their births.

Reasons for HIV/AIDS-affected children's poor access to enabling documents

HIV/AIDS often aggravates poverty levels in families. This in turn aggravates the cost barriers preventing access to enabling documents.¹⁸

Sick parents and caregivers often cannot attend to the registration of births themselves and this creates a need for additional supporting documents when someone other than the biological parent seeks to register the birth of the baby (these additional documents come at extra effort and cost for the child's caregivers).

Often children are cared for by elderly caregivers, which results in additional barriers to accessing birth certificates. These include the difficulties of travelling and the fact that the elderly are not the target of registration messages in awareness-raising and publicity campaigns.

The prevalence of child mobility in families affected by HIV/AIDS often results in lost documents and difficulties in accessing the parents' and/or the child's documents

Family feuds involving orphans can result in the withholding of the child's documents from the custodial caregiver.

The stigma of HIV/AIDS inhibits relatives from applying for documents as they do not want to explain the situation to judgemental officials.

The prevalence of orphaning compounds the plethora of maternal and paternal identity issues inherent in the birth registration regulatory processes. For example, proof of maternal identity is problematic if a child's mother has died.

The Turnaround Strategy

The DoHA initiated a Turnaround Strategy in 2007 to address a number of the underlying obstacles preventing realisation of the right to an identity, to birth registration and other enabling documents. The Strategy aims to create a 'more efficient, customer- and business-friendly Home Affairs structure able to fight corruption effectively, deliver services on time, and serve the needs of the population' (DoHA 2007: 8).

The Department notes in its 2010–2013 Strategic Plan that the Turnaround initiatives have reduced errors, increased efficiency and reduced fraud through more stringent security features in order to secure the identity and status of citizens, and that this has 'been particularly appreciated by the rural poor' (DoHA 2010: 10).

The Department has announced plans to further reduce fraudulent sales of enabling documents by corrupt officials and syndicates through legal amendments to the births registration process, which will see the early registration of birth (in other words, registration within 30 days of birth) as the only entry point to the NPR for citizens. The corollary of this is that the late birth registration process (registration after the age of one year) will be replaced with a far more stringent process (DoHA 2010: 10). These proposals emerged in two Bills tabled before Parliament in July 2010, namely the Births and Deaths Registration Amendment Bill (B18–2010) and the South African Citizenship Amendment Bill (B17–2010).

¹⁸ Giese S, presentation made to the SA Aids Conference, April 2009 (unpublished; a copy of the presentation is in the possession of the author of this report)

There is the danger that the proposed amendments contained in these two Bills, whilst they may reduce fraud, will make the birth registration process more onerous, especially for the most vulnerable of children, such as those living in poverty in rural areas and those living with families affected by HIV/AIDS.

Births and Deaths Registration Amendment Bill

This Bill proposes a number of amendments to the birth registration process which will have an impact on the ability of caregivers, especially of vulnerable children, to register their births.

The Bill proposes that the birth of a child may only be registered by one of the child's parents, unless the parents are deceased. At present, the Act allows an alternative person to register the birth of a child if the parent(s) are unable to register the birth themselves. This raises concern in the case of absent parents or the case of parents being too ill to register the birth of their baby.

The Bill appears to reduce the time allowed for the early, as opposed to the late, registration of the birth of a baby. The current law regards any registration before the age of one year as an early birth registration and imposes an already onerous process and set of criteria on applicants seeking to register the birth after one year. Article 4 of the Bill reduces the time within which an early registration may take place from one year to 30 days after the birth, and further envisages an even more onerous late birth registration process after the 30-day period has expired. This creates the risk of frustrating the registration of the birth of vulnerable children whose births are not registered within 30 days of their birth.

Article 6 of the Bill does, however, seek to introduce some relief for vulnerable children who have lost their parents, by allowing for the registration of the birth of an orphaned or abandoned child by a social worker. Moreover, the Bill seeks to make provision for recording adoptions in the birth register in accordance with an adoption order granted by the court. The latter provision is one among a number which seek to align the terms and provisions of the Births and Deaths Registration Act with the Children's Act of 2005.

South African Citizenship Amendment Bill

The main objective of the Bill is to revise the provision in the South African Citizenship Act of 1995 relating to the acquisition of citizenship by birth, descent or naturalisation.

The Bill provides for the acquisition of citizenship by birth for a child born outside the Republic of South Africa, but whose parents, or one of whom, is a South African citizen.

The Bill confirms that if a child is born in South Africa to parents, one of whom lives in South Africa but has not been granted permanent residence and the other who is not a South African citizen, the child is not a South African citizen.

The Bill introduces a progressive measure in guaranteeing the right of a child with no citizenship or nationality and no right to such citizenship or nationality in any other country, the right to South African citizenship.

Furthermore, the Bill recognises a child born to parents who have been granted permanent residence status, as a South African citizen by birth, provided the child has lived in South Africa from birth to the age of majority and his or her birth is registered in the NPR. The Bill further provides that an adopted child acquires citizenship by descent.

Department of Social Development

Introduction

The Department of Social Development (DoSD) is mandated to facilitate human development and improve the quality of life through the provision of comprehensive, integrated, sustainable and high-quality social development services to help reduce vulnerability and poverty.

The Department's mandate is realised through its three core functions (DoSD 2010a): to provide comprehensive social security systems; to provide developmental social welfare services; and to provide community development services.

Key responsibilities related to vulnerable children and their families

The DoSD is responsible for realising and protecting the following constitutional, regional and international rights of children and their families:

- family care, parental care or appropriate alternative care;¹⁹
- basic social services;²⁰
- protection from maltreatment, neglect, abuse or degradation;²¹
- access to social security, including appropriate social assistance.²²

Key policies

- White Paper on Social Welfare, 1997
- The National Integrated Plan for Children and Youth Infected and Affected by HIV/AIDS, 2000
- Integrated Food Security Strategy, 2002
- National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS, 2002
- Policy Framework on Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- The Service Delivery Model, 2006
- National Integrated Plan for Early Childhood Development in South Africa, 2005–2010
- HIV & AIDS and STI National Strategic Plan, 2007–2011
- Strategic Plan 2010–2015, Department of Social Development
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2009–2012
- Policy on Financial Awards to Service Providers
- Expanded Public Works Programme Social Sector Plan, 2004/05–2008/09

19 South African Constitution, s28(1)(b); ACRWC, Articles 18, 19; UNCRC, Article 9

20 South African Constitution, s28(1)(c); ACRWC, Article 20(2); UNCRC, Article 18(2)

21 South African Constitution, s28(1)(d)(e)(f); ACRWC, Articles 15, 16, 21; UNCRC, Articles 19, 34, 37, 39

22 South African Constitution, s27(1)(c); ACRWC, Article 20(2); UNCRC, Article 26(1)

Key legislation

- Social Services Professions Act, No. 110 of 1978
- Social Assistance Act, No. 59 of 1992
- Welfare Law Amendment Act, No. 106 of 1997
- Social Assistance Act, No. 13 of 2004
- Children's Act, No. 38 of 2005 as amended by Act No. 41 of 2007 and the Child Justice Act, No. 75 of 2008 ('the Children's Act')
- Social Assistance Amendment Act, No. 6 of 2008
- South African Social Security Agency Act, No. 9 of 2004
- Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008

Programmes and services provided

The programmes and services provided by the DoSD to realise and protect the rights of children and their families fall into three categories:²³ comprehensive social security, developmental social welfare services, and community development services.

Comprehensive social security

The right to social security is protected internationally, regionally and nationally. The UNCRC specifically obliges 'State Parties [to] recognize for every child the right to benefit from social security, including social insurance, and [to] take the necessary measures to achieve the full realization of this right' (Article 26(1)). The ACRWC in turn obliges State Parties to 'assist parents and other persons responsible for the child and in case of need provide material assistance and support programmes' (Article 20(2)). At a national level, the South African Constitution guarantees that 'everyone has the right to have access to social security, including, if they are unable to support themselves and their dependents, appropriate social assistance' (section 27(1)(c)).

Social security includes both social assistance (non-contributory schemes) and social insurance (contributory schemes).²⁴ Social security is aimed at:

- supporting adults whose earning power has permanently ceased, been interrupted, never developed, or is being exercised only at unacceptable social cost and such a person is in consequence not able to avoid poverty;
- supporting children in need of maintenance.²⁵ The obligation to provide social security for children in need of maintenance applies, in the first instance, to children who are removed from their family setting. However, it is not limited to this scenario. There is also an obligation on government to provide social security to children whose parents are unable to provide their children's rights.²⁶

²³ The author has organised the programmes and services offered in the programmatic order provided by the Department's 2010–2015 Strategic Plan (DoSD 2010).

²⁴ Social security is defined in the White Paper for Social Welfare in South Africa (1997) as 'a wide range of public and private measures that provide cash or in-kind benefits, or both, first in the event of an individual's earning power permanently ceasing, being interrupted, never developing, or being exercised only at unacceptable social cost and such person being unable to avoid poverty. And secondly, to maintain children...It includes both social assistance and social insurance (contributory schemes)'.

²⁵ White Paper for Social Welfare in South Africa, 1997

²⁶ In both the *Grootboom* (Government of the Republic of South Africa and others v *Grootboom* and Others 2001 (1), SA 46 (CC) 2000 (11) BCLR 1169 (CC)) and the *TAC* (Minister of Health & Others v *Treatment Action Campaign* and Others 2002 (5) SA 721 (CC) 2002 (10) BCLR 1033 (CC)) cases, the courts decided that parents carry the primary responsibility for providing children's socio-economic rights. Where children are removed from the family setting, then the state is the primary duty bearer and must provide the child's socio-economic rights provided for in sections 27 and 28 of the Constitution. This does not mean that the state has no obligation to a child living with his or her family. While parents are the main providers, if the parents are unable to provide their children's rights, the state must ensure that the rights are protected.

Contributory schemes include the Unemployment Insurance Fund and the Workmen's Compensation Fund, which fall within the mandate of the Department of Labour (see Chapter 6).

Non-contributory social assistance services that are provided for vulnerable children and their families include the following:

- CSG;
- foster child grant (FCG);
- care dependency grant (CDG);
- social relief of distress benefit;
- the older person's grant;
- disability grant;
- grant-in-aid.

Developmental social welfare services

The DoSD identifies as one of its core functions the provision of developmental social welfare services that help reduce poverty, vulnerability and the impact of HIV/AIDS. 'Developmental social welfare covers a range of services and programmes that are directed at enhancing the capacities of people to address the causes and consequences of poverty and vulnerability' (DoSD 2006b: 6).

It provides these services through sustainable development programmes in partnership with implementing agents such as state-funded institutions, non-governmental organisations (NGOs), community-based organisations and faith-based organisations. The services provided within the sphere of social services are classified into various levels of intervention by the Service Delivery Model and the Children's Act.

Prevention services

This is regarded as the most important aspect of developmental social service delivery. These services are aimed at strengthening and building the capacity and self-reliance of the client.

The Children's Act dedicates an entire chapter (Chapter 8) to prevention and early intervention services. Prevention services are, in terms of this Act, to be 'provided to families with children in order to strengthen and build their capacity and self-reliance to address problems that may or are bound to occur in the family environment which, if not attended to, may lead to statutory intervention' (section 143(1)).

Early intervention services

Services at this level are aimed at assisting people identified as being at risk before their circumstances deteriorate to the extent that they need statutory services, more intensive intervention or placement in alternative care.

Early intervention programmes are to be 'provided to families where there are children identified as being vulnerable to or at risk of harm or removal into alternative care' (section 143(2)).

The Act identifies prevention and early intervention services as fulfilling the following purposes (section 143(1)):

- (a) Preserving a child's family structure

- (b) Developing appropriate parenting skills and the capacity of parents and care-givers to safeguard the well-being and best interests of their children, including those with disabilities and chronic illnesses
- (c) Promoting appropriate interpersonal relationships within the family
- (d) Providing psychological, rehabilitation and therapeutic programmes for children
- (e) Preventing neglect, exploitation, abuse or inadequate supervision of children and preventing other failures in the family environment
- (f) Preventing the recurrence of problems in the family environment
- (g) Diverting children away from the child and youth care system and the criminal justice system

Statutory intervention/residential/alternative care

These services are aimed at supporting a child who has already become involved in court-based protection proceedings and/or who needs to be removed from their home environment and placed in alternative care or a residential facility.

Reconstruction and aftercare services

Statutory intervention should ideally be followed by these services so as to enable the client to return to their family or community.

The current policies and laws envisage these interventions being provided and/or facilitated through the following programmes:

- ECD programmes and services:²⁷
 - the Expanded Public Works ECD programme;
 - the National Integrated Plan for ECD;
 - registration of ECD centres;
 - ECD per learner subsidy;
 - partial care facilities;
 - non-centre-based ECD programmes.
- Prevention and early intervention programmes:²⁸
 - family assistance and empowerment to obtain the basic necessities of life;
 - provision of information to enable families to access services;
 - support for families with a chronically or terminally ill member of the family;
 - ECD;
 - promotion of the well-being of children and the realisation of their full potential.
- Statutory services for children in need of care and protection from abuse, neglect, maltreatment, exploitative labour, or because they have been orphaned or abandoned:²⁹
 - prevention services;
 - early intervention services;
 - reporting of suspected cases of abuse, neglect and/or abandonment;
 - intervention and removal of children in appropriate cases;
 - investigations and assessments in cases of suspected abuse, neglect or abandonment of children;
 - placement and integration of children in alternative care;

²⁷ Early childhood development is identified as an independent social welfare development programme and is dealt with in Chapter 6 of the Children's Act. It is, however, also one of the DoSD's core prevention and early intervention strategies and is therefore identified under the 'prevention and early intervention' heading and chapter as well.

²⁸ The Children's Act articulates these prevention and early intervention programmes in section 144(2).

²⁹ These services are provided for in Chapters 7, 9, 11, 15 and sections 104–142 of the Children's Act.

- therapeutic programmes;
 - foster/cluster foster care;
 - adoption of children;
 - reunification and reintegration services.
- Child protection services for children in a child-headed household:³⁰
 - designation of a supervising adult.
- The National Food Relief Programme:
 - food parcels.

Community development services

Home- and community-based care

Home- and community-based care (HCBC)³¹ is 'the provision of comprehensive quality health and social services in the home and community in order to promote, restore and maintain people's maximum level of comfort, social functioning and health'.³²

Community care forums

Community care forums (DoSD 2004) are 'community-based structures focusing on the needs of OVC in the community and ensuring that their needs are addressed. The purpose of community care forums is to ensure early identification of OVC, be aware of initiatives involving childcare and support, create awareness, assess children's needs, promote advocacy, and build capacity in families and communities'.³³

Drop-in centres

A drop-in centre³⁴ is a facility providing basic services aimed at meeting the emotional, physical and social development needs of vulnerable children.³⁵

³⁰ Section 137, Children's Act

³¹ Home- and community-based care has been regulated by a variety of policies and guidelines over the last decade. These include the National Integrated Plan for Children Affected and Infected by HIV/AIDS, 2000; the NSP 2007–2011; the OVC Policy Framework; various departments of Health and Social Development guidelines; and the Community Care Worker Policy Framework. These have all most recently been synthesised, in so far as they relate to HCBC, into a draft South African National Policy Framework for Home and Community Based Care and Support Programme, November 2009, departments of Social Development and Health. At the time of writing (August 2010), the DoSD advised that the draft was still open for comment, but was expected to be completed into a final version later in 2010.

³² National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS, 2009–2012

³³ National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS, 2009–2012

³⁴ Chapter 14, Children's Act

³⁵ Section 213, Children's Act

Table 3.1 Programme/service map: Department of Social Development

Comprehensive social security			
Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Child support grant (CSG)ⁱ	<p>A cash transfer of R250 per month paid to the qualifying primary caregiver for every child born on or after 1 October 1994 to supplement household income (CASE 2008)ⁱⁱ</p> <p>The sum of R250ⁱⁱⁱ per month is the amount paid as from 1 April 2010. This amount will in all likelihood increase in 2011 as the grant amounts are generally increased at the start of each new financial year to take inflation into account.</p>	<p>Targeted beneficiaries The caregivers of children born on or after 1 October 1994^{iv} living in poverty</p> <p>Qualifying criteria</p> <ul style="list-style-type: none"> • The child/children must have been born on or after 1 October 1994. • The income of the primary caregiver^v must fall below the means test income threshold.^{vi} If the caregiver is unmarried, the caregiver's annual income must be less than 10 times the annual grant amount. If the caregiver is married, then the joint annual income of the spouses must, when divided by two, be less than 10 times the annual grant amount. In practice, in 2010, this amounts to an income of less than R2 500 per month for single caregivers and R5 000 per month for married caregivers. • If the children are not the biological or adopted children of the caregiver, the caregiver may receive a grant for a 	<p>The South African Social Security Agency (SASSA)</p> <p>Thusong centres</p>



- maximum of six such children. If the children are the biological children, there is no limit.
- The child and caregiver must be South African citizens.
 - Documents needed for a grant application include a 13-digit bar-coded identity document for the primary caregiver and a 13-digit bar-coded birth certificate for the children. If these documents are not available, application can still be made with a sworn statement or an affidavit in a format prescribed by SASSA.^{vii}
 - The child must not be cared for in a state institution.
 - As of 1 January 2010, the DoSD has imposed additional requirements on the caregivers of children receiving the CSG with regards to the child's attendance at school:^{viii}
 - The caregiver of a child receiving the CSG that is between the ages of 7 and 18 must ensure that the child is enrolled at and is attending school.





- Within one month of approval of a CSG, the caregiver must provide proof of school or an educational institution enrolment and attendance to the SASSA.
- In addition, every six months the caregiver must submit, to the Director General of the DoSD, the child's school report card signed by the school principle.
- If the child is not enrolled or does not attend school, it does not mean that the CSG will be terminated or not granted. The Regulations provide that if the child is not enrolled at or attending school, the Director General (DG) of the DoSD must, in consultation with the National Department of Basic Education, initiate a social worker investigation. Once the DG receives the social worker's report, he or she must take appropriate steps to ensure that the child is enrolled at and attends school.



→	Foster care grant^{ix}	<p>A cash transfer of R710 per month per child (as at 1 April 2010) up to the age of 18 or until the child leaves school</p> <p>This amount will in all likelihood increase in 2011 as the grant amounts are generally increased at the start of each new financial year to take into account inflation.</p> <p>It is paid to a court-appointed foster parent for as long as the foster child is in the custody and care of the foster parent.</p> <p>The FCG can be extended or continued after the foster child turns 18 or leaves school, on the recommendation of a social worker, to enable the child to complete his or her secondary schooling or training or special education.</p>	<p>Targeted beneficiaries</p> <p>Foster parents appointed by a children's court in terms of the Children's Amendment Act, 2007</p> <p>Qualifying criteria^x</p> <ul style="list-style-type: none"> • A foster parent may not get a FCG for more than six foster children if the children are not his or her siblings or blood relatives. • All foster parents qualify, regardless of whether they are South African citizens, permanent residents or refugees. • There is no means test for the FCG. • Documents that must be provided when applying for the FCG include the 13-digit bar-coded identity document of the foster parent, if South African, an identity document issued to a refugee in terms of s30 of the Refugees Act, 1998, and a 13-digit bar-coded birth certificate for the foster child. • If these documents are not available, application may be made using alternative documents, including a sworn statement or an affidavit in a format prescribed by SASSA.^{xi} 	<p>SASSA</p> <p>Application is, however, often made with the assistance of a social worker – both those in the employ of the state and NGOs.</p>
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→	<p>Care dependency grant^{xii}</p>	<p>A cash transfer of R1 080 per month (as at 1 April 2010) paid to a parent, a primary caregiver or a foster parent of a child up to the age of 18 who requires and receives permanent home care due to his or her physical or mental disability</p> <p>This amount will in all likelihood increase in 2011 as the grant amounts are generally increased at the start of each new financial year to take into account inflation.</p>	<p>Targeted beneficiaries</p> <p>The parents/caregivers of a child (0–18) who receives permanent care or support services due to his or her disability</p> <p>A disability is defined in the Social Assistance Amendment Bill (effective from 1 March 2010) as the moderate to severe limitation of an applicant’s ability to function as a result of a physical, sensory, communication, intellectual or mental disability.</p> <p>In practice, in the case of children with AIDS, they qualify for the CDG only if they are so ill that they require permanent home care (in other words, they are at a terminally advanced stage of the illness).</p> <p>Exclusion</p> <p>The caregiver will not qualify if the child is cared for on a 24-hour basis for a period not exceeding six months in a state-funded institution.</p> <p>Qualifying criteria^{xiii}</p> <ul style="list-style-type: none"> • The parents and the care-dependent child must be South African citizens. • The child must be between the ages of 0–18. • Natural parents, adoptive parents and foster parents can apply. 	<p>SASSA</p>
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- If a foster parent is getting the FCG, they can also get the CDG. Foster parents do not have to pass the means test for the CDG.^{xiv}
- All parents/caregivers (other than foster parents) must earn less than the means test income threshold. If the caregiver is unmarried, then he or she must earn, in a year, less than 10 times the annual amount of the CDG. In practice, this means that he or she must earn (as at 1 April 2010) less than R10 800 per month. If married, the monthly joint income must be less than R21 600 per month.

Social relief of distress^{xv}	<p>A temporary form of help either in the form of food, food vouchers or a cash transfer which will be given for a maximum of three months</p> <p>Application can be made for an extension for a further three months under exceptional circumstances.</p> <p>When an application is made at the SASSA offices, the designated officer must approve or reject the application for SROD immediately.</p>	<p>Targeted beneficiaries Persons living in poverty in need of immediate temporary assistance</p> <p>Qualifying criteria^{xvi}</p> <ul style="list-style-type: none"> • The applicant does not have the means to care for him- or herself and their family. • The applicant must be a South African citizen, a permanent resident or a refugee. • The applicant could be waiting for payment of a social grant; or • has been assessed to be medically unfit to work for less than six months; or 	<p>SASSA</p> <p>Often, however, application is made with the support of a social worker, whether in the employ of the state or an NGO.</p>
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- is not receiving maintenance from a parent, child or spouse that is obliged in law to pay maintenance; or
- the breadwinner of the family has died. In which case the application must be made within three months of the death; or
- the applicant has been affected by a disaster as defined in the Disaster Management Act, 2002; or
- refusal of the benefit may cause undue hardship as set out in the DoSD's Procedural Manual for Social Relief of Distress.^{xvii}
- Examples of undue hardship that may qualify include:
 - a single parent who has to care for one or more children and is unable to take up employment because of their caring responsibilities;
 - children who live alone and have no access to daily meals;
 - families where there are symptoms of malnutrition and stunted growth in children.

Exclusions

No one may get a SROD benefit if they are in receipt of another grant.





Documents that must be submitted with the application for a SROD benefit

The identity document or birth certificate *or any other document acceptable to the agency* which proves the identity of the applicant, his or her spouse and the children dependent on the applicant.^{xviii}

Older person's grant^{xix}

Payment of a cash transfer of R1 080 per month (as from 1 April 2010) to older persons

Targeted beneficiaries
Older men and women living in poverty

SASSA

Qualifying criteria^{xx}

- Women aged 60 and over
- Men 61 and older from April 2009 and from 1 April 2010, 60 years and older^{xxi}
- The applicants must be South African citizens or permanent residents.
- They may not be cared for in a state institution.
- They must not be receiving another grant.
- The applicant must own less and earn less than the means test income and asset threshold.^{xxii}

Income threshold

R2 606 per month (R31 296 per year) if the applicant is not married and R5 216 jointly per month (R62 592 per year) if the applicant is married.





Even if the applicant qualifies in terms of the income threshold, but receives a regular income on a monthly basis above R606 per month, the applicant will not get the full pension amount. The applicant will receive a portion only of the full amount of R1 010.

Asset threshold^{xxiii}
 Assets up to the value of R518 400 if the applicant is not married and assets up to the value of R1 036 800 if the applicant is married.

Disability grant^{xxiv}	<p>A monthly cash transfer of R1 080 (as at 1 April 2010)</p> <p>The applicant can get a temporary disability grant if the disability will last between six months and one year.</p> <p>The applicant will get a permanent disability grant if the disability will last for more than one year.</p>	<p>Targeted beneficiaries</p> <p>Adults who are disabled and living in poverty, who because of their disability cannot support themselves</p> <p>A disability is defined in the Social Assistance Amendment Bill (effective from 1 March 2010) as the moderate to severe limitation of an applicant's ability to function as a result of a physical, sensory, communication, intellectual or mental disability, which makes an applicant unable to obtain the means needed to enable him or her to provide for his or her own maintenance or be gainfully employed.</p>	SASSA
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**Qualifying criteria^{xxv}**

- The applicant must be a South African citizen, permanent resident or refugee.
- The applicant must be resident in South Africa.
- The applicant must be between 18–60 years of age if a woman and 18–61 if a man (this will drop to 60 as from 1 April 2010).
- The application must be supported by a medical/assessment report confirming the disability.
- The applicant must not be maintained or cared for by a state institution.
- The applicant may not be receiving any other social grant.
- The applicant and applicant's spouse must meet the means test income and asset threshold.

Income threshold

If single, not more than R2 606 per month (R31 296 per year). If married, a joint income of no more than R5 216 per month (R65 593 per year).

Asset threshold^{xxvi}

If unmarried, assets less than R518 400 are regarded as below the threshold and, if married, joint assets up to the value of R1 036 800 will fall below the threshold.



→	<p>Grant-in-aid^{xxvii}</p> <p>A cash transfer of R250 per month (as at 1 April 2010)</p>	<p>Targeted beneficiaries</p> <p>An adult living in poverty that is unable to care for him/herself and who needs regular assistance of another person</p> <p>The Social Assistance Amendment Bill, 2010, provides that a person with a disability that requires regular attention by another person is entitled to a grant-in-aid</p> <p>Qualifying criteria^{xxviii}</p> <ul style="list-style-type: none"> • The applicant must already be receiving either the older person's grant, a disability grant or a war veteran's grant. • The applicant must require full-time care from someone else. • The applicant must be a citizen, permanent resident or a refugee. • The applicant must be living in South Africa. • The applicant's income must be below the means test threshold relevant to the primary grant the applicant is already receiving. 	<p>SASSA</p>
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Early childhood development services and programmes ^{xxix}			
Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
<p>Expanded public works ECD programme (EPWP ECD) initiative^{xxx}</p>	<p>The EPWP ECD programme aims to:</p> <ul style="list-style-type: none"> • expand access to ECD services in centres; • improve the quality of ECD services in ECD centres; 	<p>Targeted beneficiaries</p> <p>Caregivers, parents and children (0–4) living in poor and otherwise vulnerable circumstances/ communities</p>	<p>National DoSD is responsible for developing the relevant policies and monitoring the programme.</p>

→	<ul style="list-style-type: none"> • develop skills, create jobs and create income-earning opportunities. <p>The DoSD is responsible for achieving these objectives by:</p> <ul style="list-style-type: none"> • increasing the number of registered ECD centres; • increasing the number of children receiving the per-child ECD subsidy; • increasing the value of the per-child subsidy in registered subsidised ECD centres. 	<p>The NIP for ECD and the EPWP ECD plan identify the 2.5–3 million children living in poverty as the priority target for scaling up ECD in terms of the NIP.</p>	<p>The provincial DoSDs are responsible for the bulk of the funding and implementation responsibility.</p> <p>Local government's role is limited to inspection of ECD centres for compliance with health and safety requirements and to the registration of ECD centres.</p>
<p>The National Integrated Plan for Early Childhood Development^{xxxix}</p>	<p>The NIP for ECD has been developed to foster coordinated planning and action to address the comprehensive needs of young children (0–4) holistically through collective action by all government departments and role-players, including NGOs and community-based organisations.</p> <p>The NIP services and programmes are divided into primary and secondary services and programmes, which are the responsibility of a range of departments.</p> <p>Primary services include:</p> <ul style="list-style-type: none"> • referral services for health and social development services (including grants); • early learning stimulation; 	<p>Targeted beneficiaries</p> <p>Vulnerable children, including those affected by poverty, disability and HIV/AIDS</p>	<p>A number of departments, including Social Development, Education and Health</p> <p>ECD centres</p> <p>Parents</p> <p>NGOs</p>



→	<ul style="list-style-type: none"> • developing and implementing psychosocial programmes. <p>Secondary services include:</p> <ul style="list-style-type: none"> • human resource development (parents, caregivers and community development workers); • research; • monitoring and evaluation. 		
	<p>The provision of ECD programmes through partial care facilities and child and youth care centres^{xxxii}</p> <p>In terms of section 93(1) of the Children's Amendment Act, the MEC for social development in the provinces <i>may</i> provide and fund ECD programmes for that province.</p> <p>ECD programmes are defined by the Children's Act as 'a programme within an early childhood development service to provide <i>learning and support</i> appropriate to the child's developmental age and stage' (s91(3)).</p> <p>ECD programmes must be provided by a partial care facility providing partial care services for any children up to school-going age, and a child and youth care centre which has in its care any children up to school-going age (s93(5)).</p>	<p>Targeted beneficiaries</p> <p>Children from birth to school-going age, with priority to be given to funding of programmes:</p> <ul style="list-style-type: none"> • in communities where families lack the means of providing proper shelter, food and other basic necessities; • for children with disabilities. 	<p>Funding is provided by the provincial DoSD.</p> <p>The ECD programmes are provided by partial care facilities and child and youth care centres (s93(5)).</p> <p>Partial care facilities are facilities that provide care for more than six children on behalf of their parents during specific hours of the day or night (s76).</p> <p>A child and youth care centre is a residential facility (s191) that provides therapeutic programmes to more than six children outside the child's family environment, in accordance with a residential care programme suited to the children in the facility, but excludes:</p> <ul style="list-style-type: none"> • a partial care facility; • a drop-in centre; • a boarding school; • a school hostel; • a prison.



Only ECD programmes that comply with the prescribed National Norms and Standards for ECD and which are registered with the provincial head of social development of the province may receive funding from the provincial DoSD (s93(3); 95(1)(a-c)).

The National Norms and Standards for ECD are contained in Part II of Annexure B to the Regulations to the Children's Act. The norms and standards provide the minimum requirements deemed necessary for ECD programmes to provide appropriate developmental opportunities; to help children realise their full potential; to care for children in a constructive manner and provide support and security; to ensure the development of positive social behaviour; to respect and nurture the culture, spirit, dignity, individuality, language and development of each child; and to meet the emotional, cognitive, sensory, spiritual, moral, physical, social and communication development needs of children (s94(2)).



→	<p>Registration of compliant ECD programmes with the DoSD^{xxxiii}</p>	<p>ECD centres running ECD programmes may receive funding from the provincial DoSD provided that they comply with prescribed national ECD, partial care and child and youth care centre norms and standards and provided they register with the provincial head of social development of the province where that programme is offered.</p> <p>The norms and standards for partial care^{xxxiv} and child and youth care facilities relate to the level of infrastructure and basic services that must be provided by the centre.</p> <p>The DoSD also allows for the conditional registration of ECD centres to allow receipt of the per-child subsidy to enable the centre to meet the prescribed minimum standards.^{xxxv}</p>	<p>Targeted beneficiaries</p> <p>ECD centres that comply with registration requirements</p> <p>ECD centres that do not comply with registration requirements, but are in the process of complying, making use of the subsidy to enable them to do so</p>	<p>Provincial DoSDs</p>
	<p>Per-learner subsidy for learners at registered ECD centres</p>	<p>ECD centres are funded through the payment of a per-learner subsidy.</p> <p>Payment of the subsidy is not compulsory. It <i>may</i> be paid by the DoSD. This depends on budget availability.</p> <p>The subsidy is paid per (qualifying) child to registered ECD centres.</p> <p>The subsidy is paid to the ECD centre for nutritional and other basic needs of the child (not for payment of the practitioners).</p>	<p>Targeted beneficiaries</p> <p>Registered ECD centres that comply with the requirements of the Children’s Amendment Act, 2007, and which are providing services to children living in poverty</p> <p>The centres must have a constitution and be registered with the DoSD as non-profit organisations</p>	<p>The ECD centre must apply for the subsidy each year.</p> <p>The provincial DoSD is responsible for paying the subsidy to registered ECD centres.</p>



→	<p>The amount of the subsidy is recommended at R12 per day (in 2008). Note that not all provinces pay the same or the recommended amount.</p> <p>Sites that are registered must apply for the subsidy each year.</p> <p>The amount of the subsidy paid in the 2008/09 year in following provinces^{xxxvi}</p> <p>Eastern Cape – R12 Free State – R9 Gauteng – R11 KwaZulu-Natal – R12 Limpopo – R9 Mpumalanga – R11 Northern Cape – R10 North West – R12 Western Cape – R9 (increased to R12 in the 2009/10 year, as per information provided by Julinda Kruger, Deputy Director, Children, Provincial Government of the Western Cape)</p>	<p>The parents of the children must pass the means test. The means test (differs provincially):</p> <ul style="list-style-type: none"> • in the E Cape, Western Cape, Mpumalanga, Limpopo and the North West: for 1 child, a maximum income of R2 460; for 2 children, a maximum of R1 800; for 3 children, a maximum of R2 020; for 4 children, a maximum of R2 240;^{xxxvii} • in the Free State: the means test is either no fixed income or earnings of less than R1 500 per month. If the applicant is in receipt of the CSG or FCG,^{xxxviii} they will also qualify. 	
Partial care facilities^{xxxix}	<p>Section 76 of the Children's Act makes provision for the provincial MEC for social development to provide and fund partial care facilities and services in a province.</p> <p>The obligation on the MEC is, however, not mandatory but rather voluntary, as the Act provides that s/he 'may' rather than 'must' provide partial care facilities.</p>	<p>Targeted priority beneficiaries</p> <p>Children in communities where families lack the means of providing proper shelter, food and other basic necessities of life to their children</p> <p>Children with disabilities</p>	<p>Partial care facilities can be run by the government, by an NGO or by a private person.</p>



→	<p>Government-funded partial care facilities must be prioritised in communities living in poverty and for children with disabilities.</p> <p>All partial care facilities must comply with the prescribed norms and standards and structural safety, health and other requirements of the local municipality. Only partial care facilities that comply with these prescripts may be funded by the DoSD.</p> <p>A partial care facility is a facility that provides care, whether for reward or not, for more than six children on behalf of their parents or caregivers during specific hours during the day or night.</p>		
	<p>Non-centre-based ECD programmes and services^{xi}</p> <p>The DoSD is obliged to provide not only centre-based but also family- and community-based programmes and services for children aged 0–4.</p> <p>The NIP for ECD envisages that the majority of ECD services for children aged 0–4 will be provided through home- and community-based services.</p> <p>This translates into an obligation on the part of the DoSD to provide home- and community-based integrated services, capacity building and awareness raising (Streak & Norushe 2008) for families and community-based programmes.</p>	<p>Targeted beneficiaries</p> <p>Young children (0–4) who are not accessing ECD centres and centre-based programmes, with a focus on those living in poverty</p>	<p>NGOs providing home- and community-based services</p>



Prevention and early intervention services			
Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
<p>→</p> <p>Prevention and early intervention programmes^{xli}</p>	<p>The Children's Act compels the MEC for social development to provide and fund prevention and early intervention programmes in each province (s146(1)). The obligation is mandatory and not discretionary.</p> <p>Prevention programmes are provided to families with children in order to strengthen and build their capacity and self-reliance to address problems that may or are bound to occur in the family environment which, if not attended to, may lead to statutory intervention.</p> <p>Early intervention programmes are provided to families where there are children identified as being vulnerable to or at risk of harm or removal into alternative care.^{xlii}</p> <p>'While prevention programmes are more general in nature in that they seek to ensure the wellbeing of all children in a community, early intervention programmes target specific families and children who have been identified as "at risk" or vulnerable in this regard. These therapeutic and developmental programmes are provided to individual children and</p>	<p>Targeted beneficiaries</p> <p>Families with children, parents, caregivers and children across the Republic of South Africa (s145(1)). The provision of these services must be prioritised in communities where families lack the means to provide proper shelter, food and other basic necessities of life to their children and for children with disabilities (s146(4)).</p>	<p>Prevention and early intervention programmes can either be provided directly by the provincial DoSDs or the provincial departments can fund NGOs and community-based organisations to provide the services and programmes (s146(1)).</p> <p>Section 146(3) provides that prevention and early intervention services will only qualify for funding if the programmes comply with the national norms and standards prescribed for prevention and early interventions services. The norms and standards are spelt out in the Regulations to the Children's Act.</p>





parents/caregivers to avoid children's removal from his/her normal place of abode, either by court order *or* on the recommendation of a designated social worker to alternative care, e.g. foster care.^{xliii}

These programmes must focus on (s144(1)):

- (a) Preserving a child's family structure;
- (b) Developing appropriate parenting skills and the capacity of parents and caregivers to safeguard the well-being and best interests of their children, including the promotion of positive, non-violent forms of discipline;
- (c) Developing appropriate parenting skills and the capacity of parents and caregivers to safeguard the well-being and best interests of children with disabilities and chronic illnesses;
- (d) Promoting appropriate interpersonal relationships within the family;
- (e) Providing psychological, rehabilitation and therapeutic programmes for children;
- (f) Preventing the neglect, exploitation, abuse or inadequate supervision





of children and preventing other failures in the family environment to meet children's needs;

- (g) Diverting children away from the child and youth care system and the criminal justice system;
- (h) Avoiding the removal of a child from the family environment.

Prevention and early intervention programmes may include (s144(2)):

- (a) Assisting families to obtain the basic necessities of life;
- (b) Empowering families to obtain such necessities for themselves;
- (c) Providing families with information to enable them to access services;
- (d) Supporting and assisting families with a chronically ill or terminally ill family member;
- (e) Early childhood development;
- (f) Promoting the well-being of children and the realisation of their full potential.

Prevention and early intervention programmes must involve and promote the participation of families, parents, caregivers and children in identifying and seeking solutions to their problems (s144(3)).



→	<p>Prevention of substance abuse^{xliv}</p>	<p>Chapter 4 of the Prevention of and Treatment for Substance Abuse Act, 2008, focuses exclusively on prevention and early intervention services for people at risk of substance abuse (s8).</p> <p>The purpose of the prevention programmes is to prevent a person from using or continuing to use substances that may lead to abuse or result in dependence.</p> <p>The early intervention services are intended to identify and treat potentially harmful substance use prior to the onset of overt symptoms associated with dependency on substances.</p> <p>Section 9 of the Act requires that prevention programmes focus on:</p> <ul style="list-style-type: none"> (a) Preserving the family structure of the persons affected by substance abuse; (b) Developing appropriate parenting skills; (c) Creating awareness and educating the public on the dangers and consequences of substance abuse; (d) Engaging young people in sports, arts and recreational activities; (e) Peer education programmes; (f) Enabling parents and 	<p>Targeted beneficiaries</p> <p>Persons affected by substance abuse</p> <p>The Act prioritises the provision of community-based services to children and youth, people with disabilities, older persons and families and communities, and requires that underserved areas be prioritised (s12, 13).</p>	<p>The Act is premised on the provision of holistic multi-stakeholder responses by a range of government departments and civil society. It does, however, impose an obligation on the minister of social development to take the lead in the process.</p> <p>The Act envisages the delivery of the prevention and early intervention services by either organs of state or NGOs. Furthermore, the minister of social development is obliged to make provision for the establishment of these services.</p> <p>The minister may provide or fund these services, but only those organisations that comply with the norms and standards created in terms of the Act may receive funding (s11).</p>
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- families to recognise the early warning signs and equip them with information about appropriate responses and available services;
- (g) Empowering communities to understand and to be proactive in dealing with challenges related to substance abuse and its link to crime, HIV/AIDS and other health conditions.

Section 10 of the Act requires early intervention programmes to focus on:

- (a) Identification of individuals, families and communities at risk;
- (b) Screening for problematic substance use to facilitate early detection and appropriate interventions;
- (c) Enabling affected persons to recognise the warning signals of substance abuse and conditions related to it;
- (d) Providing families and communities with information to enable them to access resources and professional help;
- (e) Involving and promoting the participation of children, youth, parents and families in identifying and seeking

Furthermore, Chapter 5 of the Act is dedicated to the establishment of community-based services. The minister may fund community-based services, but only those that are registered in terms of the Act may be funded.



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- solutions to the problems;
 - (f) Promoting appropriate interpersonal relations within families;
 - (g) Promoting the well-being of the service user and the realisation of his or her full potential;
 - (h) Sensitising users and their families to the link between substance abuse, crime, HIV/AIDS and other conditions;
 - (i) Promoting the diversion of children away from the criminal justice system;
 - (j) Skills development and economic empowerment of people affected by substance abuse.

Services for the protection of children in need of care and protection from abuse, neglect, maltreatment, exploitative labour, or because they have been orphaned or abandoned

Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
A continuum of care ranging from prevention and early intervention to removal and placement of a child in foster care or adoption and/or reunification	The policies and laws envisage the provision of a continuum of care for children in need of care and protection, ranging from prevention and early intervention services, to the reporting of suspected cases of abuse, neglect and abandonment, intervention and removal of children, investigations and assessments of cases, placement and integration of children in alternative care, therapeutic programmes such as counselling, treatment	Targeted beneficiaries Children in need of care and protection	A combination of DoSD employees and offices (such as social workers, social auxiliary workers, community development workers) and NGOs, specifically social workers, social auxiliary workers, educators, community care workers, volunteers and others



and rehabilitation for children who have suffered abuse, neglect, trauma, grief or who have behaviour or substance abuse problems, as well as reunification and reintegration services.

The prevention and early intervention elements have been dealt with extensively in the immediately preceding section and the remainder of the elements making up the continuum are explained in more detail below.

