THE RIGHT TO BELONG AND PARTICIPATE

Support Services to Children with Disabilities

Integrated National Strategy

Integrated National Strategy on Support Services to Children with Disabilities

Revised Draft

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

P utting children with disabilities on the agenda

1.1.1 Introduction

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

1.1.2. The social protection agenda

Comprehensive social protection includes both *social transfers* as well as *social services* for the most vulnerable and marginalized members of society. However, evidence suggests that in many countries, progress is often measured by the extent of cash transfers to vulnerable households with little attention on the provision of appropriate services across the different government sectors, NGO's, CBO's, FBO's and the private sector. There is a need to expand the conceptualization of social protection towards a comprehensive, inclusive and integrated approach to improve access to social transfers and social services.

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

1.1.3 Poverty Reduction

The recognition of disability as a development issue, as both a cause and a consequence of poverty has facilitated a broadened understanding of disabilitiy, contributing towards social transformation. Disability increases vulnerability to poverty, while poverty creates the conditions for increased risk of disability. Furthermore, disability increases vulnerability to poverty because of the costs associated in living with a disability, discrimination in the labour market, difficulties related to access to education and assistive devices (Emmett, 2006).

Poverty is indeed a multi-dimensional concept and includes unacceptable social and economic deprivation, and lack of empowerment and security (Inclusion International, 2006: 5). As Amartya Sen suggests, poverty should also be understood in relation to human development and the 'capabilities' necessary

for maximising potential in the life of each and every individual, family and community (Sen, 1999). The OECD (Organisation for Economic Cooperation and Development) uses this approach to define five dimensions of deprivation in relation to **economic**, **human** (health, education, clean water, etc), **socio-cultural** (valued participation in community life), **political** and **protective capabilities** for a good and productive life (OECD, 2005).

A study conducted by the Nelson Mandela Foundation (NMF) on the educational status of children in rural communities point out that children with disabilities are a large group whose needs generally go unnoticed. Widespread biases and exclusionary practices affect the educational possibilities of boys and girls who have disabilities (NMF, 2005: 59). A large percentage of children with severe and profound disabilities stay at home, placing an additional burden on the family because of their need for full-time care and prevents the mother to go to work. Many families are forced to pay for day care and even school hostels from the social grants received by their children.

Globally and also in South Africa, the group of disabled children who are most vulnerable to living in extreme poverty, are those with intellectual disability and those in rural areas, contributing to the high numbers of children living in poverty. Children with disabilities who are hidden are also not recorded by the system and consequently do not access any services. The link between poverty and disability has also not been systematically examined. Information therefore relies heavily on anecdotal evidence and case studies. (Elwan, 1999 as quoted in Emmett, 2006)

Unless disability is specifically emphasised in all programmes related to poverty relief, South Africa will not be able to achieve the visions and targets by 2015 as set out in the Millennium Development Goals.

> *Eliminating world poverty is unlikely to be achieved unless the rights and needs of people with disabilities are taken into account. DFID 2000, p.1*

> *" If development is about bringing excluded people into society, then disabled people belong in schools, in legislatures, at work, on buses, at the theatre and everywhere else that those who are not disabled take for granted… Unless disabled people are brought into the development mainstream, it will be impossible to cut poverty in half by 2015 or to give every girl and boy the chance to achieve a primary education by the same date- goals agreed to by more than 180 world leaders at the United Nations Millennium Summit in September 2000."*
>
> *James D. Wolfensohn, President, World Bank , Washington Pos)*

1.2. Historical Perspective

1.2.1. Impact of past neglect and marginalisation

During the Apartheid era, services for children with disabilities were systematically under funded and non existent, especially in rural areas. Only children living in the large metropolitan areas had access to basic education and health services which predominantly favoured white children. The complex racially segregated systems resulted in fragmentation, duplication and disparity.

The large scale policy reforms of the nineties emphasised access, equity and equality. Access to basic health and education services for all children became the main priorities and the language of equal opportunities and rights-based approaches became prevalent in all government and non-government initiatives. In spite of the fact that the Integrated National Disability Strategy (INDS) of 1997 proposed that services for persons with disabilities should be mainstreamed, this ideal was realised to a limited extent. The South African Human Rights Commission (SAHRC) reported that the implementation of the INDS by government is "disappointingly slow" (SAHRC, 2002:20). In reality limited progress was made in expanding access to mainstream services and even less to specialised services.

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

What people with disabilities can positively achieve is influenced by economic opportunities, political liberties, social powers, the enabling conditions of good health, basic education and the encouragement and cultivation of initiatives,

and the liberty to participate in social choices (Amartya Sen, 1999). This reconceptualisation of disability, by disability rights advocates and reflected in some government policies and programmes recognizes disabled people's criticism of the medical and individualistic approach to defining disability.

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

A rights-based and social approach indicates that if society cannot cater for people with disabilities, it is society that must change. The goal must be the right of people with disabilities to play a full, participatory role in society (*Integrated National Disability Strategy,* 1997). Most policies in South Africa have therefore adopted a social model according to which the right of people with disabilities to play a full, participatory role in society is acknowledged (INDS, 1997). All systems and services should be structured in such a way that they do not create barriers to participation, learning and development.

1.3. CURRENT SITUATION

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

In spite of large scale reform in government policies, systems and programmes, services to children with disabilities still remain fragmented and unequal. Government Departments still work in silos and services are not coordinated. Specifically, the systems to identify learners with disabilities at birth and track their progress through early childhood on to school going age are sadly deficient. Many children who grow up in poor socio-economic conditions are never assessed with a view to planning and designing early intervention and appropriate support for them in a structured and coordinated way. The only

assessment that is carried out is to determine eligibility to receive social grants. Within a social model, it would therefore also be inappropriate to simplistically assess and classify persons with disabilities according to the category and severity of their disability. The traditional medical diagnostic approaches can no longer be used in isolation to organise and fund support services for children with disabilities. The context in which a child lives and learns must also be taken into account.

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

1.3.2. Evidence informing the strategy

The generation of this strategy is informed by two direct research activities undertaken by the Department of Social Development: (i) an audit report of national departments and Non-Profit Organizations on their roles and responsibilities in the delivery of services to children with disabilities and (ii) a desk top study on the Social Needs of People with Disabilities conducted during the period 1995-2006 in Gauteng, KwaZulu-Natal, Limpopo and Mpumalanga provinces. The results of these studies is used as a guideline for the national status of service provision for children with disabilities in South Africa. The main findings are summarised:

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

addition children with disabilities living in rural areas are less likely to receive services due to inadequate facilities.