<p>There is a statutory duty on certain officials and service providers to report suspected cases of abuse, neglect, abandonment^{xlv}</p>	<p>There is a statutory duty on some people/offices to report all cases of apparent abuse or neglect of a child and children that are in need of care and protection (as defined by the Children's Act) to a designated child protection organisation, the provincial DoSD or a police official.</p> <p>Once a report is made, the Department or designated child protection organisation must:</p> <ul style="list-style-type: none"> • ensure the safety and well-being of the child; • make an initial assessment of the report of abuse or neglect; • investigate the truthfulness of the report; and • if the report is substantiated, initiate proceedings for the protection of the child in terms of the Act. 	<p>Targeted beneficiaries</p> <p>Abused or neglected children</p> <p>Children in need of care and protection as defined by the Children's Act^{xlvi}</p>	<p>Who bears the duty to report?</p> <p>Correctional officials, dentists, homeopaths, immigration officials, labour inspectors, legal practitioners, medical practitioners, midwives, ministers of religion, nurses, occupational therapists, physiotherapists, psychologists, social service professionals, social workers, speech therapists, teachers, traditional health practitioners, traditional leaders, staff at partial care facilities, drop-in centres, child and youth care centres</p>
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→	<p>Intervention and removal of a child at risk^{xlvii}</p>	<p>A child in need of care and protection who needs immediate emergency protection may be removed to temporary safe care, with/without a court order, before an investigation is conducted by a designated social worker or a police officer.^{xlviii}</p> <p>Temporary safe care is defined by section 1 of the Act as: 'An approved child and youth care centre, shelter or private home, or any other place where the child can safely be accommodated pending a decision or order by a court concerning the placement of the child.'</p>	<p>Targeted beneficiaries</p> <p>A child in need of care and protection who needs immediate emergency protection which can be secured through removal of the child from his or her home environment</p>	<p>A designated social worker (i.e. a government employee or employee of a designated child protection organisation)</p> <p>Police officer</p>
	<p>Investigations and assessments in cases of suspected abuse, neglect or abandonment to determine if the child is in need of care and protection^{xlix}</p>	<p>The DoSD or the designated child protection organisation to whom the suspected abuse/abandonment has been reported, must appoint a person that is suitable to investigate cases of child abuse or neglect.</p> <p>The investigator must investigate whether the child is in need of care and protection as defined by the Act. Upon completion of the investigation, he or she must report to the Children's Court on whether the child is in need of care and protection.</p>	<p>Targeted beneficiaries</p> <p>Abused and/or neglected children</p> <p>Children in need of care and protection</p>	<p>A person is suitable to investigate these cases if:</p> <ul style="list-style-type: none"> • they are a registered social worker employed by the national or a provincial DoSD; or • a registered social worker employed by a designated child protection organisation. <p>In both cases, the social worker must have sufficient experience in the field of child protection.</p>





The report must, inter alia:

- indicate whether the child concerned is considered to be in need of care and protection;
- contain a recommendation as to the order that should be made by the court;
- contain recommendations, where necessary, regarding measures to assist the child's parent, guardian or caregiver, including:
 - (i) counselling;
 - (ii) mediation; (iii) prevention and early intervention services; (iv) family reconstruction and rehabilitation; (v) behaviour modification;
 - (vi) problem solving; and (vii) referral to another suitably qualified person or organisation;
- contain an assessment of the therapeutic, educational, cultural, linguistic, developmental, socio-economic and spiritual needs of the child.



<p>→ Court inquiry by the Children's Court resulting in an order for the placement of the child^l</p>	<p>After the investigation, the Children's Court must conduct an inquiry into whether the child is in need of care and protection.</p> <p>The court must make a placement order in respect of the child, if it is found to be in need of care and protection.</p> <p>See Chapter 12 services and programmes for further details about the jurisdiction and role of the courts in providing protection services for vulnerable children.</p>	<p>Targeted beneficiaries Children in need of care and protection that require alternative care</p>	<p>Presiding officer of the Children's Court, based on the designated social worker's report</p>
<p>Foster care placement/ cluster foster care placement</p>	<p>The court may order the child to be placed in foster care or in a cluster foster care scheme.</p> <p>A foster care placement may be with a person who is not a family member of the child, or with a family member who is not the parent or guardian of the child, or in a registered cluster foster care scheme.^{li}</p> <p>There is a limit on the number of children that can be placed in the care of one foster parent. No more than six children may be placed in foster care with a single person that is not the child's sibling or blood relative.</p> <p>However, more than six children may be placed in foster care in terms of a cluster foster care scheme.^{lii}</p>	<p>Targeted beneficiaries A child who has no parents or caregiver A child who has a parent or caregiver but that person is unable or unsuitable to care for the child</p>	<p>A cluster foster care scheme must be managed by a non-profit organisation registered in terms of the Non-profit Organisations Act, 1997. In addition, it must have been approved for providing cluster foster care by the provincial head of social development, and be registered with the provincial head of social development.</p>





Cluster foster care is essentially a group care setting, where the group foster care arrangements are managed under one umbrella management structure that is beholden to the requirements in the Act, and which will be able to access support provided in terms of the Act.

The purposes of a foster care placement are to:^{liii}

- provide the child with a safe and caring environment,
- either as a temporary measure, so as to promote reunification with the child's parents, or
- as a permanent measure through which to connect the child to other safe and nurturing family relationships intended to last a lifetime.

<p>Placement in a child and youth care centre</p>	<p>The court may place a child in a child and youth care centre that provides a residential care programme suited to the child's needs.</p> <p>A child and youth care centre is a facility that provides residential care to more than six children outside the child's family environment, in accordance with a residential care programme suited for the children in the facility. It excludes a partial care facility, a drop-in centre, a boarding school, a school hostel or a prison.^{liv}</p>	<p>Targeted beneficiaries</p> <p>A child who has no parents or caregiver</p> <p>A child who has a parent or caregiver but that person is unable or unsuitable to care for the child</p>	<p>Child and youth care centres must be established and run by the provincial government (section 195 of the Children's Act).</p> <p>However, municipalities and accredited organisations (NGOs) may also establish and operate a child and youth care centre, provided it is registered and complies with the provisions of the Act.</p>
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→	<p>Placement in a state-run facility providing care for children with disabilities or chronic illnesses</p>	<p>The court may place the child in a state-run facility or one registered or recognised by the law for the care of children with disabilities or chronic illnesses.</p>	<p>Targeted beneficiaries A child in need of care and protection that has a physical or mental disability or that has a chronic illness</p>	<p>The provincial DoSD must provide these facilities.</p>
	<p>Placement in a child-headed household under the supervision of a designated adult person</p>	<p>The court may place the child in the care of another child heading a household, under the supervision of a designated adult.</p> <p>For more detail on the consequences of this placement, see the section below on child protection services for child-headed households.</p>	<p>Targeted beneficiaries A child in need of care and protection living in a child-headed household</p>	<p>A child-headed household may be recognised as such a household by the provincial head of social development.</p> <p>A child-headed household must function under the supervision of an adult designated to supervise the household by a Children's Court or an organ of state or NGO determined by the provincial head of social development.^{lv}</p>
	<p>Placement of the child with adoptive parents</p>	<p>The objectives of an adoption:^{lvi}</p> <ul style="list-style-type: none"> • to protect and nurture children by providing a safe, healthy environment with positive support; • to promote the goals of permanency planning by connecting children to other safe and nurturing family relationships intended to last a lifetime. <p>An adoption order confers full parental rights and responsibilities in respect of the child on the adoptive parent; confers the adoptive</p>	<p>Targeted beneficiaries A child:^{lvii}</p> <ul style="list-style-type: none"> • who is an orphan^{lviii} and has no guardian or caregiver who is willing to adopt the child; • the whereabouts of whose parents/ guardian cannot be established; • who has been abandoned; • who has been deliberately abused by their parent/guardian; • who is in need of permanent alternative care. 	<p>Only certain persons are allowed to provide adoption services.^{lix} These persons include both government agencies and civil society agencies.</p> <p>The following persons may provide the services:</p> <ul style="list-style-type: none"> • a child protection organisation accredited in terms of s251 to provide adoption services;^{lx} • this includes a social worker in private practice or a child protection organisation that



→		<p>parents surname on the child; prohibits marriage or sexual intercourse between the child and adoptive parents; does not affect any proprietary rights the child enjoyed before the adoption.^{lxii}</p> <p>The adopted child must for all purposes be regarded as the child of the adoptive parents and the parents must for all purposes be regarded as the parents of the child.</p>	<p>has been accredited by the DG of social development as an adoption social worker or to provide adoption services.</p>
	<p>Placement in a child and youth care centre that provides a secure care programme</p>	<p>The court may place the child in a child and youth care centre that provides a secure care programme.</p>	<p>Targeted beneficiaries A child in need of care and protection whose parents cannot control him or her, or who displays criminal behaviour</p> <p>The DoSD must provide these secure facilities.</p>
	<p>Admission as an out- or in-patient to an appropriate facility</p>	<p>Admission as an out- or in-patient to an appropriate facility</p> <p>This process is jointly regulated by the Children's Act and the Prevention of and Treatment for Substance Abuse Act.</p> <p>A children's court may place a child in an appropriate facility.</p> <p>The Prevention of and Treatment for Substance Abuse Act requires the minister of social development to establish at least one public treatment centre in each province for the reception, treatment, rehabilitation and skills development of users (s17).</p>	<p>Targeted beneficiaries A child in need of care and protection that is addicted to a dependence-producing substance</p> <p>Family members, youth, older persons and community members that are at risk of substance abuse and/or dependency</p> <p>Facilities can be state-run or run by NGOs or private-run facilities.</p>





In addition, the minister may establish halfway houses to provide homes for people who have been discharged from a treatment centre and for persons undergoing treatment.

Section 28 of the Act expressly requires that children must be treated in separate facilities and apart from adults.

Reunification services^{lxii}	<p>If a child has been removed from home, the designated social worker must work with the child and the family to restore the family relationship so that the child may ultimately be returned to his or her family.</p> <p>Reunification and counselling services must include an investigation into why the child left the family home, must address these causes to prevent recurrence, and provide counselling to the child and family before and after reunification.</p>	<p>Targeted beneficiaries A child in need of care and protection who left the family home</p>	<p>Social workers in the employ of the state or civil society</p>
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<p>Aftercare and reintegration services for those affected by substance abuse^{lxiii}</p>	<p>Section 30 of the Prevention of and Treatment for Substance Abuse Act provides that the minister of social development must prescribe aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce and the family and community.</p>	<p>Targeted beneficiaries A child, family members, youth, older persons and community members who have been addicted to a dependence-producing substance</p>	<p>Aftercare and reintegration services can be provided by the DoSD, other organs of state or NGOs.</p> <p>Support groups may be established at community level by professionals, NGOs, or a group of service users or persons affected by substance abuse (s31(3)).</p>
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These services must include elements that:

- allow service users to interact with other service users, their families and communities;
- allow the sharing of long-term sobriety experiences;
- enable service users to abstain from substance abuse;
- focus on successful reintegration of a service user into society and family and community life;
- prevent the recurrence of problems in the family that may contribute to substance abuse.

Section 31 of the Act allows service users and persons affected by substance abuse to establish support groups that focus on ongoing integrated support to service users in their recovery.

The purpose of the support groups is to:

- provide a safe and substance-free group experience to allow space to practise resocialisation skills;
- to facilitate access by service users to persons in recovery who can serve as role models;
- encourage service users to broaden their support system.



→	<p>Child protection services for children in a child-headed household^{lxiv}</p>	<p>A provincial head of social development may recognise a household as a child-headed household.</p> <p>An adult must be designated to supervise the child-headed households.</p> <p>The supervising adult must:</p> <ul style="list-style-type: none"> • facilitate psychological, social and emotional support to all members of the household; • ensure that all household members required by law to attend school, do in fact attend school; • assist with the supervision of homework; • educate the household members on basic health and hygiene, and if possible, sexually transmitted infections; • assist with the healthcare requirements of members of the household, including the supervision of the taking of medicine and assistance to members with disabilities; • assist with legal documentation when required; • compile a domestic chore roster; • in consultation with a social worker, attempt to reconnect the family members with parents or relatives; 	<p>Targeted beneficiaries</p> <p>Children in a child-headed household may be recognised as a child-headed household if:</p> <ul style="list-style-type: none"> • the parent, guardian or caregiver of the household is terminally ill, has died or has abandoned the children in the household; • no adult family member is available to provide care for the children in the household; • a child over the age of 16 has assumed the role of caregiver in respect of the children in the household; • it is in the best interests of the children for the household to be recognised as a child-headed household. 	<p>The supervising adult must be designated by the children's courts or an organ of state or an NGO determined by the provincial head of social development.</p>
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- ensure proper provision of resources for the household's basic needs;
- ensure proper use of resources and assist in adherence to a budget;
- keep record of household expenditure;
- use available and applicable child protection services to ensure the safety and well-being of the members of the household.

The child heading the household or the supervising adult may collect and administer for the household any social security grant or other grant in terms of the Social Assistance Act, 2004, or other assistance to which the household is entitled (s137(5)).

The national food relief programme^{lxv}	This programme gives food to poor individuals and families.	Targeted beneficiaries Households that do not have money for their next meal Poor households spending less than R300 per month for food Vulnerable children and child-headed households Orphaned children People with disabilities Female-headed households with insufficient or no income HIV/AIDS-infected and -affected households	The provincial DoSDs
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→ Home- and community-based programmes and services			
<p>The home- and community-based care and support programme for people living with HIV and AIDS^{lxvi}</p>	<p>The DoSD provides funding and support to organisations that offer a range of services to individuals and families affected by HIV/AIDS. These organisations provide home-based/ community-based care and services to ensure that the basic needs of people living with HIV/AIDS are met.^{lxvii}</p>	<p>Targeted beneficiaries^{lxviii} Children, youth, women, older persons and people with a disability People living with HIV/AIDS and their families Child- and adolescent-headed households Households headed by older persons and orphans</p>	<p>The services are provided by registered non-profit organisations. The Department provides funding on application and support in the way of training to the non-profit organisations.</p>
	<p>Home- and community-based care is defined by the National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS 2009–12 as ‘the provision of comprehensive quality health and social services in the home and community in order to promote, restore and maintain people’s maximum level of comfort, social functioning and health’.</p>		
	<p>This programme, run jointly by the departments of Health and Social Development, aims to facilitate access to comprehensive services, including health and social services, to promote, restore and maintain the individual’s level of comfort, function and health, including care and support to the family members.</p>		





Services provided

(Maluleke 2008):

- early identification of families in need, orphans and vulnerable children;
- addressing the needs of child-headed households;
- linking families and caregivers with poverty alleviation programmes and social grants;
- providing material assistance;
- ensuring that children are placed in appropriate alternative care through appropriate referrals;
- counselling to address the psychological needs of children and their families, especially prior to the death of a family member and after;
- capacity building to vulnerable children, families and caregivers;
- establishing community childcare forums and multi-purpose centres.

Specific services include:

- residential care;
- HIV testing;
- traditional medicine;
- treatment support;
- pre- and post-counselling;
- ongoing counselling;
- family support;
- support groups;
- TB/Dots training;
- HIV/AIDS training;
- VCT training;
- holistic care training;
- food and nutritional support in the form of food parcels.



→	<p>Childcare forums</p>	<p>Childcare forums are defined in the National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS 2009–12 as ‘community-based structures focusing on the needs of OVC in the community and ensuring that their needs are addressed. The purpose of Childcare forums is to ensure early identification of OVC, be aware of initiatives involving childcare and support, create awareness, assess children’s needs, promote advocacy, and build capacity in families and communities’.</p> <p>In short, these forums identify vulnerable children and facilitate access to government-funded programmes. They do not actually deliver these services themselves (Mathambo et al. 2009).</p> <p>Services offered by Childcare forums include:</p> <ul style="list-style-type: none"> • identification of OVC; • food and nutrition support; • educational support; • psychosocial support; • household visits and home-based care; • treatment support; • child fostering/ recruiting of foster parents; • relief; 	<p>Targeted beneficiaries</p> <p>OVC</p>	<p>They are non-profit initiatives which are specifically community-based.</p> <p>The DoSD provides funding and support.</p>
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- companionship;
- reducing stigma and discrimination by facilitating activities that enable community members to talk more openly about HIV/AIDS and its impact;
- community income-generating projects to assist vulnerable households;
- building capacity of primary caregivers, community members and volunteers to respond to the different needs of children;
- after-school care and holiday programmes;
- use of community-based day-care facilities for young children to provide respite for their caregivers;
- promoting and strengthening links between community-based response to OVC and prevention, treatment and care programmes, including PMTCT interventions;
- providing community-based multi-purpose centres (Mathambo et al. 2009).

Childcare forums can be part of an HCBC programme, can stand on their own, or can be the starting point for establishing an HCBC programme.^{lxix}



→	<p>Drop-in centres</p>	<p>A drop-in centre is a facility providing basic services aimed at meeting the emotional, physical and social development needs of vulnerable children.^{lxx}</p> <p>They are currently defined by the DoSD as ‘any premises used for the reception, protection and temporary care of more than 6 children between the ages of 8 months and 18 years – in especially difficult circumstance’.^{lxxi}</p> <p>The DoSD registers and partially funds a number of these centres.</p> <p>A drop-in centre must be a registered non-profit organisation and must be registered with the provincial DoSD.</p> <p>It must comply with the norms and standards to be developed in terms of the Children’s Amendment Act.</p> <p>A drop-in centre must, in terms of the Children’s Act, offer the following services:</p> <ul style="list-style-type: none"> • provision of food; • school attendance support; • assistance with personal hygiene; • laundry services. 	<p>Targeted priority beneficiaries</p> <p>Children in communities where families lack the means of providing proper shelter, food and other basic necessities of life to their children</p> <p>Children with disabilities</p>	<p>Drop-in centres are run by registered non-profit organisations.</p> <p>They must, however, be registered and run in accordance with the norms and standards prescribed by the Act.</p>
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- It may offer:
- guidance counselling and psychosocial support;
 - social skills and life skills;
 - educational programmes;
 - recreation;
 - community services;
 - school holiday programmes;
 - primary healthcare in collaboration with the local health clinic;
 - reporting of children and referrals to social workers or social services professionals;
 - promotion of family preservation and reunification;
 - computer literacy;
 - outreach services;
 - prevention and early intervention.

*Notes:*

(i) *Social Assistance Act 13/2004 as amended by the Social Assistance Amendment Act, 2008, and accompanying Regulations*
 (ii) *The authors emphasise that the CSG in the amount of R250 per month is intended to supplement (rather than replace) household income.*

(iii) *http://www.blackssash.org.za/index.php?option=com_content&view=article&id=1235&Itemid=226. The author sought to obtain the latest grant amounts for 2010 on the SASSA website. On 1 August 2010, the SASSA website did not provide the latest grant amounts, but still published the outdated 2009 amounts. The correct amounts were, however, published on the Black Sash's website.*

(iv) *The Regulations to the Social Assistance Act governing the eligibility criteria for the CSG were amended on 1 January 2010. Prior to this date, the CSG was only available for children younger than 15. The amendment effectively extends the eligibility age of children to 18 in a stepped, phased-in manner over the next three years, starting with children aged 15–16 in 2010, 16–17 year olds in 2011 and those between the ages of 17–18 in 2012 (Regulation No. 32853, 31 December 2009).*

(v) *A primary caregiver is a person over the age of 16 years who looks after the daily needs of the child. This person does not have to be related to the child. It excludes a person caring for a child for remuneration or an institution which receives an award for taking care of the child or a person who does not have the implied or express consent of a parent, guardian or custodian of the child (section 1, Social Assistance Act 13/2004).*

(vi) *The means test changed in August 2008. Prior to August 2008, the means test for the CSG was R800 per month in urban areas and R1 100 per month in rural areas. It had not been changed in a decade (Regulation No. 31356, 22 August 2008).*

(vii) *The application process for applying for a grant without an identity document(s) is provided for in Regulations 27316, 22 February 2005, and Regulations 31356, 22 August 2008. The full procedure for applying for a grant without a bar-coded identity document or birth certificate is spelt out in ACCESS (2009).*

(viii) *Regulation 6(5): Regulations to the Social Assistance Act, Regulation No. 32853, 31 December 2009*

(ix) *Section 8 of the Social Assistance Act 13/2004.*

(x) *Regulations 27316 and 31356 to the Social Assistance Act, 2004, and the Social Assistance Amendment Act, 2008*

(xi) *Regulations 27316 and 31356. The full procedure for applying for a grant without a bar-coded identity document or birth certificate is spelt out in ACCESS (2009).*

(xii) *Section 7 of the Social Assistance Act 13/2004, as amended by the Social Assistance Amendment Bill, 2010*

(xiii) *Regulations 27316 and 31356 to the Social Assistance Act, 2004, and the Social Assistance Amendment Act, 2008*

(xiv) *SASSA (2009)*

(xv) *Section 13 of the Social Assistance Act 13/2004.*

(xvi) *Regulations 27316 and 31356 to the Social Assistance Act, 2004, and the Social Assistance Amendment Act, 2008*

(xvii) *DoSD (2006a)*

- (xviii) The applicant does not need a bar-coded identity document or birth certificate as is prescribed for applications for the other grants. In fact, prior to the amendment to the Regulations allowing for the use of alternative forms of identity documents when applying for grants, the DoSD diverted people in need without bar-coded identity documents and certificates to the SROD benefit because these documents are not prescribed for the SROD benefit. Other documents that are required when applying for the SROD benefit include: proof of lack of means by way of an affidavit or a letter from a social worker; proof of distress circumstances, for example, a medical certificate stating your temporary medical disability; proof of the breadwinner's death in the way of a death certificate; proof of application for a grant. In addition, the Regulations allow, in exceptional circumstances (Regulation 15(2)), such as when the documents have been lost, stolen or destroyed, the application to be made in the absence of required documents.
- (xix) Section 10 of the Social Assistance Amendment Act 6/2008 and accompanying Regulations
- (xx) Regulations 27316 and 31356 to the Social Assistance Act, 2004, and the Social Assistance Amendment Act, 2008
- (xxi) DoSD (2008)
- (xxii) Black Sasb (2010a)
- (xxiii) The value of the applicant's home is not included in the value of the assets as long as the applicant lives in the home.
- (xxiv) Section 9 of the Social Assistance Act 13/2004
- (xxv) SASSA (2009) and Black Sasb (2010b)
- (xxvi) The value of the applicant's home is not included in the value of the assets as long as the applicant lives in the home
- (xxvii) Section 12 of the Social Assistance Act, 2004
- (xxviii) SASSA (2009) and Black Sasb (2010b)
- (xxix) ECD programmes and services are regulated by Chapter 6 of the Children's Act and relate to 'the process of emotional, cognitive, sensory, spiritual, moral, physical, and social and communication development of children from birth to school-going age' (section 91(1)). The Act distinguishes between ECD services and programmes. ECD services are defined as services that promote ECD and are provided by someone other than a child's caregiver (section 91(2)). ECD programmes are defined as programmes structured within an ECD service to provide learning and support appropriate to the child's developmental age and stage (section 91(3)).
- (xxx) There is no mechanism for tracking the budget allocations and spending by DoSD and DoE on ECD 0–4 programmes or on the EPWP ECD scaling-up initiative. This creates some difficulty in tracking government-funded programmes other than the subsidy and training of ECD practitioners. The two core funders of ECD programmes and facilities are parents and donors (Streak & Norusbe 2008).
- (xxxi) National Integrated Plan for Early Childhood Development in South Africa 2005–10 and Tshwaragano Ka Bana sub-programme
- (xxxii) Section 93, Children's Act
- (xxxiii) Sections 94 and 95, Children's Act
- (xxxiv) Annexure B, part 1 of Children's Act Regulation
- (xxxv) DoSD (2007) and section 98 of the Children's Act
- (xxxvi) Communicated by Linda Biersteker – results of unpublished research done by the HSRC, March 2009
- (xxxvii) Streak & Norusbe (2008), interviews with DoH and Social Services and other relevant government departments
- (xxxviii) Streak & Norusbe (2008)
- (xxxix) Partial care and ECD are described separately in the Children's Amendment Act. These services are, however, in most instances provided at a single facility.
- (xl) The National Integrated Plan for Early Childhood Development in South Africa, 2005–2010 (the 'NIP for ECD')
- (xli) Chapter 8, sections 143–149 of the Children's Act
- (xlii) Sections 143(1) and (2) define prevention and early intervention programmes.
- (xliii) DoSD (2009b) in De Sas Kropiwnicki (2010a: 4)
- (xliv) Chapter 4 of the Prevention of and Treatment for Substance Abuse Act 70/2008
- (xlv) Section 110, Children's Act
- (xlvi) Section 150 of the Children's Act states that a child is in need of care and protection if the child (1) has been abandoned or orphaned, (2) displays behaviour which cannot be controlled by the parent or caregiver, (3) lives or works on the streets or begs for a living, (4) is addicted to drugs or alcohol and is without support to obtain treatment, (5) is exploited or exposed to exploitation, (6) may be at risk if returned to the custody of its parents or caregivers because that return will expose him or her to risk of serious harm, (7) is physically or mentally neglected, (8) is being maltreated abused, neglected or degraded by a parent or caregiver. Section 150 further provides that the following children may be in need of care and protection: (1) A child that is a victim of child labour, or (2) a child in a child-headed household.
- (xlvii) Section 152(1), Children's Act
- (xlviii) The services provided by SAPS (i.e. the Department of Safety and Security) are services that support the primary services provided by the DoSD. Therefore, some of the SAPS services are included in this table, as well as in the dedicated chapter on the SAPS later in the book.
- (xlix) Section 155, Children's Act
- (l) Section 156, Children's Act
- (li) Section 180(3), Children's Act
- (lii) Section 185, Children's Act
- (liii) Section 181, Children's Act
- (liv) Section 191, Children's Act
- (lv) Section 137(2), Children's Act
- (lvi) Section 228, Children's Act
- (lvii) Section 230(3), Children's Act
- (lviii) An orphan is defined by the Act as 'a child who has no surviving parent caring for him or her'.
- (lix) Section 250, Children's Act
- (lx) Any appropriate child protection organisation may apply in writing to the DG or provincial head of social development for designation as 'child protection organisation' (section 107 of the Children's Amendment Act, 2007). Designation is dependent

on the organisation complying with criteria prescribed in the Regulations to the Children's Amendment Act. The prescribed criteria set out in the Regulations: The organisation must be a legal persona and registered with all appropriate and prescribed authorities; must be a non-profit organisation in terms of the NPO Act 71/1997; must have the necessary capacity and expertise to deliver statutory services in terms of the Act; must have a constitution which embraces the provision of child protection services; has the ability to provide effective and efficient services; promotes an equitable distribution of services.

(lxi) Section 242, Children's Act

(lxii) Section 156(b), Children's Act

(lxiii) Prevention of and Treatment for Substance Abuse Act, 2008

(lxiv) Section 137, Children's Act, and accompanying Regulations

(lxv) www.dsd.gov.za/index.php?option=com_content...id

(lxvi) The National Integrated Plan for Children Affected and Infected by HIV/AIDS, 2000, and the National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS, 2009. The policy framework governing home- and community-based care and support is set to be consolidated and improved. A draft South African National Policy Framework for Home and Community Based Care and Support Programme, November 2009, has been developed. It is at an advanced stage of development and is likely to be finalised in 2010. 'It serves as a guiding tool for the establishment and implementation of an integrated care and support programme to all organisations working in the front line in addressing developmental challenges posed by HIV and AIDS and other socio-economic challenges...It is envisaged that the Policy Framework will create a conducive environment for the HCBC programmes nationally to be standardised and monitored in terms of coverage, quality of service provided and the impact thereof.'

(lxvii) http://www.DoSD.gov.za/index.php?option=com_content&task=view&id=97

(lxviii) The range of beneficiaries is set to expand to include 'Vulnerable household' in terms of the Draft Policy Framework which envisages the HCBC programme supporting households in poverty with the aim of reducing their vulnerability.

(lxix) DoSD (2004)

(lxx) Section 213, Children's Act

(lxxi) http://www.DoSD.gov.za/index.php?option=com_content&task=view&id=104

Some key policy and service delivery gaps

Comprehensive social security for vulnerable children and their caregivers

Access to the CSG

Access to the CSG has increased over the last few years. The current national average is estimated to be between 71 and 86 per cent of all eligible children (Hall 2009a: 39). However, there are a number of especially vulnerable constituencies that do not enjoy the same level of access to the CSG, resulting in further disadvantages for already vulnerable children and caregivers.

In the first instance, children and caregivers in poorer provinces such as KwaZulu-Natal, the Eastern Cape and the North West province, especially in the rural marginalised areas of these provinces, are experiencing difficulties in accessing the CSG, resulting in much lower than average take-up rates in these areas. For example, in 2005 in KwaZulu-Natal, 70 per cent of children living in poverty were eligible for the CSG. However, as a provincial average, only 64 per cent of eligible children received the grant. As one moves into the more rural areas, the eligibility rate increases to as much as 90 per cent. This increase in eligibility does not, as one would hope, see an increase in the take-up rate above the provincial average. Instead, we see a significant drop in the take-up rate. The rate in many of the rural districts in KwaZulu-Natal in 2005 dropped to as low as 40 per cent and less (Noble et al. 2005: 8, 21).

A study conducted in 2009 in the rural districts of Mbizana in the Eastern Cape and Ratlou in the North West province confirms the disadvantages faced by rural communities in poor provinces in accessing the CSG (Peters & Williams 2009). The take-up of the CSG in these areas is very low. Only 56 per cent of children that qualify for the CSG in Mbizana receive it, and this figure is even lower in Ratlou, where only 37 per cent of children receive it.

The younger the children in these rural areas, the greater the risk that they will not access the CSG. A number of studies have found that the caregivers of babies under the age

of one are not accessing the CSG. A national study commissioned by the DoSD in 2008 found widespread evidence of caregivers, especially in rural areas, not accessing the CSG for their children until the fourth quarter of their first year (CASE 2008). In KwaZulu-Natal, where the rural take-up rate is lower than the provincial average, the take-up rate for children in these rural areas drops even further for young children. For example, in 2005 in the 0–1 age group, it dropped to below 20 per cent in many rural districts (Noble et al. 2005: 34). In 2009, at a national level, only 38 per cent of children under the age of one were accessing the CSG, although about 60 per cent of children in this age group qualified for the grant (Scorecard 2009). Given the importance of proper nutrition, healthcare and other critical developmental essentials in the first two years of a child's life, the lack of access to the CSG in the early years is of particular concern for ensuring the well-being and development of children living in extreme poverty in rural areas.

Reasons for the low levels of access to the grant in rural communities and for young children include lack of early access to enabling documents required by the social security laws, such as birth certificates, identity documents and death certificates (CASE 2008; Peters & Williams 2009).

The Peters and Williams (2009) research in rural areas was conducted after the promulgation of the revised Regulations (No. 31356) to the Social Assistance Act of 2004 which introduced a legal innovation to address the barrier posed by identification documents to accessing grants. In mid-2008, the DoSD implemented a new Regulation which permits caregivers who do not have enabling documents (their identity documents or the bar-coded birth certificates of their children) to apply for the CSG. The Regulation goes as far as to permit applications for the CSG (and all other grants such as the FCG, CDG, OAP, etc.) even before the applicant has applied to the DoHA for their enabling documents. If the application for the CSG succeeds on all other grounds, the applicant will receive the grant for at least three months, but during that time the applicant must apply to Home Affairs for their enabling documents. The logic is that once they are receiving the grant, they will receive money to overcome the cost barrier.

The research in question reveals that the Regulation has not been applied properly in the targeted rural, vulnerable areas and as a result has not provided the intended relief. The reasons for the new Regulation not being applied properly are the same reasons that prevent access to enabling documents and the CSG in the first place. These include lack of knowledge and awareness of the new Regulation and the rights it bestows; lack of knowledge (by beneficiaries and social security administrators/Home Affairs administrators) on how to navigate the procedures involved; lack of consistency in interpreting and applying the Regulation and procedures by administrators (especially with regards to the alternative forms of proof of identity that may be accepted in support of the application); and a widespread misinterpretation of the Regulation, resulting in administrators not allowing grant applications until such time as beneficiaries have actually applied to Home Affairs for their enabling documents (Peters & Williams 2009).

A lack of accessible sites of service delivery in rural areas and the cost of transport to travel to obtain documents and to apply for the grant are further reasons for the low levels of access to the grant.

As noted earlier in this report, Thusong centres (previously known as Multi-Purpose Community Centres) were established in terms of the Thusong Service Centre Programme in 1999. The objective of the centres is to extend government services, in an integrated

manner, into rural and outlying underserved communities. The services offered at the centres include accessing birth certificates and identity documents, grants and housing applications.³⁶

There are not enough Thusong centres in the targeted communities, so the travelling distance and cost involved remain barriers in some of the communities serviced by these centres. In addition, the centres are insufficiently resourced. For example, the study conducted by Peters and Williams (2009) in the Ratlou district in the North West province found that there was only one Thusong centre in the district. It was at least 10 kilometres from the closest villages. At the time of the study, the cost of transport for those closest to the centre was R7, a significant sum of money for the impoverished community members of Ratlou. Furthermore, there is only one staff member staffing the centre and the centre has no computer facilities, so all applications have to be sent to district offices to be processed.

The South African Social Security Agency (SASSA) does deploy mobile units into rural communities. However, as in the case of the DoHA's mobile units, rural communities find it difficult to access some of these mobile services.

Reasons for their difficulties include insufficient consultation with communities about where mobile services should be sent, and lack of accessible and accurate information about where and when mobile service delivery units will be available in rural areas. For example, in the Ratlou district, reliance is placed on a social network for the distribution of information about the days on which mobile trucks will visit a particular area. The social network is made up of community development workers, ward councillors, ward committees, tribal authorities, chiefs and local pension committees. The social network cannot be relied on to convey the information (Peters & Williams 2009).

No social assistance for children aged 16–18 in 2010/11

Section 28(3) of the Constitution defines a child as anyone younger than the age of 18 years. Up until 31 December 2009, the CSG was only available for poor children younger than 15 years of age. This age limit was increased on 1 January 2010. The new Regulations to the Social Assistance Act, described in some detail in Table 3.1, have effectively increased the eligibility age to 18 in a phased-in manner between 2010 and 2012. In effect, children between the ages of 15 and 16 can apply in 2010. However, the Regulations exclude poor children who are over the age of 16 but younger than 18 in 2010 from applying for the grant, and will exclude those older than 17 but younger than 18 from applying in 2011. The latter two groups will only qualify in 2011 and 2012 respectively.

The complexity of the manner in which the age limit is to be incrementally increased already caused confusion and improper application of the new Regulations by SASSA officials and social workers in the first two months of 2010. The Black Sash noted in a letter to the *Cape Times* (9 February 2010) that they had received numerous calls to their paralegal help desks regarding the phased-in extension of the CSG 'from social workers in [the DoSD] asking us to explain how the extension of the grant works. It is a bit disheartening when the officials don't even know what's going on. They may well be turning away eligible applicants simply because they are confused'.

³⁶ Thusong Service Centres, Business Plan 2006–2014 and www.thusong.gov.za

School enrolment, attendance and documentation

The imposition of school enrolment, attendance and documentation requirements for CSG beneficiaries may hinder easy access to the CSG by vulnerable children.

As described in some detail in Table 3.1, the new Regulations to the Social Assistance Act require the caregivers of all children between the ages of 7 and 18 who apply for or receive the CSG to provide proof of the child's enrolment and attendance at school. Furthermore, the Regulations require the Department of Education (DoE) to monitor the attendance of CSG recipients and advise the DoSD if such recipients are not attending school.

There are three potential problems inherent in these requirements. First, even though the Regulations very clearly do not make school enrolment or attendance a qualifying condition for receipt of the CSG, there is a risk that the SASSA officials may read the imposition of this condition as a qualifying criterion. If this happens, we will see, as has happened in relation to misinterpretations of other documentation requirements by SASSA officials, that children are barred from accessing the CSG because they cannot obtain the necessary school documents or cannot enrol at or attend school. This is particularly problematic in the context of children made more vulnerable by HIV/AIDS as they are particularly at risk of not enrolling or attending school, for the many reasons spelt out in more detail in Chapter 5. The introduction of this new requirement linked to the CSG may aggravate the exclusion of vulnerable children from school rather than serve to improve their rate of enrolment and attendance.

A further problem that may arise in relation to these new requirements is the lack of proper attendance record keeping and information management at schools, especially the more vulnerable schools which register higher volumes of vulnerable children. The systems as they are currently implemented and managed at school level will make it difficult for all schools to be able to record attendance and produce reports to the DoSD regarding attendance or lack thereof by CSG recipients.³⁷

The third problem that will inhibit the implementation of the new Regulations is the severe shortage of social workers in South Africa, which already inhibits the proper implementation of child protection services in the country. The new Regulations require a social worker investigation whenever a report of non-enrolment or non-attendance by a CSG recipient is made to the DoSD. As discussed in some detail later, South Africa is experiencing a severe shortage of social workers, which will make it impossible to meet the investigative obligations required by the Regulations.

Oversubscription of the FCG

The FCG has become a primary source of financial support for family members caring for orphaned or abandoned children (Meintjies et al. 2003). This saw the number of FCG beneficiaries increasing tenfold between 2000 and 2008 from 49 843 in 2000 to 445 282 in 2008.³⁸ The underlying problem, from a service delivery point of view, is that access to the FCG must be preceded by a full and formal foster care investigation by a social worker and hearing by a children's court. This has resulted in the caseload of social workers becoming completely unmanageable and their role has turned into a largely administrative one of rubber-stamping foster care investigations so as to expedite the foster parent's access to the FCG. Likewise, it has caused bottlenecks in the courts, which results in keeping children

³⁷ Private correspondence with Kevin Roussel, director of ACESS

³⁸ Statistics from the DoSD Annual Report, 2000/01, and SASSA Social Security Statistical Report, 29 February 2008, quoted in National Welfare, Social Service and Development Forum, 2008

who are in urgent need of care and protection out of the protection system, and children and caregivers in need of financial support away from the FCG.³⁹

This has placed the foster care system in crisis. The growth in the number of orphans in South Africa over the past few years, a trend which is likely to continue, is indicative of the growing scale of demand that we are likely to see. In 2008, there were approximately 3.95 million orphans in South Africa, a million more than in 2002 (Meintjies & Hall 2010: 102).

There is an urgent need for the development of an alternative source of financial and other necessary support for orphaned and abandoned children living with their relatives, other than the formal foster/child protection system that is currently available. There is a need for a system that does not rely so extensively and indiscriminately on onerous use of social workers and the children's courts.

The DoSD has recognised this need and has initiated early steps towards developing a social assistance programme for caregivers, with the objective of caregivers' benefits by 2010/11 (DoSD 2009d).

Reach of the CDG and the disability grant

The reach of the CDG and the disability grant is limited – it excludes support for children with moderate disabilities and with chronic illnesses.

Eligibility criteria for the CDG (and the disability grant) are narrow, resulting in the exclusion of many vulnerable children and adults with a disability or a chronic illness from benefiting from the grants. For example, the CDG has only been available for children with a disability so severe that they require permanent home care. This has meant the exclusion of children with moderate and mild disabilities such as hearing and visual impairments. There is a further requirement, in addition to the need for 24-hour care, that the condition must be permanent. Therefore a child who is HIV positive and not in the terminal stages of the disease will not qualify for the CDG, regardless of the fact that their additional nutritional and healthcare needs require additional resources. The researcher was advised by SASSA's General Manager of Operations in the Grant Administration Branch, Dianne Dunkerley, that changes are being considered so as to provide a CDG for temporary conditions.

In the case of the disability grant for adults, the impact that the illness or disability has on the person is the criterion for determining eligibility. If the condition affects the applicant's ability to work, then a disability grant will be considered. This may be a permanent or a temporary grant. This means that an adult caregiver who has AIDS may qualify for the disability grant if it affects their ability to work. If, however, the caregiver's health improves as a result of antiretroviral therapy (ART), then the disability grant will cease.⁴⁰

The Social Assistance Amendment Bill of 2010⁴¹ offers some relief by expanding the scope of the CDG and the disability grant to children and adults with not only severe but also moderate disabilities, which either require permanent care or services, or which impair their ability to obtain gainful employment or to obtain the means necessary to provide for their own maintenance.⁴²

39 National Welfare, Social Service and Development Forum, 2008

40 Personal communication with Dianne Dunkerley, General Manager, Operations, Grants Administration Branch, SASSA

41 *Government Gazette* No. 32986, 1 March 2010

42 Article 12 and the definition section

Social welfare services policy and service delivery gaps

A review of the 2009–12 Strategic Plan (DoSD 2009d) perhaps tells us more about the gaps in the current framework than the social welfare programmes and services that are currently available through the DoSD.

The Strategic Plan set a number of goals to fill the gaps that exist within the social welfare framework by 2012, including:

- developing norms and standards for the delivery of social welfare services;
- finalising the Social Services Professions Bill so as to increase the pool of social service providers and to regulate standards of service;
- developing legislation by 2010/11 on social services for people with disabilities;
- developing statutory services for youth- (formerly child-)headed households;
- developing a framework for statutory services for children living and working on the streets;
- developing regulations for the prevention and treatment of substance abuse;
- developing a national policy framework to guide the development and implementation of prevention and early intervention programmes.

In essence, the last commitment to the development of a national policy framework for prevention and early intervention programmes points to the primary gap that we are currently facing in the delivery of integrated developmental social welfare services. The focus in the last 10 years has been on reactive statutory services, rather than on prevention and early intervention. In fact, not only have the last 10 years seen a neglect of prevention and early intervention programmes, but also of statutory services (DoSD 2006). Social services have been forced over the last decade to adopt a ‘make do’ approach, dictated by resource limitations rather than need, priority, or statutory and internationally ratified obligations (DoSD 2006).