- Children with Disabilities continue to experience discrimination at all levels of society. Children with Disabilities are excluded from mainstream services that are relatively more resourced, less costly and within reach. These services are not accessible due to physical structures, communication barriers, negative attitudes and inexperienced service providers.

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

- Currently only 1,36% of children with disabilities attend ECD centres. (Ambrose, Philpott)

- Children with disabilities face barriers to accessing welfare services, partly due to difficulties in obtaining a birth certificate and an identity document (Philpott, Ambrose February 2009).

- A high number of children with disabilities do not receive care dependency grants. In Mpumalanga province, 43% and in Gauteng less than a half of children with disabilities did not receive a care dependency grant. (Saloojee 2003, DART desk top research)

- Children with disabilities do not access services (mainly educational and rehabilitation) despite policies on their rights, and the roles and responsibilities of departments.

- Rehabilitation services are not integral to primary care programmes and remain largely a specialised service at tertiary level. The current service provision highlights deficiencies and gaps, for example although there is free health service for children under 6 years of age, this does not include assistive devices. In Mpumalanga, 67% of children with disabilities did not have any assistive device, which makes them less functional and more dependent on care givers.

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

- There is inadequate data collection of children with disabilities. There is no certainty on the prevalence of children with disabilities which informs programme planning
- There is poor collaboration between government departments, for example, children with disabilities in the Ingwavuma district of KwaZulu Natal and Orange farm, Gauteng, reported that affordable and convenient transport was identified as a major obstacle and therefore need in the district for accessing services. (DART report, Saloojee 2003, Orange farm)

1.3.3. Prevalence of childhood disability

Currently, there is little consensus on the prevalence of childhood disability. The prevalence rates for children with disabilities ranges from 2 to 6% of the population as indicated in the Table 1. The South African National Census Report of 2001 indicates that there are 4.9 million children of a total population of approximately 44 million and that 5-6% of the total population was disabled. A report by the Department of Health (DoH) in 2001 conferred that 5.9% of the population were disabled. Of this population of persons with disabilities, 9.4% of them were children between the ages of 1 and 15 years (CASE study, 1999). There were however a few other studies on the prevalence of childhood disability, although from more regional and local perspectives.

Table 1: Prevalence of childhood disability

Area of study	Age of children	% of population (reported)	% of population (confirmed)	Source
National	0-9		2.1 (males=2.2, females = 1.9	Census 2001, Stats SA 2005
National	10-19		3.0 (males 3.2, females 2.9)	Census 2001 Stats SA 2005
Kwa-Zulu Natal - Ntuze	2-19	3.8	3.3	James Irlam [1]
KwaZulu Natal-Manguzi	0-9	8.3	6.0	J Couper [2]
Bushbuckridge	2-9		6.4	Kromberg, Christianson [3]

Sources:

1. Irlam J. A rural disability prevalence study in KwaZulu-Natal. Unpublished report
2. Couper, J. 2002. Prevalence of childhood disability in rural KwaZulu-Natal. *South African Medical Journal*. 92(7) (July): 549-552.
3. Kromberg JGR, Christianson AL, Manga P, Zwane ME, Rosen E, Venter A et al. Intellectual disability in rural black children in the Bushbuckridge district of South Africa. Southern Africa Journal of child and adolescent metal health 1997; 9 (4): 2-11.

The Census 2001 and other data suggest that there were more male children with disabilities. The number of children with disabilities increased with age (2.1 – 3.0%). The CASE study also established that disabled children living in rural areas were twice more likely to have more than one type of impairment than those living in urban areas. Fifty nine percent (59%) of rural children had three or more disabilities compared to 24% of urban children. In addition, children with disabilities living in rural areas were more severe than those in urban areas. However, there were more children with disabilities living in urban areas than in rural areas, which may be related to more known children with milder impairments in the urban areas. Of all the children with disabilities in the age range 0 – 5 years, 43% had 3 or more impairments, 26% had two impairments and 31% only one. This suggests that the children who were identified as disabled in the young age group (0-5 years) tend to have multi impairments with greater severity. The prevalence of childhood disability increases with age as seen in Table 2.

Table 2: National data on disability: National survey on disability (undertaken in 1998)

Age range	% of the population
0 – 5 years	1.6
6 – 10 years	3.3
11 – 15 years	4.5
16 – 20 years	4.1

C A S E 1999: 'We also count! The extent of moderate and severe reported disability and the nature of disability experience in South Africa.'

Prevalence rates are available for children based on their different impairments, without more recent figures available. An international report on the state of the Nation's children in (?) indicated that the prevalence of disabilities reported in children with a visual impairment was the highest (36%), followed by hearing impairment (22%), physical impairment (16%), mental and multiple impairments (5%). South Africa has a high prevalence rate of children with cerebral palsy (10 per 1000), with birth related trauma being one of the main causes, with intellectual impairments most common (Couper, 2002). There was a prevalence rate of 15 per 1000 (Bushbuckridge) and 17 per 1000 (KwaZulu Natal-Manguzi) for

mild intellectual impairment, and 7 per 1000 respectively for children with severe intellectual impairments under 9 years. Hearing impairment also had a high prevalence rate (39 per 1000) in the Manguzi study due to mostly chronic ear infections, which is a preventable cause of childhood disability.

Limited literature is available on the impact of HIV/AIDS on the prevalence of children with disabilities. Children with HIV/AIDS experience difficulties in their development, including learning abilities. This will certainly increase the prevalence of children with disabilities and have an impact on services in the different service sectors.

Planning for services without more current prevalence rates for children with disabilities is therefore a major challenge, compounded further by poor systems of data collection on the number of children receiving services.

- There are more children with disabilities living in rural areas
- Children living in rural areas are more likely to be more severely disabled
- The level of socio economic has an impact on the prevalence of disability
- Prevalence of disability in children is an indicator of the general health status of children in an area.
- Children with HIV/AIDS have an impact on services
- There is no data collection system for services with children with disabilities which informs programme planning

1.3.4. Causes of childhood disability

Causes of childhood disability is categorised as **before birth** (prenatal: e.g. genetic; foetal alcohol syndrome), **during birth** (perinatal: e.g. birth trauma) and **after birth** (postnatal: e.g. poverty; illnesses; injury). In some cases no known causes can be found. Preventable causes of disability have been estimated to be up to 40%, implying that preventable measures can reduce the incidence of childhood disability greatly, especially with regard to antenatal care; improving women's health services; and even addressing environmental and social circumstances like in the case of foetal alcohol syndrome of the Western and Northern Cape.