The failure to invest adequately in social services led to a variety of gaps and inadequacies preventing realisation of the ‘priority, or statutory and internationally ratified obligations’. A key gap is the acute shortage of social workers and social auxiliary workers to provide statutory social services (DoSD 2009d). The number of social workers required to implement the Children’s Act exceeds the number of registered social workers by 55 000 (Barberton 2006: 95). It has been suggested that greater use must be made of auxiliary social workers. However, the shortage of auxiliary social workers is just as acute.

ECD programmes and services

The DoSD acknowledges that access to ECD services and programmes, one of the few active prevention programmes, remains a challenge, especially for children made vulnerable by poverty and HIV/AIDS. This is so for a variety of reasons (DoSD 2009d).

First, few ECD facilities are equipped to provide the level of sustained early childhood support appropriate to the developmental needs specific to vulnerable young children. There are some ECD practitioners who provide extra support; however, it does not appear to be a standard or widespread practice (Biersteker & Rudolph 2005). For example, most ECD practitioners are ill equipped to deal with children living with HIV/AIDS. Their psychosocial and developmental needs are not being met because of a lack of appropriate assessment and development programmes, and due to insufficient attention being paid to the stressors experienced by the caregivers of HIV-positive children (Markovitz 2008; Potterton 2006). There is an urgent need for appropriate training and development, for example, in non-discrimination in ECD centres.

Second, insufficient funds at a provincial level has not allowed for the scaling up of ECD services and programmes as envisaged by the expanded public works ECD (EPWP ECD) programme and the NIP for ECD, especially in poor and vulnerable communities. Scaling up of ECD 0–4 has been given a low priority status in provinces in terms of the budget allocated to it (less than 1 per cent of the provincial equitable shares were allocated to scale up ECD in 2007/08) (Streak & Norushe 2008: 13). Funds from the equitable share to provinces that may have been intended for ECD scaling up are often diverted by provinces to other programmes because the funds are not ring-fenced for this specific purpose before being allocated to provinces. The lack of funding has limited the growth in the number of ECD centres and programmes in vulnerable communities, as envisaged by the EPWP ECD plan and the NIP for ECD. In addition, it has limited the improvement of infrastructure and an increase in trained ECD staff at centres (Streak 2005).

The slow pace of expanding the reach of registered centres into poor areas is further inhibited by the poor state of infrastructure, programme and human capacity in the majority of unregistered ECD centres in poor communities. The registration process for these centres is inefficient, cumbersome and difficult to navigate. Not only is it difficult for poorly resourced centres in vulnerable communities to navigate the registration process, it is also costly for them to comply with the statutory requirements prescribed as a prerequisite for registration. This obstacle is recognised by the Children's Act, which introduces a conditional registration process to help struggling community-based projects to register as ECD centres (Proudlock & Jamieson 2008).

Third, poverty excludes many vulnerable children from benefiting from ECD services and programmes. Children living in poverty remain at risk of not accessing ECD centres, given the fact that most centres charge fees and very few exempt poor children from the relevant fee obligation. A study conducted by the Department of Economics at Stellenbosch University on behalf of UNICEF and the departments of Education and Social Development found that almost all centres that participated in their study charged fees and at least two-thirds did not grant fee exemptions. At the same time, many of the centres received subsidies from the DoSD for children who qualified in terms of the means test. The latter observation tends to show that the subsidy model adopted by the DoSD does not make ECD more affordable or accessible for the individual child to which the subsidy is linked. The report notes that the subsidy improves the financial situation of the facility as a whole and this may in turn lead to lower fees which benefit all children equally (Van der Berg et al. 2010).

The reach of the per-child ECD subsidy is poor. Only 10 per cent of eligible poor children nationally receive an ECD subsidy.⁴³ In addition, there is variation across the provinces in the value of the subsidy provided. There is not only variation in the sum of the subsidy, but also in the means test that is applied between provinces. The application of the means test by officials results in exclusions of qualifying beneficiaries because the means test is poorly understood by departmental staff and difficult to implement (Streak & Norushe 2008).

Fourth, there is insufficient funding and support for home- and community-based ECD services and programmes. The NIP for ECD has what Budlender refers to as a 'poverty sub-programme aimed at delivering integrated services to 2,5 million to 3 million children

⁴³ Taken from Streak & Norushe (2008), based on calculations by Budlender (2010) using the 2005 General Household Survey, defining poor children as those living in a household with a monthly expenditure of R1 200 or less

through services at centre, community and household level' (2010: 9). She notes that even though the NIP for ECD envisages the majority of its services being delivered through home- and community-based services, to date virtually all existing social development ECD funding and energy has been directed to support centre-based provision, in particular, through the child-based ECD centre subsidy.

Apart from the funding of toy libraries by the North West province, it is only the Western Cape and Gauteng that have funded some home- and community-based programmes through their programme funding for non-profit organisations (NPOs) (Budlender 2010). Home- or non-centre-based ECD programmes are not registered and they receive no funding, training or other forms of support. It is critical that these caregivers be taken into account in planning for funding, training and development. The crux of the problem is that there is very little funding available for non-centre-based programmes. The centre-based budget (primarily the subsidy) crowds out any money for non-centre-based initiatives. For example, 97 per cent of the total ECD budget in the Western Cape in 2007/08 was allocated to the subsidy (Streak & Norushe 2008).

There is an urgent need to scale up the funding and provision of home- and community-based ECD services and programmes if the target of reaching 2.5 to 3 million children living in poverty is to be reached. The services in question are already provided by many NPOs and include location-based integrated ECD strategies, community child protection strategies, the use of ECD centres as supports for outreach work, parent education courses, playgroups, home visiting, toy libraries, support to childminders, and care and support for HIV-infected and -affected young children. These, however, need to be scaled up dramatically. The prospects for the requisite scaling up are limited, however, by the lack of a shared ECD framework and funding model to govern the development, implementation, monitoring and evaluation of home- and community-based services for young children in a manner which contributes to the realisation of the goals of, inter alia, the NIP for ECD (Budlender 2010).

In addition to the lack of a funding, planning and implementation framework to govern home- and community-based ECD programmes and services, there is a regulatory gap in the Children's Act and the accompanying ECD norms and standards which will frustrate the requisite scaling up of non-centre-based ECD services and programmes. The Children's Act expressly recognises a range of ECD services and programmes outside of the traditional 'partial care' paradigm. However, as pointed out by the Early Learning Resource Unit in its July 2008 submission to the DoSD on the regulations and ECD norms and standards:

[the] regulations and norms and standards do not cover the range of ECD Programmes as indicated in [section 91] of the Act. Registration as an ECD programme is intended to cover all types of ECD programmes. This will enable the Department to implement the National Integrated Plan for ECD which envisages the majority of ECD services will not be in the context of partial care. Similarly the Department's model of ECD sites as Centres of Care and Support for Vulnerable Young Children and their Families requires broader thinking and regulation. (ELRU 2008)

Prevention and early intervention programmes

The DoSD's focus over the last few years on social security has, by its own admission, 'crowded out' social welfare services, especially the prevention and early intervention programmes for vulnerable children and their families (DoSD 2007: 50). As a result, the intended policy shift towards improved prevention and early intervention, as expressed

in the 1997 White Paper, has not found traction at a service delivery level (Giese 2010). The 'crowding out' of social services by the social security budget has translated into low levels of prevention and early intervention services being provided, especially in communities in the more marginalised and rural provinces.⁴⁴ This is so for a number of reasons.

First, there is a scarcity of appropriate skills to provide social services, which impacts significantly on the delivery of prevention and early intervention services. Giese (2010: 4) observes that the number of social workers required to implement the Children's Act is estimated at 60 000 and in February 2009 there were less than 25 per cent of the required numbers, with only 14 322 registered social workers. She notes further that this impacts heavily on the provision of prevention and early intervention services, as '[t]he lack of capacity in the system forces social workers to prioritise the most urgent cases, neglecting prevention and early intervention services. This leads to a greater number of children requiring protection, further reducing the capacity' (Giese 2010: 4).

The National Department of Social Development has taken two steps towards addressing this gap. The first is the introduction of a social work scholarship '[a]s part of the recruitment and retention strategy and initiative to address critical and scarce skills in the sector'.⁴⁵ The scholarship is available to South African citizens wanting to pursue social work degrees.

The second step is the creation of space within the Children's Act for the recognition and more active use of other social services practitioners to provide statutory social services, for example, child and youth care workers, auxiliary social workers and community development workers. It formally recognises that these practitioners may provide certain statutory services, such as assessing partial care centres, ECD programmes and drop-in centres for registration, and monitoring long-term foster placements (Proudlock & Jamieson 2008). However, this innovation, which has the potential to significantly address the lack of capacity to provide social services, especially prevention and early intervention services, is on hold until the current Social Services Professions Act (No. 110 of 1978) is replaced with the Social Services Professions and Occupations Bill, 2008. The latter Bill is currently under consideration by Parliament. The reason for this is that the Children's Act requires the registration of all practitioners that will perform the assigned statutory functions. At present, the Social Services Professions Act only permits the registration of social workers; the Social Services Professions and Occupations Bill permits the registration of a much wider class of social service practitioners.

Second, the scarcity of appropriate human resources is compounded by the widespread inappropriate use of the child protection system to access FCGs for children living with their extended family members. A social worker employed by the DoSD in the Eastern Cape confirmed this in an interview conducted in August 2010 in her statement that 'our core business is foster care grants'. (This concern is discussed in more detail below.)

Third, insufficient funding affects the quality and sustainability of child protection services. Given the severe capacity constraints within government, NPOs currently provide the bulk

⁴⁴ For example, in Limpopo province, where 83 per cent of poor children live in poverty, only R15 per capita was allocated for social services, compared to the Western Cape where only 36 per cent of children live in poverty but where R114 per capita was allocated in 2008 (Giese 2010: 4).

⁴⁵ http://www.dsd.gov.za/index.php?option=com_content&task=view&id=240&Itemid=143

of prevention and early intervention services to children and families. These NPOs face severe financial and other challenges which impact negatively on the quality, continuity and sustainability of the prevention and early intervention services they provide (De Sas Kropiwnicki 2010a).

The DoSD conducted a review of prevention and early intervention projects and services and observed that some of the NGO-run projects are beset by '[p]oor management and leadership [which] weakens the structural provision of services exposing the communities to more maltreatment, sexual violence and family dysfunctionality' (DoSD 2009a, in De Sas Kropiwnicki 2010a).

Fourth, given that prevention and early intervention services aim, in part, to address the underlying socio-economic and cultural risk antecedents in communities, it is not surprising that the most effective prevention and early intervention models of service delivery are premised on collaboration between all stakeholders with a development mandate. A challenge in providing quality and sustainable effective prevention and early intervention services is the inconsistent and erratic quality of the relationships between NPOs and government departments. In addition, the level of support provided to NPOs by municipalities tends to be ad hoc, situational and determined on a case-by-case basis by local variables. In summary, 'Networking, coordination and meaningful collaboration between civil society, NGOs and government is an ongoing challenge' (De Sas Kropiwnicki 2010a: 7).

A related challenge identified by De Sas Kropiwnicki (2010a) is the lack of intergovernmental collaboration and coordination to provide integrated care and support to families.

The Children's Act anticipates and seeks to address a number of these resource, funding and quality concerns.

Section 145 requires the minister for social development to develop a comprehensive national strategy aimed at securing the provision of prevention and early intervention programmes to families, parents, caregivers and children across the country. Once this is established, the MEC for social development must, within the national strategy, provide for a provincial strategy aimed at the provision of properly resourced, coordinated and managed prevention and early intervention programmes.

In preparation for the development of the national and provincial strategies, the DoSD has initiated the process of developing a national conceptual framework for prevention and early intervention services in South Africa. The Department has commissioned the development of a conceptual framework which will provide guidance and regulate the development of standardised quality prevention and early intervention programmes within a common framework. The process for the development of the framework builds on the work done thus far in the arena of prevention and early intervention, through a review of relevant programmes that have been implemented in South Africa in order to identify and document relevant best practices which will inform the framework. The framework will be premised on the standardisation and replication of these sound elements of best practice, which will ensure sustainable and quality early intervention and prevention programmes in South Africa (De Sas Kropiwnicki 2010b).

In addition to addressing questions of quality, standardisation and accountability of prevention and early intervention programmes, the Children's Act also potentially addresses some of the funding constraints and sustainability challenges faced by many

programmes. The Act expressly requires the MEC for social development to 'provide and fund prevention and early intervention programmes for that province' (section 146(1)).

However, a recent analysis of the adequacy of provincial budgets to provide the services prescribed by the Children's Act indicates that this obligation imposed on the MEC is not being met. The report, by Budlender and Proudlock (2010), reviews the adequacy of the provincial budgets to provide the following services:

- partial care facilities (ECD facilities/crèches);
- drop-in centres;
- ECD programmes;
- prevention and early intervention services;
- protection services (including a support scheme for child-headed households);
- foster care and cluster foster care;
- adoption;
- child and youth care residential facilities.

The analysis tracked the budgeting as far as it was able to do so. The exercise was made difficult by the fact that current budgets and narratives are not organised or framed so as to mirror the language of the Act, so it is not possible to determine with certainty how much has been allocated, or not, to these services. There is an urgent need for an adjustment in the way that budget figures, narratives and indicators are presented so that they mirror the language and priorities of the Act.

Despite this difficulty, the report reviewed the budgets allocated to the DoSD's four sub-programmes, which together make up the Social Welfare Services Programme:

- childcare and protection (allocated R2.6 billion across the nine provinces in the 2010/11 budget);
- care and support to families (allocated R168 million across the provinces for 2010/11);
- HIV/AIDS (allocated R628 million across the provinces for 2010/11);
- crime prevention and support (allocated R673 million across the provinces for 2010/11).

Budgeting patterns in relation to care and support to families is less than optimistic. The figures show that allocations to this sub-programme, within which prevention and early intervention services tend to fall, were on the whole insufficient in the 2008/09 financial year to fulfil the services required by the Act. The prognosis for 2010 is not any better. The national average increase in allocated amounts for 2010/11 is lower than national Treasury's estimated inflation rate of 6.4 per cent. The increases in the provinces with the lowest adjustments (the Free State, the Western Cape and Gauteng) range from a negative -2 per cent to a +3 per cent adjustment. Moreover, the estimated allocated amounts reduce in the future. This sub-programme accounts for 2.4 per cent of the Social Welfare Programme budget in 2010/11, but decreases to 2 per cent in the following two years.

The pattern of low and decreasing allocations for this sub-programme indicates an inability to implement many of the family support programmes required in terms of the prevention and early intervention chapter of the Act. The report notes that resource inadequacy in respect of these services is especially troubling, given that prevention and early intervention services could, over time, reduce the large numbers of children in need of more expensive child protection services like court inquiries and state alternative care. This calls for a much bigger investment than is currently being made into prevention and early intervention services.

Statutory interventions and placement in alternative care

The exaggerated demand for foster placements results in backlogs in finalising foster care orders. Foster care placements are thus creating an onerous drain on protection services. The placement of children in foster care has traditionally been linked to the need for temporary removal of the child from the home to ensure the protection of the child from a risk at home. However, the foster placement system has become oversubscribed. It has become a mechanism for formalising the placement of children orphaned by HIV/AIDS with extended family members. This placement option has become preferable because the foster placement permits access to the FCG, which is needed by the families to meet the costs of the additional child. This has resulted in huge backlogs in processing foster care placements (Briede & Loffell 2005; Meintjies et al. 2003).

This has been compounded by the Children's Act, which now automatically regards an orphaned child as a child in need of care and protection, and therefore in need of court interventions and placement in alternative care. This official sanction of the use of the foster care system and the FCG for children orphaned by HIV/AIDS is driven by recognition of their need for the financial support that is available through this route. It is noteworthy that the DoSD is investigating, and has identified in its 2009–12 Strategic Plan, the option of a caregiver's grant for children who are orphaned and/or abandoned and living with extended family members (DoSD 2009d).

Insufficient residential facilities also make it difficult to place a child in alternative care when necessary. There has been a long history of both policy and funding neglect of residential facilities for children in need. This has led to a dire shortage of such facilities. While keeping the child in a home environment is correct and a desirable goal, the emphasis on this approach has meant that not enough residential facilities have been set up or funded. Therefore, it is difficult for Children's Court commissioners to find facilities for children who urgently require them due to factors – behavioural, disability, substance abuse or other – that prevent them from being placed in foster care (Streak 2005). The residential facilities that do exist are primarily in urban areas, leaving rural areas very under-resourced in this regard (Mabetoa 2007).

Furthermore, child protection systems lack adequate resources to meet the needs of children with disabilities (DoSD 2009d). This inadequacy has been recognised by the Children's Act, which specifically prioritises the provision of child protection services to such children.⁴⁶

There are not enough secure-care facilities for children in conflict with the law, so children awaiting trial wait in police cells and correctional facilities (DoSD 2009d) (see Chapter 12 for further information and statistics related to children in conflict with the law).

The child protection system is also not equipped to meet the growth in demand for alternative care for orphans. The number of children requiring alternative care has grown due to the increasing numbers of orphaned children in South Africa. An orphan is defined as 'a child under the age of 18 whose mother, father, or both biological parents have died' (Meintjies & Hall 2010: 102). Statistics South Africa's 2008 General Household Survey indicates that there are 3.95 million orphans in South African across all three categories.

⁴⁶ See, for example, sections 2, 6, 7, 11, 13 and 42, and the clauses directing the development of strategic plans and frameworks.

This amounts to 21 per cent of all children in South Africa.

The General Household Survey results were analysed by the Children's Institute at the University of Cape Town, which observed that (Meintjies & Hall 2010):

- between 2002 and 2008, the number of orphans increased by almost 1 million;
- 63 per cent of orphans are paternal orphans, in other words, they have a living mother;
- the number of double orphans more than doubled between 2002 and 2008, from 350 000 to 850 000.

The national adoption programme has not been able to attract enough prospective adoptive parents.⁴⁷

Reunification services are essentially non-existent. Because of the shortage of social workers and the high caseload that they carry, there has been a neglect of adequate reunification services by social workers. Placements of children in alternative care are meant to be temporary placements and the child and family should be reunified. However, these placements have tended to become permanent because the child-family relationship has not been restored (Padayachee 2005).

The acute shortage of social workers and auxiliary social workers has resulted in a severe lack of capacity to respond to the demand for social welfare services by vulnerable children and their families (Loffell et al. 2008). Statutory care and protection services are insufficient because they, like prevention and early intervention services, are also insufficiently resourced. The primary service providers of statutory care and protection services are NGOs and community-based organisations, although government is responsible for funding these services. NGOs are not fully funded to provide the services, which impacts negatively on the quality and sustainability of social services (Barberton 2006; DoSD 2009d). These barriers have largely been brought about by insufficient resource allocation for social services over a protracted period of time. It is worrying that we are not seeing a turn in the tide of resource allocation for social services. Two key costing reviews of the funding that is necessary, in comparison to the funds that have been made available for the comprehensive developmental social welfare service contained in the Children's Act, have both found that provincial budgets are inadequate to deliver the prescribed statutory services.

An analysis of 2006 provincial DoSD budgets by Barberton (2006) revealed that the provinces had underfunded their social services obligations in terms of the Child Care Act, No. 74 of 1983 (essentially the same as the obligations in terms of the Children's Act) by 50.5 per cent. Projecting these figures onto the Children's Act would leave the Children's Act mandate underfunded by 53.3 per cent. Barberton also found that there are huge discrepancies between the provinces in the level of funding for social services, and that this discrepancy is likely to continue.

A subsequent analysis of the adequacy of the 2010/11 provincial budgets by Budlender and Proudlock (2010) shows a continued significant shortfall in ensuring that vulnerable children in need of the Children's Act statutory services in fact receive them. The authors conclude that the funds allocated to the whole Social Welfare Programme by provincial

⁴⁷ DoSD Annual Report, 31 March 2008

departments of social development are sufficient, as a best-case scenario, to cover only 49 per cent of the statutory services and interventions required by the Children's Act (Budlender & Proudlock 2010: 40).

HCBC services and programmes

Insufficient funding

The provision of HCBC services and programmes is dependent on government funding. Many of the organisations providing these services struggle to access government funding. When they do manage to access funding, it is in the form of a subsidy rather than full funding based on the cost of the service provided. This means that the organisations have to look for additional donor funding. The lack of adequate and consistent funding raises questions about the consistency of the availability of these services and their long-term sustainability (Giese 2008).

A significant barrier impacting on the levels of service delivery through these structures is the over-reliance on unpaid volunteers. As pointed out by Mathambo et al. (2009), the mostly female volunteers are exposed to stress in the care and support that they provide to people affected by HIV/AIDS, and there is little or no support for them in turn.

Low literacy levels and insufficient training

The generally low literacy levels of volunteers and the limited organisational capacity within the HCBC structures often result in low levels of training, which impact on the quality of care that is provided through these services (Mathambo et al. 2009).

Duplication of services

Within the departments of Health and Social Development, there has been a duplication and fragmentation of HCBC programmes falling under different programme headings within different departmental directorates. Up until now, there has been no clear linking of the different programmes or an understanding of how they fit together (if at all) (Streak 2005).

Insufficient internal and cross-departmental coordination has seen the proliferation of many HCBC programmes that are in essence the same in terms of targeted beneficiaries, mode of operation and services provided. 'This fragmented approach to service delivery remained despite it being a cost multiplier and its constraint on system responsiveness to new disease and social challenge...An example from health could see a household have as many as five lay cadres targeting it, and not necessarily in a coordinated manner' (DoH & DoSD 2009: 11).

There has, however, been national recognition and response to the duplication, fragmentation and related concerns about the capacity of HCBCs and the quality of services provided. Attention has also been paid to the exploitation of workers who have been engaged to do very important work, but have not benefited from legislative protection such as that provided to other workers in terms of South African labour law. This recognition has been captured in two draft policies, currently under development by the departments of Health and Social Development jointly – they are the South African National Policy Framework for Home and Community Based Care and Support Programme (Revised draft, November 2009) and the Community Care Worker Management Policy Framework (DoH & DoSD 2009).

These two draft policy documents respond to the current challenges to HCBC programmes by creating a common framework within which to synergise HCBC and

community care worker (CCW) activity across the departments of Health and Social Development. The principle is to have a single approach to CCWs, without creating multiple cadres who essentially perform similar generic tasks, and to skill up CCWs to offer a wider and more comprehensive range of services.

Lack of effective coordination and reliable data

There are a host of departments that must work together to ensure the delivery of effective child protection services, including the departments of Social Development, Justice, Education, Health, the National Prosecuting Authority (NPA) and the South African Police Services (SAPS). Poor coordination between these different departments impacts negatively on the provision of effective and comprehensive child protection services (Giese & Sanders 2008).

The DoSD is responsible for leading the coordination of different stakeholders and has established a number of coordinating structures, including the National Child Care and Protection Forum and the national, provincial and local child protection committees. The effectiveness of these structures is undermined by factors such as lack of protocols, erratic attendance of government departments and poor communication (Giese & Sanders 2008).

A key challenge to all child protection services and programmes is the lack of reliable national and sub-national data on child protection issues that could help inform and better target programmes.

There are two sources of child protection data in South Africa. SAPS provides annual statistics of crimes committed against children. The Child Protection Register, compiled by the national DoSD, provides annual overall statistics which are disaggregated according to provinces. Both sources are deemed unreliable. SAPS data are dependent on the accuracy of police reporting. The Child Protection Register relies on reporting from the provinces. There is general consensus that the information provided by provinces must be treated with caution. Dawes et al. (2006) express the concern of many when they state that, 'Current data on the CPR [Child Protection Register] cannot be regarded as [an] accurate, valid and reliable record of reported child abuse' (in Chames et al. 2010: xii).

Chames et al. (2010) note that the DoSD is mindful of this problem and has sought to address it through a five-year research study on child abuse, neglect and exploitation called the National Child Protection Surveillance Study.

The DoSD's draft Child Protection Strategic Plan 2010/11–2014/15 commits the Department '[t]o ensure the development of a research policy framework for child abuse, neglect and exploitation'. It further recognises that:

Ongoing coordinated research in the field of child abuse, neglect and exploitation is needed. A national clearing house must be established to invest in research to illuminate the magnitude of the problem, the cause, parties involved, intervention patterns and outcomes. The clearing house must be accorded a mandate to address all the methodological, legal and ethical issues in the child protection field. An accessible and updated data base must be established. Provide sustainable CANE [child abuse, neglect and exploitation] programmes which facilitate the empowerment of children including children with disabilities and chronic illness... (DoSD 2010b: 75)

Department of Health

Introduction

The Department of Health (DoH) is primarily responsible for the realisation of the right of children and their families to health and related care, which rights enjoy extensive protection under the UNCRC (Article 24) and the ACRWC (Article 14).

Both instruments guarantee the right to healthcare and services for infants, children, expectant and nursing mothers and the mothers, families and caregivers of infants and children. They require State Parties to take steps to realise children's rights to physical, mental and spiritual health⁴⁸ and the right to enjoy the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health.⁴⁹

State Parties are required to take key steps to ensure the full implementation of these rights, with a specific focus on ensuring:

- a reduction of infant and child mortality rates;⁵⁰
- the provision of necessary medical assistance and healthcare to all children, with an emphasis on the development of primary healthcare;⁵¹
- the prevention of disease and malnutrition through the provision of adequate nutrition, safe drinking water and the application of readily available technology;⁵²
- the provision of appropriate pre- and post-natal healthcare for expectant and nursing mothers and mothers of infants and small children;⁵³
- the development of preventive healthcare and family life education, family planning education and services;⁵⁴
- that all sectors in society, especially parents, children, community leaders and community workers, are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;⁵⁵
- the abolition of traditional practices prejudicial to the health of children;⁵⁶
- the integration of basic health service programmes in national development plans;⁵⁷
- the meaningful participation of NGOs, local communities and the beneficiary population in the planning and management of basic health service programmes for children;⁵⁸
- the mobilisation of local community resources in the development of primary healthcare for children.⁵⁹

The Constitution of the Republic of South Africa (Act No. 108 of 1996) has provided national protection of the right to healthcare through the recognition of the following

48 ACRWC, Article 14(1)

49 UNCRC, Article 24(1)

50 UNCRC, Article 24(2)(a); ACRWC, Article 14(2)(a)

51 UNCRC, Article 24(2)(b); ACRWC, Article 14(2)(b)

52 UNCRC, Article 24(2)(c); ACRWC, Article 14(2)(c)(d)

53 UNCRC, Articles 24(2)(d) and 14(2)(e)

54 UNCRC Articles 24(2)(f) and 14(2)(f)

55 UNCRC Articles 24(2)(e) and 14(2)(h)

56 UNCRC, Article 24(3)

57 ACRWC, Article 14(2)(g)

58 ACRWC, Article 14(2)(i)

59 ACRWC, Article 14(2)(j)

rights of vulnerable children and their families to health and related care:

- the right of everyone to healthcare services, including reproductive healthcare services (section 27(1)(a));
- the right of everyone to emergency medical treatment (section 27(3));
- the right of all children to basic nutrition and healthcare services (section 28(1)(c)).

Key policies⁶⁰

- White Paper for the Transformation of the Health System in South Africa, 1997
- Patient Rights Charter, 1999
- Free Health Care Policy, 1994
- Free Primary Health Care Policy, 1996
- Breastfeeding Guidelines for Health Workers, 2000
- Policy Guidelines for the Management and Prevention of Genetic Disorders, Birth Defects and Disabilities, 2001
- Strategy for the Implementation of the Baby Friendly Hospital Initiative, 2001
- Integrated Food Security and Nutrition Programme, 2002
- Integrated Food Security Strategy for South Africa, 2002
- The Primary Health Care Package for South Africa, 2002
- Comprehensive HIV and AIDS Care, Management and Treatment Plan, 2003
- The Assistive Devices Policy, 2003
- The Standardization of Provision of Assistive Devices in South Africa, 2003
- Free Health Care for Disabled People at Hospital Level, 2003
- The National Adolescent-friendly Clinic Initiative, 2003
- School Health Policy and Implementation Guidelines, Department of Health, 2003
- Policy Guidelines on Child and Youth Mental Health Services, 2004
- Guidelines for the Management of HIV-infected Children, 2005
- Policy Framework on Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- The National Integrated Plan for Early Childhood Development in South Africa, 2005–2010
- Infant and Young Child Feeding Policy, 2007
- South African National Guidelines on Nutrition for People Living with HIV, AIDS, TB and other Chronic Debilitating Conditions, 2007
- The HIV and AIDS and STI National Strategic Plan, 2007–2011
- Policy Guidelines – Child and Adolescent Mental Health, 2007
- Policy and Guidelines for the Implementation of the PMTCT Programme, 2008
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2009–2012
- The Expanded Programme on Immunisation – Revised National Immunisation Schedule as at 1 April 2009
- Strategic Plan 2010/11–2012/13, National Department of Health
- Policy Guidelines for HIV Counselling and Testing, National Department of Health, 2009

⁶⁰ The process of identifying and documenting all health-related policies was challenging due to the number of policies and the diversity of publication media and sites. Not all policies are published on the DoH's website. The process of identification was made much easier by a number of earlier mapping projects to which the author turned for significant guidance in this regard, including Kallmann (2008), Giese and Koch (2008a), Coetzee and Streak (2004), Save the Children UK (2006), and Khoza (2007).

- Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission) 2010, National Department of Health, South African National Aids Council
- Guidelines for the Management of HIV in Children, 2nd Edition, 2010, National Department of Health, 2010, National Department of Health and SANAC
- Clinical Guidelines for the Management of HIV and AIDS in Adults and Adolescents, 2010, National Department of Health and SANAC
- The South African Antiretroviral Treatment Guidelines, 2010, National Department of Health and SANAC

Key legislation

- Constitution of the Republic of South Africa, Act No. 108 of 1996
- National Health Act, No. 61 of 2003
- The Children's Act, No. 38 of 2005 as amended by Act No. 41 of 2007
- The Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007

Programmes and services provided

The following programmes and services are provided by the DoH to realise and protect the rights of vulnerable children:

- free primary, secondary and tertiary healthcare services for pregnant and lactating women – at primary, secondary and tertiary level;
- free primary, secondary and tertiary healthcare services for children under six;
- free primary healthcare for all children aged 6–18 years and their family members;
- free secondary and tertiary healthcare for children older than six whose parents/caregivers are unemployed and/or receive one of the children's grants;
- subsidised secondary and tertiary healthcare for children aged 6–18 and their families where the families benefit from some income other than social grants;
- free primary, secondary and tertiary healthcare services for children and adults with moderate and severe disabilities;
- Integrated Nutrition Programme (INP):
 - vitamin A supplementation programme,
 - nutrition supplementation programme,
 - the baby-friendly hospital initiative,
 - infant and young child feeding,
 - growth monitoring and promotion,
 - national food fortification programme,
 - nutrition promotion, education and advocacy;
- comprehensive HIV/AIDS care, management and treatment plan;
- PMTCT;
- HIV counselling and testing;
- access to contraceptives;
- ART;
- post-exposure prophylaxis (PEP);
- integrated management of childhood illnesses (IMCI) programme;
- extended programme on immunisation;
- school health services and health-promoting schools.

Table 4.1 Programme/service map: Department of Health

Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Free healthcare services for pregnant and lactating women – at primary, secondary and tertiary level ⁱ	Free primary, secondary and tertiary healthcare from the time of the diagnosis of the pregnancy, or if a complication occurs, for up to 42 days after termination of the pregnancy or until such time as the complication has been cured or the condition stabilised Services include basic antenatal monitoring and care, nutritional supplementation and support and PMTCT services – all of which are described in more detail in the programmes contained in the remainder of this table.	Targeted beneficiaries All pregnant and lactating women not on a private medical aid	All public health facilities, including clinics, community health centres and hospitals – especially at the primary level of care
Free healthcare services for children under six ⁱⁱ	This includes free primary, secondary and tertiary healthcare. Primary healthcare includes health promotion, prevention and basic curative care at clinics and community healthcare services. See the list of primary healthcare services making up the primary healthcare package under the next programme in this table ('Free primary healthcare for all children 6–18 years and their family members'). Secondary healthcare involves hospitalisation.	Targeted beneficiaries Children younger than six It excludes people (and their dependents): <ul style="list-style-type: none"> • who are on medical aid; • non-South Africans who visit South Africa specifically for the purpose of obtaining healthcare. 	Primary level public health facilities include clinics, mobile clinics and satellite clinics, community healthcare centres and district hospitals. Secondary healthcare facilities are hospitals that deal with slightly more complicated cases requiring hospital care or further investigation.



→	Tertiary healthcare includes complex or severe cases that can only be treated with specialist care.	Tertiary facilities are hospitals that offer highly specialised care and investigations, such as the Red Cross Children's Hospital (Shung King et al. 2005).
Free primary healthcare for all children 6–18 years and their family membersⁱⁱⁱ	<p>Free primary healthcare, which includes health promotion, prevention and basic curative care at clinics and community healthcare services</p> <p>Primary healthcare services that are potentially available as part of the primary healthcare package for all children include (Reagan et al. 2003):</p> <ul style="list-style-type: none"> • immunisation services; • contraception, emergency contraception and counselling on terminations of pregnancy; • antenatal care and monitoring; • developmental and genetic screening, for example, the management and prevention of genetic disorders; • trauma care services; • treatment of STIs; • HIV/AIDS services, including voluntary counselling and testing, PEP, Nevirapine (NVP) and ART; • tuberculosis services; 	<p>Targeted beneficiaries All children 6–18 and all adult South Africans without private medical aid^{iv}</p> <p>Public healthcare facilities – clinics and community health centres</p>





- community outreach services, including school health, youth services, ECD, home-based care, nutrition projects, etc.;
- on-site laboratory testing;
- emergency transport services to transfer patients between facilities.

<p>Free secondary and tertiary healthcare for children older than six of caregivers who are unemployed and/or receive one of the children's grants^v</p>	<p>Children over six and adults living in poverty qualify for free primary, secondary and tertiary healthcare.</p>	<p>Targeted beneficiaries</p> <p>Public hospitals</p> <p>Children older than six of unemployed caregivers</p> <p>Children over the age of six who receive social grants such as the CSG, the FCG and the CDG</p> <p>Children who are dependent on adults who get the older persons grant</p> <p>Qualifying criteria</p> <ul style="list-style-type: none"> • Families where the caregiver(s) are formally unemployed and supported by the Unemployment Insurance Fund. Proof of unemployment must be provided. • Receipt of a child grant or an older persons grant by the primary caregiver(s) 	<p>Public hospitals</p>
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<p>→ Subsidised secondary and tertiary healthcare for children 6–18 and their families where the families benefit from some income other than social grants^{vi}</p>	<p>Children over the age of six and adults who have income over a certain limit have to pay for their healthcare according to a means-tested sliding scale. Patients are classified according to their level of income and charged a rate, which increases as the level of income increases. For example:^{vii}</p> <ul style="list-style-type: none"> • patients classified at level H1 are those in households with unmarried parents that earn less than R36 000 per annum, or in households with married parents with a combined gross income of less than R50 000 per annum. Patients at this level are charged an all-inclusive flat fee as an inpatient or an outpatient; • patients classified at level H2 are those in households with unmarried parents that earn between R36 000 and R72 000 per annum, or in households with married parents with a combined gross income of between R50 000 and R100 000 per annum. Patients at this level are charged 50 per cent of the full public hospital tariffs (Uniform Patient Fee Schedule [UPFS] tariffs); 	<p>Targeted beneficiaries Children and families living in poverty</p> <p>What must be provided when applying? Proof of income has to be submitted.</p> <p>Income is the combined gross family income of the parent(s) or primary caregiver(s).</p>	<p>Public hospitals</p>
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- patients classified at level H3 are those in households with a private medical aid of whose medical costs are being paid by the Road Accident Fund or who are receiving compensation for occupational diseases. Patients at this level are charged the full public hospital tariffs (UPFS tariffs).

<p>Free healthcare services for all children younger than six and for children older than six with moderate and severe disabilities whose parents are unemployed or receive a child/older persons' grant</p> <p>Subsidised healthcare for children older than six and adults with moderate and severe disabilities</p>	<p>Services provided^{viii}</p> <ul style="list-style-type: none"> • All in- and out-patient services, including day admissions • Specialist medical interventions for prevention, correction or rehabilitation of a disability, provided it is motivated by a treating specialist and approved by a committee appointed by the Head of Health. Motivation is not required for emergency cases. • All assistive devices needed for the prevention of complications, for rehabilitation, or for the correction of a disability. This includes orthotics, prosthetics, wheelchairs, walking aids, hearing aids, spectacles, maintenance and repairs. 	<p>Targeted beneficiaries</p> <p>All children and adults living in poverty with moderate and severe disabilities</p> <p>Qualifying criteria^{ix}</p> <ul style="list-style-type: none"> • All children with moderate to severe disabilities who are younger than six, children older than six who receive a CSG or whose caregivers receive an older person's grant qualify for free healthcare. • Children older than six and their caregivers who live in households that are classified at levels H1 or H2 in terms of the current UPFS subsidy provisions as described above will qualify for the prescribed subsidised rates. • The disability must be permanent. • The disability must be moderate to severe. 	<p>All public healthcare facilities</p>
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- People with an incurable psychiatric diagnosis will qualify too.

Exclusions

- Children with a temporary disability or with a chronic illness that does not cause difficulty in daily functioning are excluded.
- Children in households on medical aid or receiving compensation from the Road Accident Fund are excluded.

<p>Integrated Nutrition Programme^x</p>	<p>Provides nutrition education and promotion to nutritionally vulnerable communities</p> <p>The programme includes:</p> <ul style="list-style-type: none"> • the Nutrition Supplementation Programme; • the Vitamin A supplementation programme; • the 10 steps to successful breastfeeding programme and infant feeding programme; • the baby-friendly hospital initiative; • growth monitoring and promotion; • the national food fortification programme; • nutrition promotion, education and advocacy. 	<p>Targeted beneficiaries</p> <p>Nutritionally vulnerable communities and groups</p>	<p>Health workers and dieticians employed at all public healthcare facilities</p> <p>Community healthcare workers working under the DoH or an NGO may provide a range of services related to nutrition education and promotion in the home and community. These include:</p> <ul style="list-style-type: none"> • providing information on mixed infant feeding, healthier nutritional choices and establishing food gardens; • promoting exclusive breastfeeding, good hygiene practices and the safe preparation of food, including infant formula feeding; • monitoring the growth of children.
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<p>→ Nutrition Supplementation Programme^{xi}</p>	<p>The objective of the NSP is to identify and treat undernourished adults and children at primary healthcare level.</p> <p>Targeted vulnerable beneficiaries are entitled to food supplements, including fortified maize meal and a high energy drink.</p> <p>Children under the age of five that experience growth faltering get formula milk, Diva rice cereal, energy drinks and porridge.</p> <p>Nutritional supplementation for HIV+ children</p> <p>This is prioritised in terms of governing policies and guidelines.^{xii}</p> <p>The policies and guidelines on nutritional support and supplementation for children aim to ensure that children with asymptomatic HIV infection enjoy a 10 per cent increase in energy consumption, those with symptomatic infection receive the 30 per cent additional energy recommended by the WHO, and that symptomatic children with severe malnutrition receive 100 per cent extra energy.^{xiii}</p>	<p>Targeted beneficiaries</p> <p>Children under the age of five (not just those that are HIV+) that experience growth faltering. Growth faltering is when the child's growth curve drops over two consecutive months on their growth monitoring Road to Health Card.</p> <p>Exit criteria:</p> <ul style="list-style-type: none"> • once the child has gained adequate weight to attain a growth curve in relation to his or her normal growth and maintains this for three months; • if the child fails over a period of 12 months to attain a normal growth curve and there is no underlying disease present; • if the child defaults – i.e. fails to attend clinic for a period of three consecutive months. <p>HIV+ children under the age of 14 receiving ARVs</p> <p>Nutritionally at risk pregnant women who exhibit insufficient growth according to the curve on the symphysis-fundus graph on the antenatal chart</p>	<p>Primary healthcare facilities, including public clinics and community health centres</p> <p>Community-based healthcare workers employed by the state and NGOs may give nutritional advice and support to caregivers that are HIV+ and/or whose children are HIV+, including information on the benefits of exclusive breastfeeding and information on mixed infant feeding and safe food preparation practices in the case of formula feeding.</p>
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<p>→</p> <p>In order to meet these objectives, healthcare workers are required to assess the nutritional status of children and their nutritional needs in relation to their status and relevant treatment regime and provide them and their caregivers with nutritional support in terms of the Policy Guidelines for the Nutrition Supplementation Programme of the Health Facility Based Nutrition Programme & National Guidelines on Nutrition for People Living with HIV, AIDS, TB and other Chronic Debilitating Conditions, 2007.^{xiv}</p> <p>The support to be given to children who are HIV+ includes:</p> <ul style="list-style-type: none"> • giving nutritional advice and guidelines to caregivers of HIV+ infants and children on how to meet energy requirements and how to overcome feeding difficulties like nausea, vomiting and sores in the mouth; • food supplementation for children who are of eligible age (under five) and who fall below the goal weight for age, as prescribed by the Nutrition Supplementation 	<p>Lactating women with a growth faltering infant under the age of six months. Once the infant reaches the age of 6–12 months, the infant will also get fortified mealie meal.</p> <p>Adults who are HIV+ and show signs of undernourishment</p> <p>Adults who have tuberculosis and show signs of undernourishment</p>
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- Programme administered in terms of the Integrated Nutrition Programme;
- the comprehensive HIV and AIDS care, management and treatment plan (CCMT) provides that children under the age of 14 who are on ART should get a nutritional package of vitamin syrup and a supplement meal;
 - pregnant and lactating women receive a high-energy drink and nutritional counselling and advice on feeding practices once their infant is born;
 - children with severe malnutrition and specified danger signs such as jaundice, hypoglycaemia, diarrhoea for more than seven days, weeping skin lesions and refusing feeds must be hospitalised and receive urgent treatment, including daily assessment by a doctor.^{xv}



→	Vitamin A supplementation programme	<p>Post-partum mothers get a single dose of vitamin A immediately after delivery to meet their own and their newborn's vitamin A needs through breastfeeding.</p> <p>Infants receive their next vitamin A supplement at six months and at six monthly intervals thereafter.</p> <p>Children between the ages of 6–59 months with low birth weights receive two doses per year.</p>	<p>Targeted beneficiaries</p> <p>Children aged 6–59 months with low birth weights</p> <p>Children who are severely malnourished</p> <p>Children with persistent infectious diseases such as diarrhoea, measles or HIV</p> <p>Post-partum mothers</p>	<p>Public clinics and community health centres</p> <p>Community healthcare workers are required to monitor vitamin A supplementation using the Road to Health Card.</p>
	Protein energy malnutrition programme	<p>Seriously malnourished children are admitted to hospital where they are treated and provided with an intensive diet until they recover.</p>	<p>Targeted beneficiaries</p> <p>Children with acute protein energy malnutrition</p>	<p>Secondary level hospitals</p>
	Baby-friendly hospital initiative	<p>The objective of the initiative is to support new mothers to breastfeed.</p> <p>Health facilities are being transformed to comply with the Ten Steps to Successful Breastfeeding.^{xvi} They provide support and counselling to new mothers to facilitate early, effective and sustained breastfeeding.</p>	<p>Targeted beneficiaries</p> <p>New mothers and their infants</p>	<p>All hospitals in South Africa, both public and private, providing maternity services</p>



→ Infant and young child feeding programme^{xvii}	<p>The DoH's policies regarding infant and young child feeding have these primary goals:</p> <ul style="list-style-type: none"> • optimal nutritional status, growth, development and health of infants and young children; • prevention of mother to child transmission of HIV in the post-natal period through breastfeeding; • to reduce the mortality of HIV-exposed infants through appropriate feeding options, supported by appropriate ARV treatment regimes for the lactating mother and baby. The relevant ARV treatment regimes for pregnant and lactating women and those who have infants, as well as for infants, are discussed later in this table. 	<p>Targeted beneficiaries</p> <p>All pregnant women and mothers of infants and young children</p> <p>All infants and young children</p> <p>Infants born to HIV+ mothers</p> <p>HIV+ mothers</p> <p>Adolescent mothers</p> <p>Infants that are HIV+</p> <p>Infants with a low birth weight</p> <p>Severely malnourished children</p> <p>Orphans, children in foster care, children separated from their mothers for long time and children whose mothers cannot care for them due to ill health or mental disabilities</p>	<p>All health facilities, public and private, providing maternity/antenatal services as well as trained lay counsellors and healthcare professionals</p> <p>National, provincial and district managers, health establishments and all healthcare personnel caring for parents and children during pregnancy, childbirth and in the first five years of life</p> <p>Healthcare professionals implementing nutrition and HIV/AIDS programmes at all levels</p> <p>Community health workers, both those employed within civil society and government, may provide information to pregnant women and mothers with small children regarding HIV and key services provided; promote exclusive breastfeeding; and provide information on mixed infant feeding.</p>
	<p>These objectives are to be achieved through:</p> <ul style="list-style-type: none"> • protection, promotion and support of optimal safe feeding of infants and young children; • promotion, protection and support of breastfeeding through counselling and support to mothers by healthcare personnel during antenatal, intra-partum, post-natal and follow-up care. 		





- This means that all pregnant women should be educated on exclusive breastfeeding for six months and continued breastfeeding until two years and beyond, with appropriate complementary feeding.
- All pregnant women should be provided with evidence-based, objective and unbiased infant feeding information to ensure they make informed infant feeding choices. The information provided must include information about the risk of HIV transmission through breastfeeding, ART prophylaxis to reduce this risk, and the risks of replacement feeding.
- Mixed feeding during the first six months of life should be strongly discouraged as it increases the risk of childhood infections.
- In the case of HIV+ women, quality, objective and individualised counselling on safe infant feeding practices as described in the Clinical Guidelines: PMTCT, 2010, must be provided by all health





- facilities offering routine antenatal services, by trained lay counsellors and healthcare professionals.
- All pregnant women should be encouraged to go for voluntary counselling and testing.
 - All pregnant women should receive encouragement, education and support on how they can achieve their own adequate nutritional status.
 - At-risk pregnant and lactating women, for example adolescents, women with low weights and HIV+ women, should receive appropriate specialised counselling.
 - All pregnant women should be encouraged to bring partners or a family member for antenatal education.
 - Once an HIV+ woman has been counselled and has decided on her infant feeding option, she should be educated and supported during antenatal care and post-natal care so that she can safely pursue her feeding choice.
 - HIV+ women must receive individual and





unbiased counselling on infant feeding to allow them to make choices appropriate to their circumstances.

- Counselling must start in the antenatal period as part of the voluntary counselling and testing strategy, and not be left to the time of birth.

In the antenatal period

- All pregnant women must receive routine antenatal care, including micronutrient supplementation. All HIV+ pregnant women should receive iron and folate supplementation.
- All pregnant women must be offered information on PMTCT interventions at all healthcare consultations.
- All pregnant women must be counselled on safe infant feeding options and assisted in making appropriate feeding choices. Counselling on infant feeding must commence after the first post-test counselling session in pregnancy. HIV+ women should be counselled on feeding options at every





antenatal visit, with the objective of each woman receiving four antenatal counselling sessions on infant feeding and ARV prophylaxis.

In the intra-partum and post-natal period

- All women who are HIV negative or of unknown status who choose to breastfeed should be supported to hold their infants in skin-to-skin contact within 30 minutes of birth, to initiate breastfeeding within an hour of birth, be taught through demonstration and observation to ensure correct positioning and attachment of their babies to breastfeeding, and be encouraged to breastfeed exclusively for the first six months.
- All HIV+ women should be encouraged to commence and continue exclusive breastfeeding for at least two years.
- During the post-natal period, mother and infant pairs should have a follow-up visit within three days of delivery to review feeding practices, check breast health, and maternal and child health.





- Mothers must be shown how to maintain lactation when they are separated from their babies.
- Mothers must be educated about the dangers of mixed feeding.
- Mothers should be advised of available infant feeding support groups in the community.
- Mothers should be encouraged to attend well-baby clinics for immunisations and monitoring of the baby's growth and development.
- HIV+ mothers who are breastfeeding must be counselled on post-natal transmission of HIV.
- HIV+ mothers who choose to formula feed should be supported to hold their baby in skin-to skin contact as soon as possible after delivery.
- All mothers who choose replacement feeding must be taught through demonstrations how to prepare and use formula feeds safely.

Follow-up support for mothers within post-natal services for infants and young children must include:





- support in the chosen feeding option;
- advice on complementary foods and when and how to introduce them;
- advice to introduce solids after six months;
- growth monitoring at every child visit to the health facility;
- growth charts must be made available to the public free of charge;
- children must receive vitamin A supplementation;
- parents should be educated on appropriate childcare practices.

Follow-up support for breastfeeding mothers who are HIV negative or of unknown status

- Support must be given to mothers to exclusively breastfeed up to six months and to continue breastfeeding up to two years, in combination with appropriate, nutrient dense and easily ingested foods.

Follow-up support of HIV+ women who choose exclusive breastfeeding

- Nutritional support must be offered to HIV-infected women choosing to breastfeed.





- At six weeks, following the PCR test, all HIV+ mothers should again be counselled. If the infant is HIV+, advise the mother to continue exclusive breastfeeding and if the baby is HIV negative, the mother must be counselled on feeding options and should be informed of all the risks.
- Mothers must be supported to make the transition to appropriate replacement feeding.

Follow-up support of HIV+ mothers who choose replacement feeding

- If mothers choose to practise replacement feeding, they must be supported to exclusively replacement feed for six months.
- Free commercial infant formula will be provided to HIV+ women who choose to replacement feed.
- Women should receive practical support, including demonstrations on how safely to prepare formula and feed their babies.
- Healthcare workers must observe and assess if mothers/ caregivers prepare and use formula safely.





- The amount of formulae required by the infant must be reviewed at each visit.
- Health workers must identify problems and take appropriate actions.

Children in exceptionally difficult circumstances

- Mothers of low birth weight infants must be supported to exclusively breastfeed for six months and to practise sustained breastfeeding for two years.
- If infant formula is used, a special low birth weight formula should be given.
- Kangaroo Mother Care must be encouraged.

Severely malnourished children

- Children should be assessed when admitted to hospital.
 - Skilled healthcare personnel should manage severely malnourished children and support and teach the parents about proper nutrition.
 - Therapeutic feeds must be provided in hospital or in the community until nutritional recovery is complete.
 - Appropriate community-based referral systems or rehabilitation facilities should be identified to prevent relapse.
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→	<p>Growth monitoring and promotion^{xviii}</p>	<p>Each newborn must be issued with a Road to Health Card when they are born.</p>	<p>Targeted beneficiaries All infants and young children up to the age of five</p>	<p>Public and private primary healthcare facilities</p>
		<p>Regular measurement and recording of weight-for-age (and developmental milestones) of infants is documented on the Road to Health Card.</p>		
		<p>The Road to Health Card monitors the growth and development of the child and records immunisations until the child is five years old. The Card is given to the mother free of charge when a baby is born in either a state or a private hospital. If the baby is not born in a hospital, the mother will receive the Card on the mother and baby's first contact visit with the primary health services. The Road to Health Card is the property of the child's parent or legal guardian.</p>		
		<p>The Road to Health Card has recently been expanded to record and monitor the infant's HIV status, whether the infant has received ARVs and what feeding choices the mother has made.</p>		



→	National food fortification programme	All maize meal and bread flour must be fortified with vitamin A, thiamine, niacin, riboflavin, pyridoxine, iron, folate and zinc.	Targeted beneficiaries Pregnant women and young children	The DoH is responsible for monitoring compliance by manufacturers.
	Nutrition education, promotion and advocacy	Health workers, dieticians and community health workers are required to provide counselling, information and education about healthy diets and the healthiest ways of preparing food to improve nutritional status and reduce nutrition-related diseases.	Targeted beneficiaries Vulnerable communities	Health workers and dieticians at all public health facilities and community health workers
	Comprehensive HIV and AIDS care, management and treatment plan^{xix}	<p>This programme aims to prevent children and caregivers from becoming infected with HIV, to reduce mortality and to improve the quality of life of those who do become infected.</p> <p>The programme provides for:</p> <ul style="list-style-type: none"> • prevention of HIV infection; • provider-initiated testing for pregnant women and, if HIV+, ART therapy to prevent transmission; • ART for mothers where indicated; • support for exclusive breastfeeding; • testing of HIV-exposed infants at six weeks; • provision of ARV prophylaxis for all HIV-exposed infants; • care and treatment for HIV-infected children; 	Targeted beneficiaries Infants, pregnant women, mothers with infants, and children affected by and infected with HIV/AIDS Adult caregivers vulnerable to and/or infected with HIV/AIDS	The elements of the CCMT are integrated within all packages, including the PMTCT programme, the IMCI programme, the Integrated Nutrition Programme and others (DoH et al. 2008).



→	<ul style="list-style-type: none"> • ART for children and adults with AIDS; • nutritional support for HIV+ children and adults and those on treatment. <p>The nutritional support components and feeding options support were covered in previous sections of this table (see 'Infant and Young Child Feeding Programme').</p> <p>The remaining components will be dealt with in detail in the remainder of this table under the various specialised programme headings as the CCMT is integrated within all healthcare programmes.</p>		
<p>HIV counselling and testing (HCT) programme^{xx}</p> <p>and</p> <p>The national adolescent-friendly clinic initiative</p>	<p>The HCT programme, as supplemented by the new 2010 Guidelines for the Management of HIV in Children, aims to provide an integrated testing service at all levels of the public health service delivery system for infants, children and adults. It seeks to ensure that all infants, children and adults are tested, that infants and children are tested as early as possible, that those that test HIV negative maintain their negative status, and that people who test HIV+ are supported, through appropriate treatment and support, to live long and healthy lives.</p>	<p>Targeted beneficiaries</p> <p>Infants, children and adolescents</p> <p>More specifically, the testing of the following children is expressly required:^{xxi}</p> <ul style="list-style-type: none"> • all HIV-exposed infants; • children with clinical features suggestive of HIV infection and with acute illnesses; • all children with suspected symptomatic HIV infection; • all children diagnosed with TB; • if a parent requests it; • if the child's father/sibling has HIV infection; 	<p>HCT can take place at any primary, secondary or tertiary health facility.</p> <p>HCT is provided at both state and private health facilities.</p> <p>Regulations to the Health Act have been promulgated (Gazette No. 33188) which allow certain persons who are not healthcare providers, subject to certain conditions, to withdraw blood from a living person. Key conditions are that:</p> <ul style="list-style-type: none"> • the person must receive training at a healthcare establishment; and



**Counselling and testing**

Infants, children and adolescents have a right to HCT. No child may be tested until the child and the child's caregiver have received pre-test counselling.^{xxii} Counselling must also be provided after the test.

HIV counselling is defined as an intervention which gives the client an opportunity to be educated and supported in order to explore his or her HIV risk; to learn about his or her HIV status and manage the consequences; to learn about HIV prevention and HIV/AIDS treatment, care and support services; and to learn how to modify their behaviour to reduce the risk of HIV infection.^{xxiii}

Consent

The Children's Act provides that no child may be tested for HIV unless the child/parent/other person has consented to the test (s130).

If the child is younger than 12 and is not sufficiently mature, then the parent, caregiver, provincial head of social development or a designated social protection organisation may consent to the test.

- if the child's mother, father or sibling died from AIDS;
- when the mother's HIV status is unknown and her whereabouts are unknown;
- a child that has been breastfed by a woman of unknown status;
- a child who has experienced/is at risk of sexual assault;
- when it is in the best interests of a child being considered for foster or adoption placement.

- the removal of blood may only be by pricking a finger with designated equipment to obtain a small quantity of blood sufficient for testing.

Counselling is provided by HIV counsellors who are trained individuals and who have completed an HIV counselling course prescribed in the National Minimum Standards for Counselling and Training. Counselling in terms of the HCT programme can be administered by medical professionals or lay counsellors at medical and non-medical sites.

Even though counselling may be delegated to lay counsellors, the healthcare worker remains responsible for the overall psychosocial well-being of children and their caregivers.^{xxiv}



→	<p>A child over the age of 12 or a child younger than 12 who is sufficiently mature may consent to HIV testing.</p> <p>If there is no parent/ caregiver or designated child protection organisation available to consent, the superintendent of the hospital may provide the consent.</p> <p>The child's HIV status is protected from disclosure. Section 133 of the Children's Act prohibits the disclosure of the HIV status of a child without appropriate consent.</p> <p>Testing of infants and young children</p> <p>The revised Guidelines for the Management of HIV in children (2nd edition, 2010) recognises that without PMTCT interventions, MTCT occurs in about 30% of infants and that most of the children infected at the time of birth will develop features of the disease by six months of age. HIV disease progresses much more rapidly in infants and children than in adults. The reality is that 40% of HIV-infected infants die before they reach the first year of life and there is a 75% increased risk of mortality in infants and children deferring ART in</p>	<p>Non-medical sites are situated away from medical services, though they have relationships with them, e.g. NGOs, faith- and community-based organisations. The objective of services in these settings is to increase access to counselling and testing by groups not receiving them in government facilities.^{xxv}</p>
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the first few months of life. Therefore, the revised Guidelines stress the importance of testing all HIV-exposed infants and identifying those who are HIV+ as early as possible. The Guidelines require that all HIV-exposed infants be tested for HIV at the age of six weeks, and every six weeks thereafter if the test is negative, and then again at the age of 18 months.

The section below on the PMTCT programme deals with the testing and treatment of HIV-exposed infants in more detail.

Testing of adolescents

The national adolescent-friendly clinic initiative seeks to make healthcare facilities more accessible and acceptable to adolescents. A key part of the initiative is peer outreach to encourage young people to make use of healthcare facilities.

The provision of youth- and child-friendly counselling and testing is reinforced in the Policy Guideline for HCT, which requires HCT services to be provided in a child- and youth-friendly environment where their needs, questions and personal concerns can comfortably be communicated.





The Policy further recommends that HCT services should, as far as possible, be provided to young people in a 'one-stop-shop' fashion. There is a greater risk of young people not showing up for services when they are referred to a further physical location. Where 'one-stop-shop' HCT services are not available, HCT staff must refer and link young people to responsible agencies that provide appropriate, youth-friendly support.

Access to contraceptives	<p>The Children's Act entitles a child who is older than 12 years to contraceptives without the need for parental consent (s133).</p> <p>The child must be given proper medical advice and must undergo a medical examination to determine the most appropriate form of contraception.</p> <p>The child has a right to confidentiality about the use of contraception.</p>	Targeted beneficiaries Children who are 12 and older	Primary healthcare facilities
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→ The prevention of mother-to-child transmission programme^{xxvi}	<p>There are four elements of PMTCT:</p> <ul style="list-style-type: none"> • primary prevention of HIV, especially among women of childbearing age; • preventing unintended pregnancies among women living with HIV; • preventing HIV transmission from a woman living with HIV to her infant; • providing appropriate treatment, care and support to women living with HIV. <p>The expanded package of PMTCT services includes:</p> <ul style="list-style-type: none"> • routine offer of HIV counselling and testing for all pregnant women attending antenatal care; • provision of provider-initiated counselling and testing services in the context of PMTCT in facilities offering routine antenatal care; • involvement of the partner and the family in order to ensure a comprehensive approach; • counselling on safe infant feeding options and assistance in making appropriate feeding choices using the Acceptability, Feasibility, Safety and Sustainability (AFFS) criteria; 	<p>Targeted beneficiaries</p> <p>Pregnant HIV+ women and HIV-exposed infants (both those who are HIV+ and those who are not)</p>	<p>PMTCT must be integrated into all existing mother and child public health services and facilities.</p> <p>Community healthcare workers employed by both the state and NGOs are seen as key agents for the education of communities, families, women and children and the enhancement of utilisation rates of the PMTCT programme (as well as other health programmes).</p> <p>Primary healthcare facilities (clinics) are now expected to be able to initiate and provide ART for both adults and children.^{xxvii} Up until 2010, ART could only be initiated by doctors at accredited sites. It can now be initiated and provided by nurses at primary healthcare facilities, with the objective of caring for an increasing number of children and pregnant women at primary healthcare level.</p>
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- nutritional support in the form of micronutrient supplementation (which is the same as for all other pregnant mothers, including multivitamins, iron and folate);
- in the case of advanced HIV accompanied by malnutrition/wasting and/or poor weight gain, the mother must receive vitamin- and mineral-fortified porridge;
- provision of appropriate regimes to prevent MTCT according to the risk profile of the mother, based on the HIV test results, CD4 cell count and clinical staging – this means either the provision of ARV prophylaxis with AZT from 14 weeks of pregnancy or lifelong ART if her CD4 cell count is below 350 cells/mm³;
- provision of other appropriate treatments, such as those for opportunistic infections management and nutritional support;
- provision of psychosocial support to HIV+ pregnant women;
- strengthened obstetric practices which reduce MTCT;





- provision of quality, objective and individualised counselling on and support for safe infant feeding practices (this service was described in more detail earlier in this table, under the heading 'Infant and Young Child Feeding'. In summary, an HIV+ woman should receive at least four antenatal counselling sessions on infant feeding. If she did not get this, she must get it once the baby is born. The mother must be encouraged to feed the baby immediately in the chosen feeding option. If she chooses to formula feed, she must be given two weeks supply of formula on discharge; thereafter she must be given formula every month for six months at her local clinic. She must be assured of an uninterrupted supply of formula. If the mother chooses to breastfeed or if she chooses to formula feed and will experience food insecurity, she must be provided with nutritional support);





- the provision of antiretroviral prophylaxis to infants. The expanded regime provides for the commencement of ARV prophylaxis (infant NVP) to all neonates born to HIV+ mothers immediately at birth;
- at six weeks of age, all HIV-exposed infants undergo an HIV PCR test, which is integrated into the Expanded Programme on Immunisations so it is done at the time of the six week immunisation visit to the primary healthcare facility. Depending on the feeding option practised by the HIV+ mother, the HIV status of the infant and the PCR test results, different treatment regimes are prescribed:
 - If the infant is exclusively formula-fed, at the same time as the PCR test being administered, the infant NVP is stopped and the infant starts Cotrimoxazole (CTX) at age six weeks. If the PCR test is negative, the CTX is stopped and a further Rapid HIV test is conducted at 18 months.





- If the infant is breastfed and the mother is on lifelong ART, then at the six-week visit a PCR HIV test is conducted, the infant NVP is stopped and CTX is started.

If the PCR test is negative, the mother continues breastfeeding for six months and CTX continues until the breastfeeding is stopped and the infant tests negative for HIV. The infant is tested every six weeks.

Once the breastfeeding is stopped, a Rapid HIV test must be done at 18 months.

If the PCR test is positive, there must be a prompt referral for ART. The status of the child must be confirmed with a viral load test. The mother must exclusively breastfeed for two years. Infant CTX is continued.

- If the infant is breastfed and the mother is not on lifelong ART:

At six weeks a PCR test is conducted, the infant NVP continues and CTX is started.

If the PCR test is negative, the mother continues exclusive breastfeeding for six months and the NVP is continued until





breastfeeding stops. In addition, CTX is also continued until the breastfeeding stops and the infant tests negative.

If the infant tests negative, the PCR HIV test is repeated six weeks after cessation of breastfeeding. If the PCR test is negative, the CTX is stopped and the Rapid HIV test is conducted at 18 months.

If the PCR test is positive, there must be a prompt referral for ART. The infant's status must be confirmed with a viral load test and breastfeeding must be continued for two years. The infant NVP is stopped, but the CTX continues;

- the HIV-infected mother receives ongoing post-natal care and support, which includes family planning, feeding advice and support, TB screening and other forms of routine healthcare.

If she is on lifelong ART, at her six-week post-partum visit she must be supported and her treatment adherence must be monitored. She must be referred to a primary healthcare facility for ongoing ART.





Family planning must be discussed with her and she should be encouraged to have her infant tested.

If she is not on lifelong ART, then at the six-week post-partum visit her CD4 count must be measured, she must be clinically staged and screened for TB.

If her CD4 cell count is higher than 200, she must be referred for wellness services^{xxviii} and family planning.

If her CD cell count is less than 200 or she is at stages 3 or 4 of disease progression, she must urgently be referred for lifelong ART;

- all women of unknown HIV status should be offered testing and counselling before discharge (and at post-natal care visits) to ensure that their infants get ARV prophylaxis if the mother's test is positive;
- all abandoned infants judged to be in the first 72 hours of life should be given infant NVP as soon as possible and then daily for six weeks or until testing of the mother/infant confirms the absence of HIV exposure.



<p>→ Treatment of HIV infection in children and adults^{xxix}</p>	<p>Every infant and child that is exposed to and/or infected with HIV has a right to comprehensive therapy which includes PEP, counselling and support, nutritional support, supplementation and an extended immunisation schedule.</p> <p>Counselling and support and nutritional support for HIV-infected children are dealt with under the preceding sections on nutritional programmes, PMTCT and testing and counselling. The extended immunisation schedule for HIV-infected children is dealt with below under the IMCI programme and immunisations.</p> <p>Prevention and treatment for HIV-exposed and/or -infected infants under the age of one year includes:</p> <ul style="list-style-type: none"> • the provision of PEP to all HIV-exposed infants (infant NVP) from birth up until the age of six weeks; • the provision of CTX as a prophylaxis against opportunistic infections for all HIV-exposed and HIV+ children. CTX is given to all HIV-exposed infants from six weeks 	<p>Targeted beneficiaries</p> <p>All HIV-exposed infants younger than one year of age</p> <p>All HIV+ infants and children younger than one year</p> <p>HIV+ children older than one, but younger than 15 at stages 3 or 4 of the disease or who have a CD4 count below 750 if the child is younger than five, or below 350 cells/mm³ if the child is older than five</p> <p>HIV+ children between the ages of 15 and 18 (adolescents) and HIV+ adults with a CD4 count of less than 200 or at clinical stage 4</p> <p>HIV+ pregnant adolescents and women and all HIV+ adolescents and adults with TB with a CD4 count less than 350</p> <p>All HIV+ people older than 15</p>	<p>Primary, secondary and tertiary health facilities</p> <p>Primary healthcare facilities (clinics) are now expected to be able to initiate and provide ART for both adults and children.^{xxx} Up until 2010, ART could only be initiated by doctors at accredited sites. It can now be initiated and provided by nurses at primary healthcare facilities, with the objective of caring for an increasing number of children and pregnant women at primary healthcare level.</p>
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- until HIV infection is ruled out and/or the mother has stopped breastfeeding;
- the continued provision of CTX and ART for all HIV+ infants until the child's immune system is restored.

Treatment for HIV-infected children between 1 and 15 years includes:

- ART for all HIV+ children between the ages of one and five years who are symptomatic and at WHO's clinical stages 3 or 4 of the disease or who have a CD4 count less than or equal to 25% or an absolute count less than 750 cells/mm³;
- ART for all HIV+ children between the ages of 5 and 15 years of age who are symptomatic and at the WHO's clinical stages 3 or 4 or who have a CD4 count less than 350 cells/mm³;
- in addition to the medical criteria for ART eligibility, there are a number of social criteria that must also be met before ART can be prescribed for children. There must be at least one identifiable caregiver who is able to





supervise medication. (All efforts must be made to ensure that the social circumstances of vulnerable children, for example, orphans, are addressed so that they can receive treatment.)^{xxxii} It is further recommended that the child's status is disclosed to another adult in the house to ensure ongoing support.

Treatment for HIV+ children older than 15 and adults^{xxxiii}

- All children older than 15 (adolescents) and adults who are HIV+ and meet the following criteria qualify for ART:
 - have a CD4 count equal to or less than 200 cells/mm³ regardless of clinical stage;
 - are at WHO clinical stage 4 regardless of CD4 count.
- All adolescents and adults who are either pregnant or have TB qualify for lifelong ART if:
 - their CD4 count is equal to or less than 350 cells/mm³; or
 - they have MDR/XDR TB.





Pregnant women eligible for lifelong ART, patients with a CD4 count lower than 100, patients at clinical stage 4 and those who have MDR or XDR TB are eligible for fast-tracked ART. This means ART must commence within two weeks of becoming eligible.

Other forms of treatment for all HIV+ adolescent and adult patients include:

- patients not yet eligible for ART must be transferred to the wellness programme for regular follow-up and repeat CD4 count testing;
- advice on how to avoid HIV transmission to partners and children;
- initiation of Isoniazid prophylaxis for patients asymptomatic for TB;
- contraceptives and annual pap smears.



<p>→ PEP treatment for children who have been sexually assaulted</p>	<p>Children who have been sexually assaulted may access PEP after the assault.^{xxxiii} The treatment is free.</p> <p>PEP is available if the child has been sexually assaulted and tests HIV negative. If the child is not emotionally ready to be tested and counselled when reporting the assault, or if the test results are not available, the child should be started on PEP with a three-day starter pack while waiting to be tested or for the results to become available. If the results come back positive, the child should be counselled and referred to appropriate services for management and support. If the results come back negative, a full course of PEP treatment should be provided.^{xxxv}</p> <p>A combination of AZT and Lamivudine is administered when the child presents at the health facility.</p> <p>The child must thereafter return at one-, two- and three-weekly intervals for further medication. The child must return at three- and six-monthly intervals for further HIV testing.</p>	<p>Targeted beneficiaries</p> <p>Children (and adults) who have been sexually assaulted will qualify for PEP if:</p> <ul style="list-style-type: none"> • they report the assault to the SAPS or to a state health facility within 72 hours of the assault; and • they test negative for HIV at the time they present at the health facility.^{xxxiv} 	<p>Hospitals and certain primary health clinics</p>
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→	Integrated management of childhood illnesses programme	<p>The IMCI programme seeks to provide services that will promote child well-being through monitoring and promoting; that will prevent illness (e.g. through immunisations); and which will cure and rehabilitate ill children.</p> <p>It provides for the delivery of services and regulation of standard case management of priority child health conditions in accordance with protocols, including pneumonia, diarrhoea, fever and malnutrition, HIV/AIDS and TB, anaemia and micronutrient deficiencies, intestinal parasite control, identification and treatment of ear conditions and asthma as well as childhood illnesses such as measles.</p>	Targeted beneficiaries Children under the age of six	<p>Public sector clinics and hospitals</p> <p>Each clinic is supposed to have two staff members trained on the IMCI protocol and should be subject to six-monthly assessments of quality of care.</p>
	Extended programme on immunisation	<p>The programme provides vaccinations/ immunisations to prevent measles, tuberculosis, tetanus, diphtheria, Rotavirus and Pneumococcal diseases.</p> <p>The immunisation schedule as at 1 April 2009 was as follows:</p> <ul style="list-style-type: none"> • at birth – BCG vaccine and oral polio vaccine; 	<p>Targeted beneficiaries</p> <p>All children between birth and 12 years of age</p> <p>All infants and children that are HIV+</p>	All primary healthcare facilities





- 6 weeks – Oral polio vaccine, Rotavirus vaccine, a Diphtheria, tetanus, pertussis, polio and haemophilus influenza vaccine, pneumococcal conjugated vaccine;
- 10 weeks – Diphtheria, tetanus, pertussis, polio and haemophilus influenza vaccine and a Hepatitis B vaccine;
- 14 weeks – Rotavirus vaccine, combined Diphtheria, tetanus, pertussis, polio and haemophilus influenza vaccine, Hepatitis B and Pneumococcal conjugated vaccine;
- 9 months – Measles (1) and Pneumococcal conjugated vaccines;
- 18 months – Combined Diphtheria, tetanus, pertussis, polio and haemophilus influenza vaccine and Measles (2) vaccines;
- 6 years – Tetanus and diphtheria;
- 12 years – Tetanus and diphtheria;
- children who are HIV+ are entitled to receive additional measles immunisation, the VZIG immunisation against chicken-pox and an annual influenza vaccination.^{xxxvi}



→	<p>School health services^{xxxvii}</p> <p>The School Health Policy develops an inter-sectoral strategy between the departments of Health and Education to optimise the healthy growth and development of children and the communities in which they live.</p> <p>The objective of the School Health Policy is:</p> <ul style="list-style-type: none"> • to support educators and the entire school community by creating health-promoting schools; • to address barriers to learning; • to act as a safety net for children who did not access healthcare in their pre-school years; • to provide appropriate health education and health promotion within schools. <p>The role of the schools/ education system is to create a supportive environment within the school for health and development by establishing health-promoting schools and by integrating School Health Services within education programmes and services.</p> <p>The School Health Service package includes a combination of:</p> <ul style="list-style-type: none"> • health assessments for learners; 	<p>Targeted beneficiaries</p> <p>Children at school (Grades R–12)</p>	<p>School health nurses where they still exist, or nurses at primary healthcare facilities, are supposed to provide the services at local schools.</p> <p>Educators and other employees at schools</p>
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- health promotion for learners. The policy requires that issues of sexuality, HIV/AIDS, reproductive health, trauma and violence, and mental health problems be accommodated in the life skills and life orientation curricula;
- health education for all learners;
- appropriate referral and follow-up of learners requiring further assistance.

The role of the DoH, specifically of community level healthcare nurses, is to provide the following services to children at schools:^{xxxviii}

- nutrition screening and counselling;
- counselling on sexual activity;
- counselling on trauma and violence;
- hearing, vision and speech assessments of Grades R and 1 learners;
- health promotion and education for Grades 2–12;
- regular and timely screening to facilitate early detection of disabilities;
- identification and rectification of immunisation gaps;
- deworming and general parasite control.



Notes:

(i) *National Health Act 61/2003, s4(3)(b)*

- (ii) National Health Act 61/2003, s4(3)(b)
- (iii) National Health Act 61/2003, s4(3)(a)
- (iv) Free Primary Health Care for All Policy, 1996
- (v) National Health Act 61/2003
- (vi) National Health Act 61/2003
- (vii) UPFS Fee Schedule, DoH, 1 April 2010, as provided by the Western Cape DoH
- (viii) Free Health Care for Disabled People at Hospital Level, 2003, DoH, read together with the Standardisation of Provision of Assistive Devices in South Africa, 2003, DoH
- (ix) Free Health Care for Disabled People at Hospital Level, 2003, DoH
- (x) www.doh.gov.za/programmes/index.html
- (xi) Policy Guidelines for the Nutrition Supplementation Programme of the Health Facility Based Nutrition Programme & National Guidelines on Nutrition for People Living with HIV, AIDS, TB and other Chronic Debilitating Conditions, 2007, and The Guidelines for the Management of HIV in Children, 2nd edition, 2010
- (xii) The Comprehensive HIV and AIDS, Care, Management and Treatment plan (CCMT), 2003, and The Guidelines for the Management of HIV in Children, 2nd edition, 2010
- (xiii) The Guidelines for the Management of HIV in Children, 2nd edition, 2010: 25–26
- (xiv) The Guidelines for the Management of HIV in Children, 2nd edition, 2010: 24
- (xv) The Guidelines for the Management of HIV in Children, 2nd edition, 2010: 28
- (xvi) Breastfeeding guidelines for health workers, 2000
- (xvii) Infant and Young Child Feeding Policy, 2007, and Clinical Guidelines: PMTCT, 2010
- (xviii) The Road to Health Chart Guidelines for Health Workers, 2003, DoH
- (xix) The original 2003 CCMT was amended by the introduction of a range of innovative prevention and treatment regimes in 2010, with the objective of reducing mortality rates among infants, children and women through increased prevention of HIV transmission from mother to child and improved treatment of HIV+ pregnant women and women with small children. These innovations are contained in the Clinical Guidelines: PMTCT, 2010; Guidelines for the Management of HIV in Children, 2nd edition, 2010; the Clinical Guidelines for the Management of HIV and AIDS in Adults and Adolescents, 2010; and The South African Antiretroviral Treatment Guidelines, 2010.
- (xx) Policy Guideline for HIV Counselling and Testing, October 2009, the Children's Act and the Guidelines for the Management of HIV in Children, 2nd edition, 2010
- (xxi) Guidelines for the Management of HIV in Children, 2nd edition, 2010: 14
- (xxii) Children's Act, s132
- (xxiii) Policy Guideline for HIV Counselling and Testing, October 2009: 9
- (xxiv) Guidelines for the Management of HIV in Children, 2nd edition, 2010
- (xxv) Policy Guideline for HIV Counselling and Testing, October 2009: 11
- (xxvi) Policy and Guidelines for the Implementation of the PMTCT Programme, 2008, as amended and expanded by Clinical Guidelines: PMTCT, 2010
- (xxvii) The South African Antiretroviral Treatment Guidelines, 2010
- (xxviii) Wellness services entail follow-up of HIV-infected individuals not yet on ART and include TB screening, nutritional and psychosocial support, cervical cancer screening, monitoring of CD4 cell count, clinical staging and preparedness for ART.
- (xxix) Guidelines for the Management of HIV in Children, 2nd edition, 2010; Clinical Guidelines: PMTCT, 2010; The South African Antiretroviral Treatment Guidelines, 2010
- (xxx) The South African Antiretroviral Treatment Guidelines, 2010
- (xxxi) Guidelines for the Management of HIV in Children, 2nd edition, 2010: 31
- (xxxii) The South African Antiretroviral Treatment Guidelines, 2010
- (xxxiii) Section 28 of Act 32/2007
- (xxxiv) Section 28(2) of Act 32/2007
- (xxxv) Policy Guideline for HIV Counselling and Testing (HCT), October 2009: 68
- (xxxvi) Guidelines for the Management of HIV in Children, 2nd edition, 2010: 21
- (xxxvii) School Health Policy and Implementation Guidelines, 2003
- (xxxviii) School Health Policy and Implementation Guidelines, 2003

Overview of child and maternal health in South Africa

International and regional child rights and development instruments, such as the UNCRC and the ACRWC, place a high premium on the provision of adequate ante- and post-natal care to pregnant women and to infants. This prioritisation is aimed at realising the express goals of reduced infant and maternal mortality rates, which rates are a key indicator of the state of child well-being in a country.

It is thus appropriate to review the infant, child and maternal mortality rates in South Africa to gauge the soundness and effectiveness of the national healthcare system to realise the rights of children and their caregivers to adequate healthcare.

Infant, child and maternal mortality rates

There is uncertainty in South Africa about the exact current levels of child mortality. This lack of clarity on the crucial indicator of child well-being is in itself a significant gap. Sanders et al. (2010) note that despite the lack of certainty on the actual current levels, there is consensus that the levels are unacceptably high and that they have not improved, but rather increased, over the last 10 to 15 years, leaving South Africa way behind in meeting its Millennium Development Goal target of reducing the under-five mortality rate to 20 per 1 000 live births by 2015 (Sanders et al. 2010: 29).

In 1990, the infant mortality rate was estimated to be 44 deaths per 1 000 live births and the under-five mortality rate was estimated to be 56 deaths per 1 000 live births. UNICEF estimates that this increased to 48 and 67 deaths respectively in 2008 (UNICEF Statistics 2010). 'The distribution and pattern of morbidity and mortality are shaped by persistent inequalities' (Sanders et al. 2010: 35). Sanders et al. note that child mortality rates coincide with the rates and demography of poverty in South Africa; both are higher in non-urban areas and the child mortality rate is four times higher among African than white children. Diseases of poverty, including low birth weight, diarrhoea, lower respiratory infections and protein-energy malnutrition account for 30 per cent of these deaths (Bradshaw et al. 2009: 29).

There are correspondingly poor levels of maternal health, which are cause for equal concern. At least 1 600 mothers die every year due to complications of pregnancy and childbirth (DoH et al. 2008). At least 60 per cent of these deaths are avoidable and 55 per cent are caused by what Harrison (2009) refers to as health systems failures.

Some key policy and service delivery gaps

Given the plethora of policies, legislative instruments, programmes and services listed at the start of this chapter which target the health and well-being of pregnant women, infants and young children, the question is why these often avoidable infant, child and maternal mortality rates remain so high.

This section reviews some of the broad systemic failings within the healthcare system which contribute to poor health outcomes for children and their caregivers. In addition, the section aims to identify how some of these systemic failings impact negatively on the implementation of some of the child- and family-specific policies and programmes identified in Table 4.1.

Unsafe water, sanitation and hygiene

In 2000, almost 20 per cent of deaths of children under the age of five years were attributable to unsafe water. As in the case of nutritional status, there are insufficient data to track progress related to diarrhoeal diseases at primary healthcare facilities. Harrison (2009) notes that the introduction of the rotavirus vaccination in 2008 should make a positive difference in this regard, but that these gains may be offset by the poor water management practices of local authorities in marginalised communities. He refers specifically to the death of 80 infants due to contaminated water in 2008 in the Ukhahlamba district in the Eastern Cape (Harrison 2009: 13). He argues that instances such as these call for 'heightened vigilance and pre-emptive action between the Department of Health and local municipalities' (Harrison 2009: 12) to ensure better health outcomes in relation to diarrhoeal diseases among children.

Inequitable coverage of maternal, neonatal and child health interventions

There are significant disparities in the coverage of maternal, neonatal and child health interventions between different parts of the country. Coverage is better in better resourced districts and provinces. For example, in the Eastern Cape only 71 per cent of women deliver in facilities, compared to 98 per cent in the Western Cape (Sanders et al. 2010: 35). This unequal distribution of healthcare services severely compromises the health rights of children in South Africa. Westwood et al. (2010) argue that healthcare services play a key role in the prevention and treatment of childhood illnesses. The delivery of these services through the essential healthcare programmes has been designed to be realised as part of the district level healthcare package. They conclude that ‘the goal to deliver the package successfully in all districts is still elusive, with dire consequences for the realisation of the right to basic [healthcare] services’ (Westwood et al. 2010: 61).

Insufficient healthcare services in the rural areas and informal settlements

Poor children living with sick or dying caregivers are often unable to access healthcare because there are not enough services in rural areas and informal settlements. As noted, there is unequal implementation of healthcare services across districts and provinces, with the poorer, less well-resourced provinces experiencing the greatest difficulties (Sanders et al. 2010; Westwood et al. 2010).

Free healthcare policy

Lack of knowledge of the free healthcare policy

Grandmothers and older caregivers who are increasingly taking care of vulnerable children in South Africa are at risk of not knowing about mandatory, free, essential health services for young children, such as the immunisation programme (Giese, Meintjies et al. 2003).

Cost of transport

The high cost of transport to medical facilities renders free healthcare unaffordable for vulnerable children (Giese, Meintjies et al. 2003). Four out of every ten children in South Africa live far from a clinic (more than 30 minutes travelling time). The majority of these children are African (42%), whereas only 12–13 per cent of those living far from a clinic are coloured, Indian or white (Lake & Marera 2009: 91).

Unlawful imposition of user fees

There is anecdotal evidence of admission clerks turning children away who qualify for free healthcare if they are unaccompanied or if their caregivers are unable to pay the required fee. As such, user fees at hospitals may still pose a barrier to access to healthcare at hospital level (Shung-King et al. 2005).

Free healthcare limited to children younger than six

Free healthcare for children older than six is limited to primary level care. Children older than five years of age primarily suffer from health conditions relating to trauma, HIV and chronic health conditions, among others, all of which are likely to require some level of hospitalisation.

Free healthcare for children with disabilities

Insufficient services and devices

Services and devices are not available for children with temporary disabilities or a chronic illness that does not cause difficulty in daily functioning (Philpott 2004).