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

1.3.5. Availability of resources and capacity for implementation

Government departments and Non Profit Organisations

All government departments and non profit organisations (NPOs) have clear objectives relating to children with disabilities (Audit report, 2008, DoSD) although several gaps in service provision have been identified. These include:

- Poor coordination of services between departments and NPOs is mentioned frequently as a challenge to developing integrated services for children with disabilities. This fragmentation of services for children with disabilities contributes to poor access to services by the 'consumers'.
- NPOs working with children with disabilities receive limited support from government departments and there is poor collaboration. (Audit report 2008)

Human resource capacity

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

> *"There is too much mystification concerning the skills required to work with disabled children. Many of these skills - not all - can be learned comparatively quickly by families, volunteers, community workers and staff without formal qualifications. Skilled professionals are, however, needed to provide leadership, staff training and support."*
> *Mittler-Serpell, 1984*

Although community health workers provide primary level care, many are not trained to work with children with disabilities. There is no agreement or coordination between government departments on the category of workers who would be able to provide adequate coverage for services to children as well as adults with disabilities. There is no consensus within and between government agencies; professional groups; and disability activists on the international

experience of adopting the concept of community rehabilitation facilitators/workers, in line with the other categories of midlevel workers amongst medical doctors, pharmacists, and dentists.

- Severe shortage of professionals working with children with disabilities in both government and NPO sectors.
- No consensus and coordination between department on a community worker (community based rehabilitation worker or facilitator) with people/children with disabilities

Physical, material and financial resources

Transport, professional skills and finances were specified in the audit report (DoSD, 2008) as the main obstacles to delivering services for children with disabilities. Transport that is affordable and convenient was identified as a major obstacle to accessing services in different areas, for example Orange farm, Gauteng province and Ingwavuma district, KwaZuluNatal province.

Societal Attitudes

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

1.3.6. Silo approach to service delivery

The primary national and provincial departments who provided direct services to children with disabilities are Social Development, Health and Education, while Transport, Justice, Safety and Security have policies relating to disability, but depend on municipalities for more local level implementation approaches. Figure 1 illustrates the main programmes within each of the primary government departments.

Figure 1   **Silo approach to service delivery**

HEALTH	SOCIAL DEVELOPMENT	EDUCATION

| ✓ **Primary Health Care Package**
✓ **Free Health Care**
✓ **Specialized rehab**
✓ **Early Childhood Development -ECD** | ✓ **Protection services**
✓ **Statutory services**
✓ **Social security**
✓ **Reconstruction and after care**
✓ **ECD** | ✓ **Inclusive education**
✓ **Special education**
✓ **Therapeutic services**
✓ **Early Childhood Development (ECD)** |
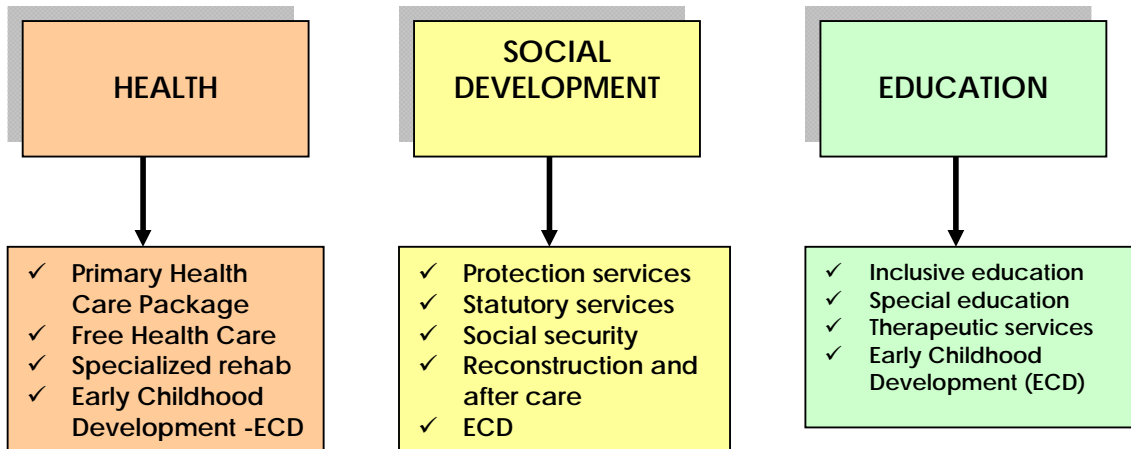
Programmes, projects and activities which aim to improve the quality of life of children with disabilities are still found to dominate within the sectors that initiate them, with little functional integration to make a meaningful impact. At best, there may be inter-referrals between professionals across the sectors, but the overall institutional context has not undergone any structural changes and does not facilitate integrated service delivery. The recent ECD strategy has been the most positive initiative to coordinate and integrate the specific educational and development needs of all children, but with little attention on the needs of children with disabilities.

1.4. RATIONALE FOR AN INTEGRATED STRATEGY

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

1. Serve as guide for the development and implementation of all Government frameworks on Children with Disabilities
2. Serve as an inter-sectoral collaboration mechanism to mobilize resources for service provision

3. Integrate and align all budgets related to Children with Disabilities

4. Ensure the implementation of the Children's Act

5. Implement the research findings on the needs of Children with Disabilities

6. Address barriers faced by children with disabilities in service delivery

7. Outline family and community based services without exclusion of alternative care where it is required in the best interest of the child

8. Create an enabling environment in order to prepare children with disabilities to become independent adults

9. Facilitate developmental programmes in order to support families and children who are vulnerable, including children with disabilities living in , poor and rural areas and to reduce dependency on disability grants

10. Target group/age is based on the Children's Bill Act (0-18 years)

LEGISLATIVE FRAMEWORK

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

2.1 International Context

International actors in the field of development work, human rights and child protection have influenced states to adopt the rights-based approach in framing policy content aimed at improving the lives of all children. The adoption of the Unite Nations Convention on the Rights of the Child in 1989 introduced a new era for all children globally. It was in recognition that children also have rights. The four core principles of the Convention are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and to participate fully in family, cultural and social life. The Convention goes further by specifically emphasizing that children with disabilities should enjoy a full and decent life in conditions which ensures dignity; promote self reliance and active participation in society.

In 2006, the rights of the disabled child were lifted through the ratification of the UN Convention on the Rights of Persons with Disabilities, which replaces the 'Standard Rules on the Equalization of Opportunities for Person's with Disabilities' of 1993. The 2006 Convention contain a number of articles outlining the rights of children with disabilities (refer to appendix 1). Mainstreaming of disability issues is emphasized in Article 4.1.(c) of the Convention which states that : 'States Parties undertake to take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes'. According to the Convention, mainstreaming of disability issues is recommended to cover a wide

institutional frame ranging from Human Rights Councils to Census data and sectoral policies.

2.2. National policy and legislative framework

South Africa ratified both UN Conventions in reviewing public policies since 1994. The disability movement strongly influenced not only government views on disability but also facilitated the process of transforming society's attitudes and understanding of disability. Currently, South Africa is reported to have developed the most progressive and comprehensive policies towards an enabling, rights-based framework for people with disabilities. Children with disabilities are regarded as a particularly vulnerable group in South African society, and therefore targeted specifically for social protection measures. One of the most enabling policy instruments for all children and specifically the most vulnerable is the recent Children's Act (no. 38 of 2005) which replaced the Child Care Act of 1983.

The planning and development of all strategies and programmes for children with disabilities are required to be aligned to the basic principles entrenched in the international convention. In this the Children's Amendment Act (No 41 of 2007) and the Promotion of Equality and Prevention of Discrimination Act leads the way. Replacing the Child Care Act (no. 74 of 1983), the Children's Act (No: 38 of 2005) and the amended version of 2007, gives effect to the rights of children as contained in the Constitution, mandating various government sectors to fulfil the obligation in meeting these rights. The Mission of the National Programme of Action for Children is clear in its intentions for all children, as well as for children with disabilities, namely:

- To advance the best interests of the child in all matters affecting them;
- To promote and enable the realization of child rights to survival development, protection, and participation;
- To mobilise resources at all levels.

2.3. Applying the convention and the disability framework to children

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

- An emphasis on their rights – their right to protection, development and participation in society (Dawes, Bray and Van der Merwe, 2007).
- The equalization of opportunities for children with disabilities through the provision of additional support so that they can realize their full potential; to enjoy a full and decent life in conditions which ensures dignity, promote self reliance and active participation in society.
- The acknowledgement that disabled children should as far as possible have a say in decisions which affect their lives and should no longer be seen as passive recipients of welfare.

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

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

Source: Child Rights Programming: How to Apply Rights-Based Approaches to Programming - A Handbook for International Save the Children Alliance Members, Save the Children Sweden, 2005

2.4 Definitions and terminology

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

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

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

The core definition of disability as approved by Cabinet in 2005:

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

The **UN Convention on the Rights of Persons with Disability (2007)** takes the terminology debate one step forward by standardising the terminology to be used. Article 1 defines persons with disabilities as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

2.5 Applying the South African Children's Act to children with disabilities

This Act provides the primary legal framework for the realization of every child's right to social services, parental care, family care or appropriate alternative care

and protection from abuse and neglect. It specifically recognises the special needs of children with disability. The provisions of the Children's Act impact on several key service provision areas, requiring an intersectoral approach for successful implementation. Specific sections of the Act can be referred to in appendix 1. While all children have the right to survival, protection, development and participation in society, children with disabilities require additional support, services and technical expertise in order to realise these rights and utilise the opportunities provided to fully participate in all family and community life.

Right to life.

The right to life is to be recognised and promoted especially within the context of the high infant mortality and the under five mortality rates in South Africa. While this applies to all children, some children are found to be particularly at risk. These include children infected and affected by HIV & AIDS as well as children with disabilities, compounded further by spatial factors, where children from rural or poorly resourced areas are more vulnerable. Even though the act states that children reach their full potential, these contextual factors draws attention to a basic right to survival, let alone reaching their full potential.

Right to standard of living and to benefit from social security

One of the specific purposes outlined in the Act is *"to develop appropriate parenting skills and the capacity of parents and care-givers to safeguard the best interests of children with disability"* (Clause 144 1 (c)). Children with disabilities are often found to be neglected, malnourished or not able to participate fully in family and community life. Stating the right to a decent standard of living for children with disabilities implies improving the quality of life, and therefore poses a challenge to change the current status quo for every child with a disability in South Africa. In addition, of the four types of social grants provided for through the Social Assistance Act, the Care Dependency Grant (CDG) is aimed specifically to children with disabilities, although the Foster Care Grant or the Social Relief of Distress is additionally provided for children with disabilities.

Protection from abuse.

Children with disabilities become helpless and are the most vulnerable when faced with violence and sexual abuse. Although there is a lack of data for South

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

Right to education

The Children's Amendment Act indicates that funding must be prioritized to make ECD programmes available to children with disabilities (clause 93(4)(b). National norms and standards stress that programmes must be appropriate for all children, including those with disabilities (clause 94(3)). The Inclusive Education Policy has made great strides in improving access to education and the provision of educational service. However, there is still a significant number of children with disabilities who do not attend both mainstream ECD centres and schools or specialized schools. They remain undetected by the education sector, which stipulates that all children from the age of 7 years are legally bound to attend a school. The right to education can only be realised with accurate data on school enrolment and on the prevalence of childhood disability.

Right to healthcare

The National Health Act (No: 61 of 2003) provides for the conditions under which vulnerable groups such as pregnant women, children under 6 years of age, older persons and people with disabilities are eligible for free health care services. There are several administrative measures required to ensure that all vulnerable groups have access to these services.