Insufficient and inappropriate assistive devices

Many children who do qualify for assistive devices do not get them as they are not easily available. When they do manage to get them, they are often not appropriate to the needs of the patient. This results in a greater chance of secondary disabilities and increased dependency on the state. The application process for assistive devices – even in the case of a child with severe, progressive or multiple disabilities that require specialised devices – is complicated and the delivery of the devices is not guaranteed. The child's treatment team will have to motivate for the device, based on the child's home circumstances, his or her physical needs, and the potential for enrolment at school. The team would have to build a reasoned case motivating for the purchase of the device. Even if the motivation succeeds, there is no guarantee the child will receive the device as it depends on the availability of funds (Philpott 2004).

The budgets for assistive devices are not ring-fenced so allocation within provincial budgets for purchasing these devices is discretionary. In practice, this often means that there is no budget available for the provision of these services to children who are disabled (Philpott 2004).

Integrated Nutrition Programme***Overview of child underweight/under-nutrition***

Harrison (2009) notes that, given the importance of child nutrition to child well-being, it is cause for concern that our knowledge in South Africa of the nutritional status of children is seriously inadequate. There are insufficient data to gauge, with any accuracy, the progress that has been made in this regard since 1994.

The data that are available show significant levels of under-nutrition among children and a failure to improve child nutrition levels over time. In 1999, 11.1 per cent of children between the ages of 12 and 71 months were underweight, 23.8 per cent suffered stunting and 3.8 per cent suffered from wasting.⁶¹ According to the National Food Consumption Survey 2005, stunting and underweight are by far the most common nutritional disorders affecting, respectively, almost one out of five and one out of ten children aged one to nine years. Younger children in the one- to three-year age group are most severely affected, having almost a twofold higher prevalence of stunting and wasting than the seven- to nine-year-old group. Furthermore, the nutritional status of children has only marginally improved in comparison with the 1999 data.

Sanders et al. (2010) confirm that severe childhood malnutrition is a common and often fatal condition that presents regularly in hospitals, but it is poorly managed, especially in rural districts, contributing to high levels of child mortality in the country.

Poor coverage of INP interventions

Several of the interventions provided by the INP, such as the promotion of breastfeeding and complementary feeding, vitamin A and zinc supplementation and the appropriate management of childhood malnutrition have the potential to reduce child mortality by 25 per cent and stunting by 33 per cent when implemented to scale (Hendricks et al. 2010: 50). However, rather than seeing these interventions being implemented to scale, the contrary is true. For example, a 2005 National Food Consumption survey showed an increase in vitamin A deficiency in children aged one to five, with a coverage rate of only

⁶¹ Health Systems Trust, South African Health Reviews, in Harrison (2009: 13)

20.5 per cent (in Hendricks et al. 2010: 50). A further example of very poor coverage is the rate of exclusive breastfeeding. Despite the fact that almost half of all public hospitals are 'baby friendly', coverage for exclusive breastfeeding is a low 7 per cent (DoH et al. 2008).

Insufficient/ly trained INP staff

Hendricks et al. (2010) observe that overall the INP has had limited success in addressing the causes of malnutrition. The reasons for this include a lack of sufficient and/or trained staff in the public sector, lack of pre and in-service training of healthcare workers on the INP, and poor implementation of policies due to poor supervision and support. This is confirmed in the DoH's 2007 Annual Report, which notes that there are not enough trained and capacitated personnel to implement the INP and related programmes (DoH 2007b). Staff at health facilities are stretched to provide primary curative services and do not have the time to provide nutritional and related support. Moreover, the limited staff are not supported in their role by a strong and active community-based support network. Consequently, the INP remains clinic-bound, failing to reach into vulnerable communities.

Nutrition Supplementation Programme (NSP)

The nutritional support system is limited in the sustainable difference it can make to nutritional outcomes for vulnerable children. The primary reason for this is that it is not designed as a preventative intervention. Nutritional support only becomes available to vulnerable children once they are severely malnourished and about to be admitted to hospital. There is not enough community level assessment of the nutritional needs and vulnerabilities of children before the onset of severe malnutrition and there are insufficient services to prevent malnutrition when children are found to be at risk.⁶²

Not only does the programme not make provision for effective preventative community level screening, it also fails to provide for ongoing nutritional care and support once the child is discharged from the hospital/clinic. The hospital or clinic needs to work more closely with community-based organisations. Information must be shared so as to impact at community level through nutritional counsellors outside of the clinic.⁶³

The benefits of the NSP are short-lived. Children on the NSP are excluded from the programme once they gain weight. As a general rule, children are admitted to the NSP for a maximum of six months. If a child has entered a programme because they became malnourished due to the socio-economic vulnerability at home, it is likely that they will be returning to the same circumstances which will expose them to the danger of malnutrition again. For vulnerable children, the NSP is often the only source of secure nutrition (Giese & Hussey 2002).

Vitamin A supplementation programme

There is inadequate coverage of the vitamin A supplementation programme. The 2005 National Food Consumption Survey revealed that only 21 per cent of children nationally between the ages of one and nine had received a high-dose vitamin A supplement in the six months preceding the survey. At a provincial level, the supplementation coverage ranges from 10 per cent in Mpumalanga to 33 per cent in the Eastern Cape. More recently, a 2007

⁶² Personal communication between Nigel Rollins, the Department of Paediatrics and Child Health, Nelson Mandela School of Medicine, and Laura Markovitz, in Markovitz (2008)

⁶³ Private communication with Gilbert Tshitavadi, Deputy Director HIV/AIDS, Nutrition Support, DoH, recorded in Markovitz (2008)

study in the Western Cape found that only 29 per cent of children younger than five got the prescribed two doses of vitamin A per year (Hendricks et al. 2007: 1087). The factors impeding implementation include insufficient stock at healthcare facilities, inadequate training to implement the policy, staff's lack of knowledge of the enrolment and discharge criteria, and insufficient complementary counselling of mothers on addressing the nutritional needs of their child in need of supplementation (Hendricks et al. 2003: 6). In addition, there is a lack of awareness among the public of the value of vitamin A supplementation for the well-being of children, resulting in a lack of demand for the service.

Inadequate HIV/AIDS prevention and treatment policies and programmes

The failure by the state to mount a 'concerted and comprehensive' prevention programme has resulted in high morbidity and mortality rates. Similarly, the failure up until now to implement early antiretroviral treatment has placed a 'massive burden of orphanhood on the socio-economy' (Harrison 2009: 20).

The impact of this has been felt most profoundly in the high infant and child mortality rates in South Africa, which most medical professionals, academics as well as the current minister of health attribute to the HIV/AIDS pandemic in the country (Motsoaledi 2010). The main cause of premature deaths among children and younger adults who bear the primary responsibility of care for children (especially women) is overwhelmingly HIV/AIDS which, together with TB, accounts for 75 per cent of premature deaths (Harrison 2009: 9). Harrison (2009: 9) observes that:

While the prevalence of HIV has now peaked, and there are indicators of significant declines amongst younger people, the enormity of the epidemic will continue to dwarf other causes of mortality for the next decade at least. The number of deaths from AIDS will continue to exceed 300,000 per annum even if 90% ART coverage is achieved.

This failure has been acknowledged by the minister of health and corrective measures were introduced in 2010 to remedy some of the significant policy and implementation gaps created by the previous national HIV/AIDS policies and programmes.

The minister acknowledged that the lack of progress in South Africa towards reducing the child mortality rate is attributable to the effects of the HIV pandemic, and that an estimated 40–50 per cent of childhood deaths are related to HIV infection (Motsoaledi 2010: 90). The government has responded proactively with a series of new and revised HIV/AIDS prevention and treatment interventions. President Zuma announced in 2009 that the Comprehensive Care, Management, Treatment and Support Programme would be changed to reflect a shift in focus and the prioritisation of prevention and early intervention.⁶⁴

The new interventions aim to improve outcomes for mothers and children by, inter alia:

- decentralising service delivery of relevant health services to primary healthcare level. They action government's commitment to ensuring that ART is available at all primary healthcare facilities and that professional nurses are able to initiate and provide ART;

⁶⁴ These innovations were introduced in March 2010 in the Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission) 2010; the Guidelines for the Management of HIV in Children, 2nd edition, 2010; the Clinical Guidelines for the Management of HIV and AIDS in Adults and Adolescents, 2010; and the South African Antiretroviral Treatment Guidelines, 2010.

- lowering the criteria for eligibility of pregnant women to have lifelong ART so that more women are placed earlier on ART. The aim is to reduce the number of mothers who die from HIV infection during pregnancy or during the post-natal period.
- providing more effective prophylaxis to prevent vertical transmission in pregnant women who do not qualify for lifelong ART;
- making breastfeeding safer for HIV-exposed infants through the provision of prophylactic ART to these infants;
- initiating ART in all HIV-infected infants younger than one year, as this has been shown to significantly reduce mortality.

These innovations were only introduced in 2010 and it remains to be seen as to how effectively they will be implemented, given the systemic difficulties within the current healthcare system, as well as the more specific difficulties and gaps which have prevented full realisation of many of the other healthcare policies and programmes (discussed below).

This section now turns its attention to how the inadequate HIV/AIDS policies resulted in gaps and disjunctures in the child and maternal HIV/AIDS policies and programmes listed in Table 4.1.

Infant and young child feeding support

High infant mortality rates linked to HIV/AIDS

There are many policies in place to address malnutrition and HIV/AIDS in South Africa. However, the high levels of infant and child mortality are testimony to inadequate implementation of these policies. In South Africa, 20 000 babies are stillborn every year and another 22 000 die before they reach one month of age. In total, 75 000 children die before they reach their fifth birthday. Many of these deaths are preventable, as many are caused by malnutrition and HIV/AIDS (DoH et al. 2008).

Poor knowledge of safe infant feeding practices

One of the primary modes of HIV transmission to infants is through inappropriate infant feeding practices by HIV-positive mothers. A study in rural KwaZulu-Natal on breastfeeding knowledge among health workers found their knowledge about feeding options and choices, breastfeeding and the facts about HIV transmission to babies to be outdated and contrary to the latest World Health Organisation recommendations (Sonal et al. 2004). This lack of knowledge was evident among doctors, nurses and community health workers, although in the study in question, knowledge among community health workers was the worst.

Insufficient information and counselling on infant feeding practices

A lack of adequate and sustained support in terms of information and counselling, as well as sustained patient follow-up, results in many mothers adopting incorrect feeding choices, even when they have received counselling on feeding choices.⁶⁵ The quality of infant feeding counselling is of serious concern and was found by the Good Start study⁶⁶ to be poor. The information provided to women is inadequate to enable them to make appropriate and safe feeding choices. The counselling provided does not prepare women for the challenges of adhering to their feeding choice. Ongoing community-based support for women in the post-partum period is crucial to sustaining infant feeding choices. Ultimately, poor infant feeding practices are contributing to lower infant HIV-free survival.

65 Infant and Young Child Feeding Policy, 2007

66 Policy Brief, June 2007

The recent changes to the PMTCT guidelines and the guidelines on the management of HIV in children have the potential to make a positive difference to the level and quality of support on infant feeding choices for HIV-positive mothers. It is, however, still early days and these guidelines only commenced at the beginning of 2010. As such, it remains to be seen how well systemic challenges within the health system can be overcome to realise the potential of these guidelines.

It is cause for concern that these new guidelines, being split into as many guiding documents as they are, are difficult to piece together and in fact do introduce confusion through inconsistent provisions appearing on the same issue in different documents. One such contradiction appears in the PMTCT guidelines and the guidelines for the management of HIV in children. The latter guidelines provide that exclusive breastfeeding for six months is the preferred option and that mothers who choose to formula feed will be required to purchase their own formula (section 4.1). The PMTCT guidelines contradict this in the provision that mothers who choose to formula feed will be provided with at least six months of free age- and weight-appropriate formula.

Inconsistencies such as these add to the already troubling confusion and poor quality of feeding option counselling that has been provided up until now.

Insufficient provision of nutritional support

The infant and young child feeding policy makes provision for nutritional support to HIV-infected pregnant women and those who choose to breastfeed. However, Hendricks et al. (2003) found in their study that HIV-positive pregnant and lactating women were not put on the nutritional support programme, primarily because clinic staff were not aware that they were entitled to this benefit.

PMTCT programme

Insufficient HIV testing and provision of prophylaxis

Approximately 168 000 of the 800 000 public sector births in 2006 were to HIV-positive women. Only 50 per cent (74 052) of these HIV-positive pregnant women received nevirapine prophylaxis. Furthermore, the testing rate of babies in public sector births is very low. Of the 800 000 births in 2006, the HIV status of only 3 per cent of the babies was known and, of these 3 per cent, the transmission rate was 18 per cent, which is much higher than the targeted 5 per cent transmission rate (Barron et al. 2006; Ministry of Health 2007). These statistics are the product of the previously limited PMTCT policies and programmes. The 2010 amendments to these policies have been designed to remedy the shortcomings, but whether the desired impact will be achieved depends on the proper and timely application of the various progressive guidelines and the ability to overcome the more systemic health challenges which impact on all healthcare programmes and services.

Poor coverage of antenatal visits

The coverage of antenatal visits in South Africa is high for one visit, standing at 94 per cent, but it drops to 73 per cent for four visits or more and to below 30 per cent for antenatal visits before 20 weeks. This means that there are significant missed opportunities for counselling, testing and introducing the PMTCT programme to the pregnant mothers and infants that are not accessing antenatal clinics and maternity health facilities (DoH et al. 2008). In addition, the care that is provided at the visits that do take place does not include sufficient access to counselling and HIV testing. Access to the PMTCT programme is via HIV testing by a pregnant woman at her antenatal facility. If she

is found to be HIV positive, she is invited to join the PMTCT programme. Recent evidence indicates that a significant number of women attending antenatal facilities are not offered HIV testing and counselling. The reasons for this include inadequate counselling of patients, as well as shortages of counsellors and testing supplies (Nkonki et al. 2007).

HIV interventions in the post-natal period

The Every Death Counts report (DoH et al. 2008) found that, while antenatal care is accessible to and accessed by the majority of South African pregnant women, the same cannot be said for post-natal care and support. Availability of and access to key HIV interventions drop significantly from the time of childbirth and in the post-natal period, when they are the most crucial. The post-natal period is crucial for counselling and support in respect of infant feeding options and maternal nutrition, testing and the commencement of treatment of the infant. Once the mother and baby leave the clinic or hospital, there is no system for routine follow-up of mother and baby.

Insufficient trained personnel to prescribe antiretrovirals

Until the ART amended guidelines were introduced in March 2010, only doctors could initiate and prescribe antiretrovirals (ARVs). Nurses are now authorised to initiate and administer ART. Once again, the challenge that remains is the inadequacy of existing human resources to meet current, let alone additional, healthcare obligations.

Lack of coordination between adult and paediatric treatment programmes

There is a lack of coordination and linkages between adult and paediatric care and treatment programmes. As a consequence, the mother's HIV status is often not linked to her HIV-exposed child, resulting in a lack of appropriate and adequate follow-up and treatment for both the mother and the baby. In addition, the lack of coordination across prevention and treatment programmes means that there are not quick and effective referrals between PMTCT and ARV programmes (which are often available at different physical locations/facilities). This results in delayed commencement of ART for pregnant mothers with low CD4 counts, which in turn contributes to increased rates of transmission to their infants (Kak et al. 2006, in Markovitz 2008). There is a similar lack of coordination between maternal and child health programmes. At the moment, if a baby goes through the PMTCT programme, they should be, but are not, followed up and tested. If they test positive, they need to be referred to a clinic where they can access ART. This is not happening, and as a result, clinics are seeing children when they are desperately ill. The service needs to be anticipatory and preventative. Children should be coming from maternity services much earlier.⁶⁷

Poor partner participation

There has been a consistent lack of partner participation in the PMTCT programmes.

HIV testing and counselling

Testing of infants

Not enough babies are tested. Of the 800 000 births in 2006, the HIV status of only 3 per cent of these babies was known (Barron et al. 2006; Ministry of Health 2007). Once again, the revised 2010 PMTCT guidelines aim to remedy this deficiency by ensuring the early testing of all infants.

⁶⁷ Personal communication between Dr David Power and Laura Markovitz, in Markovitz (2008)

Infant testing is complicated, requiring specialised equipment and reliable transport. As a result, infant testing is often not available at all health facilities, especially those in more remote rural areas. The polymerase chain reaction (PCR) test for infants, for example, is effective but complicated. Clinical capacity is a major obstacle inhibiting scaling up of PCR testing. In 2006, it was only available at six sites. In addition, the results can take up to two weeks, during which time patients are lost to follow-up.

Children diagnosed too late

Children are being diagnosed too late. They are only being diagnosed and treated when they are seriously ill. One of the reasons for this is the lack of early HIV screening at community health facilities providing routine baby and childcare services, such as immunisations and growth monitoring (Shung-King & Roux 2005). One of the innovations of the 2010 HIV/AIDS policies is the decentralisation of HIV/AIDS services to primary healthcare facilities, with the aim of integrating testing, prevention and treatment services into all primary healthcare programmes for women, infants and children.

Facilities not youth-friendly

Despite the National Adolescent-Friendly Clinic Initiative, many youth are reticent about being tested because of healthcare workers' moralistic attitudes to sexually active youth (Shung-King 2005).

Antiretroviral therapy/treatment

ART started too late

Treatment has been starting too late for infants and children, largely because testing and diagnosis have been happening too late.

ART does not reach enough children

Cotrimoxazole is not reaching enough children. Cotrimoxazole is not reaching enough children. In 2008, 9% of HIV-exposed and HIV-infected infants in Southern Africa were receiving it. (WHO, UNAIDS, UNICEF 2009: 110). In South Africa, the Cotrimoxazole coverage is not much better at 26 per cent (DoH et al. 2008).

Not enough children are on ART. On average, only 36 per cent of children in need of ART are receiving it. There are, however, significant provincial variances in coverage rates. For example, coverage in 2007/08 was 97 per cent in the Western Cape, but only 22 per cent in the Free State (Scorecard 2009).

The reasons for poor ART coverage have included, to date, an insufficient number of treatment sites; a lack of qualified and skilled staff to screen and identify children in need of ART, and then to prescribe and administer ARVs at accredited sites; insufficient staff to cope with the size of the demand in a community; lack of supplies and medications; and lack of administrative services in clinics, so preventing the proper patient record keeping necessary for effective case management and treatment (Shung-King 2005). Treatment sites are too far from communities needing the service, which is especially problematic in the case of children who are seriously ill. These barriers have been addressed in the revised 2010 ART guidelines, which provide for nurse-initiated ART in primary healthcare facilities.

Impediments to maintaining ART

Once on treatment, the distance to clinics, transport costs, and lack of accessible financial and psychosocial support means that many children do not adhere to their treatment.

Poor coordination between adult and child treatment programmes

A lack of coordination means that adult and child family members in the same household affected by HIV/AIDS cannot access their treatment from the same treatment site on the same day, resulting in duplicated travel and other costs.

Post-exposure prophylaxis

Forty per cent of child rape survivors do not qualify for PEP because they refuse testing or present more than the prescribed 72 hours after the rape (Collings et al. 2008: 480).

Where PEP is initiated, there are often low follow-up testing rates and low drug adherence rates.

Poor infrastructure in rural areas inhibits the availability of PEP.

Integrated management of childhood illnesses

There is a high turnover of staff trained in IMCI protocols, leaving the clinics and facilities short of the prescribed number of staff able to implement the programme at all levels of healthcare (DoH 2007b).

Expanded programme on immunisation***Immunisation treated as a vertical programme***

Immunisation coverage in South Africa is quite good. It is currently at 84 per cent (DoH et al. 2008). A number of challenges have prevented the vaccine coverage rate in one year olds reaching 90 per cent. These include the treatment of the vaccine programme as a vertical programme by health workers, rather than integrating it into all aspects of child healthcare delivery, the non-availability of vaccines at hospitals, and lack of access to clinics after hours and over weekends to allow working parents to vaccinate their babies and children.

High vaccine drop-out rate

The biggest challenge to full coverage is vaccine drop-out. The drop-out rate between the 14-week and 9-month immunisations is relatively high. The drop-out rate between the 9-month and 18-month immunisations is very high (20 per cent nationally) (DoH et al. 2008).

Department of Basic Education

Introduction

The Department of Basic Education (DoBE) is responsible for the realisation of the right of everyone to a basic education, including adult basic education.

The UNCRC (Article 28), the ACRWC (Article 11) and the South African Constitution (section 29(1)) all acknowledge and protect the right of all children (aged 0–17) to education. The scope of the right to a basic education is rendered wide by the fact that international and regional instruments recognise that this right is dependent on the prior realisation of a host of other children's rights. For example, without food, healthcare and protection from abuse, neglect and exploitation (among others), the right to education is not possible. For this reason, the international and regional child rights instruments require the South African government to realise the right to education through the provision of a comprehensive package of care and support to vulnerable children.

Internationally and regionally, the realisation of the right to education is premised on the realisation of a number of obligations by South Africa, including:

- making primary school compulsory, accessible and available free to all children;⁶⁸
- making secondary education available and accessible for every child and taking appropriate measures to ensure that school fees do not exclude children from secondary school, for example, by progressively introducing free secondary education⁶⁹ and offering financial assistance to those in need;⁷⁰
- taking measures to encourage attendance and prevent children from dropping out of schools;⁷¹
- providing education that ensures the advancement of the cognitive, creative, emotional, mental and physical development of all children to their full potential;⁷²
- in addition, international and regional laws recognise that additionally vulnerable children are at greater risk of not enjoying their right to an education and oblige states to take special measures to protect and to actively promote their inclusion and participation in school. The South African government must take special measures (as in the case of all signatory states) that will:
 - ensure equal access to education for all female and disadvantaged children in all sections of the community;⁷³
 - protect children against discrimination and take all steps necessary to ensure that children are not denied any of their rights, including the right to education, on the basis of their race, ethnic group, colour, sex, language, national origin, birth or other status or disability;⁷⁴
 - ensure that children with a mental or physical disability receive an education, training and healthcare services in a manner conducive to the child achieving the fullest possible social integration and individual development;⁷⁵

68 UNCRC, Article 28(1)(a); ACRWC, Article 11(3)(a); UN MDGs, Goal 19

69 ACRWC, Article 11(3)(b); UNCRC, Article 28(b)

70 UNCRC, Article 28(b)

71 UNCRC, Article 28(e); ACRWC, Article 11(3)(d)

72 UNCRC, Article 29(a); ACRWC, Article 11(2)(a)

73 ACRWC, Article 11(3)(e)

74 UNCRC, Article 2; ACRWC, Article 3

75 UNCRC, Article 23; ACRWC, Article 13

- ensure that all refugee children are guaranteed the rights guaranteed to other children, which would include the right to education;⁷⁶
- ensure that children who become pregnant before completing their education are given an opportunity to continue with their education on the basis of their individual ability;⁷⁷
- protect children from child labour (including economic exploitation and domestic work) that is harmful to the child's education or development.⁷⁸

The DoBE has recognised that vulnerable children, including those made vulnerable by poverty, HIV/AIDS and/or a disability, have historically faced numerous barriers to education. These barriers have included cost barriers related to school fees, school uniforms and transport, discrimination and inadequate facilities appropriate to meet the specific needs linked to the vulnerability in question. The poor quality of education has also proven to be a barrier, especially for children made vulnerable by poverty and for children with disabilities. The Department has sought to address these barriers through the following policies and laws so as to realise its vision of 'a South Africa in which all our people will have access to lifelong learning, education and training opportunities which will, in turn, contribute towards improving the quality of life and building a peaceful, prosperous and democratic South Africa' (DoE 2009a: 18).

Key policies⁷⁹

- Education and Training White Paper, 1995
- Language in Education Policy, 1996
- National Policy on HIV/AIDS for Learners, Educators in Public Schools, and Students in Further Education and Training Institutions, 1999
- Education White Paper 6: Special Needs Education – Building an Inclusive Education and Training System, 2001
- Education White Paper 5 on Early Childhood Education, 2001
- School Health Policy, 2003
- Policy Framework on Orphans and other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- National Guidelines on School Uniforms, 2006
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2006–2008
- National Norms and Standards for Grade R Funding, 2008
- Strategic Plan 2009–2013 and Operational Plans for 2009–2010, Department of Education
- National School Nutrition Programme – A Guide for Secondary Schools, 2009
- The revised National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2009–2012
- The Child Labour Programme of Action for South Africa: Phase 2: 2008–2012, Department of Labour
- HIV & AIDS and STI National Strategic Plan, 2007–2011
- Measures for the Prevention and Management of Learner Pregnancy, 2007, Department of Education

76 UNCRC, Article 22; ACRWC, Article 23

77 ACRWC, Article 11(6); African Youth Charter, Article 13(4)(h)

78 UNCRC, Article 32(1); ACRWC, Article 15(1)

79 This study drew on previous policy mapping exercises conducted by Kallmann (2008) and Giese and Koch (2008a) to assist with the identification and navigation of a number of the key policies and laws.

- National Policy for an Equitable Provision of an Enabling School Physical Teaching and Learning Environment, 2008
- Policy for the Registration of Learners for Home Education (in terms of the National Education Policy Act, 1996)
- Policy on Learner Attendance, May 2010, Department of Education

Key legislation

- The Constitution of the Republic of South Africa, Act No. 108 of 1996
- Admission Policy for Ordinary Schools Act, No. 27 of 1996
- The National Education Policy Act, 1996
- The South African Schools Act, 1996
- The National Norms and Standards for Public School Funding, 1998
- The Exemption of Parents from the Payment of School Fees Regulations, 1998
- Education Laws Amendment Act, No. 24 of 2005
- The Children's Act, No. 38 of 2005 as amended by Act No. 41 of 2007 and Act No. 75 of 2008
- Amended National Norms and Standards for School Funding, 2006
- Revised Exemption of Parents from the Payment of School Fees Regulations, 2006
- National Minimum Norms and Standards for School Infrastructure, 2008

Programmes and services provided

The DoE provides programmes and services that guarantee admission, accommodation and retention of vulnerable learners in schools in accordance with the national admissions policy which prohibits discrimination against children on any grounds, and programmes that provide care and support to promote inclusion and continued attendance of vulnerable learners, including:

- admission and registration of children without supporting documents;⁸⁰
- admission to public schools for foreign children;
- admission and accommodation of learners with disabilities and/or special needs in public schools;
- admission, accommodation and retention of learners affected by HIV/AIDS and poverty;
- provision of psychosocial support;
- protection of learners from abuse and neglect;
- protection against discrimination for learners who become pregnant;
- protection against discrimination for failure to pay school fees.

Assisting children with school fees, transport/accessibility and school uniforms

- No-fee schools
- School fee exemptions
- Duty to protect the rights of parents to participate in decisions about school fees and their rights to school fee exemptions
- School uniform guidelines to make uniforms more affordable
- Physical access to schools and access to transport

⁸⁰ Section 5 of the South African Schools Act and the Admission Policy for Ordinary Schools

Early childhood development

- The National Integrated Plan for Early Childhood Development
- EPWP ECD initiative to scale up ECD for 0–4 year olds
- Grade R

National School Nutrition Programme

The National School Nutrition Programme (NSNP) provides nutrition education, parasite control and micronutrient supplementation and food in the form of one meal or snack a day.

Table 5.1 Programme/service map: Department of Education

Programmes and services that guaranteed admission, accommodation and retention of vulnerable learners in schools			
Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Admission and registration of all vulnerable children at public schools	<p>Schooling is compulsory for all children between the ages of 7 and 15 years.</p> <p>The South African Schools Act prohibits schools from unfairly discriminating against children in their admission policies and practices (s5(1)).</p>	<p>Targeted beneficiaries All children</p> <p>In order to register a child at a public school, the following documents are required:</p> <ul style="list-style-type: none"> • birth certificate; • immunisation card; • transfer card or last school report from previous school of attendance. 	<p>The school governing bodies are responsible for developing the individual school admission policies.</p> <p>The policies must comply with the National Admission Policy and Schools Act.</p> <p>Application for admission is made to local schools.</p>
Admission and registration of children without supporting documentsⁱ	<p>In order to register a child at a public school, the following documents are required:</p> <ul style="list-style-type: none"> • birth certificate; • immunisation card; • transfer card or last school report from previous school of attendance. 	<p>Targeted beneficiaries All children</p> <p>Children who do not have documents</p> <ul style="list-style-type: none"> • If the child has no birth certificate, the child must be conditionally accepted by the school until a copy of the birth certificate can be obtained from the DoHA. 	Local school



→	<p>However, if these documents are not available, the child must be provisionally registered until such time as the documents can be obtained.</p>	<ul style="list-style-type: none"> • Proof of immunisation: if a learner has not been immunised, the principal must advise the caregiver on how to get the learner immunised • Transfer card: if the learner does not have a transfer card from the previous school, then the caregiver must produce a report card or any other document from the previous school with an affidavit stating why there is no transfer card. 	
<p>Admission to public schools for foreign children</p>	<p>Schools must admit and register children whose parents are in possession of a permit for temporary or permanent residence.</p> <p>The admission laws and policiesⁱⁱ apply equally to children that are South African citizens as to children whose parents are in possession of a permit for temporary or permanent residence.</p> <p>This includes foreigners who have applied for temporary residence, but have not yet received it.</p>	<p>Targeted beneficiaries</p> <p>Local school Foreign children Children of refugees</p> <p>Enrolment requirements</p> <p>Parents of non-South African citizen learners must produce the child's parents' temporary or permanent residence permit. If they have not yet received their permits, they must produce proof of application to the DoHA to legalise their residency in South Africa.ⁱⁱⁱ</p> <p>No foreign learner may be denied admission to a school due to insufficient documentation. So if the child's parents have not yet applied for their permits, they must be admitted pending such an application.</p>	<p>Local school</p>



→	<p>Admission and accommodation of learners with special needs, including those living with disabilities</p>	<p>Education White Paper 6 (DoE 2001: 15) on inclusive education makes provision for three levels of schools for children with additional educational needs, linked to their specific circumstances:</p> <ul style="list-style-type: none"> • ordinary public schools which must be equipped to register and accommodate the needs of learners facing barriers that require low-intensive support; • full-service schools that are equipped to provide moderate levels of support. The White Paper requires one such school per school district; • special schools providing high-intensive support. 	<p>Targeted beneficiaries</p> <p>Children with different learning needs due to their vulnerable circumstances, including children living with a disability</p>	<p>Ordinary public schools Full-service schools Special schools</p>
		<p>Education policies require that children with different learning needs/challenges, including those who are HIV+ and children living with a disability, be accommodated in ordinary public schools or full-service schools (ordinary public schools with additional teaching facilities) and that referral to special schools be the last action of choice.</p>		





Learners with special needs must be admitted to and accommodated at ordinary schools, where reasonably practical.^{iv}

All ordinary public schools must make their facilities accessible, as far as is possible, for the admission of learners with disabilities. If the learner cannot be accommodated at the school to which application is made because of inadequate facilities to accommodate the special education needs of the learner, then the principal of the school must apply to the Head of Department (HoD) to have the child accommodated at another appropriate school in the province. The HoD must, before referring the child to another school, consult with the learner's parents, educators and other support personnel as part of the assessment of the learner.^v

White Paper 6 recognises that the physical environment of most schools is not conducive to access by learners with disabilities. For example, they lack wheelchair ramps, lifts, toilets that are suitable for wheelchair users, etc.





The White Paper requires that this be remedied through the design and construction of new buildings and renovation of existing buildings to ensure physically accessible and supportive school environments for learners with a disability (DoE 2001).

The National Minimum Norms and Standards for School Infrastructure^{vi} makes provision for architectural and design norms relating to access and the learning spaces that must be provided for learners in the schools that are to be built and renovated over a 10-year period (2011–21). These Norms must be applied in accordance with the provisions of the accompanying National Policy for an Equitable Provision of an Enabling School Physical Teaching and Learning Environment.^{vii} The latter policy requires that the Norms be implemented to give effect to the dictates of Education White Paper 6. This means that full-service schools (newly built and existing schools) for children with physical and other learning barriers must be





adapted to be accessible to all children.

This requires that infrastructure like toilet facilities, wheelchair ramps and furniture must be able to accommodate children with limited mobility and other disabilities (s2.10).

Access to learning is inhibited not only by inaccessible spaces, but also by a lack of assistive devices necessary for mobility and participation in lessons. This includes devices such as wheelchairs and hearing aids, which must be made progressively available to learners who are denied access because of lack of appropriate resources. These services must be prioritised in full-service schools (DoE 2001).

<p>Admission, accommodation and retention of learners affected by HIV/AIDS and poverty</p>	<p>Revised National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2009–2012 This Plan obliges the education system (as part of strategy 4) to increase the level of support it provides to children infected with and affected by HIV/AIDS.</p>	<p>Targeted beneficiaries Children infected with HIV Children affected by HIV/AIDS in one of the following ways:</p> <ul style="list-style-type: none"> • grief and trauma associated with the illness or death of family/household members • increased domestic responsibility • HIV/AIDS-related stigma and discrimination 	<p>Provincial DoEs and local schools The Policy on Learner Attendance recognises that various stakeholders, including learners, school governing bodies, school management teams, provincial education departments, educators and principals all have a role to play in monitoring attendance</p>
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The interventions identified to achieve this objective in the coming four-year period include training teachers and other community structures on treatment literacy; developing an education access and retention strategy for OVC; developing a system in schools to support OVC; developing a system to identify OVC who have dropped out of school.

National Policy on HIV/AIDS for Learners and Educators in Public Schools

This 1999 Policy provides guidelines to ensure that children affected by HIV/AIDS are not discriminated against.

- No learner (or parent on behalf of a learner) can be forced to reveal his or her HIV/AIDS status to a school (s6). In addition, no learner can be required to undergo an HIV test as a condition for admission or continued attendance at school.
- No learner may be unfairly discriminated against, either directly or indirectly, on the basis of his or her HIV status.

Children who are absent from school because of their vulnerable circumstances brought about by poverty, HIV/AIDS, chronic illnesses, TB, poor nutrition and hunger and an unstable/dysfunctional family life

and providing support to vulnerable learners to ensure that they attend school regularly.





- Children living with HIV/AIDS have a right to attend any school/institution, and their needs should as far as possible be accommodated (s5).
- If a learner develops serious HIV/AIDS-related illnesses and is unable to attend school, the learner may either be home schooled (if the HoD believes it to be in the best interest of the child) or placed in a specialised residential institution for learners with special education needs (s5.4, 5.5).

Policy on Learner Attendance

This Policy has recently been gazetted.^{viii}

It aims to improve learner attendance and punctuality by promoting punctual and regular attendance by learners and by providing public schools and provincial education departments with procedures to monitor and manage learner attendance (s3).

It introduces, as from January 2011, an obligation on schools to:

- monitor learner attendance;





- take action where attendance is poor. Schools must give guidance to learners who are frequently absent without a valid reason and must make prompt follow-up with parents and, where necessary, local government, provincial government and NGOs responsible for the well-being of children (s2);
- provide a safe and supportive environment conducive to promoting attendance; and
- facilitate support for learners to overcome poverty-linked and other social and economic stresses that inhibit regular school attendance, such as HIV/AIDS, TB, other chronic illnesses, poor nutrition and hunger, and an unstable/dysfunctional family life.

Monitoring attendance of children receiving the CSG

In terms of a recent amendment to the laws governing the CSG,^{ix} schools will have to play a more active role in monitoring attendance and ensuring the enrolment and retention of all poor learners





whose parents/
caregivers are receiving
the CSG.

Children under 18
receiving the CSG
must be enrolled at
school and the parent/
caregiver must produce
proof from the school,
within one month of
approval of the grant,
of enrolment and
attendance by the child.
In addition, the child's
report, signed by the
school principal, must
be submitted to the
DoSD by the parent
every six months.

In addition, the
provincial Head of the
Education Department
must notify the DoSD
of any child who is
receiving the CSG that
is not registered at or
attending school. In the
case of a child receiving
the CSG not attending
school, a social worker
must, in consultation
with the DoE,
investigate and report
to the DoSD as to why
the child is not enrolled
or attending school. The
DoSD must take steps to
ensure that the child is
enrolled or does attend
school.

**National Child Labour
Programme of Action**

This Programme, which
has been endorsed by





the DoE, requires the Department to address excessive domestic responsibilities/child labour by (pp67, 83):

- identifying children that are frequently absent from school and in need of care and protection, and report them to the DoSD and assist them to apply for social grants and exemptions from school fees;
- developing a clearer policy and better monitoring system in respect of learner absenteeism;
- providing for continued education of children under the age of 18 who have left school to work, by establishing special education centres or classes in the regular school setting;
- training teachers on the specific needs and problems of children that are working;
- incorporating the needs and problems of children that are working into the life orientation curriculum;
- promoting child care facilities in areas where children often have to look after their younger siblings;





- promoting equal sharing of housework between boys and girls;
- being more flexible about school hours to allow children to work without compromising their schooling during high seasons.

<p>Early identification, support and referral of learners with a disability and/or those affected by HIV/AIDS</p>	<p>Early identification of learners with disabilities</p> <p>Education White Paper 6 identifies clinics as being responsible for early and initial assessment and interventions in relation to sensory (sight and hearing) and other physical disabilities which create learning barriers.</p> <p>At the same time, the White Paper requires that links be established between the local clinics and schools. Once children enter the formal schooling system, multidisciplinary school-based support teams (drawing in the health sector's expertise) must identify at-risk learners and address their barriers to learning. Early identification of barriers must focus on identification of learners in the foundation phase (Grades 1–3).</p>	<p>Targeted beneficiaries</p> <p>Children with disabilities</p> <p>Children affected by HIV/AIDS</p> <p>Orphans and victims of child labour</p> <p>Child-headed households</p>	<p>Schools and teachers</p>
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Learners made vulnerable by HIV/AIDS

White Paper 6 requires the Ministry of Education to:

- develop programmes and systems for use in schools to identify orphans and other vulnerable children;
- develop referral procedures to be followed by educators to link identified vulnerable learners with the care and support they need (s2.2.8.2);
- develop guidelines for teachers on how to support orphans and other children in distress (s2.2.8.2).

Children that are orphaned, victims of child labour or in child-headed households

Section 10 of the Children's Act requires teachers (as well as other officials such as doctors, etc.) to report any children that they suspect are victims of child labour, orphaned, or living in a child-headed household to a designated child protection agency, the provincial DoSD or a police official.



<p>→ Psychosocial support and counselling for children suffering grief and trauma and other psychosocial disturbances</p>	<p>Psychosocial support from peer educators The National Policy for an Equitable Provision of an Enabling School Physical Teaching and Learning Environment, 2008, recognises that school counselling services have become a necessity in the light of high levels of grief and trauma experienced by vulnerable children, especially those affected by HIV/AIDS.</p>	<p>Targeted beneficiaries Children suffering grief and trauma</p>	<p>Peer educators Educators External professionals such as social workers and psychologists</p>
	<p>The Policy requires that children in Grades 6–12 receive counselling from peer educators through the peer education and support programme.</p>		
	<p>Psychosocial support from educators The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS, 2009–12, envisages the provision of psychosocial support by a range of stakeholders, including teachers. It further aims to improve the quality and availability of psychosocial support by all stakeholders, including teachers, through an increase in training in this regard.</p>		





Identification by educators of learners in need of psychosocial support and referrals to psychosocial services outside of the education system
 Education White Paper 6 requires that full-service schools be equipped to deal with a greater range of learning needs and address barriers such as psychosocial disturbances. These schools must identify learners experiencing these difficulties and provide the necessary psychosocial and other support required. The Guidelines for Inclusive Learning Programmes (DoE 2005) suggest that the school must ensure this support through appropriate referrals to professionals to deal with the stress and depression.

<p>Protection of children from abuse and/or neglect</p>	<p>Identification and reporting of learners suffering abuse and neglect Education White Paper 6 recognises abuse and neglect as barriers to education for vulnerable children. It requires the establishment of Institutional Based Support Teams which must identify and address all barriers to education, including children that are suffering abuse and neglect.</p>	<p>Targeted beneficiaries Children suffering abuse and neglect</p>	<p>Educators in all schools</p>
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A teacher who on reasonable grounds suspects that a child has been abused or deliberately neglected must report this to a designated child protection agency, the provincial DoSD or a police official.^x

In addition, the Prevention of Family Violence Act (133/1993) requires a number of officials, including teachers, to report cases of suspected child abuse to the police.

The signposts for safe schools programme calls on educators to watch for signs of abuse, record it, report the abuse and follow the case up with relevant authorities.^{xi}

Referral of children suffering abuse

White Paper 6 and the Guidelines for District Based Support Teams recommend that schools establish relationships with external service providers like the police, NGOs and the DoSD and establish joint procedures for the referral of children identified as abused or neglected.

Protection of learners from abuse at schools

The Children's Act (s126)





requires the provincial heads of education departments to screen potential employees that will work with children to see whether they are in Part B of the National Child Protection Register. The National Child Protection Register is a record of persons who have been found unsuitable to work with children and is intended to protect children against abuses from these persons (who have been convicted of murder, rape, indecent assault with regard to a child). Persons in Part B may not be employed to work in a school.

<p>Adequate school infrastructure to meet the basic needs of all children in accordance with their different vulnerabilities. For example, sanitation that is suitable to meet the needs of teenage girls, children with physical disabilities and very young children</p>	<p>Schools must be provided with and in turn provide basic services such as water, electricity and sanitation. The National Norms and Standards for School Infrastructure (2008) and the Framework Document on Health and Wellness (DoE 2008a) require the provision of:</p> <ul style="list-style-type: none"> • a safe supply of portable clean water at schools (s3.20 and s6(3)(l) respectively); • adequate sanitation that meets the needs of vulnerable children, especially the girl child. Plain pit latrines and bucket toilets are prohibited (s3.19 and s6(3)(l)); 	<p>Targeted beneficiaries All children of school-going age, with a priority focus on children made vulnerable by their gender, age and additional needs brought about by factors such as illness</p>	<p>Provincial education departments Schools Local government</p>
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- some form of electricity in accordance with the National Building Regulations (s3.21 of the National Norms and Standards);
- some form of connectivity for communication, including telephone, fax, internet access, public announcement system.