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

THE INTEGRATED STRATEGY ON SUPPORT SERVICES FOR CHILDREN WITH DISABILITIES

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

3.1 Vision and principles of the strategy

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

PRINCIPLES OF THE STRATEGY

The principles of the strategy are:

- children with disabilities have inherent dignity and have a right to survival and development to their maximum abilities like their counterparts
- Children with disabilities should enjoy their human rights on an equal basis with other children, fundamental freedoms and full participation in their communities.
- Children with disabilities should be respected for being different and accepted as part of human diversity and humanity. The acceptance should be promoted among their counterparts

- There is a need for ongoing promotion of self representation and participation of children with disabilities, parents and care givers in all decision making processes affecting them. They have a right to have their views heard and taken seriously.
- Respect for the evolving capacity of children with disabilities and respect for the right of children with disabilities to preserve their identity
- Children with disabilities have a right to be part of their families, and the society into which they were born and are entitled to parent care. They should receive alternative care when family environment is not conducive
- Children with Disabilities should have access to basic education and developmental opportunities.
- Children with Disabilities should enjoy civil rights such as identity such as nationality and name, freedom of association and expression ,
- Equitable allocation of resources: All resources available to other children should be equally and equitably available to children with disabilities

3.2. Aim and objectives

3.2.1. Aim

To improve the quality of life of all children with disabilities in the South African context by creating an enabling environment within which they can have equal and accessible services in order for them to achieve independent functioning, enjoy a full and decent quality of life in conditions which ensures dignity, promote self reliance and active participation in society.

3.2.2. Objectives

- To strengthen inter-sectoral collaboration between government departments for effective and efficient use of resources in the provision of services to children with disabilities
- To ensure that the legislative mandates which have intersectoral implications are realized
- To ensure alignment and integration of key legislative provisions, national policies and services for children with disabilities
- To ensure that the strategy serves as guide for the implementation of all Government frameworks on children with disabilities

- To facilitate service responses to the research findings on the needs of children with disabilities
- To increase access to services and opportunities for development by addressing the barriers faced by children with disabilities in all spheres of life.

3.3 Scope of the Strategy

The target group for the strategy is children between the ages of 0 to 18 years as stipulated in the Children's Act (no. 38 of 2005)

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

3.4 Components of the strategy

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

    i.   Survival and well-being

    ii.   Childhood Development

iii.   Protection

iv.   Participation

v.   Mobilization of resources

3.4.1 Strategic area 1:

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

Prevention of childhood disability

In ensuring the right to survival and well-being of children who are at risk for childhood disability, a specific understanding of causes and disability prevention programmes is required. This will reduce the risk and ultimately the incidence of childhood disability.   Prevention of impairments and disabilities are therefore integral to the goals of service delivery, which are guided by the medical as well as the social models of disability, as defined in the policy framework. At all levels of prevention, the public must be made aware of both social and medical causes of childhood disability. The lack of coherent policy on the prevention of disability demonstrates that the focus is more curative rather than preventative. The prevention of childhood disability is not necessarily the absence of impairment but the well being and promotion of health of all children. As was noted in the previous chapter, poor information and national data on the prevalence of childhood disability demonstrates the need to identify population groups who are at risk or have higher childhood prevalence rates in order to develop integrated programmes across all sectors, based on need.

Research is recommended on the causes of childhood disability to inform prevention programmes.   Some causes of childhood disability may be related to the mental and physical well being of mothers during pregnancy, ante natal care, and infectious diseases. Genetic abnormalities in children are also one of the causes of childhood disability. Social causes of childhood disability are not to be ignored; substance and alcohol abuse in pregnant mothers is a social cause of intellectual disability in children (Foetal Alcohol Syndrome); child abuse and violence lead to trauma and mental health conditions. Road traffic accidents

are another major cause of death and disability, compounded by substance abuse. There is a need for collaboration between the different sectors to focus on prevention and awareness programmes in reducing the risk and incidence of childhood disability.

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

Promotion of general well being of children with disabilities

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

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

mainstream activities, however if identified can be solved using an integrated approach.

Older children with disabilities are encouraged to represent themselves on issues that affect them, for example, information on the management of their own disability.   All children should have access to information on issues of sex education, abuse (physical, sexual and emotional), domestic violence and substance abuse etc. without excluding those with disabilities.   Children with disabilities need encouragement and continuous capacity building to ensure confidence in self representation and understanding their rights, which ultimately will assist them to interact with the mainstream society and enhance their independence.

3.4.2 Strategic area 2:

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

Early identification and intervention

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

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

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

Early identification does not only refer to young children. It is critical that systems are in place to identify symptoms of mental health problems as early as possible so as to take preventative measures. Young children and adolescents are extremely vulnerable to depression and other mental health disorders, which if identified early can be treated. Children who have been victims of abuse and substance abuse especially need to have access to counselling services, life skills programmes and peer counselling. The Mental Health Care Act, No 17 of 2002 emphasises a holistic, integrated and community-based care approach at primary, secondary and tertiary levels.

Successful early identification programmes therefore depend on an integrated and efficient referral system across the different sectors. Rehabilitation services form an integral part of early identification and intervention, and therefore if these services continue to be viewed and delivered as a specialized service only accessible to a few, or remains predominantly within the Health Sector, it compromises on the goal of equitable and efficient service delivery where scarce public resources are wasted, fragmented or duplicated.

Parent mobilisation and empowerment

Children with disabilities and their families need access to community programmes of empowerment and life skills training that will enable them to function optimally within society. The parents of children with severe and profound disabilities should be linked to community based poverty alleviation programs and other forms of support such as respite care services or support from other families. There is a continuous need for parental programs in order to assist

the families to handle challenges they face. Psychosocial intervention is aimed at an individual, family or a group of people who experience trauma or any serious change in their life situation. Without ongoing support, families may run the risk of breakdown or remain maladjusted.

Habilitation and rehabilitation

Rehabilitation (including habilitation) offers support to a child with a disability with the ultimate aim of "attaining and maintaining maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life" (CRPD, Article 26). To this end government should "organise, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services." (see terminology at end of the strategy)

The 'medical' and 'social' rehabilitation models should not be seen as separate approaches. Combining both these approaches simultaneously is evidence of viewing the child with a disability as a whole and managing all their needs, which ultimately leads to inclusion into a family and community. Habilitation and rehabilitation involve several processes - assessment, intervention and reassessment. It is most beneficial if delivered through multidisciplinary teams who can assess individual needs and strengths as early as possible and take the necessary steps to enhance participation and inclusion in the community and all aspects of society. The service must be available to children with disabilities as close as possible to their own communities, including in rural areas.

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

- Rehabilitation is multi disciplinary and intersectoral
- Rehabilitation must integrate the medical and social models
- Rehabilitation approach should follow the International Classification of Functioning, Disability and Health (WHO, 2001)
- Rehabilitation professionals are scarce for the high prevalence rate of children with disabilities.
- Community Based Rehabilitation is an approach recommended by the WHO
- The role of the Community Based Facilitator within a CBR approach should be reviewed by government sectors.

Appropriate assessment of individual needs and strengths

The main aim of any assessment is to obtain information in order to intervene appropriately. An assessment of a child with a disability involves understanding and measuring each child's ability, potential, attitude, opinion, interest, knowledge and personality. The assessment not only focuses on a child's ability to care for him/herself, move, see, hear and learn but to participate in play with other children and in the community. The process of assessment should be guided by sound principles with the child and the parents being central and having the right to all information about the process.

Historically in South Africa, people with disabilities have been given labels or categorized into 'boxes', due to the method of assessment. This has resulted in discrimination and negative attitudes towards people with disabilities making it difficult for them to reach their full potential. Assessment also did not go hand in hand with the planning and provisioning of support, but more often led to exclusion and segregation.

Assessment for support must be seen separately from assessment for planning of resources and funding of services. Within the Department of Health, the **International Classification of Functioning, Disability and Health** (ICF) (WHO, 2001) introduced a social model of assessment taking into consideration not only the extent to which the impairment limits functioning, but also how contextual factors need to be taken into consideration when determining levels and nature of support needs. The assessment and classification system directly informs decisions

on the type of intervention programme to implement in order to minimise the barriers to participation in family and community life.

The assessment protocol introduced by the Department of Social Development to determine eligibility to receive social grants, has also been aligned to the ICF approach.

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

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

Table 3 is an example of assessing children with disabilities to determine the level and nature of support services (See full table in Appendix A)

Domain of activity	Severity of difficulty	Educational needs	Social and services needs (Care needs)	Physical / environmental needs	Impairment
Intellectual functioning	Mild / moderate / severe				
Lower body	Mild / moderate / severe				
Arm and hand use, dexterity	Mild / moderate / severe				
Behaviour	Mild / moderate / severe				
Self care	Mild / moderate / severe				
Social skills-communication	Mild / moderate / severe				
Community skills	Mild / moderate / severe				

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

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

In order to meet the constitutional right to basic education and provisions, inclusive education policy provides for children with disabilities of compulsory school going age. to have support in local mainstream schools. Only learners with very high needs will be admitted to special schools. The limited number and capacity of special schools in rural areas forces children with disabilities to travel far from their families in order to access educational services. Those who have multiple disabilities experience more barriers. The education sector acknowledges

the fact that barriers to learning need to be detected as early as possible so that they can be effectively addressed in order to avoid learning breakdown. Learners with permanent disabilities should have access to early intervention to ensure their optimal opportunity to develop their full potential.

Within Social Development, emphasis has been placed on the early identification of children with disabilities through the legislative requirement of promoting Early Childhood Development (ECD). According to the Children's Act, 2005 ECD centres are aimed at providing emotional, cognitive and physical development of children from 0 – 4 years (Tswaragano Kabane Programme) and also up to school going age. It is further indicated in the Act that ECD programmes must meet the needs of children with disabilities or chronic illness. Steps must be taken to train more ECD practitioners in skills to support and accommodate children with disabilities.

Informal education – day care and stimulation centres

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

Children with profound and multiple disabilities are eligible to be admitted to special care or stimulation centres. These centres are currently administered by both the Department of Health and of Social Development. There is currently no

synergy between provinces regarding the provision of services in stimulation centres. In terms of the Children's Amendment Act (Section 79), these centres should be registered and funded and stimulation and/or education programmes need to be jointly provided by the Departments of Health, Social Development and Education. Proposals that the centres should be linked to existing special schools as satellite centres, should be further explored so that children have access to structured curricula.

Children with **psychiatric disorders and mental health problems** also need to be identified early so that early intervention and prevention programmes can be made available. Older children of school going age should have access to education programmes, even if these should be delivered at psychiatric hospitals. The Departments of Education and Health should coordinate processes around the implementation of the Mental Health Care Act and its Regulations.

Special needs and services

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

3.4.3 Strategic area 3:

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

Social security for children with disabilities

Evidence based on research studies in Gauteng and Mpumalanga have estimated that more than 50% of children with disabilities are eligible, but do not receive a care dependency grant. This finding is specific to children with

disabilities, but is also supported on a broader level by findings from the Children's Institute where studies were conducted on the child support grant.

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

Community development

Social Security grants are not sustainable without linking them to the reintegration into family life and community development activities. The security of employment amongst adults who care for children is one of the factors associated with a sustainable reduction in childhood poverty and well being. One of the recommendations is for parents of children with disabilities themselves to be employed by ECD or day care centres. Departments of Labour, Health, Social Development and Education should identify common employment projects in rural or target areas as an effort to improve the situation of poverty and reducing the dependency on social grants.

Child protection and statutory services

The National Policy Framework and Strategic Plan for the Prevention and Management of Child Abuse, Neglect and Exploitation indicate that Children with Disabilities are vulnerable to abuse and violence. Children with disabilities are not sufficiently accommodated in the child protection system. There is currently no profile or statistics of children with disabilities in child protection system. These services include court proceedings, implementing of court order investigation and assessments. The existing protocols should take into account children with disabilities and ensure that the court systems are friendly to children with disabilities. There is a need for information in this area to plan and design systems that include the protection of children with disabilities from abuse and successful conviction of perpetrators. Children with disabilities are often unable or afraid to report abuse which can lead to them becoming victims of repeated abuse.

Children with intellectual, communication and visual impairments have difficulty reporting the perpetrator, and therefore require support from their family and community. In addition, service providers in this field such as probation officers, social workers, magistrates, commissioners including judges should be exposed to disability sensitivity training.

Alternative care

Children with disabilities who are vulnerable to abuse and neglect within the family setting and by primary care givers themselves, need protection through statutory intervention and alternative care. There are a number of alternative care options for abused children with disabilities, namely foster care, group foster care, residential care, respite care and partial care. These alternative care placements are also used for children with severe disabilities when the family is not able to cope and require temporary relief. Caring for a child with a disability requires additional support and resources to ensure optimal growth and development. Respite care services are provided by The Child and Youth Care Centres, registered and funded according to the Children's Amendment Act. Respite care services are another form of supporting parents of children with severe and profound disabilities to provide temporary relief for parents and care givers.