The National Policy for an Equitable Provision of an Enabling School Physical Teaching and Learning Environment, 2008, recognises the link between inadequate school infrastructure, materials and basic services and poor rates of attendance and school retention. It identifies a key objective of the Policy as the facilitation of equitable access through improved infrastructure, materials and basic services in a manner that responds to the range of learning and physical needs, especially for students who are at risk of exclusion. For example, the Policy identifies the need for schools to match sanitation facilities to the needs of different gender groups, to match road access





and building access to the physical needs of learners with disabilities, etc.

As such, schools and the relevant DoEs must, in the interpretation and fulfilment of their responsibilities to provide adequate water, sanitation and access, be guided by what is adequate for the full range of (especially vulnerable) learners.

Protection against discrimination for failure to pay school fees

The South African Schools Act (s5) prohibits any discrimination or the exclusion of any child from school on the grounds that the child/ caregiver is unable to pay school fees.

Targeted beneficiaries
Children and their caregivers living in poverty

Local school

In addition, the Act prohibits the withholding of school reports, the withholding of textbooks, or sending the child home, or any other discriminatory acts on the grounds that school fees have not been paid.



→	<p>Support for teenage parents to return and complete their schooling</p>	<p>Educators must strive to prevent early pregnancies among learners by educating them through the life skills programmes about the risks of early sexual activity and strongly advising them to avoid early sexual encounters.^{xii}</p> <p>Schools may not expel or otherwise unfairly discriminate against learners that become pregnant.</p> <p>Schools must encourage pregnant learners to continue with their education before and after the birth of the baby.</p> <p>In addition, schools must prevent unfair discrimination, stigmatisation and any other forms of unlawful behaviour by other learners or educators in the school against the pregnant learner.^{xiii}</p>	<p>Targeted beneficiaries</p> <p>Children who become pregnant</p>	<p>Schools</p> <p>Educators</p>
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Programmes and services to assist children made vulnerable by poverty with school fees, the cost of transport/accessibility and school uniforms

Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
<p>Free primary schooling and free or subsidised secondary schooling for children^{xiv}</p>	<p>All schools in quintiles^{xv} 1, 2 and 3 are no-fee schools.</p> <p>These schools may not charge learners school fees (or any registration, administration or other fee).</p>	<p>Targeted beneficiaries</p> <p>Children living in poor communities</p> <p>Qualifying criteria</p> <p>Children attending schools in quintiles 1, 2 and 3 that have been listed as no-fee schools</p>	<p>The provincial DoEs determine the eligibility of schools as no-fee schools in accordance with the national quintile criteria, and the provincial DoE</p>



→	<p>This means that these schools receive a per-learner subsidy from the DoE at least equal to the no-fee threshold^{xvi} (adequacy benchmark).</p>	<p>by the minister of education in the Government Gazette by 30 September of each year</p>	<p>is responsible for funding allocations and related matters. The relevant school implements the no-fee benefits.</p>
<p>School fee exemptions</p>	<p>This policy makes provision for the exemption of parents from paying school fees at public schools that are not classified as no-fee schools.</p> <p>The law provides for a number of different kinds of exemptions from school fees:^{xvii}</p> <ul style="list-style-type: none"> • automatic exemptions; • total exemptions; • partial exemptions; • conditional exemptions. <p>Automatic exemptions</p> <p>The following caregivers are automatically exempt from all school fees:</p> <ul style="list-style-type: none"> • a caregiver who has the responsibility of a parent in respect of a child placed in a foster home, a youth care centre, a place of safety or an orphanage; • a person who is the kinship caregiver of an orphan or of a child who has been abandoned by his or her parents and who has no visible means of support; 	<p>Targeted beneficiaries</p> <p>For automatic exemptions</p> <p>Foster parents</p> <p>Children in places of safety, in child and youth care centres or in an orphanage</p> <p>Children who have been orphaned or abandoned and are being cared for by their extended family members without a formal foster care or adoption order</p> <p>Children living in poverty who qualify for the CSG</p> <p>A child heading a child-headed household or a child living in a child-headed household</p> <p>For total and partial exemptions</p> <p>Children living in poverty</p> <p>Eligibility is determined by the caregiver's income levels^{xviii}</p> <p>Full exemption</p> <p>Caregivers will qualify for a full exemption if the annual school fees are 10% or more of the parents' combined gross annual income.</p>	<p>Application is made by the parent/caregiver directly to the school governing body.</p> <p>If the school governing body declines the application, an appeal may be lodged with the head of the DoE in the province.</p>





- a person who receives a grant (e.g. the CSG) on behalf of a child;
- a child who heads a household or who is part of a child-headed household.

Total or partial exemption

If there is no automatic exemption, a parent or caregiver living in poverty may still apply for a total exemption or a partial exemption.

A total exemption exempts the parent from paying 100% of the school fees.

A partial exemption exempts the parent from paying a portion of the fees (between 10–90%).

Conditional exemption

If a parent does not qualify for a full or partial exemption based on the formula, but his or her personal circumstances make it impossible to pay school fees, the parent may apply to the school governing body for a full/partial exemption which may be granted, subject to the condition that the exemption will apply only as long as the relevant circumstances apply.

Partial exemption

If the annual school fees are between 3.5% and 10% of the parents' combined income

How to apply

Parents/caregivers must complete an application form provided by the school and submit it together with proof of the gross income of both parents/caregivers (if applicable).



→	<p>Duty to protect the rights of parents to participate in decisions about school fees and their rights to school fee exemptions</p>	<p>Schools are obliged to:^{xix}</p> <ul style="list-style-type: none"> • Consult with all parents at an annual year-end general meeting of all parents called by the school governing body to decide whether or not to charge school fees. If the general meeting votes against school fees, the school may not charge fees. • If the vote is to charge school fees, then the school must advise all parents/ caregivers in writing about how much the next year's school fees will be. • The school must also advise parents/ caregivers of their right to apply for a school fee exemption, and must inform them as to the procedure to follow in this regard. • The school may not sue a parent for school fees before first investigating whether the parent qualifies for a school fee exemption and, if they do, they cannot sue the parent. 	<p>Targeted beneficiaries The parents and caregivers of children</p>	<p>Local school</p>
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→	<p>School uniform guidelines to make uniforms more affordable^{xx}</p>	<p>The National Guidelines on School Uniforms seek to make uniforms more affordable for poor learners by imposing the following obligations on the school governing body.</p> <p>The obligations imposed are to:</p> <ul style="list-style-type: none"> • allow parents to participate in deciding on the introduction of a new uniform if that is being contemplated; • allow all learners to attend school even if they do not have the prescribed school uniform; • assist learners who are unable to afford school uniforms, subject to the financial means of the school; • allow learners to participate in extramural activities/ special activities even if they do not have the prescribed additional clothes. 	<p>Targeted beneficiaries Poor learners</p>	<p>School governing bodies at schools</p>
	<p>Access to schools that are within a 'catchment area' or, alternatively, access to safe, reliable transport for learners outside of catchment areas</p>	<p>The National Policy for an Equitable Provision of an Enabling School Physical, Teaching and Learning Environment, 2008, and the accompanying National Norms and Standards for School Infrastructure introduce an obligation on the DoE to ensure, at full implementation of the Norms in 2010,</p>	<p>Targeted beneficiaries All children, with priority given to children living in poverty</p> <p>The National Policy for an Equitable Provision of an Enabling School Physical, Teaching and Learning Environment policy and accompanying Norms</p>	<p>National and provincial DoEs</p>





that all schools have a catchment area with a radius of a maximum of 3 km. This means that schools may not be more than a total of 6 km walking distance to and from school (3 km each way). The catchment area is the area to be served by a school. It defines the distance between a school and the community it is serving (s3.1 of the Norms and Standards).

In addition, schools must be in a location which makes access safe and easy. Section 3.4 of the Norms and Standards prohibits the location of schools next to cemeteries, business centres, railway stations, taxi ranks, sewage works, hotels and busy roads. The location should also ensure easy access to roads, sewage lines and basic services, etc.

The National Policy for an Equitable Provision of an Enabling School Physical, Teaching and Learning Environment, 2008, and the accompanying National Norms and Standards for School Infrastructure provide that where a school falls outside

and Standards will be phased in, in a pro-poor sequence.



→ of the 3 km radius catchment area, then learners who fall beyond the catchment area must be provided with transport or hostel accommodation in a phased-in, pro-poor sequence. To this end, the minister of education must finalise a scholar transport and hostel policy.^{xxi}

Early childhood development			
Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
The National Integrated Plan for Early Childhood Development in South Africa, 2005–2010	<p>The NIP services and programmes are divided into primary and secondary services and programmes which are the responsibility of a range of departments. The DoE has a number of responsibilities:</p> <p>Primary</p> <ul style="list-style-type: none"> • To identify vulnerable children and offer referral services for health and social development services (including grants) • Early learning stimulation through strengthening programmes for children and their families • Development and implementation of psychosocial programmes 	<p>Targeted beneficiaries</p> <p>Caregivers, parents and children (0–4) living in poor and otherwise vulnerable circumstances/ communities</p> <p>The NIP for ECD and the EPWP ECD plan identify the 2.5–3 million children living in poverty as the priority target for scaling up ECD in terms of the NIP.</p>	





	<p>Secondary Human resource development (parents, caregivers and community development workers)</p>		
<p>EPWP ECD initiative to scale up ECD for 0–4s^{xxii}</p>	<p>The EPWP ECD programme aims to expand access to ECD services, improve the quality of ECD services and, at the same time, develop skills, create jobs and create income-earning opportunities.</p> <p>The DoE is responsible for achieving these objectives by:</p> <ul style="list-style-type: none"> • training ECD practitioners; • paying stipends to trainees; • developing and disseminating learning materials for ECD trainees and for use in ECD centre learning programmes. <p>The DoE has identified a key intervention towards realising its commitment as the production of materials to guide teachers and parents in early intellectual stimulation. It aims to reach 10% of children per year aged 0–4 from 2009–13.^{xxiii}</p>	<p>Targeted beneficiaries Children aged 0–4 ECD practitioners</p>	<p>National DoE is responsible for policy and monitoring.</p> <p>Provincial departments are responsible for funding and implementation.^{xxiv}</p> <p>Privately run ECD centres employ the learners trained through the EPWP ECD initiative and use the developed materials.</p>



→	Grade R scaling up – the reception year for 5 year olds	<p>Grade R is not compulsory.</p> <p>The Department aims to make it available in all public schools to all five year olds by 2011 (DoE 2009a). The DoE aims to expand substantive access (not just nominal access) from about 200 000 children at present, to the full 900 000 children of eligible age by 2011.</p>	<p>Targeted beneficiaries Children aged five years</p>	<p>Through Grade R facilities to be established at ordinary public schools</p>
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National School Nutrition Programme

National School Nutrition Programme	<p>The Programme provides nutrition education, parasite control and micronutrient supplementation and food in the way of one meal or snack a day.</p> <p>Meals are provided to all learners in quintile 1, 2 and 3 public primary schools from Grades R to 7 and all learners at quintile 1 secondary schools. Quintile 1 secondary schools were included in the programme in April 2009. Quintile 2 and 3 public secondary schools will be included in 2010 and 2011.</p> <p>Primary schools that do not fall into these quintiles but which house poor learners may apply for state funding to provide lunches for individual learners requiring</p>	<p>Targeted beneficiaries Children of primary and secondary school-going age living in poverty, especially in rural and peri-urban areas</p>	<p>Local schools</p>
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support. In such a case, eligibility for a social grant should be used as a criterion for eligibility for a publicly funded lunch.

All learners in the schools must be provided with daily meals. The DoE with the DoH provides a variety of menu options which the district office makes available to schools. School menus are supposed to provide tasty and adequate meals which must provide at least 30% of the daily nutritional needs of learners per meal. The meal should provide protein, starch and vegetables. Menus must be socially acceptable and the use of indigenous food in the menu is recommended.

Learners must be fed before 10.00am so that they can be alert in class.

The Programme also facilitates the establishment of food gardens at the beneficiary schools as a form of support for the Programme and as a means of involving local communities.



Notes:

(i) South African Schools Act, 1996, s5, and the Admission Policy for Ordinary Schools, 1996

(ii) The Admission Policy for Ordinary Public Schools, 2006, and the South African Schools Act, 2006

(iii) The Admission Policy for Ordinary Public Schools, 2006, s19

(iv) The South African Schools Act, 2006, s22

(v) The Admission Policy for Ordinary Public Schools, s23 and s24

- (vi) National Minimum Norms and Standards for School Infrastructure, 2008. The Norms and Standards are to be achieved by schools over a 10-year period, between 2011–21.
- (vii) The National Policy only becomes effective as from 1 January 2011.
- (viii) Policy on Learner Attendance, May 2010, DoE (comes into effect on 1 January 2011)
- (ix) Social Assistance Act 13/2004: Amendment regulations relating to the application for and payment of social assistance and the requirements or conditions in respect of eligibility for social assistance, 31 December 2010, s6(5)
- (x) Section 110, Children's Act
- (xi) Signposts for safe schools (DoE and DoSS)
- (xii) Measures for the Prevention and Management of Learner Pregnancy, 2007, DoE
- (xiii) Measures for the Prevention and Management of Learner Pregnancy, s24 and s27
- (xiv) The South African Schools Act, 1996, as amended by the Education Laws Amendment Act 24/2005 and Amended National Norms and Standards for School Funding, 2006
- (xv) Schools in South Africa are divided into five categories or 'quintiles', according to their poverty ranking. The ranking procedure is as follows: first a national poverty table is prepared by Treasury which determines the poverty of geographical areas based on data from the national census. Provinces then rank schools as being in quintiles 1 through 5 according to the geographical location of the catchment area of the school (Hall & Giese 2009).
- (xvi) The no-fee threshold is different for each quintile. It is the recommended per-learner subsidy that ought to be allocated for each learner in schools in the different quintiles. The subsidy is higher for quintile 1 learners and the lowest for quintile 5 learners. The recommended per-learner allocation is determined by the national DoE and is published annually in the Government Gazette.
- (xvii) Amended National Norms and Standards for School Funding, 2006
- (xviii) The formula that is applied to determine eligibility for total and partial exemptions is:
- $$E = 100 \frac{(F+A)}{C}$$
- E* = School fees, as a proportion of the income of the parent. *F* = Annual school fees, for one child, that a school charges in terms of section 39 of the Act.
- A* = Additional monetary contributions paid by a parent in relation to a learner's attendance of, or participation in, any programme of a public school.
- C* = combined annual gross income of parents. 100 = the number by which the answer arrived at in the brackets is multiplied so as to convert it into a percentage.
- (xix) Amended National Norms and Standards for School Funding, 2006
- (xx) National Guidelines on School Uniforms, 173/2006
- (xxi) Until the Norms are implemented, there is no national transport or hostel policy. At the time of writing this report, the minister of education did not appear to have developed the transport/hostel policy. In addition, the policy goals are long-term goals to be implemented over a 10-year period, from 2010–20.
- (xxii) EPWP Social Sector Plan 2004/5–2008/9 and the NIP for ECD
- (xxiii) Strategic Plan 2009–2013
- (xxiv) There is no mechanism for tracking the budget allocations and spending by DoSD and DoBE on ECD 0–4 programmes or on the EPWP ECD scaling-up initiative. This creates some difficulty in tracking government-funded programmes other than the subsidy and training of ECD practitioners. The two core funders of ECD programmes and facilities are parents and donors (Streak & Norushe 2008).

Some key policy and service delivery gaps

In South Africa, children's rights, including the right to education, enjoy high level protection in terms of various international, regional and national treaties, charters, other legal instruments and, of course, the South African Constitution.⁸¹

The right to basic education is even more strongly protected than other socio-economic rights in our Constitution. It is not subject to progressive realisation, in other words, it is not subject to the availability of government funds, as is, for example, the right to social assistance.

The constitutional guarantee that 'everyone has the right to a basic education' (section 29(1)) is supported by a large body of national policies and laws governing the rights and responsibilities of the different parties, such as the education departments, schools, school governing bodies, teachers, parents and learners in the realisation of this right.

⁸¹ See Chapter 3 for a brief discussion of the various international and regional instruments which guarantee the right to an education.

The sheer scope of protection of this right should translate in practice into all children in South Africa being enrolled at school, attending regularly until they complete secondary school, and achieving to their maximum potential while at school.

Unfortunately, this is not the situation in South Africa. A scan of some recent reports on the status of education for children in the country reveals, inter alia, that while the enrolment rate for children of compulsory school-going age is relatively high (estimated at 95.4 per cent for children in Grades 1–9), there are still large numbers of children aged 7–15 years that are not attending school. According to the Community Survey 2007, 4.6 per cent or 408 000 children in this age cohort are out of school (Fleisch et al. 2009: 43).

Fourteen per cent of primary school-age children are not enrolled in the appropriate education level (UNICEF 2009: 90–92). At secondary level, the number of children out of school escalates significantly. It is estimated that 30 per cent of boys and 25 per cent of girls from the typical age cohort for secondary education are not enrolled at all (UNICEF 2009: 14).

Estimates vary as to the number of children with a disability that are out of school. Fleisch et al. (2009: 43) interpret the Community Survey 2007 to indicate that 22.5 per cent of children with a disability are out of school, whereas the 2009 General Household Survey (Stats SA 2010a) places the figure lower at 10 per cent. Moreover, the GHS recognises significant provincial disparities, with 27 per cent of children with disabilities in the Northern Cape, 15 per cent in the North West, and 12 per cent in Gauteng and Limpopo not attending school. The quality of education and the resultant educational outcomes for children in public schools are poor. Literacy and numeracy rates in public schools are very low. The DoE has set a benchmark of at least 50 per cent for standardised achievement tests, yet in 2007, only 20 per cent of participating schools met this benchmark in either literacy or numeracy or both, and 31 per cent of participating learners achieved the benchmark or higher. The national average percentage scores for Grade 3s were 36 per cent for literacy and 35 per cent for numeracy (DoE 2008b, in Pendlebury 2009: 26).

The DoE has acknowledged many of these deficiencies and inequities and developed a draft action plan – entitled *Action Plan to 2014: Towards the Realisation of Schooling 2025* – which was open for public comment in 2010 and will be finalised for implementation in 2011.

The Plan identifies 27 national educational goals to be achieved by 2014 and explains what is being done by government and what other stakeholders, including parents, can do to contribute to the realisation of the goals.

The goals are directed towards addressing poor-quality learning and learning outcomes, especially in the lower grades, and seeing a shift in focus away from the Grade 12 exams to learning outcomes in Grades R, 3, 6, 8 and 9.

The first 13 goals include:

- increasing the number of Grade 3 learners with minimum language and numeracy competencies;
- increasing the number of Grades 6 and 9 learners with minimum language and maths competencies and improving their performance in language and maths;
- increasing the number of Grade 12 learners that pass maths and physical science;
- improving maths performance of those in Grade 8;

- ensuring retention of all learners until the end of their 15th year;
- improving access to quality ECD below Grade 1;
- improving grade promotion;
- improving access to Further Education and Training after Grade 9.

Discrimination

Discrimination against children with disabilities

The policy and legislative framework for guaranteeing that children with disabilities are admitted to and retained at ordinary public schools in the first instance, and at special needs schools where necessity dictates, is fairly progressive. However, the implementation of this policy has been inadequate. Many children with disabilities of school-going age are not in school. It is estimated that, on average, approximately 22.5 per cent of children (380 000) with disabilities between the ages of 7 and 15 were out of school in 2007 (Fleisch et al. 2009: 43).

The reasons for the poor enrolment rate of children with disabilities are insufficient learning and support facilities and ongoing discrimination (Coetzee & Streak 2004). Children with disabilities require specialised services and learning support to facilitate their meaningful access to school and to ensure quality educational outcomes. The lack of services and support is particularly problematic in rural areas where there is a lack of special needs schools, inadequate facilities and insufficiently trained teachers in ordinary public schools to accommodate learners with special learning needs (Padayachee 2005). Physical access is a problem, as the majority of public schools (97 per cent) have no paved access from the school gate to the buildings, no ramps into their buildings and no toilets for people with disabilities (Presidency 2009: 120).

Discrimination and stigmatisation contribute to erratic attendance and even to children with disabilities dropping out of school. 'Discrimination and participation are closely linked. Stigmatising attitudes to disability lead to discrimination, which in turn becomes a barrier to social inclusion and participation' (Presidency 2009: 120).

The DoE recognised these inadequacies in Education White Paper 6 and developed a plan – documented in its 2009–2013 Strategic Plan – to scale up accessible inclusive education for children with special needs. Its 2012 target is to review 400 special schools, rationalise them and upgrade the facilities they have so as to ensure quality education for learners with special learning needs. In addition, special schools will be upgraded to become special needs centres that will serve as centres of support to ordinary schools and offer support to out-of-school youth with disabilities. The Department further commits to improving the resources and infrastructure at 80 per cent of ordinary schools so as to ensure that they can provide inclusive education for learners with a range of learning needs.⁸²

Discrimination against children affected by HIV/AIDS

A large body of policies have been developed with the objective of addressing the barriers to education for children affected by HIV/AIDS, including:

- HIV-related illness of learners;

⁸² Strategic Plan 2009–2013 (DoE 2009) and the National Policy for an Equitable Provision of an Enabling School Physical, Teaching and Learning Environment

- grief and trauma associated with illness and death of family/household members;
- increased domestic responsibility and risk of child labour for children facing both poverty and HIV/AIDS;
- HIV/AIDS-related stigma and discrimination.

However, these policies are not being implemented properly because of insufficient policy coordination and lack of policy coherence, as well as insufficient communication and training of the people responsible for developing school level implementation policies and plans and those responsible for actual implementation. The school governing bodies are primarily tasked with developing operational and implementation plans at school level. There are too many policies and the school governing bodies, or those who know of the policies, do not know how they fit together or how they ought to be applied. They are not given sufficient guidance on how to navigate the complex web of policies or how to translate them into practical plans of action. The policy guidelines and manuals that have been produced do not provide concrete and practical advice on how to deal with, prevent and avoid the barriers in question, especially with regards to stigma and discrimination. The recommendations are often too vague (Giese & Koch 2008b).

The process for the identification of learners affected by HIV/AIDS in ordinary public schools as learners with special needs (which would result in their being placed in special schools) is not sufficiently inclusive of affected parties. There is a lack of involvement of educators, parents and learners themselves in the assessment process for determining the special needs of learners. At present, the process is dominated by medical professionals.

There are too many referrals of children with unique learning needs to special schools. Learners continue to be unnecessarily referred to special schools primarily because the mainstream schools do not have adequate resources to provide for the needs of children with additional/special needs. There must be improved investment in infrastructure and in professional and financial support for mainstream schools so that they can accommodate and meet the needs and rights of vulnerable children and/or children with special needs (Giese & Koch 2008b).

More than 2 million learners enrolled in ordinary schools in 2007 were orphans who had lost either one or both parents; 460 000 learners had lost both parents.⁸³ There is a lack of appropriate referral options and insufficient training for educators on dealing with children affected by grief and trauma brought about by, inter alia, illness and death of family/household members. There are not enough appropriately qualified professional support staff at schools to provide support to the numbers of grief-stricken children living in households affected by HIV/AIDS that experience multiple bereavements, and to ensure that children are not further traumatised by inappropriate counselling/intervention (Giese & Koch 2008b).

The response by the DoBE and schools to the increase in domestic responsibilities, especially for girls, brought on by HIV and poverty in the family is inadequate.

A report by the World Bank (2002: ix) found that a 'good basic education ranks amongst the most effective – and cost effective – means of HIV prevention'. The HIV & AIDS and STI National Strategic Plan 2007–2011 identifies girls and young women as being

83 Annual School Survey, 2010

particularly vulnerable to HIV/AIDS. The World Bank report observes that a lack of education makes girls and young women even more vulnerable to infection and that the impact of the epidemic on them is more likely to impede their access to school than it is that of their male counterparts. This finding is supported by a recent joint study by the Wits Schools of Public Health and the London School of Hygiene and Tropical Medicine, which found that secondary school attendance can lead to a lower risk of HIV infection among young people in rural South Africa. The report found that youths in school reported fewer sexual partners than those out of school. For female learners, the reduction in numbers of partners was accompanied by other protective behaviours, such as greater condom use, less frequent sex and partners who were closer to their own age (Hargreaves et al. 2008).

In view of the link between education and reducing the infection rate and the impact of HIV/AIDS, especially on girls, the report recommends that countries urgently strengthen their education systems, 'which offer a window of hope unlike any other for escaping the grip of HIV/AIDS' (World Bank 2002: xv).

Girls and young women affected by HIV/AIDS are more vulnerable than their male counterparts to having to shoulder additional domestic responsibilities when a family member is ill or dies. The current education policy framework does not provide any concrete remedies to address this situation in order to minimise the extent of the barrier that additional responsibilities present to their access to education and, ultimately, to minimise their vulnerability to infection.

Not only are the policy responses insufficient, there also appears to be a reluctance on the part of educators to get involved in identifying and addressing the needs of schoolchildren whose education is negatively affected by excessive domestic responsibilities. This appears to be linked to a lack of understanding of the problem and what would constitute appropriate solutions. This is not surprising, given that there is an absence of data on the nature, extent and complexities of excessive domestic responsibilities and child labour among school-age children in South Africa.

There needs to be further research into the situation and needs of learners whose access to education is hampered by domestic responsibilities, so that the conditions that keep them out of school can be understood and appropriate processes and mechanisms developed, implemented and monitored by the DoE's Inclusive Education Directorate.

There must be advocacy and training within the DoE to ensure that this barrier is included as part of the 'core business' of education as outlined in the Child Labour Programme of Action (endorsed by the DoE) (Giese & Koch 2008b).

Insufficient school infrastructure and learning resources

The quality of infrastructure and learning resources as well as the sufficiency of teaching staff in schools, especially those providing education to poorer communities, is problematic. For example, in 2009, only 10 per cent of public schools had libraries stocked with books and other materials; 11 per cent had library space, but no books; and the remaining 79 per cent had no library facilities at all. A similar deficit applies in the case of secondary school laboratories. Only 15.6 per cent of public secondary schools have stocked laboratories and 85 per cent have no labs at all. More than three-quarters (77 per cent) of South Africa's public ordinary schools have no computers (DoE 2009b).

At a more basic level, many schools are hampered by insufficient desks and chairs for both learners and educators.⁸⁴

The average class has 38 learners.⁸⁵ Although the teacher to learner ratio is, on average, below the official norm of 40 to 1, 'overcrowded classrooms and high learner-to-teacher ratios remain a dominant feature in pockets of South Africa's schooling system, especially in schools catering to children from disadvantaged communities' (Pendlebury 2009: 27). Large class sizes and overcrowding are particularly problematic in the early foundational years of schooling, and especially so in rural areas. A survey of schools in a selection of rural districts in Limpopo, KwaZulu-Natal and the Eastern Cape revealed that a typical foundation phase (Grades 1–3) class accommodated more than 45 learners in a classroom, with an average of 62 children per classroom in the rural sites in KwaZulu-Natal (Presidency 2009: 92).

There are significant backlogs in the provision of water, sanitation and electricity to schools housing poor learners. For example, in 2009, almost 15 per cent of ordinary public schools (3 603) had no electricity supply; 10 per cent (2 444) had no water supply and 3 422 had no sanitation facilities, while 11 231 still made use of pit latrines (DoE 2009b).

No-fee school policy

The current ranking system which determines no-fee status appears to be flawed. At present, the key factor determining no-fee status is the physical location of the school, rather than the levels of poverty among the children accommodated at the school. As such, there are a number of schools housing a majority of poor learners that deserve no-fee status but that do not qualify because they fall into quintiles 3, 4 or 5. In addition, they have no recourse to effective, evidence-based, consultative procedures to apply for a re-ranking based on their circumstances (Giese & Koch 2008b).

The complexity of the no-fee policies requires effective administration, communication, monitoring, support and capacity building by the provincial DoE to allow for the proper and accountable implementation of the no-fee policies at school level. This does not appear to be happening, especially in schools in communities where effective implementation of the policies is most urgently needed to address the needs of large numbers of poor children.

School fee exemption policy

A significant number of schools are, often deliberately, failing to implement the school fee exemption policy. They are not advising parents of their school fee exemption rights, they are refusing legitimate exemption applications and, when parents default on school fee payments, the schools are ignoring their duty to investigate whether parents qualify for an exemption before suing them for payment. In addition, there are widespread unlawful discriminatory practices against learners who cannot afford to pay school fees. For example, learners' report cards are withheld and they are refused admission to the school at the start of a new year if fees are outstanding from previous years. The reason for the widespread abuse of these rights appears to be because the school fee exemption policy is not funded by the DoE. Individual schools are obliged to honour the policy, but to find the funds within their own resources/reserves to cover the costs of the exempted learners.

⁸⁴ 2006 National Assessment Report (Public Ordinary Schools), in Presidency (2009: 93)
⁸⁵ Annual School Survey, 2010

The only source of funds for many schools, especially those with a significant number of poor learners, is the school fee revenue, which leaves them little option but to pursue this revenue aggressively (Giese, Hombakazi et al. 2009).

The DoE has recognised this problem and identified the development of appropriate policies and plans to address funding of the school fee exemption in its 2009–2013 Strategic Plan.

The most vulnerable children whom the current school fee exemption policy seeks to protect are not spared the impact of the policy failings. Despite the fact that the law expressly provides for an automatic exemption from paying school fees for the caregivers of children receiving the CSG and the FCG, this is not happening in practice. Schools are charging these parents school fees and not advising them of their rights in this regard. The majority of children receiving the CSG are not getting an automatic full school fee exemption. Instead, they are paying their school fees with their CSG income, resulting in one department cross-subsidising another department's legal obligations, at the expense of the children requiring support (CASE 2008).⁸⁶

The extent of the government's funding per learner at fee-paying schools is less than the 'adequacy' benchmark for providing a quality education. In the context of operating in poor communities, many of these schools are unable to make up the difference through fundraising or fees (most notably the poorer schools). As such, the ability of these schools to deliver a quality education and provide an environment conducive to learning is compromised (Hall & Giese 2009).

School uniform assistance policy

The assistance provided at a policy level to poor learners to make uniforms more affordable does not provide material relief. There is no obligation in terms of the current guidelines to actually provide uniforms for free or to subsidise the cost of uniforms for poor learners. The guidelines go no further than obliging the school governing body to take measures, within its available resources, to make uniforms more affordable. Schools with significant numbers of poor learners will in all likelihood not have access to resources to make uniforms more affordable, other than perhaps establishing a second-hand school uniform shop (Roussel 2007).

The burden of implementation of the guidelines rests with the school governing bodies. The guidelines have little or no legal force and therefore it is not possible to compel action by these bodies, which means that the implementation of the guidelines depends on their voluntary compliance. Evidence in the report by Roussel (2007) shows a tendency by school governing bodies not to act proactively in the implementation of the guidelines.

The guidelines are at times contradictory. For example, in an effort to prevent the lack of a school uniform becoming a barrier and excluding learners, the guidelines prohibit the exclusion of a learner from school on the basis that they do not have a uniform. At the same time, the guidelines allow not wearing the appropriate uniform to constitute a disciplinary offence.

⁸⁶ In a study of 2 700 primary caregivers of children aged 0–13 in low-income areas in the CASE study, it was found that two-thirds of the CSG recipients were paying school fees. This was confirmed in a study conducted by Giese, Hombakazi et al. (2009).

Grade R learners

There is uncertainty as to whether Grade R in public schools qualifies for school fee exemptions at fee-paying schools or no-fee status in a no-fee school. The norms and standards for school funding, which create fee exemptions and no-fee schools, apply only to ordinary public schools. It is not clear if Grade R is included in this definition.⁸⁷

In theory, Grade R does not qualify for school fee exemptions or no-fee school status. However, what is happening practically is that if a school is declared no fee, there is an assumption that it extends to the Grade R learners, except there is no guarantee of additional funding to the Grade R phase.

National School Nutrition Programme

- Inconsistent and insufficient levels of funding for the NSNP have compromised the delivery of school feeding programmes at many primary and secondary schools (Wildeman 2009).
- The NSNP is not available for most learners at secondary school level.
- The NSNP is not automatically available for poor learners attending schools in quintiles 2, 3, 4 and 5. It is up to the school to apply for access to the programme. Some schools that have made these applications have been refused entry to the NSNP (Kallmann 2005).

⁸⁷ Personal communication with Kevin Roussel, Catholic Institute of Education

Department of Labour

Introduction

The Department of Labour (DoL) has two core responsibilities in relation to providing care and support for vulnerable children and their families.

Taking its lead from the UNCRC (Article 32) and the ACRWC (Article 15), which prohibit the economic exploitation of children and employment of children to do hazardous work, section 28(1)(f) of the Constitution provides that, 'Every child under 18 years has the right not to be required or permitted to perform work or provide services that are inappropriate for someone of that age or that place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development.' The DoL is responsible for giving effect to this right by protecting children from child labour.

Section 27 of the Constitution gives national effect to the international protection of the right of children to social insurance.⁸⁸ It guarantees all vulnerable people the right to social security, including social assistance. The White Paper for Social Welfare in South Africa (1997) defines social security as:

[a] wide range of public and private measures that provide cash or in-kind benefits, or both, first in the event of an individual's earning power permanently ceasing, being interrupted, never developing, or being exercised only at unacceptable social cost and such person being unable to avoid poverty. It includes both social assistance and social insurance (contributory schemes).

The DoL is responsible for the administration of the social insurance/contributory schemes linked to unemployment for vulnerable children and their families.

Key policies

- International Labour Organisation Minimum Age Convention, 1973
- International Labour Organisation Convention on the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour, 1999
- The National Child Labour Programme of Action for South Africa: Phase 2: 2008 to 2012, Department of Labour

Key legislation

- The Constitution of the Republic of South Africa, Act No. 108 of 1996
- The Basic Conditions of Employment Act, No. 75 of 1997 as amended by the Basic Conditions of Employment Act, 2002
- The Children's Act, No. 38 of 2005 as amended by Act No. 41 of 2007 and Act No. 75 of 2008
- Unemployment Insurance Fund Act, No. 63 of 2001 as amended by the Unemployment Insurance Amendment Act, No. 32 of 2003

⁸⁸ UNCRC, Article 26

Programmes and services provided

- The national child labour action programme is a holistic, multi-departmental plan of action to develop appropriate policies and a national action programme to combat child labour.
- Protection against child labour: young and other vulnerable children may not be employed.
- Unemployment insurance benefits are short-term financial benefits for workers who have lost their jobs or are unable to work because of illness or for maternity reasons.

Table 6.1 Programme/service map: Department of Labour

Programmes/services protecting children against child labour			
Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
The National Child Labour Programme of Action	<p>The NCLPA is a holistic, multi-departmental plan of action to develop appropriate policies and a national action programme to combat child labour.</p> <p>It is intended to complement and supplement existing programmes to adequately prevent child labour.</p> <p>The emphasis is on prevention of child labour by addressing the socio-economic circumstances creating fertile ground for child labour and exploitation, most notably, poverty. It also seeks to address child labour where it is a reality.</p>	<p>Targeted beneficiaries</p> <p>Children employed in economic activity as well as those doing household chores which are exploitative, hazardous, inappropriate for their age or detrimental to their schooling or development</p> <p>The NCLPA defines child labour as, 'Work by persons between 5–17 which is exploitative, hazardous or otherwise inappropriate for their age, or detrimental to their schooling or their social, physical or moral development. It includes chores in the home or work for the family if these are excessive or unsuitable.'</p>	<p>The NCLPA obliges all government departments to work together to achieve the objectives.</p> <p>The DoL is the lead department.</p>





So, for example, the Department of Water Affairs and Forestry would be responsible for improving access to piped water, because a lack of piped water forces children to spend more time fetching and carrying water.

Some of the DoL's responsibilities include:¹

- training of labour inspectors to address child labour;
- enforcing child labour provisions such as those contained in the Basic Conditions of Employment Act 75/1997;
- raising public awareness on child labour.

Protection from child labour	<p>The Basic Conditions of Employment Act prohibits the employment of children under certain circumstances (see 'Targeted beneficiaries').</p> <p>If a case of child labour is reported to the DoL, or to any DoL inspector, the Department can prosecute the employer and, if found guilty, the employer can be fined or imprisoned for up to three years.</p>	<p>Targeted beneficiaries</p> <p>The Act prohibits employment of:</p> <ul style="list-style-type: none"> • children under the under the age of 15; • children under the minimum school-leaving age where this is higher than 15; • children older than 15, but younger than 18, whose employment is inappropriate for the age of the child, whose employment places the child's well-being, education, physical or mental health, or spiritual or moral development at risk; • children forced into labour. 	DoL
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→	Protection of children from hazardous work conditionsⁱⁱ	<p>The Regulations on Hazardous Work by Children in South Africa came into effect on 7 February 2010.</p> <p>They seek to prevent the exploitation and abuse of child workers at work and to ensure that they work in a safe environment.</p> <p>The Regulations require employers to consider and address risk factors when employing a child, including:</p> <ul style="list-style-type: none"> • the child's sensitivity to chemicals; • possible sleep deprivation as a result of the work; • a child's reduced ability to perceive danger correctly; • lack of experience and maturity in making safety judgements. 	Targeted beneficiaries Child workers, defined as any person under the age of 18 years who works for an employer and who receives or is entitled to receive remuneration	If any of the Regulations are contravened, labour inspectors are required to refer cases to child protection organisations in accordance with the Children's Act.
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Social insurance contributory schemes

Unemployment insurance fund (UIF)ⁱⁱⁱ	<p>Short-term financial relief to workers who have lost their jobs or are unable to work because of illness or for maternity reasons</p> <p>UIF also provides relief to the dependants of contributors who have died.</p> <p>Benefits^{iv}</p> <ul style="list-style-type: none"> • Unemployment benefits • Illness benefits • Maternity benefits 	<p>Targeted beneficiaries</p> <p>Workers who lose their jobs</p> <p>Workers who are unable to work because of illness</p> <p>Workers who need to take maternity or adoption leave</p> <p>Dependants of deceased workers</p> <p>The employers of all employees who work for 24 hours or</p>	DoL
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- Adoption benefits
- Dependents' benefits

How much is paid?

The benefits range from 38% for highly paid workers up to 58% of the worker's salary.

For how long is the benefit paid?

All unemployed contributors can claim a maximum of 238 days of benefits (if they have accumulated enough credits in a four-year period).

In the case of maternity benefits, a total of 121 days is payable, if sufficient credits are available.

more per month (for the same employer) must make monthly contributions to the UIF. This includes domestic workers and their employers.

Qualifying criteria for the UIF (Who can claim?)^v

- An employee whose employment has been terminated
- A worker whose fixed contract has ended and not been renewed
- A worker who has been fired from their job
- A worker whose employer has been declared insolvent
- A worker whose contract has been terminated by the death of his or her employer
- A registered work-seeker with a labour centre
- A worker who is capable of and available for work

Qualifying criteria for maternity benefits

- Workers who fall pregnant while contributing to the UIF may claim up to 121 days benefit.





- Workers who have a miscarriage during the third trimester or who deliver a stillborn baby may claim up to six weeks maternity benefit.

Qualifying criteria for adoption benefits

- Only one contributor of the adopting parties can claim adoption benefits and only if the child is adopted in terms of the Child Care Act (the Children's Act when it comes into effect).
- The benefit may only commence from the date of the adoption order granted by the court.
- The benefit only applies if the adopted child is under the age of two.
- The applicant must apply within six months of the date of the adoption order.

Qualifying criteria for dependant's benefits

- The surviving spouse or life partner of a deceased contributor may apply for dependant's benefits.





- A dependent child of the deceased contributor may only apply if there is no surviving spouse, or if the surviving spouse has not applied for the benefits within six months of the death of the contributor.
- Application must be made within six months of the death of the spouse or partner.

*Notes:**(i) NCLPA, Annexure A, p81**(ii) Regulations on hazardous work by children in South Africa, Government Gazette 32862, 15 January 2010**(iii) Unemployment Insurance Fund Act 63/2001 as amended by the Unemployment Insurance Amendment Act 32/2003**(iv) Black Sash (2010c)**(v) Black Sash (2010c)*

Some key policy and service delivery gaps

Child labour policies

Almost no data are available on the prevalence of child labour in South Africa. The DoL estimates that 1 million children between the ages of 5–17 are engaged in child labour (Presidency 2009: xiii). The practice of child labour is common in vulnerable households affected by poverty, HIV/AIDS and households living in rural areas. Families living in poverty require their children to work, either to supplement the family income or to engage in domestic chores like caring for younger siblings or ill adults. Many children living in poverty in rural areas are additionally required to fetch wood and water and herd cattle.

Many children in South Africa, whether employed for economic gain or doing domestic chores, do so at the expense of their education. Child labour can keep children away from their homework and renders them too tired to attend school punctually and regularly. In addition, it is a cause of children dropping out of school.

A participant in an ACCESS (2003: 45) child participation process described his experience as follows:

My problem is I do not even have a chance to read my books. After school I go to work. When I come back from work I already feel like sleeping and I just sleep because I am tired. I wake up late. I am always late here at school. I've never been early. Another problem is that I am always tired, I am always tired.
(Boy, 12, E Cape)

The Institute for Democracy in South Africa has found that many children living in poverty are compelled to sacrifice their education and drop out of school to go and work to help ensure their families' survival. About half the children interviewed in a research project

in KwaZulu-Natal 'had had to trade their right to education for the right to food for the family' (Ewing 2003: 6).