Children with disabilities who do not have the support of their families are placed in the partial care programme. In terms of the Children's Amendment Act partial care is a service provided through day or night care to more than six children, including those with disabilities, on behalf of their parents with or without any reward for a temporary period. Children with disabilities who function independently should be integrated in the mainstream partial care facilities. All the norms and standards for partial care facilities should take into account the needs of children with disabilities, for example, children with a communication or hearing disability require staff members to understand basic sign language. The service providers should be provided with training that will enable them to take care of and integrate children with disabilities in the stimulation programmes.

3.4.4 Strategic area 4:

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

Integration and reintegration into family and community life

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

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

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

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

Community workers, whether employed by Social Development, Health, Education, Local Government, the NGO or private sector, in partnership with parents and family members all have the responsibility of facilitating and monitoring the process of integrating children into **mainstream community activities**.

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

Prevocational skills/ work training skills/ Life skills development

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

For children with moderate and severe intellectual disability or those who find it difficult to attain the National Senior Certificate or Grade 9, the curriculum should be adapted to emphasise transition-to-work content. Schools should in all cases support learners to develop their full potential so that they eventually have the

opportunity to work in the open labour market or become economically and socially independent in the case where they will be working in protective or sheltered employment.

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

Assistive Devices and Technology

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

a. Education related devices

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

The process of ensuring that children in both ordinary and special schools have access to the required assistive technology and specialised equipment, involves the following:

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

b.   Devices to support Personal Mobility and Daily Living

The Convention on the Rights of Persons with Disabilities (CRPD, Article 20) further outlines the obligation of government to "take effective measures to ensure personal mobility with the greatest possible independence for persons/children with disabilities."

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

Participation in leisure, arts, culture and sport activities

This is a grossly neglected area in service delivery for children with disabilities and deserves to be given individual attention. It is an expansion of the section on

integration and reintegration, where the activities into community life are further defined. The family, school, religious and cultural organizations operating within the communities need to review their policies and programmes and all leisure, arts, culture and sport activities to include children with disabilities. This is supported by the municipalities to make facilities and amenities accessible to children with disabilities.

Article 30 of the Convention on the Rights of Persons with Disabilities not only emphasises the right of participating in mainstream arts, culture, sports and recreation but also the opportunity organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources. The Departments of Education, Arts and Culture and Sport and Recreation should jointly be responsible for this area of services.

Awareness-raising

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

3.4.5 Strategic area 5:

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

Production, supply and utilisation of human resources

Professionals providing expertise in the assessment, care, treatment, and integration of the disabled child are collectively providing a rehabilitation service. Several professions thus contribute to the process of rehabilitation, the availability of which differs from province to province and facility to facility. The core rehabilitation team consists of the Audiologist, Community Based Facilitator,

Occupational Therapist, Physiotherapist, Speech Therapist, and Social Worker, while Doctors, Psychologists, Orthotists & Prosthetists, Remedial Teachers, Dieticians and individual medium therapists enhance the team to provide a more comprehensive rehabilitation service. An effective rehabilitation service depends on the availability and coordination of all the rehabilitation professionals.

These service providers have been reported to be a scarce human resource within South Africa, and where available, are concentrated in urban areas. They continue to predominate within the health sector, with some employed in education, despite the INDS stipulating the need to establish services within all service sectors. The establishment of posts within all sector departments should take priority if there is to be alignment of legislative frameworks and national policies with service delivery to people with disabilities. These posts should include opportunities for career mobility to attract and retain these scarce human resources. However, recruitment and retention of human resources is only feasible if the production of adequate workers is also given due attention. Within this context of human resources for the delivery of services to children with disabilities, the role of all categories of workers: health managers; rehabilitation professionals; and community rehabilitation workers; need to be reviewed in line with the establishment of the mid-level worker, which is primarily aimed at improving coverage to all people in need of support services.

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

Financial Resources

Dedicated financial resources to key service delivery functions for children with disabilities should be reflected in all targeted programmes both horizontally across

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

Informational

The lack of adequate and disaggregated data for children with disabilities has been a common thread in many areas of service delivery, leading to poor planning and social exclusion. There is a need to develop a data base on children with disabilities. This will assist in the ongoing monitoring and evaluation of programmes for children with disabilities. Information with regard to receiving a care dependency grant and attending rehabilitation and educational services and also provide information for planning of services. The data base must include for example, the number of children with disabilities, the access and availability of services (including NPOs and support groups), the number of assistive devices required, issued and repaired.

Physical resources

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

IMPLEMENTATION OF THE STRATEGY

4.1. Integration of services

The Children's Act (No. 38, of 2005) outlines specific considerations in the implementation of the Act, noting that successful implementation depends on several sectors working together. Section 4 (1)(2) states that: "*This Act must be implemented by organs of state in the national, provincial and where applicable, local spheres of government subject to any specific sections of the Act and regulations allocating roles and responsibilities, in an integrated, coordinated and uniform manner.* Specific mention is made on inter-sectoral implementation of the Act in section 5: "*…all organs of state…involved in the care, protection and well-being of children must co-operate in the development of a uniform approach aimed at co-coordinating and integrating the services delivered to children*". Integration of services and policy coherence has thus emerged as crucial issues in the implementation of this strategy. Other key issues are coordination and a uniform approach for successful implementation.

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

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

4.2. Institutional arrangements

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

Planning should be guided by strategy generation, in this case being the integrated strategy for all services rendered to children with disabilities. While there are various systems for gathering information, it is also recognised that many gaps still exist, most notably the poor prevalence data for children with disabilities. Figure 4.1 below demonstrates the basic planning cycle as outlined by National Treasury. The institutional context includes national and provincial departments across *all* sectors. All government departments mandated to provide support services to children with disabilities are therefore urged to use this strategy as a

guide and begin filling these gaps, while constantly communicating and providing feedback through the appropriate channels established.