In addition to paid labour, domestic chores like fetching fuel and water and caring for siblings can be as harmful to a child's education as paid labour. This is particularly problematic in poor households which do not have access to running water and electricity (DoL 2007). A study conducted by the TECL (Towards the Elimination of the Worst Forms of Child Labour) project sought to assess the impact of fetching water on children's education. The study found, inter alia, that children in the rural areas that were studied spent on average 12.5 hours a week collecting water. This time was as high as 40 hours a week for some children. The impact on the children's education was negative: children complained of being late at school, being unable to concentrate in class, having poor morale and needing to leave school as early as possible to collect water. The impact on educational outcomes appears to be significant: 85 per cent of the children involved in fetching water, compared to 15 per cent of those who were not, were not in the appropriate age group for their grade (DoL 2007: 49).

The National Child Labour Programme of Action (NCLPA) recognises the negative impact of poverty and HIV/AIDS on child labour. It recognises that children affected by poverty and/or HIV/AIDS are often forced into taking on additional domestic responsibilities as well as (often exploitative) paid work.⁸⁹ The NCLPA seeks to address this problem by obligating the DoE to develop programmes for the identification of children with added domestic responsibilities and to take corrective action by reporting these children to the DoSD and linking them up with grants. Recent research revealed that at the level of the DoE, there was little knowledge of the obligations imposed on it by the NCLPA. In addition, there does not seem to be much evidence of building the capacity of teachers and implementing the obligations related to children and domestic responsibilities. In fact, there appears to be reluctance on the part of DoE officials to get involved in the domestic responsibility arena. Education officials appear to be of the opinion that they are ill equipped and not the ideal department to deal with the matter of additional domestic responsibilities for children (Giese & Koch 2008b). As a result, there is a growing policy and implementation gap in addressing the additional domestic responsibilities of vulnerable children.

The definition of child labour in the NCLPA is wider than in the Basic Conditions of Employment Act. The NCLPA definition includes chores in the home or work for the family if these are excessive or unsuitable. The Act, however, appears to limit the definition of child labour to work for remuneration. The Act does not define child labour, or employment, but does define an employee as 'any person who works for another person or for the state and who receives or is entitled to receive any remuneration' (Chapter 1: definitions). The NCLPA obliges the DoE to address excessive domestic responsibilities; however, the Department does not appear to be fulfilling this responsibility. The DoL, on the other hand, is not authorised by the Act to address this form of child labour.

The dilemma of enforcing child labour policies

Because children in vulnerable households work to contribute to alleviating poverty in the home, the issue of child labour creates an implementation conundrum in that

⁸⁹ National Child Labour Action Programme, 2008–2012

enforcement of child labour policies may expose vulnerable families to an even greater degree of vulnerability. By stopping the child labour, one may be cutting off one of the only sources of family income. This problem could potentially be addressed through the proper implementation of the holistic vision of the NCLPA, which envisages a referral system between the different departments. This would allow for termination of the labour and referral of the family to alternative sources of income, such as the CSG, or preferential participation in the expanded public works programmes (Nicolaou & Durieux 2005). This vision is not a reality, however. There is no such referral system in place between the different government departments in the context of child labour.

Insufficient coordination among stakeholders

The lack of an appropriate supportive referral system for children and families exposed to child labour is symptomatic of a fundamental policy gap. The NCLPA, as with many other overarching holistic policies designed to address vulnerability in South Africa, is a multi-departmental initiative that requires coordination of visions, policies and programmes so that child labour is mainstreamed into the poverty alleviation strategies of all relevant departments. This requires a significant degree of coordination between government departments and civil society. There is insufficient systemic coordination of these efforts, as can be seen from the disjunctures discussed above.

Labour inspectors

Jameson et al. (2010) observe that many of the protective measures that are introduced by the Basic Conditions of Employment Act to protect children from unlawful and harmful labour practices are rendered ineffective by the fact that only a very small percentage of labour inspectors dedicate time to monitoring child labour. Furthermore, most children are employed in sectors and geographical areas where labour enforcement does not regularly reach, such as on farms, in the seasonal hospitality industry and in domestic service (Jameson et al. 2010).

Unemployment insurance benefits

Certain social insurance benefits are payable to the contributor's dependents in the event of the death of the member. Where the dependent is a minor, the benefits are meant to be received by the child's legal guardian, who is held accountable for the management of funds and the maintenance of the child. Often accessing benefits is problematic for vulnerable children for a variety of reasons, including (De Villiers & Giese 2008):

- a tendency within the legal system not to appoint legal guardians in the case of children from families that are relatively poor and who leave behind small estates. This often leaves the management of any funds received to an unaccountable extended family member;
- the hidden costs of claiming benefits inhibit access to social insurance by children living in poverty. Often claimants have to travel on multiple occasions over a protracted period of time to try and interact with the employer, the fund or some third party to lodge a claim;
- many members and potential beneficiaries probably do not know about the benefits that are available to them, given the large sums of unclaimed money held by registered funds, and the funds themselves appear not to be inclined to investigate unclaimed monies and take steps that will increase claims against them;
- the abuse and incorrect use of funds by guardians or caregivers who receive the money on behalf of children;
- claims procedures are cumbersome and difficult to navigate.

Department of Agriculture, Forestry and Fisheries

Introduction

The Department of Agriculture, Forestry and Fisheries (DAFF) is responsible, in part, for the realisation of the rights of ‘everyone to sufficient food’⁹⁰ and of ‘every child to basic nutrition’.⁹¹ In terms of the Integrated Food Security and Nutrition Programme (2002), which is an integrated multi-sectoral plan for the realisation of food security in South Africa, the DAFF is responsible for increasing food production capacities and capabilities through various agricultural support programmes.

Key policies and legislation

- Constitution of the Republic of South Africa, Act No. 108 of 1996
- Integrated Food Security Strategy for South Africa, Department of Agriculture, 2002
- Integrated Food Security and Nutrition Programme, 2002
- National Food Emergency Programme, 2002
- Integrated Food Security Strategy for South Africa, 2003

Programmes and services provided

Household Food Production Programme

The programme assists households through the provision of the following packages:

- production inputs;
- production capacity (training);
- on-farm technical provision (extension);
- on-farm production infrastructure.

Comprehensive Agricultural Support Programme

The Comprehensive Agricultural Support Programme (CASP) is aimed at assisting land reform, post-settlement, by providing the following assistance through a grant:

- on-farm and off-farm infrastructure;
- training and capacity building;
- production inputs support;
- regulatory services;
- marketing and business development;
- information and knowledge management;
- technical and advisory services.

Agricultural development fund for South Africa

The Micro-Agricultural Finance Initiative of South Africa (MAFISA) is a micro-lending scheme providing farmers and households involved in farming with finance at a lending rate cheaper than the commercial banks, to facilitate:

⁹⁰ Section 27(1)(b), South African Constitution

⁹¹ Section 28(1)(c), South African Constitution; UNCRF, Article 24(2)(c); ACRWC, Article 14(2)(c)

- a reduction of poverty;
- development of viable agricultural businesses;
- graduation of small-scale into larger commercial businesses.

Table 7.1 Programme/service map: Department of Agriculture

Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Household Food Production Programme	<p>This Programme provides agricultural starter packs or start-up grants and food production information packs to food-insecure rural households.</p> <p>The starter packs include seeds, agricultural implements and production input required by the production environment.</p>	<p>Targeted beneficiaries Families living in poverty under social protection policy programmes and families living in poverty receiving food parcels</p> <p>Not all families receiving food parcels get the starter packs.</p> <p>The Department follows a demand-driven approach.</p>	<p>The Department of Agriculture, Forestry and Fisheries coordinates the planning and implementation of these programmes.</p> <p>It is also the coordinator of the Integrated Food Security and Nutrition Task Team.</p> <p>The Department is also part of the</p>
The Comprehensive Agricultural Support Programme	CASP provides the on-farm and off-farm infrastructure to support sustainable production of the emerging farmers in South Africa.	<p>Targeted beneficiaries Newly settled land reform farmers</p> <p>CASP is a demand-driven programme.</p>	National Action Committee for Children Affected by HIV and AIDS, the committee coordinating programmes for
MAFISA	<p>Micro-lending for South Africa is a financial scheme funded and managed by the state through the Land Bank to assist emerging farmers with lower interest rates on production loans to support their production.</p> <p>This programme was initiated as a response to commercial banks' lack of support to the emerging agricultural sector, due to farmers' lack of collateral as security for their loans.</p>	<p>Targeted beneficiaries Emerging and subsistence farmers</p> <p>MAFISA is also a demand-driven programme.</p>	OVCs in South Africa.

Some key policy and service delivery gaps

Insufficient food

Malnutrition is one of the diseases of poverty, alongside low birth weight, diarrhoea and lower respiratory infections, which account for 30 per cent of under-five deaths in South Africa (Bradshaw et al. 2009: 351). An immediate cause of malnutrition is inadequate food intake, which is in turn caused by household food insecurity. Hendricks and Bourne (2010: 47) point out that 'while studies have indicated that there is sufficient food available nationally, large sectors of the population experience hunger and food insecurity'.

The National Food Consumption Survey found that 52 per cent of children aged 1–9 experience hunger, 28 per cent are at risk of hunger and only 20 per cent are food secure. Furthermore, rural households experience greater hunger and hungry households are found mainly in the Eastern Cape (66.7%), the Northern Cape (65.3%) and Limpopo (63.2%) (in Hendricks & Bourne 2010: 46).

Recent estimates indicate that 80 per cent of households in South Africa cannot afford to buy an average nutritionally adequate food basket (Altman et al. 2009).

Support for small-scale farming

The Integrated Food Security and Nutrition Programme is an integrated multi-sectoral national response to address hunger, under-nutrition and food insecurity in South Africa by 2015. It is led by the DAFF, which is also responsible for providing support to increase household food production, nutrition and food security through a number of agricultural support programmes that aim to provide support to household and on-farm agricultural production.

There are approximately 2.5 million households that engage in small-scale agricultural production and approximately 300–400 000 full-time subsistence farmers in South Africa. The majority of small-scale farmers are women, young (aged 15–19), and most are located in the former 'homeland' areas. The primary reason for small-scale farming is to supplement household food (Altman et al. 2009, in Hendricks & Bourne 2010). These farmers need great levels of support. The success of these farming initiatives depends on the level of support provided, the quality of the natural resources and access to markets. The required level of support is sporadic, resulting in varied levels of agricultural success. Only 12.6 per cent of households involved in agriculture received agricultural-related support in 2008. Two per cent reported receiving training and 9.5 per cent reported receiving dipping services (Stats SA 2010a: 40).

Insufficient arable land, water and skills

The Agricultural Support Programme has faltered as a result of lack of arable land, lack of water and lack of skills and knowledge. This has led to a decline in the availability of starter packs and an increase in the availability of grants to cover elements such as basic inputs and implements.⁹² Sibongiseni Ndimande, a director of food security within the Department, notes that CASP, which is their key programme implemented through the provincial departments, will not have the desired impact if it is not coupled with market access and logistics, mechanisation and implements to support the emerging agricultural

⁹² Integrated Food Security and Nutrition Programme, 2002

sector. These are some of the reasons why the Department developed other support programmes, such as MAFISA, to increase the impact of support provided to the emerging agricultural sector.

The lack of support for small-scale producers to access agro-food markets that cater for them is confirmed by Hendricks and Bourne (2010), who call for improvements in this regard through the agricultural support programmes.

Department of Water Affairs

Introduction

The rights to water and sanitation are guaranteed by the South African Constitution, the UNCRC (Article 24(c)) and the ACRWC (Article 14(2)(c)) and it is primarily the responsibility of the Department of Water Affairs (DWA) to realise these rights.

Section 27(1)(b) of the Constitution guarantees that 'everyone has the right to have access to sufficient water' and section 24(a) guarantees everyone the right to 'an environment that is not harmful to their health or well-being'.

The rights to water and sanitation are especially important for children, and even more so for two particularly vulnerable groups of children, namely, very young children and children living with HIV/AIDS. Young children, more so than others, are very vulnerable to the risks posed by contaminated water, poor sanitation and inadequate hygiene. In South Africa, it is argued that better sanitation alone could reduce diarrhoea-related morbidity by a third, and if one adds improved hygiene, this could be reduced by two-thirds (Coutsoudis et al. 2008: 88). In the case of children living with HIV/AIDS, more water and higher sanitation levels are required than for other children in order to ensure their health, standard of living and dignity. For example, extra care is necessary in the preparation of food to minimise the risk of gastrointestinal infections, to which HIV-infected people are more susceptible; frequent bathing is necessitated by susceptibility to skin infections; the frequency of diarrhoea for people living with HIV requires additional water to prevent dehydration and additional flushing sanitation facilities. A matter common to both very young children and to people living with HIV/AIDS is the additional water and hygiene facilities required for safe bottle feeding, the feeding method of choice for many HIV-positive mothers. Access to additional water is not only important for people and children infected with HIV, but also for their caregivers and other members of the household. Access to additional water is important to lessen the burden of caring for an HIV-infected household and to ensure that other members do not have to sacrifice their water in order to meet the additional needs of the HIV-infected members in the household.⁹³

Key policies⁹⁴

- Free Basic Water Policy, 2000
- White Paper on Basic Household Sanitation, 2001
- 'Free Basic Water' Implementation Strategy, 2001
- National Sanitation Programme, 2001
- Policy Framework on Orphans and other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2006–2008
- The National Integrated Plan for Early Childhood Development in South Africa, 2005–2010

⁹³ Affidavit in the High Court of South Africa Witwatersrand Local Division, Mazibuko v City of Johannesburg, Case No. 06/13865, www.law.wits.ac.za

⁹⁴ This study drew on previous policy mapping exercises conducted by Kallmann (2008) and Giese and Koch (2008c) to assist with the identification and navigation of a number of the key policies and laws.

- The Strategic Framework for Water Services, 2003
- HIV and AIDS and STI National Strategic Plan, 2007–2011
- Multi-Year Strategic Plan, 2007/08–2009/10, Department of Water Affairs and Forestry
- Multi-Year Strategic Plan, 2009/10–2013/14, Department of Water Affairs and Forestry
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2009–2012

Key legislation

- The Constitution of the Republic of South Africa, Act No. 108 of 1996
- The Water Services Act, No. 108 of 1997

Programmes and services provided

Free basic water programme

Table 8.1 Programme/service map: Department of Water Affairs

Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Free basic water programme	<p>The free basic water policy, adopted in July 2001, makes provision for local municipalities to provide, within their capacity, up to a maximum of 6 000 litres of free safe water per household.</p> <p>Municipalities are not obliged to give the full 6 000 litres, but rather what they are able to provide within their means.ⁱ As such, there is great variation between the levels of the benefit between different areas.</p> <p>Access to the benefit is premised on poverty levels within the household.</p>	<p>Poor households for whom free basic services represent a significant poverty alleviation measureⁱⁱ</p> <p>Who qualifies as poor for the purposes of this policy is determined by the local authorities that are responsible for the delivery of the service.</p>	Local municipalities





Municipalities adopt different means tests to determine eligibility of families, based on their local indigent policy. For some, the means test is R2 000 per household and for others R800 per household.

Each consumer who is selected for poverty relief gets a credit on their water account, which would typically be sufficient to cover the charge for the poverty relief amount (maximum of 6 kl per month).

Notes:

(i) and (ii) *Free Basic Water – Implementation Strategy Document, 2001*

Some key policy and service delivery gaps

Insufficient coverage of water and sanitation services

The statistics provided in the *Child Gauge 2009/2010* (Hall & Marera 2010: 130) on children's access to water and sanitation reveal that the free water policy is inadequate to meet the rights of children to basic water and sanitation. In 2008, nearly 7 million children lived in households without access to clean drinking water on site. A higher proportion of children (36%) than adults (27%) lived in households without water on site. There was little improvement in children's access to water on site between 2002 and 2008.

Although children's access to adequate sanitation facilities increased over the same period of time, from 47 per cent to 61 per cent, in 2008 nearly 7 million children still used unventilated pit latrines, buckets or open land, despite the government's goal of providing adequate sanitation to all and eradicating the bucket system (Hall & Marera 2010: 131).

Free basic water programme

The free basic water programme does not prioritise households with children (especially young children), breastfeeding women or households with people living with HIV/AIDS. The governing policy has not been developed around the water needs specific to these vulnerable groups. The maximum free 6 000 litres is in fact not sufficient to meet the needs of people living with HIV/AIDS.⁹⁵

⁹⁵ Affidavit in the High Court of South Africa Witwatersrand Local Division, *Mazibuko v City of Johannesburg*, Case No. 06/13865, www.law.wits.ac.za.

The policy is therefore inadequate to meet the water needs of vulnerable children and their families. This is aggravated by the fact that local governments are only obliged to implement the policy in accordance with their means. This has resulted in some local authorities not providing the full 6 000 litres, but less, leaving vulnerable children and their families at an even greater disadvantage. For example, the South African Human Rights Commission records that a 2005 Department of Provincial and Local Government survey revealed that 49 out of 256 municipalities were not implementing the policy at all. In addition, some municipalities, such as the Ilembe district municipality, were only providing 3 000 litres per family per month. Municipalities cited insufficient funds as the reason for not providing 6 000 litres per family per month, and argued that the equitable shares allocated to them for service delivery were not enough (SAHRC 2006).

No free basic sanitation policy

On the sanitation front, the government has set as a goal the provision of adequate sanitation to all and the elimination of the bucket system.⁹⁶ However, this goal has not yet translated into an implementable free basic sanitation policy. This is a critical policy gap that needs urgent attention, given that:

good sanitation is essential for safe and healthy childhoods. Poor sanitation compromises children's health, safety and nutritional status, and is associated with diarrhoea, cholera, malaria, bilharzias, eye infections and skin disease. The use of open land and the bucket toilets also impacts on water quality and contributes to the spread of disease. (Hall & Marera 2010: 131)

In 2009, 6.6 per cent of South African households had no toilet facilities at all or still used the bucket system. This national average once again hides the provincial variables: the figure is much higher in the Eastern Cape (18.9%), Limpopo (8.8%), Northern Cape (8.7%) and the Free State (7.5%) (Stats SA 2010a: 31).

⁹⁶ White Paper on Basic Household Sanitation, 2001

Department of Energy

Introduction

Neither the international, regional nor national child rights instruments expressly guarantees the right to electricity. All of them do, however, guarantee everyone the right to a healthy environment that promotes and is not harmful to one's health or well-being.⁹⁷ It is arguable that this right includes the right of access to free electricity, especially when read in conjunction with the obligation imposed on the South African state by the Constitution to take 'legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination' (section 9(2)). Based on this provision, the Centre for Applied Legal Studies argues that there should not only be no differential adverse impact on poor consumers, but that 'positive measures [should] be taken to reduce the cost of electricity to those consumers' (CALs, cited in Malzbender 2005).

Key policies and legislation

- Constitution of the Republic of South Africa, Act No. 108 of 1996
- Department of Minerals and Energy, Electricity Basic Services Support Tariff (Free Basic Electricity) Policy for the Republic of South Africa, 2003

Programmes and services provided

Free basic electricity

Table 9.1 Programme/service map: Department of Energy

Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Free basic electricity ⁱ	All households that are connected through the national electrification programme (that are on the grid) receive free basic electricity of 50 kWh per household per month. Off-grid electricity users, that is, households using solar home systems installed through the National Electrification Programme, are	Targeted beneficiaries Households living in poverty However, because of the difficulty of identifying households living in poverty, free basic electricity is provided to all households that are on the grid or off-grid and using solar home systems installed through the National Electrification Programme	Local municipalities



⁹⁷ Section 24(a), South African Constitution, UNCRC, Article 24(2)(c); ACRWC, Article 14(2)(h)



subsidised up to a maximum of 80% (R48 per household) of the monthly service fee.ⁱⁱ The subsidy for off-grid users is paid directly to the service providers, meaning that households only have to make a cash payment of R18 per month.

A household is defined by the Department as 'a residential customer with an official point of electrical supply'.ⁱⁱⁱ

Notes:

(i) DoME (2003)

(ii) and (iii) Free basic electricity, http://www.dme.gov.za/energy/elect_fbe.stm

Some key policy and service delivery gaps

Households not connected to the grid

Many poor households are not connected to the grid, either through electrification or approved solar home systems, meaning that they do not benefit from free basic energy supplies.⁹⁸

The 2009 General Household Survey indicates that 82.6 per cent of households are connected to an electricity supply. However, in the Eastern Cape and Limpopo province, there is still high usage of wood and paraffin as a source of energy (Stats SA 2010a).

Free 50 kWh insufficient

The allocation of free 50 kWh of electricity per month, as per the free basic electricity programme, is premised on the assumption that this is the amount of energy an average household consumes per month, and that it is enough to meet the needs for 'lighting, media access and limited water heating and basic ironing (or basic cooking) for a poor household' (DoME 2003: 9). This is contested by consumer and activist groups who claim that the average monthly household usage is much higher. As a result, the 50 kWh does not meet their needs and poor households are then forced to use firewood and paraffin when they have used up their free basic electricity (Malzbender 2005).

⁹⁸ NGOs to March for Free Basic and Clean Electricity, October 2008, Sangonet pulse, <http://www.ngopulse.org/press-release/ngos-march-free-basic-and-clean-electricity-0>

Solar heating installation costs

The selection criteria used to determine eligibility for installation of a solar heating system excluded those households most in need of solar systems, namely, extremely poor households, from qualifying.

Poorer households could not afford the initial once-off connection fee of R100 and the subsequent service fee of R58 (as FBE [free basic electricity] was introduced only at a later stage). [I]n addition [these families] continued to purchase wood and paraffin, given the limited capacity of SHSs [solar heating systems]. Consequently, they did not qualify for the installation of a SHS and also do not benefit from the FBE policy. Thus, some of the poorest people do not benefit from the FBE policy, thereby limiting the intended poverty reduction effect and constraining the abolishment of inequalities in service delivery. (Malzbender 2005: 16)

Free electricity policy

The free basic electricity policy does not draw a distinction between households of different sizes. All households, regardless of size, receive the same quantity of free electricity. This means that there is 'a disproportionately lower benefit for bigger households. Given the reality that larger households are mostly female headed (often by a pensioner with dependent grandchildren who lost their parents to an Aids related illness), this policy further disadvantages women and the poorest households' (Malzbender 2005: 16).

Department of Human Settlement

Introduction

The right to housing and shelter is protected by the UNCRC (Article 27) and the South African Constitution (sections 26(1), 28). The Department of Human Settlement (DHS) is responsible for the realisation of the right of everyone to have access to adequate housing (section 26(1)) and the right of children to shelter (section 28). The Department is obliged to prioritise the realisation of these rights for people living in poverty.⁹⁹

The National Housing Policy is the state's primary measure to realise the right to housing and is articulated in the following policy and legislative documents.

Key policies

- Policy Framework on Orphans and other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- The National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2006–2008
- Housing White Paper, 1994
- National Housing Code, 2000
- Comprehensive Plan for the Development of Sustainable Human Settlements, 2004

Key legislation

- The Constitution of the Republic of South Africa, Act No. 108 of 1996
- The Housing Act, No. 107 of 1997

Programmes and services provided

- Individual housing subsidy
- Older persons housing subsidy
- Housing subsidy for the disabled
- Consolidation subsidy
- Rural housing subsidy: Informal land rights
- Emergency housing assistance

⁹⁹ Section 2(1)(a), Housing Act, No. 107 of 1997

Table 10.1 Programme/service map: Department of Human Settlement

Programme/ services	Description of the programme/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Government housing subsidy (Individual subsidy)	<p>A government housing subsidy is a grant awarded by the Department to beneficiaries who qualify in accordance with the governing means test.</p> <p>The grant is not paid in cash to the beneficiaries. Instead, it is paid to the seller of the house or paid to a developer constructing new houses. In the latter case, the house must comply with minimum technical and environmental norms and standards. The house is transferred into the name of the beneficiary once it is built.</p> <p>Amount of the subsidy The amount paid for individual subsidies for a 40 square metre house in 2008/09 was:¹</p> <ul style="list-style-type: none"> • for applicants who earn between R0–R1 500 per month = R43 506 • for applicants who earn between R1 501–R3 500 = R41 027 	<p>Targeted beneficiaries Families living in poverty</p> <p>The housing subsidy programme is not targeted at children specifically. The programme is targeted at the household, on the assumption that all individuals in the household living in poverty will benefit. Administrative data suggest that women and children constitute a substantial proportion of beneficiaries of the housing subsidy scheme, despite the fact that there is no clear mechanism to prioritise them (Hall 2005).</p> <p>Qualifying criteria The applicant must:</p> <ul style="list-style-type: none"> • be married/living permanently with another person; or • be unmarried, but heading up a household with children for whom the applicant is financially responsible; and • be 21 years or older, or have acquired majority status through marriage and in all other respects have acquired contractual capacity; and 	<p>Applicants complete and submit an application form to the relevant provincial housing department or municipality for all services and programmes detailed in this table.</p>





Capital contribution

Housing subsidy applicants with an income between R1 501 and R3 500 per month must make a financial contribution of R2 479 upfront to access the housing subsidy scheme. Disabled and/or health-stricken applicants, as well as older people and applicants for a rural subsidy, do not need to make this capital contribution.

- earn less than the means test income threshold. The applicant's gross monthly income must be less than R3 500 per month.

Disqualifying criteria

- Neither the applicant, nor anyone else in the household may have benefited from a housing benefit from the government (except for disabled persons, whose benefits are described below).
- The applicant may not already own a house or have previously owned a house.

Documents that must be submitted when applying (certified copies)

- Proof of income
- The applicant's bar-coded identity document
- The applicant's spouse's identity document
- Birth certificates of all the applicant's children/dependants
- Marriage certificate
- Divorce settlement
- Spouse's death certificate
- Most recent pay slip/ other proof of income
- Agreement of sale to buy the property





		<ul style="list-style-type: none"> • Building contract and approved building plan • Proof of loan granted by a lender
Older person's housing subsidy	<p>Older persons, including those who receive a social grant from the government, who earn more than R1 500 per month, will qualify for an increased subsidy.</p> <p>Amount of the subsidy For older people earning between R1 501–R3 500 per month = R43 506</p> <p>Capital contribution No capital contribution is payable by an older person.</p>	<p>Targeted beneficiaries Older persons = men 65 and over and women 60 and older who earn between R1 501 and R3 500 per month. This includes those who receive a social grant.</p> <p>Documents required</p> <ul style="list-style-type: none"> • The same documents listed under the individual subsidy, plus proof of income received from a social grant, if relevant • A completed application for exemption for capital contribution
Housing subsidy for the disabled	<p>Applicants who are disabled can apply for the individual subsidy and, if they earn more than R1 500 per month, will not have to pay the capital contribution.</p> <p>In addition, applicants with a disability may apply for an increased subsidy to enable them to make additions to their houses to allow for independent living in normal residential areas. This would include concrete aprons and ramps to facilitate access to the house, grab rails in the bathroom, kick plates to the doors, visible doorbells and special access to toilets.</p>	<p>Target beneficiaries People with disabilities</p> <p>Documents required</p> <ul style="list-style-type: none"> • Same as for the individual subsidy • Proof of the relevant disability in the form of a medical certificate from a registered medical practitioner • Proof of income, which includes proof of income from a disability grant • Application for exemption for capital contribution



<p>→ Consolidation subsidy</p>	<p>This is a subsidy paid to applicants who already received assistance from government to acquire a serviced residential site under the pre-1994 housing schemes, to enable them to construct or upgrade a housing structure on the stand.</p> <p>Amount of the subsidy The amount of the subsidy in 2008/09 for a 40 square metre house:ⁱⁱ</p> <ul style="list-style-type: none"> • for applicants who earn between R0–R1 500 per month = R43 506; • for applicants who earn between R1 501–R3 500 = R41 027. <p>Capital contribution Housing subsidy applicants with an income between R1 501 and R3 500 per month must make a financial contribution of R2 479 upfront to access the housing subsidy scheme. Disabled and/or health-stricken applicants, as well as older people and applicants for a rural subsidy, do not need to make this capital contribution.</p>	<p>Targeted beneficiaries Families living in poverty</p>
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→	Rural housing subsidy: Informal land rights	<p>This subsidy is available to people who have been granted functional (as opposed to legal) tenure rights by traditional authorities in respect of the land they occupy.</p> <p>Amount of the subsidy The amount of the subsidy in 2008/09 for a 40 square metre house:ⁱⁱⁱ</p> <ul style="list-style-type: none"> • for applicants who earn between R0–R3 500 per month = R43 506 <p>Capital contribution There is no capital contribution for the rural housing subsidy.</p>	<p>Targeted beneficiaries People living in poverty in rural areas</p> <p>Because women are not granted tenure rights as envisaged, this subsidy is for the benefit largely of rural men.</p>	
	Emergency housing assistance	<p>This programme provides temporary aid in the form of access to land and/or basic municipal services and/or shelter.</p> <p>It is only available in emergency housing situations where there is an exceptional housing need, and it is only temporary.</p>	<p>Targeted beneficiaries For people in an emergency housing situation for reasons beyond their control, where their existing shelter has been destroyed or damaged, their prevailing situation poses an immediate threat to their health, life or safety or where they have been evicted or face imminent eviction</p>	<p>Local municipality</p>

Notes:

(i–iii) <http://www.housing.gov.za/Content/Subsidy%20Information/Subsidies%20Home.btm>

Some key policy and service delivery gaps

Inadequate housing

In 2008, nearly 2.3 million children in South Africa lived in backyard dwellings or shacks in informal settlements (Stats SA 2009, as interpreted by Hall 2010).

Forty per cent of the children living in these forms of inadequate housing are aged between 0–5, an age group which is especially vulnerable to environmental hazards associated with living in shacks and backyard dwellings, such as shack fires and paraffin poisoning.

Sixty-three per cent of children living in informal dwellings also live in overcrowded conditions (with a ratio of more than two people per room).

There are persistent racial inequalities in the demographic patterns associated with access to informal and formal housing: 98 per cent of white children live in formal housing, compared to only 66 per cent of African children.

There has been no substantial change in the distribution of informal, formal and traditional dwellings among children over the last seven years. As Hall observes, this is surprising, given the delivery of 2.5 million houses since the launch of the National Housing Subsidy Scheme in 1994.

Lack of definitions

Neither the term ‘shelter’ nor ‘adequate housing’ is defined in the housing policies in terms of minimum standards (Hall 2005).

There is uncertainty about the exact nature and scope of the obligation on the state to provide adequate housing to the many vulnerable children who live in informal/inadequate housing by virtue of their parents’ poverty. There are two competing interpretations of the scope of the state’s responsibility to provide adequate housing for vulnerable children. On the one hand, there is the conservative interpretation adopted by the Constitutional Court in the *Grootboom* case.¹⁰⁰ The limited view adopted by the Court is that only children who are physically removed from their family environment or who have lost their parents have a direct claim against the state for adequate housing. The implication of this decision is that children living with their families who are unable to afford to provide housing for their children have no direct claim against the state to provide them with housing.

On the other hand, it has been argued that a subsequent decision by the Constitutional Court in the *TAC*¹⁰¹ case expanded the ambit of the state’s responsibility to provide children’s socio-economic rights, such as the right to housing. It is argued that the obligation on the state extends beyond having to provide the socio-economic services to children removed from their families or who have lost their families, to include children who live with their parents, but whose parents are unable to afford to provide and pay

100 *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1), SA 46 (CC) 2000 (11) BCLR 1169 (CC)

101 *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 721 (CC) 2002 (10) BCLR 1033 (CC)

for the relevant services for their children (Coetzee & Streak 2004). The TAC decision is, however, not unequivocal. It was made in the context of access to healthcare, rather than housing or socio-economic rights generally, and until we see a Constitutional Court decision directly on the matter at hand, or new legislation which takes the matter forward, the ambit of the duty to provide poor children with housing remains ambiguous.

Increasing housing shortfall

The housing shortfall continues to grow with population growth, urbanisation and demographic change, resulting in a growing contravention of the rights of vulnerable children and their families to adequate housing and shelter.

The quality of housing that children live in falls into one of three categories (Hall 2005):¹⁰²

- informal housing – informal dwellings/shacks in backyards/informal settlements;
- traditional housing – traditional structures made of traditional materials;
- formal dwellings – adequate housing or dwellings/brick structures on separate stands, flats/apartments, etc.

The number of children in informal housing increased by 300 000 between 2002 and 2008. In addition, there was no improvement in the distribution of children between informal, formal and traditional housing in the same time period (Hall 2009b). This is partly explained by the fact that there has been a dramatic downturn in the pace of delivery of houses to vulnerable people. Hall (2009b) attributes this to a response to the poor quality of houses that were delivered in bulk in the initial stages of the housing programmes. The most recent departmental Annual Report (Department of Housing 2009) alludes to staff shortages and funding shortages preventing the realisation of its mandate. Hall (2005) observes that the subsidy scheme is underfunded and the budgets that are allocated are underspent.

Children in formal housing are more likely to have access to services on site (and thus access to their other socio-economic rights, such as water and sanitation) than those in informal housing. They are also more likely to be close to schools, clinics and libraries.

The current housing policies are failing the most vulnerable. Statistics reveal that the most vulnerable children are the most likely and the most at risk of living in inadequate housing, be it either informal or traditional housing. In addition, there is a racial bias to access to adequate/formal housing. As noted, while 98 per cent of white children live in formal housing, only 66 per cent of African children do (Hall 2009b: 98).

Housing laws

The Housing Act specifically targets marginalised women as intended beneficiaries. Section 2(1)(x) provides that, 'National, provincial and local spheres of government must... promote...the housing needs of marginalised women and other groups disadvantaged by unfair discrimination.'

Despite identifying marginalised women as a particular target group, prioritising single parents (i.e. mostly single mothers) and aiming to reach equal numbers of men and women, the subsidy scheme does not contain explicit mechanisms to ensure that women and single parents are prioritised.

¹⁰² Defined in the General Household Survey 2002–2007

Rural households have not been particularly targeted in the rollout of the subsidy scheme. This is evidenced by the low take-up of the rural subsidies. This may be linked to low levels of awareness of the subsidy and slow implementation by the provincial departments and district municipalities. Furthermore, women are unlikely to benefit from the rural subsidy because it only applies to land that has been traditionally allocated. Women are not likely to be beneficiaries of traditional allocations of land and therefore will not qualify.

This is a particularly problematic gap, given that most of the CSG recipients (in other words, caregivers of children living in poverty) are women in rural areas (Delaney et al. 2008).

Unmarried parents younger than 21

Unmarried parents who are under 21 years are not eligible for the subsidy. This exclusion is most likely to affect young mothers (Hall 2005). Both the national Department of Housing and a provincial department have confirmed that access to the housing subsidy by an unmarried minor would be illegal and contrary to housing policy. As Hall (2005) observes, there is currently a policy gap which leaves young adults between the ages of 18 and 21 entirely unprotected as far as their right to housing and other basic services is concerned. Young adults between the ages of 18 and 21 are neither entitled to the parental care and basic rights to shelter under section 28 of the Constitution, nor do they (or their children) have direct access to the 'adequate housing' provided for in section 26 of the Constitution.

Child-headed households and HIV/AIDS

It is of concern that HIV/AIDS and the prioritisation of the needs of children affected by HIV/AIDS do not feature in the general policy. Despite the fact that the Department's *Comprehensive Plan for Sustainable Human Settlements* (2004) acknowledges the need for holistic planning, HIV/AIDS does not seem to have been integrated into the government's general housing plans at all.

For example, there is no provision in the subsidy scheme for children who are not in the care of adult caregivers. Children cannot on their own access housing assistance, since they are not legally competent to contract. Access to the housing programmes is premised on the child living with an adult caregiver in a traditional nuclear family-type household. The need to protect the right to housing for children who are not living with an adult caregiver is important, given that there is often deterioration in housing conditions following the death of caregivers and since, in most instances, home maintenance is an impossible task for children (Giese, Meintjies et al. 2003).

Waiting lists and corruption

The individual subsidy has been almost entirely discontinued because of corruption and difficulties with waiting lists (Hall 2005).

Lack of access to supporting documents

The inability of poor and vulnerable children and their families to access enabling documents, described in detail earlier in this report, impacts negatively on their ability to apply for subsidies.

Department of Police, South African Police Services and the National Prosecuting Authority

Introduction

The SAPS, the Department of Police (DoP) and the NPA are responsible for the protection of the following rights of vulnerable children and their families:

- the right to be protected from maltreatment, neglect, abuse or degradation and exploitative labour practices;¹⁰³
- the right not to be detained, except as a measure of last resort in which case, only for the shortest appropriate period of time, and separately from persons older than 18, and in a manner that takes into account the age of the child.¹⁰⁴

Section 28 of the Constitution, in line with the ACRWC and the UNCRC, guarantees all children the right to protection from maltreatment, neglect, abuse or degradation. The realisation of this right depends on a range of government departments working together to prevent, investigate, prosecute and minimise the harmful impact on children of acts of maltreatment, neglect, abuse or degradation.

Child abuse, neglect and maltreatment are criminal acts in terms of both common law and the legislative framework. Two of the agencies responsible for the prosecution of cases of child neglect and abuse are the SAPS and the NPA. The mandate for both is not just to investigate, combat and prosecute crimes against children, but to do so through the provision of the relevant services in a manner that is 'sensitive [and] endearing to the child victim'¹⁰⁵ and that reduces secondary victimisation 'within the criminal justice system... and...[by] adopting a victim-centred approach'.¹⁰⁶

The obligations on these two agencies to provide child-sensitive and victim-centred services translate into the duty to:

- provide comprehensive, inter-sectoral and integrated support services to victims of crime to ensure a victim-friendly criminal justice system and to make sure that the negative impacts on victims is reduced (DoSD 2009b);
- provide complainants the maximum and least traumatising protection the law can provide;
- provide protection for complainants from secondary victimisation and trauma by establishing cooperation between departments;
- provide proper recognition of the needs of victims of sexual offences through timely, effective and non-discriminatory investigation and prosecution.¹⁰⁷

103 Section 28(1)(c)(d), South African Constitution; ACRWC, Article 16; UNCRC, Articles 19, 27, 32, 324

104 Section 28(1)(g), South African Constitution; ACRWC, Article 17; UNCRC, Article 37

105 SAPS website: http://www.saps.gov.za/org_profiles/core_function_components/fcs/establish.htm

106 NPA website: <http://www.npa.gov.za/ReadContent412.aspx>

107 Section 2, Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007

In addition to dealing with crimes against children, these two agencies are responsible for investigating and prosecuting crimes committed by children. Their responsibility is not just to police these crimes, but to do so in a manner that protects the constitutional rights of children in conflict with the law.

Key policies

- Service Charter for Victims of Crime in South Africa, 2004
- Minimum Standards on Services for Victims of Crime, 2004
- Policy Framework on Orphans and other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- Integrated Victim Empowerment Policy, 2007, Department of Social Development (4th draft)
- National Policy Guidelines for Victims of Sexual Offences, 2008, Department of Justice
- National Policy Guidelines for Victim Empowerment, 2009 (operational date), Department of Social Development

Key legislation

- Sexual Offences Act, No. 23 of 1957 as amended
- Criminal Procedure Act, No. 51 of 1977
- Prevention of Family Violence Act, No. 133 of 1993
- Constitution of the Republic of South Africa, Act No. 108 of 1996
- Films and Publications Act, No. 65 of 1996
- Domestic Violence Act, No. 116 of 1998
- National Prosecuting Authority Act, No. 32 of 1998
- Children's Act, No. 38 of 2005 as amended by Act No. 41 of 2007 and Act No. 75 of 2008
- Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007 ('the new sexual offences Act')
- SAPS National Instructions, 3/2008
- Child Justice Act, No. 75 of 2008

Programmes and services provided

- Protection, support and investigative services for victims of domestic violence
- Protection, support, investigative and prosecution services for children that are abused, sexually and otherwise
- Thuthuzela Centres
- Protective interventions for children in conflict with the law

Table 11.1 Programme/service map: South African Police Services and the National Prosecuting Authority

Services for victims of domestic violence			
Programme/ services	Description of the programmes/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Services for victims of domestic violence	<p>The Domestic Violence Act 116/1998 requires members of the SAPS to render support services to domestic violence complainants, either at the scene of the incident or as soon as reasonably possible thereafter.</p> <p>The Act requires the police to render 'assistance as may be required in the circumstances, including assisting or making arrangements for the complainant to find a suitable shelter and to obtain medical treatment' (s2(a)).</p> <p>The assistance that must be provided in terms of the Act and accompanying guidelines for the SAPS includes:¹</p> <ul style="list-style-type: none"> • informing the complainants of their rights to apply for a protection order and/or lay a criminal charge; • assisting the complainant in finding alternative accommodation, shelter and counselling; 	<p>Targeted beneficiaries</p> <p>Victims of domestic violence are almost always women and children.ⁱⁱ They are accordingly the primary targeted beneficiaries of the Domestic Violence Act.</p> <p>The Act recognises the vulnerability of children to domestic violence.ⁱⁱⁱ It extends the protective ambit of the Act by including them in the definition of protected 'complainants'.</p> <p>A complainant is defined as (s1(iii)):</p> <p>Any person who is or has been in a domestic relationship with a respondent and who is or has been subjected or allegedly subject to an act of domestic violence, including any child in the care of the complainant.</p> <p>Domestic violence includes (s1(viii)):</p> <ul style="list-style-type: none"> • physical abuse; • sexual abuse; • emotional, verbal and psychological abuse; • economic abuse; • intimidation; • harassment; 	SAPS officers





- collecting personal items from the complainant's residence;
- serving notice on the abuser to appear in court and serving final protection orders;
- arresting an abuser (without a warrant) who has breached a protection order or committed a crime. The SAPS commitment to victims of domestic violence includes an undertaking, in accordance with the Act, to immediately arrest the abuser at the scene of the incident, without a warrant, if there is reason to believe that an act of violence has been committed;
- searching the premises at which the incident has taken place and removing any weapons from the abuser or from the home;
- assisting the complainant to obtain medical treatment;
- ensuring that a medical officer collects and records any medical evidence in support of a criminal charge;
- stalking;
- damage to property;
- entry into the complainant's property without permission;
- or any other controlling or abusive behaviour.





- providing victims with a notice in a language they understand, and explaining how they should proceed;
- taking the victim's statement in privacy and not in the presence of the abuser or the public;
- keeping a copy of the protection order and recording every arrest made as proof for victims.

In addition to the support services that the SAPS must provide for the complainant, the SAPS are also required to investigate cases of domestic violence and refer them to the National Prosecuting Authority for prosecution.

Support and protection services for children who are abused, neglected, exploited and/or subjected to violence

<p>Services for victims of abuse</p>	<p>The SAPS is often the first line of support for children and others who suffer abuse. The services they provide include:</p> <ul style="list-style-type: none"> • accepting criminal complaints; • arresting the perpetrator; • opposing bail if it is in the interests of justice; • investigating the complaint; • gathering evidence; • keeping the victim appraised of progress. 	<p>Targeted beneficiaries</p> <p>Child and adult (especially female) victims of family violence, domestic violence and sexual abuse</p>	<p>Services for children and their families that are the victims of abuse, neglect, violence or exploitation are provided by specialised units within SAPS or specialised staff/police officers employed at station level.</p> <p>These units or personnel (FCS units or officers) deliver specialised family violence, child protection and sexual offences services.</p>
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			The FCS units/officers have been established to prevent and combat crimes against children and adult victims of family violence and sexual offences. ^{iv}
The duty to report cases of sexual abuse, physical abuse, neglect or exploitation of children, and children who are in need of care and protection, to the SAPS	<p>Section 110(1) of the Children’s Act imposes an obligation on a number of professionals that come into contact with children, such as doctors, labour inspectors, legal practitioners, midwives, nurses, teachers, etc., who on reasonable grounds conclude that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report the abuse to, inter alia, a police official.</p> <p>Section 110(2) of the same Act authorises any person who believes a child to be in need of care and protection to report this to, inter alia, a police official.</p> <p>In addition, section 141(1) of the Children’s Act requires any social worker or social service professional that becomes aware of any person procuring a child for slavery or forced or compulsory</p>	<p>Targeted beneficiaries</p> <p>Children that are abused</p> <p>The Children’s Act defines abuse as ‘any form of harm or ill-treatment deliberately inflicted on a child, and includes (a) assaulting a child or inflicting any other form of deliberate injury to a child; (b) sexually abusing a child or allowing a child to be sexually abused; (c) bullying by another child; (d) a labour practice that exploits a child; or (e) exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally’ (s1).</p> <p>Children that are deliberately neglected</p> <p>The Children’s Act defines neglect as ‘a failure in the exercise of parental responsibilities to provide for the child’s basic physical, intellectual, emotional or social needs’ (definition section).</p>	Professionals that come into contact with and are responsible for the well-being, health and development of children have a duty to report abuse and neglect of children.





labour, employing a child for the purposes of commercial sexual exploitation, using a child for trafficking, or using a child for the commission of an offence listed in Schedule 1 or 2 of the Criminal Procedure Act 51/1977, to report the matter to a police official.

Section 4 of the Prevention of Family Violence Act 133/1993 requires any person who examines, treats, attends to, advises, instructs or cares for any child who suspects that the child has been abused, to report this to, inter alia, a police official.

Section 54(1) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32/2007 imposes a mandatory duty on any person who has knowledge of a sex offence against a child to report it to the police. Failure to do so is a criminal offence.

The Children's Act requires the police official to whom a report is made in terms of the Act (or any of the other Acts, by implication), or who

Children that are exploited

The Children's Act defines exploitation as '(a) all forms of slavery or practices similar to slavery, including debt bondage or forced marriage; (b) sexual exploitation; (c) servitude; (d) forced labour or services; (e) child labour prohibited by the Act; (f) the removal of body parts' (s1).

Children in need of care and protection

Section 150(1) of the Children's Act defines a child in need of care and protection as a child that (1) has been abandoned, (2) displays behaviour which cannot be controlled by the parent or caregiver, (3) lives or works on the streets or begs for a living, (4) is addicted to drugs or alcohol and is without support to obtain treatment, (5) is exploited or exposed to exploitation, (6) may be at risk if returned to the custody of its parents or caregivers because that return will expose him or her to risk of serious harm, (7) is physically or mentally neglected, (8) is being maltreated abused, neglected or





becomes aware of a child in need of care and protection, to:

- ensure the safety and well-being of the child if the child's safety or well-being is at risk. The police official may, in terms of the Children's Act (s151, 152), remove the child from his or her place of residence and place the child in temporary safe care, with or without a court order, if the police official believes, on reasonable grounds, that the child is in need of care and protection and needs immediate emergency protection;
- within 24 hours, report the matter of abuse, neglect or other circumstances relating to the child in need of care and protection to the provincial DoSD or a designated child protection organisation, as well as any steps that have been taken with regard to the child.^v

degraded by a parent or caregiver.

Section 150(2) further provides that the following children *may* be in need of care and protection: a child that is a victim of child labour, and a child in a child-headed household.

Children that are victims of sexual abuse and other sexual offences

Section 1 of the Children's Act defines sexual abuse in relation to a child as (a) sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted, (b) encouraging, inducing or forcing a child to be used for the sexual gratification of another person, (c) using a child in or deliberately exposing a child to sexual activities or pornography, (d) procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.

The Films and Publications Act 65/1996 makes the





creation, production, possession or distribution of child pornography an offence.

The new Sexual Offences Act criminalises the following sexual offences against children: rape (which is now more broadly defined than at common law to include all acts of sexual penetration without consent by and/or against males and females); sexual (indecent) assault, which is defined as unlawful sexual violation that does not involve sexual penetration, such as kissing and touching; incest; consensual sex with all children (statutory rape) (s15); sexual exploitation (s17) of a child which involves engaging the services of a child for reward for the purposes of sexual acts; sexual grooming (s18) of a child, which includes exposing a child to pornography or any other item with the intent to encourage the child to perform a sex act, and committing any act with the intent to encourage or diminish





a child's resistance to performing a sex act; using a child for pornography (s20); and compelling a child to witness a sex act or displaying genitals to a child ('flashing') (s21).

Investigation and policing of cases of child abuse, neglect, exploitation and sexual abuse

The SAPS must receive and act on reports and complaints of child abuse, deliberate neglect, exploitation and sexual abuse by officials, as prescribed by law or reported by a child or on behalf of a child.

Targeted beneficiaries

The CPU's and FCS's role is to receive complaints of and investigate the following crimes against children (victims under the age of 18):^{vi}

- rape;
- incest;
- indecent assault;
- attempted murder;
- assault with intention to do grievous bodily harm;
- common assault (only if there are three consecutive inter-family incidents);
- kidnapping;
- abduction;
- crimes with regards to the abuse and exploitation of children under the Prevention of Family Violence Act;
- crimes against children under the Domestic Violence Act;
- crimes with regards to the sexual exploitation of children under the Sexual Offences Act;

FCS units/officers within the SAPS





- crimes of abuse, deliberate neglect and exploitation under the Children’s Act and the Children’s Amendment Act;
- crimes of child pornography in terms of the Films and Publications Act.

Protection and support services for children who are victims of sexual offences and exploitation

The new Sexual Offences Act together with the National Instructions 3/2008 on Sexual Offences make provision for a number of support services to be provided by the SAPS for victims of sexual offences.

When a victim reports a sexual offence, the police official must: take the victim’s statement in a private space; provide reassurance to the victim of his or her safety; determine if the victim requires medical assistance and, if so, make arrangements for him or her to obtain it; ask the victim if they would like another person present; record the victim’s statement in writing; be mindful of the victim’s emotions when taking the statement; and open a docket and register it.^{vii}

Targeted beneficiaries
Children younger than 18 who are victims of sexual offences as defined in the previous rows

Ideally the FCS officers/units within SAPS, failing which, any police official





The police official must also advise victims, when laying a charge, of: their right in terms of section 28 of the New Sexual Offences Act to receive PEP at health facilities at the expense of the state and of the importance of obtaining PEP;^{viii} their right to apply to a magistrate for compulsory testing of the alleged offender;^{ix} and the importance of and need to obtain medical advice and assistance for other sexually transmitted infections other than HIV/AIDS.^x

The National Instructions for Sexual Offences includes 'Guidelines relating to the taking of a statement of a child victim'. In terms of these guidelines, the police official taking a child victim's statement must:

- determine, before taking the sworn statement, that the child understands the oath or affirmation. It is generally accepted that children younger than 12 cannot understand the oath and therefore cannot give a sworn statement;





- if the child is very young (younger than seven) and cannot write their names, but can give an account of what happened, the police official who interviews the child must make a statement of the interview conducted with the child.

Victims of sexual offences must undergo a medical examination, even if the offence took place more than 72 hours before reporting the crime and even if the victim has already washed.^{xi} The police official must inform the parents/guardians of a child victim that they may accompany the child during their medical examination. If a parent/guardian of a child victim cannot be found or withholds consent for the medical examination, the police official must apply to a magistrate, in terms of section 335B of the Criminal Procedure Act, for consent to conduct the medical examination.^{xii}

The police official must provide the victim with a list of health facilities that provide PEP^{xiii} and must provide the victim with information about



→	local organisations that are willing and able to provide counselling and other support services. ^{xiv}		
The specialised prosecution of acts of domestic violence and sexual offences against, especially, women and children	<p>The National Director of Public Prosecutions is vested with the power to prosecute alleged perpetrators of criminal activities.^{xv}</p> <p>The Sexual Offences and Community Affairs Unit within the NPA is a specialised unit responsible for the prosecution of sexual offences and domestic violence against women and children.^{xvi}</p>	Targeted beneficiaries Women and children who are victims of sexual offences and domestic violence	Sexual Offences and Community Affairs Unit of the NPA
Thuthuzela Centres	<p>Thuthuzela Care Centres are one-stop facilities that have been established under the leadership of the NPA's Sexual Offences and Community Affairs Unit. They are, however, facilitated by multiple partners, including the departments of Justice, Health, Education, Treasury, Correctional Services, SAPS, Social Development and designated civil society organisations.</p> <p>They are multi-purpose 'one-stop' integrated centres of care and support for victims of sexual abuse.</p> <p>They are primarily donor funded and there are 17 centres in South Africa.^{xvii}</p>	Targeted beneficiaries Victims of sexual assault	The centres are established under the leadership of the NPA's Sexual Offences and Community Affairs Unit. They are, however, run and services are provided by a range of collaborating partners, including the departments of Justice, Health, Education, Treasury, Correctional Services, SAPS, Social Development and designated civil society organisations.





The aim of the centres is to reduce secondary victimisation, improve conviction rates and reduce the cycle time for finalisation of cases.

Most of the sites are linked to public hospitals close to communities where the incidence of rape is especially high. Services offered at the centres include:^{xviii}

- welcome and comfort from a site coordinator or nurse;
- an explanation of how the medical examination will be conducted and what clothing may be taken for evidence;
- a consent form is provided and explained to allow the doctor to conduct the medical examination;
- after the medical examination, a bath or shower is available for the victim to use;
- an investigation officer will interview the survivor and take his or her statement;
- a social worker or nurse will offer counselling;
- a nurse arranges for follow-up visits, treatment and medication for sexually transmitted infections, including HIV/AIDS;





- a referral letter or appointment will be made for long-term counselling;
- the victim is offered transport home;
- arrangements are made for the victim to go to a place of safety if necessary;
- consultations with a specialist prosecutor take place before the case goes to court;
- court preparation is done by a victim assistant officer;
- an explanation of the outcome and update of the trial process is given by a case manager.

Children in conflict with the law

Children younger than 10 years of age in conflict with the law

Children younger than 10 years of age lack criminal capacity. If they commit or are suspected of having committed a criminal act, they may not be arrested or prosecuted. If they are suspected of committing a crime, the police officer must take the child to a probation officer.

Interventions that are applied are welfare, educational or non-punitive measures, rather than criminal sanctions.

Targeted beneficiaries
Children in conflict with the law under the age of 10^{xix}

A probation officer is defined as a person who has been appointed as a probation officer under section 2 of the Probation Services Act 116/1991.

At the moment probation officers are qualified social workers.



→	Arresting and securing the attendance in court of a child in conflict with the law between the ages of 10–18	<p>In terms of the Criminal Procedure Act and the Child Justice Act,^{xx} when a child between the ages of 10 and 18 is suspected of having committed a crime, a police official must secure the child's presence in court in one of three ways.</p> <ul style="list-style-type: none"> • The first way, which is the preferred legislative option, is for the police official to issue the child with a written notice and, where possible, to issue the notice to the child in the presence of the child's parent, legal guardian or appropriate adult (Gallinetti 2009). • A summons is the second form that may be used to inform the child that he or she has been charged and to inform him or her when to appear in court. As in the case of the written notice, it is preferable that the summons be served on the child in the presence of the child's parent or caregiver. • The third means of securing the child's attendance is to arrest the child. However, the Act discourages 	Targeted beneficiaries All children suspected of having committed a crime between the ages of 10 and 18	SAPS	→
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the use of arrest. It prohibits the use of arrest for schedule 1 offences (not very serious offences) unless there are compelling reasons to justify the arrest (Gallinetti 2009).

In addition, if a child is arrested, the police official must:

- notify the child's parent, guardian or appropriate adult of the arrest;
- inform a probation officer of the arrest;
- within 48 hours of arresting the child, take the child to the relevant magistrate's court.

Notes:

(i) These obligations are prescribed by Act 116/1998 and are included in the 'Commitment of SAPS to victims of domestic violence' recorded on the SAPS website: http://www.saps.gov.za/crime_prevention/women/domestic_violence.htm.

(ii) SAPS website: http://www.saps.gov.za/docs_publs/legislation/dom_violence/dom_violence.htm

(iii) RAPAN (2009) points out that children can experience domestic violence as direct recipients of the abuse or they can experience the violence vicariously.

(iv) SAPS website: http://www.saps.gov.za/org_profiles/core_function_components/fcs/establish.htm

(v) Section 110(4)(a)(b), Act 41/2007

(vi) SAPS website: http://www.saps.gov.za/org_profiles/core_function_components/fcs/establish.htm

(vii) Section 5, National Instructions 3/2008

(viii) For further information about the right to PEP for victims of sexual offences, refer to Chapter 4.

(ix) For further information about the right to apply to a magistrate for the compulsory testing of the alleged offender, refer to Chapter 12.

(x) Section 28(3), Act 32/2007

(xi) Section 10, National Instructions 3/2008

(xii) Section 5, National Instructions 3/2008

(xiii) Section 28(a), Act 32/2007

(xiv) Section 3, National Instructions 3/2008

(xv) The NPA is established in terms of section 179(1) of the Constitution of the Republic of South Africa and derives its prosecuting powers from the National Prosecuting Act 32/1998.

(xvi) NPA website: <http://www.npa.gov.za/ReadContent412.aspx>

(xvii) Details of the location and contact details of Thuthuzela centres can be found on the NPA website: <http://www.npa.org.za> or on the UNICEF website: http://www.unicef.org/southafrica/biv_aids_998.html

(xviii) Thuthuzela: Turning Victims into Survivors, NPA, p7

(xix) Section 7(1) of the Child Justice Act 75/2008 sets the minimum age of criminal capacity at 10 years. This means that children under the age of 10 cannot be prosecuted.

(xx) Criminal Procedure Act 51/1977 and the Child Justice Act 75/2008

Some key policy and service delivery gaps

Violence against children

Violence against children in South Africa is widespread. In 2008/09, SAPS recorded a total of 48 732 (reported) crimes against children. The crimes reported included murder (843), attempted murder (782), sexual offences (20 141), common assault (14 544) and assault with intent to do grievous bodily harm (12 422) (SAPS 2009).

Although the statistics that are available are incomplete, reports from SAPS suggest that in 2008/09, 4 034 cases of neglect and ill-treatment and 2 535 cases of child abduction were reported.¹⁰⁸

It must be stressed that the figures listed above do not reflect the full extent of crimes against children in South Africa, given that most crimes go unreported and that there is no consolidated and reliable data-capturing and information management system for child protection cases and issues in South Africa (Chames et al. 2010). In 2005, the Children's Institute at the University of Cape Town estimated that between 400 000 and 500 000 children are sexually abused each year (Jacobs et al. 2005, in Chames et al. 2010).

Inadequate victim empowerment services

Victim empowerment comprises a number of interventions intended to empower the victim 'to deal with the consequences of the criminal act perpetrated against him or her, to leave it behind and suffer no further loss or damage' (DoSD 2009b: 3). Victim support is the 'empathetic, person-centred assistance rendered by an organization or individual following an incident of victimization' (DoSD 2009b: 3). The interventions and services that make up victim empowerment and support programmes are offered by a range of role-players, both governmental and non-governmental.

However, services are inadequate and inequitable and victims do not access the same services throughout the country, especially in poor communities and rural areas. The disintegrated and uncoordinated approach to service delivery within and across sectors contributes to secondary victimisation (DoSD 2009b).

Secondary victimisation

The protection and support services provided by SAPS for victims of domestic violence are inadequate to realise the vision of the victim empowerment framework to provide services that are 'sensitive [and] endearing to the child victim'¹⁰⁹ and that reduce secondary victimisation '[by] adopting a victim-centred approach'.¹¹⁰

Inadequacies include the fact that the legislative mandate for the SAPS (or any other service provider) does not compel the provision of counselling for victims of abuse. The obligations relating to counselling are voluntary, depending on availability and knowledge on the part of the police official of available services (RAPCAN 2009).

Furthermore, although the Act recognises the vulnerability of children and the need to protect them from domestic violence, the services provided by the Act fail to adequately

108 Crime Information Management, 2008/09, SAPS

109 SAPS website: http://www.saps.gov.za/org_profiles/core_function_components/fcs/establish.htm

110 NPA website: <http://www.npa.gov.za/ReadContent412.aspx>

recognise and respond to children's needs (RAPCAN 2009). In consequence, the services provided by the Act are underutilised by children. Lisa Vetten (2009) reveals that in 48–69 per cent of reported cases of domestic violence, the complainant refers to abuse of others, and in most cases these are children. Despite the significant exposure of children to domestic violence, almost no complaints are made or protection orders sought in terms of the Act, directly by or on behalf of children (Vetten 2009).

The attitudes of many police officers constitute a barrier to access to the protection services afforded by the Domestic Violence Act. Police officers are reluctant to exercise the wide protective powers of arrest afforded to them by the Act. The reluctance is premised on a widespread perception among police officers that domestic violence is a 'family matter' which they have no right to involve themselves in (Legal Resources Centre & POWA 2009).

Despite the clear directive to police officers in terms of the Act and the undertakings made by the SAPS to victims of domestic violence, many police officers do not provide the necessary and prescribed services. This includes a failure in many cases to investigate telephonic reports of domestic violence, as required, by sending out a police van; a failure to assist with the service of court papers on the accused; a failure to refer complainants to shelters or organisations that can assist them; a failure to assist complainants to obtain medical assistance or to provide them with the necessary forms for completion by a registered medical practitioner in the case of a criminal case being opened.

The reasons for these multiple failures include a lack of knowledge of their obligations by police officers; a lack of training related to domestic violence services; lack of sufficient resources, such as police vans and staff; lack of sufficient budget for the implementation of the Act; and the deprioritisation of domestic violence cases by police officers, who regard other criminal matters as being of greater urgency (Legal Resources Centre & POWA 2009; RAPCAN 2009).

Child protection police services weakened

The specialised family violence, child protection and sexual offences (FCS) services provided by the FCS units have been weakened by the restructuring of these units undertaken by SAPS in 2006. The restructuring process saw the decentralisation of these services from dedicated units which existed at area level downwards to station level. In essence, this amounted to the dissolution of the units. The rationale behind this move was explained as follows by the SAPS:

The abuse and violation of women and children takes place in a policing precinct. The first place where a sexual offence against a child is reported is at a police station. Currently FCS Units are not based at police stations, but at separate offices a distance apart with a single unit often serving a total of 28 police stations. The police officials at these units are sometimes not readily available after hours and over weekends which can result in a child-victim and his or her parents waiting up to two to three days for expert assistance from the police. (in Frank et al. 2008: 60)

The restructuring process has spread the services more widely, but has at the same time weakened the FCS services provided by the SAPS (Frank et al. 2008). The restructuring has resulted in, *inter alia*, the placement at station level of police officers to deal with child protection and family violence who are not suitably qualified to provide these services, who are not suitably experienced, who did not undergo specialised screening for suitability, and who do not have some of the basic requirements, such as a driver's licence.

Department of Justice and Constitutional Development

Introduction

The rights of vulnerable children and their families that the Department of Justice and Constitutional Development (DoJCD) is primarily responsible for include the rights:

- to family care, parental care or appropriate alternative care;¹¹¹
- to be protected from maltreatment, neglect, abuse or degradation and exploitative labour practices;¹¹²
- not to be detained, except as a measure of last resort, in which case, only for the shortest appropriate period of time, and separately from persons older than 18, and in a manner that takes into account the age of the child.¹¹³

The Department has identified the need, within its current expenditure framework, to prioritise the realisation of these and other rights, especially in vulnerable communities. The Department aims to build courts and provide all required justice services to disenfranchised communities, especially for people living in townships and rural areas (DoJCD 2009).

Key policies

- Policy Framework on Orphans and other Children Made Vulnerable by HIV and AIDS South Africa, 2005
- HIV & AIDS and STI National Strategic Plan, 2007–2011
- National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa, 2009–2012
- Medium Term Strategic Framework 2009/10, Department of Justice and Constitutional Development
- The National Policy Framework for Child Justice, May 2010, Department of Justice and Constitutional Development

Key legislation

- Constitution of the Republic of South Africa, Act No. 108 of 1996
- Criminal Procedure Act, No. 51 of 1977
- Child Care Act, No. 74 of 1983
- Domestic Violence Act, No. 116 of 1998
- The Children's Act, No. 38 of 2005 as amended by Act No. 41 of 2007 and Act No. 75 of 2008
- Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007 ('the new sexual offences Act')
- Child Justice Act, No. 75 of 2008

111 Section 28(1)(b), South African Constitution; ACRWC, Article 19; UNCRC, Articles 18, 20

112 Section 28(1)(c)(d), South African Constitution; ACRWC, Article 16; UNCRC, Articles 19, 27, 32, 34

113 Section 28(1)(g), South African Constitution; ACRWC, Article 17; UNCRC, Article 37

Programmes and services provided

- Protection services for children in need of care and protection
- Protection services for children who are victims of domestic violence
- Protection services for children who are victims of sexual offences
- Services for children in conflict with the law

Table 12.1 Programme/service map: Department of Justice and Constitutional Development

Protection services for children in need of care and protection			
Programme/ services	Description of the programme/actual service provided	Targeted beneficiaries/ qualifying criteria/how to obtain the service	Delivery mechanism/ service providers
Children's courts' adjudication of matters pertaining to protection services for vulnerable children	<p>The Children's Court plays a central role in the delivery of child protection programmes and services regulated by the Children's Act.</p> <p>Working together with the designated social worker and guided by, inter alia, the social worker's report(s), the Court may consider and make a ruling in matters involving:ⁱ</p> <ul style="list-style-type: none"> • the protection and well-being of a child; • the care of or contact with a child; • support of a child; • the provision of ECD services or prevention or early intervention services; • maltreatment, abuse, neglect, degradation or exploitation of a child; • temporary safe care of a child; • alternative care of a child; • adoption; 	<p>Targeted beneficiaries</p> <p>Children in need of care and protection because they:</p> <ul style="list-style-type: none"> • have been abandoned or orphaned and are without visible means of support; • display behaviour that cannot be controlled by the parent/caregiver; • live or work on the streets or beg for a living; • are addicted to a dependence-producing substance and are without support to obtain treatment; • are exploited; • are exposed to circumstances that may seriously harm their physical, mental or social well-being; • are physically or mentally neglected; • are being maltreated, abused, neglected or degraded by a parent or caregiver; 	<p>Children's courts</p> <p>Every magistrate's court will be a children's court and will have jurisdiction on any matter governed by the Children's Act, 2005, and the Children's Amendment Act, 2007.ⁱⁱ</p> <p>Every magistrate will be a presiding officer of a children's court.ⁱⁱⁱ</p>





- placement of a child in a child and youth care centre, a partial care facility or a shelter or drop-in centre, or any other similar facility;
- any other matter relating to the care, protection or well-being of a child provided for in the Act.
- are victims of child labour;
- are living in a child-headed household.

The Children's Court is responsible for deciding whether a child is a child in need of care and protection, as defined by the Children's Act (s155).

Orders that the Children's Court may make for a child in need of care and protection or who is otherwise in need of protection services include:^{iv}

- an alternative care order, including placement of the child in foster care, placement of the child in a child and youth care centre, or placement of the child in temporary safe care;
- an order placing a child in a child-headed household in the care of the child heading the household, under the supervision of an adult;





- an adoption order;
- a partial care order;
- an order placing the child and/or parent under the supervision of a social worker;
- an order compelling the child's parent/caregiver to be subjected to early intervention services or a family preservation programme;
- a child protection order, ordering a child to be returned to or released from the care of a person; consenting to medical treatment for the child; instructing a parent/caregiver to undergo counselling and/or an assessment, etc.; instructing a hospital to retain a child reasonably suspected of having been abused; person to undergo rehabilitation or a skills development programme deemed necessary for the well-being of the child in their care; instructing an organ of state to assist a child to obtain access to a public service to which he or she is entitled;





interdicting a person from having access to or limiting access by a person to a child.

The nature and consequences of these orders are dealt with in detail in Chapter 3, which examines the responsibility of the DoSD in making the facilities and resources available to accommodate children in the alternative care ordered and to provide the care and protections services contemplated by the relevant court order.

Protection services for children who are victims of domestic violence

<p>Protection orders for victims of domestic violence</p>	<p>In terms of the Domestic Violence Act 116/1998, a victim of domestic violence (including a child) may approach the nearest magistrate's court and apply for either an interim or a final protection order.</p> <p>A protection order is an order issued by the court ordering the person with whom the complainant has a domestic relationship, who is accused of abusing the complainant, to stop the abuse.^v</p>	<p>Targeted beneficiaries The Domestic Violence Act recognises the vulnerability of children to domestic violence.^{vi} It extends the protective ambit of the Act by including them in the definition of protected 'complainants'.</p> <p>A complainant is defined as (s1(iii)), 'Any person who is or has been in a domestic relationship with a respondent and who is or has been subjected or allegedly subject to an act of domestic violence, including any child in the care of the complainant.'</p>	<p>All magistrate's courts</p>
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→	<p>An interim order is a temporary restraining order which provides a date on which the complainant and the alleged abuser must return to court for the magistrate to decide if the final protection order should be granted.</p>	<p>Domestic violence includes (s1(xiii)):</p> <ul style="list-style-type: none"> • physical abuse; • sexual abuse; • emotional, verbal and psychological abuse; • economic abuse; • intimidation; • harassment; • stalking; • damage to property; • entry into the complainant's property without permission; • or any other controlling or abusive behaviour.
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Protection services for children who are victims of sexual offences

<p>Compulsory testing of alleged sexual offender's HIV status and disclosure of the results</p>	<p>Section 30 of the new Sexual Offences Act entitles either the victim of a sexual offence or a person acting on behalf of a victim, to apply to a magistrate within 90 days of the offence for an order that the alleged offender undergo an HIV test and that the results of the test be disclosed to the victim.</p>	<p>Targeted beneficiaries Victims of sexual offences</p>	<p>Magistrate's courts</p>
<p>Protective measures for victims of sexual offences when they appear in court</p>	<p>The Criminal Procedure Act and the new Sexual Offences Act create special procedures for the manner in which victims of sexual assault and child victims are able to give evidence in court so as to minimise their levels of anxiety and fear.</p>	<p>Targeted beneficiaries Child victims of sexual offences</p>	<p>The trial court Specialised sexual offences courts have been established at some regional courts. By March 2007, there were 59 sexual offences courts (Waterhouse 2008: 25).</p>





The three procedures that the court may, on application, permit are:

- allowing a child witness under the age of 18 to testify outside of the courtroom via a third person (intermediary). The child is linked to the courtroom via closed circuit television and testifies through the intermediary;^{vii}
- allowing a child (or adult) to testify directly via closed circuit television without an intermediary;^{viii}
- where a witness is under the age of 18, the court may order the hearing to be held in camera. This means that no other person, other than the child witness/victim and his or her parents/guardian may be present during the court proceedings.^{ix}

These provisions potentially protect the child from enduring further psychological stress caused by testifying in front of the accused and can protect the child's rights to privacy and dignity (Waterhouse 2008).



→ Programmes/services for children in conflict with the law			
<p>The criminal capacity of children aged between 10 and 14 must be determined by the presiding officer, based on a probation officer's assessment</p>	<p>Once a child between the ages of 10 and 14 has been arrested and referred to a probation officer by a police official, the probation officer must make an assessment of the criminal capacity of the child and make recommendations to the court regarding the child's criminal capacity.^x</p> <p>The presiding officer of the child justice court must make a ruling on the child's criminal capacity, having regard to the probation officer's report.</p>	<p>Targeted beneficiaries Children between the ages of 10 and 14 who have committed a crime and who lack criminal capacity (based on an assessment of factors such as their educational level, their cognitive ability, their domestic and environmental circumstances, their age and maturity)</p>	<p>The presiding officer is the inquiry magistrate or judicial officer presiding at the child justice court.</p> <p>A 'child justice court' means any court dealing with a bail application, plea, trial or sentencing of a child.</p> <p>The child justice court is not a separate court. It is any court that deals with a child accused of committing a crime and which applies the Child Justice Act to the case at hand (Gallinetti 2009).</p>
<p>The child may be diverted by the prosecutor or the magistrate before the trial, or during the trial in the child justice court</p>	<p>'One of the main principles of the Act is to minimise children's contact with the criminal justice system, and to use detention only as a measure of last resort and for the shortest appropriate period of time.'^{xi}</p> <p>Diversion is a key intervention provided for by the Act to realise this objective. Diversion involves 'the referral of cases away from the formal criminal court procedures' (Gallinetti 2009: 66).</p>	<p>Targeted beneficiaries Children aged 10–18 accused of committing a crime</p>	<p>The prosecutor or the magistrate presiding over a preliminary inquiry or the presiding officer of the child justice court</p>





The diversion options include:^{xii}

- an oral or written apology;
- formal caution, with or without conditions;
- placement under a supervision and guidance order, reporting order, compulsory school attendance order, family time order, peer association order, good behaviour order, an order prohibiting a child from frequenting certain places;
- referral to counselling or therapy;
- compulsory attendance of vocational, educational or therapeutic programmes;
- symbolic restitution;
- community service;
- payment of compensation;
- placement under the supervision of a probation officer, subject to conditions.



<p>→ A child justice court conducts the child justice proceedings</p>	<p>The child justice court is the forum where the child's trial takes place.</p> <p>Section 65 of the Child Justice Act requires that the child's parent, guardian or an appropriate adult attend the trial proceedings.</p> <p>The duties of the presiding officer are (Gallinetti 2009):</p> <ul style="list-style-type: none"> • to inform the child of the nature of the allegations against him or her; • to inform the child of his or her rights; • to ensure the best interests of the child are upheld, including ensuring the proceedings are fair, not unduly hostile towards the child and are appropriate to the age and understanding of the child; • if the child is a child in need of care and protection in terms of the Children's Act 38/2005, the presiding officer may refer the matter to the children's court. 	<p>Targeted beneficiaries</p> <p>Children aged 10–18 accused of committing a crime</p>	<p>Child justice court</p> <p>While the child justice court is the forum where the trial takes place, the National Policy Framework for Child Justice requires and regulates a coordinated and cooperative approach by all government departments, organs of state and institutions in matters related to child justice. The Framework provides guidance on the implementation and administration of the Act, and promotes cooperation and communication with the NGO sector and civil society.</p> <p>The Framework details the roles and responsibilities of the South African Police, the Department of Social Development, the National Prosecuting Authority, the Department of Correctional Services (DCS), Legal Aid South Africa, the Department of Home Affairs, the Department of Health and NGOs.</p>
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→	Sentencing	<p>‘The Act creates an effective sentencing framework for children to give effect to the constitutional mandate that detention of children should be a last resort and for the shortest appropriate period of time.’^{xiii}</p> <p>The Child Justice Act provides a number of sentence options for children that are found guilty of committing a crime, including:</p> <ul style="list-style-type: none"> • community-based sentences, including diversion options; • restorative justice sentences; • correctional supervision for children older than 14 (which involves a period of imprisonment). Children under the age of 14 may not be imprisoned; • suspended sentences; • sentences to a child and youth care centre or prison. 	Targeted beneficiaries	<p>Children aged 10–18 convicted of a crime</p> <p>The presiding officer decides on the appropriate sentence, but must do so after having considered the probation officer’s pre-sentence report, which must make a recommendation regarding sentencing.^{xiv}</p>
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→	<p>One-Stop Child Justice Centres</p> <p>The Child Justice Act makes provision for the establishment of these centres.</p> <p>The intention is that these centres will bring all services required by a child in conflict with the law under one roof.</p> <p>They have not yet been established and will have to be incrementally realised in accordance with funding constraints and available resources.^{xv}</p>	<p>Targeted beneficiaries</p> <p>Children in conflict with the law</p>	<p>Centres are to be managed by a committee of senior officials from the DoJCD, DoSD, DCS, SAPS, Legal Aid South Africa and any other relevant organ of state and must be resourced and serviced by those departments.^{xvi}</p>
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Notes:

(i) Section 45, Children's Act. The orders that the Children's Court may make in terms of the Children's Act are more expansive than the orders it was able to make in terms of the Child Care Act. The orders it was authorised to make in terms of the Child Care Act were limited to placement orders in alternative care, orders for the removal and temporary detention of a child, a contribution order, and an adoption order. This jurisdiction is increased by the Children's Act to include: the holding of inquiries and issuing of the range of orders listed above for children in need of care and protection, plus a range of orders for children who are not necessarily in need of care and protection, relating to parental rights and responsibilities, parenting plans, care and contact, paternity of a child, support of a child, and consent to medical treatment or operations.

(ii) Section 46, Children's Act

(iii) Section 42, Children's Act

(iv) In the past, the magistrate presiding over a matter in terms of the current Child Care Act was called a 'commissioner of child welfare'. Since the Children's Act became operational, they are called 'presiding officers'.

(v) SAPS website: http://www.saps.gov.za/crime_prevention/women/domestic_violence.htm

(vi) RAPCAN (2009) points out that children can experience domestic violence as direct recipients of the abuse or they can experience the violence vicariously.

(vii) Section 170A, Criminal Procedure Act

(viii) Section 158, Criminal Procedure Act

(ix) Section 153, Criminal Procedure Act

(x) Section 40(1)(f), Child Justice Act

(xi) National Policy Framework for Child Justice, 2010: 4

(xii) Section 53, Child Justice Act

(xiii) National Policy Framework, 2010: 11

(xiv) Section 71(1), Child Justice Act

(xv) National Policy Framework, 2010: 13

(xvi) National Policy Framework, 2010: 13

Some key policy and service delivery gaps

Children and the juvenile justice system

An integrated system for collecting and managing data on children's contact with the juvenile justice system is lacking in South Africa (Presidency 2009: 117). Remedying this deficiency is prioritised by the National Policy Framework for the Child Justice Act, which includes guidelines for the establishment of an integrated information management system to 'enable effective monitoring, analysis of trends and interventions, to map the flow of children through the child justice system and to provide quantitative and qualitative data' (DoJCD 2010: 7). The data that are available, albeit insufficient, do indicate that

children's rights not to be detained – except as a measure of last resort, in which case only for the shortest appropriate period of time, separately from persons older than 18, and in a manner that takes into account the age of the child – have not enjoyed sufficient protection up until now. However, the picture does seem to be improving, with an ever-growing recognition of the value of diverting children away from the mainstream criminal justice system.

Available data suggest that between 9 000 and 13 000 children are arrested monthly by the SAPS. In 2007, 1 166 unsentenced children were in prison; an improvement on the 2 934 children in 2005. The length of time that children are detained, especially unsentenced children, is cause for concern. In March 2006, 21 unsentenced children were detained for over a year (in Presidency 2009: 91).

The use of diversion is potentially having a positive effect on these figures. Of the 5 000 children whose cases were heard in courts every month in South Africa in 2009/10, between 1 300 and 1 900 were diverted from the mainstream criminal justice system into diversion programmes (DoJCD 2010: 5).

Courts beyond the reach of children in rural areas

The legacy of apartheid has left many rural areas and townships without adequate access to magistrate's courts or other justice service sites, as they are mainly located in the urban and developed areas. A number of branch courts were established to provide services to rural areas and townships, but these have historically lacked infrastructure, are under-resourced and, as a result, deliver poor-quality services (DoJCD 2010). The DoJCD does have plans, however, to transform branch courts into main magisterial courts with their own jurisdiction so that they can provide a full set of justice services to marginalised communities. This will be supplemented by building additional new courts in areas which have shown a pronounced need for justice services. These goals are included in the Department's strategic plan, but at the same time the plan acknowledges that financial resources will remain a challenge to realising these objectives.

Language barriers

Language barriers impede access to courts and court-based protection services. Many communities and courts require interpreters that are not available (DoJCD 2010).

Workload and lack of resources

The introduction of the Children's Act will see a significant increase in the jurisdiction and workload of the children's courts. This will undeniably be in the best interests of vulnerable children. However, the increase in the jurisdiction and workload will require sufficient human and financial resources to meet the increased demand. It appears that it is unlikely that the DoJCD will be able to meet the demand because of inadequate resources, both financial and human.

A costing of the Children's Act revealed that the current availability of resources is entirely inadequate to properly implement the Children's Act and for the Department to meet its obligations. For example, in 2010/11, the number of magistrates required to deliver the services contemplated by the Children's Act will exceed the total number of magistrates serving all the courts in the country in 2004/05 (Barberton 2006). In addition, it is estimated that the DoJCD will have to employ more than 1 000 family counsellors to deal with access orders and parental plans. In practice, they are social workers and this will

mean that the Department will be competing with the social welfare sector to meet the demand for social workers from an already inadequate pool (Barborton 2006).

Barborton's (2006) costing indicates that the DoJCD will see the greatest growth of all the departments in terms of obligations it must fulfil in terms of the Children's Act. An analysis of DoJCD funding of the services it was obliged to provide in 2005/06 showed an 18 per cent deficit and the prognosis was that 'the extent of under-funding is set to increase as the demand for normal services of the children's court increase more rapidly than the budgets for these courts' (Barborton 2006: 88). What is more, the 18 per cent deficit increases to a 61 per cent deficit if the Department's funding is measured against the services, over and above its current services, that will have to be provided in terms of the Children's Act.

It is not only funding that may prevent the realisation of many of the services that the DoJCD is obliged to provide in terms of the Children's Act, but also the current shortage of suitably qualified personnel. The discussion under the obligations of the DoSD reviewed the shortage of social workers which, combined with the shortage of magistrates, will impact negatively on the DoJCD's fulfilment of its responsibilities as well.

Children's courts and social workers

There needs to be close cooperation between the DoSD and the DoJCD to ensure the successful implementation of the Children's Act. The Children's Court and the social workers must work closely together to ensure that the court-based processes move quickly so that children in need of care and protection are not excluded from protection by delays. At present, there is not much evidence of close cooperation and this must be improved dramatically.

Victimisation in family courts

Domestic violence complainants are routinely subjected to secondary victimisation in family courts. They are often turned away by the relevant magistrate's court without being granted an interim protection order. Magistrates often postpone the hearing of the matter to allow for the presence of the respondent before granting the interim order and, in so doing, subject the complainant to further risk of abuse, contrary to the intent and direction given by the governing Domestic Violence Act (Legal Resources Centre & POWA 2009).

Protective measures for child victim witnesses

Protective measures that are available for the benefit of child victims who testify in court, such as the use of CCTV and intermediaries, are not automatically available. Application must be made to the court for permission for the use of these alternate procedures and a 'trial within a trial' must take place to determine if the facts merit the use of the procedures. Moreover, the court may only order the use of CCTV testimony where the facilities are readily available or obtainable (Waterhouse 2008; section 158 of the Criminal Procedure Act).

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This review of government-funded programmes for vulnerable children was undertaken as part of a five-year study to understand

how factors at the household, community, and policy levels interact to affect the wellbeing of children living in conditions jointly burdened by HIV/AIDS and poverty. One of the questions it asks is what affects whether and how families utilise services.

The review outlines policies and provisions for vulnerable children and families by all relevant government departments – health, education, housing, social development, safety and security, justice and others. For the first time in one place, it sets out the legal and policy framework ensuring the provision of services for vulnerable children, a service map for each department, delivery mechanisms and service providers. This is an invaluable resource for everyone working to improve the health and wellbeing of children and families through the fulfilment of those human rights guaranteed by the Constitution of South Africa.

The review was done by Patricia Martin of Advocacy Aid and former Director of the Alliance for Children's Entitlement to Social Security (ACCESS). A lawyer by training, Pat is an expert on the socio-economic policies and laws affecting children.

The study, called SIZE, The Wellbeing of South African Children, is being undertaken by a team of researchers from the Human Sciences Research Council in South Africa and New York University in the United States, in collaboration with colleagues from research, government and civil society, both local and international. Funding for the study has been provided by the National Institute of Child Health and Development, the Rockefeller Brothers Fund and the University of California at Los Angeles.