Figure 4.1.   **The planning, budgeting and reporting cycle**
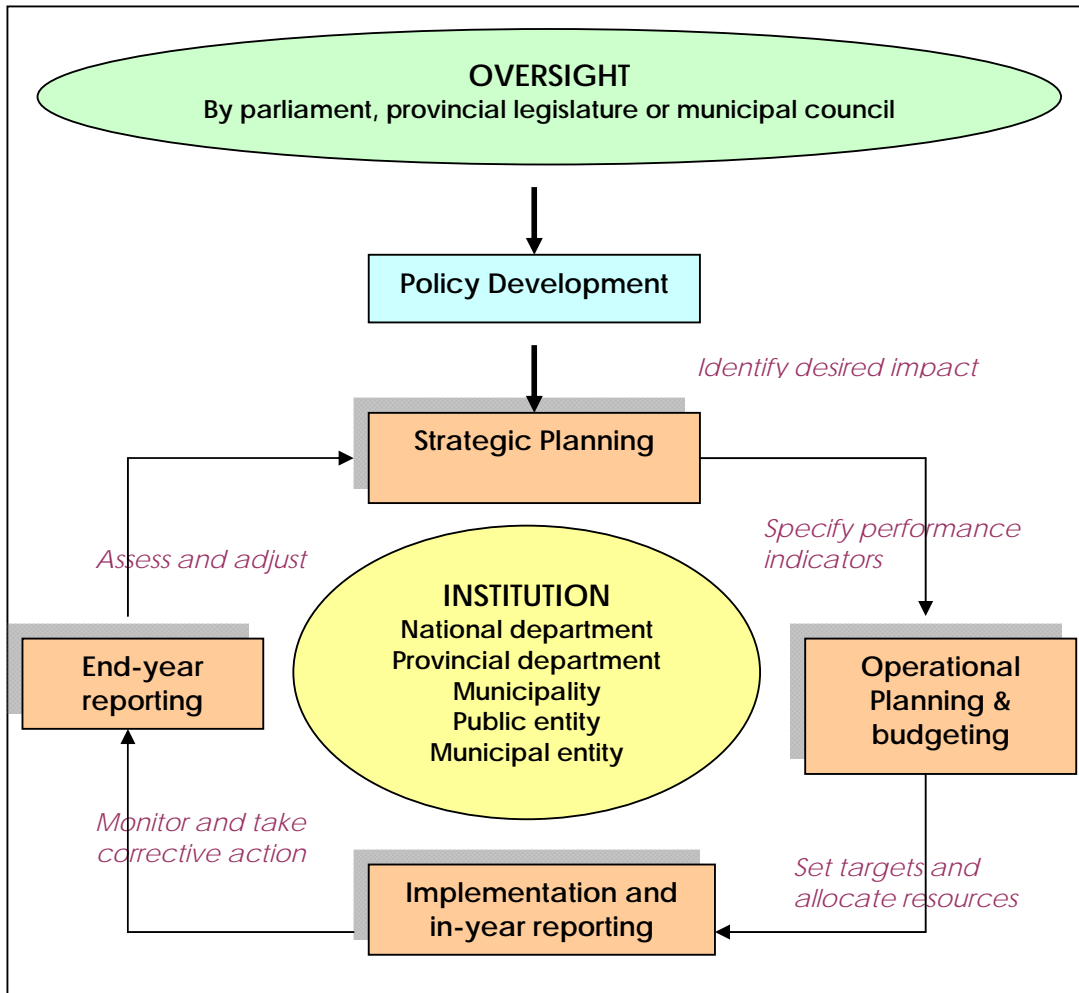
Reproduced from National Treasury in "Framework for Managing Programme Performance Information" May 2007.

4.2.1. National Departments

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

4.2.2. Provincial Departments

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

4.2.3. Local Government

Local government is responsible for including disability services with the IDP to ensure protection of people with disabilities at the community level. The role of the local government is to; make provision and allocate facilities of care and protection for day and residential facilities, provide accessible public infrastructure and amenities. Facilities should be compliant to local government legislation. Drop in centres are the responsibility of local government (chapter 14 of Child amendment Act) to offer any programme which includes primary health care in collaboration with the local health clinic and prevention and early intervention programmes.

4.3. Infrastructure Development

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

Departments should also identify areas where a single tool or a multi disciplinary tool can be developed for the benefit of key departments that are sharing responsibilities in the provision of services rather that each department developing they are own individual tools. The Department of Social Development

has initiated the Individual Development Plan (idp) for adults with a disability to identify needs within a residential care facility to inform service delivery.

4.4. Non-profit organizations

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

4.4.1. Disabled people organisations

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

4.4.2. Faith based organisations

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

4.5. Community based organisations

4.5.1. Support Groups

Support groups are voluntary social, community networks where people come together to share common experiences. Support groups are usually formed out of tragic experiences of individuals who have overcome and survived catastrophic experiences. Specialized needs of children with disabilities can best be addressed by support groups that are initiated by parents from all levels of the community

starting from local to national structures. The support groups are facilitated and managed by lay people who have a personal experience on how to take care of children with disabilities. Parents who have developed best practice family models to survive challenges are in a better position to share experiences and knowledge with other parents. Support groups provide peers counselling, information and can be therapeutic to families.

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

4.5.2. Parents Organisations

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

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

4.5.3. Children with Disabilities

Children with disabilities are direct beneficiaries of services and therefore they should also be empowered to participate in decision making processes. This can be made possible through research conducted where they can be able to articulate their needs at their own level in terms of age and disabilities. Adults can interact with children and gather information about their needs both formally and informally. Children with disabilities should and can participate in mainstream programmes such Children's Parliament where their voice their political,

educational and social issues. There are experts who are trained to interpret the actions and words of children with disabilities who have different types of disabilities (including those with mental disabilities) so that they can make sense to the adult world and vice versa.

4.5.4. Forums

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

There is a therefore a need for active participation of the disability sector in the existing for a for children in order to influence mainstreaming of children with disabilities in the existing services.

4.6. Roles and responsibilities

The scope of work in the field of disability extends to every sector that provides a service to improve the quality of life of an individual or groups of individuals. The first step is in Identifying which sector has a role to play in the delivery of support services to children with disabilities. A summary of the roles and responsibilities of government departments as informed by the audit report and objectives according to the strategic areas of this strategy is tabled in Appendix B.

4.7.   Implementation matrix

An implementation strategy model has been outline below. The purpose of this strategy is to initiate a developmental approach towards developing services for children with disabilities, and it is not an end in itself, as it is too complex for the nature   of   this   document

Strategic area 1.

- To ensure the right to survival and well being of all children with disabilities.

- To promote the best interests of children with disabilities to reach their full potential (mental, physical and social).

Thematic areas	Objectives	Indicators	Output	Lead departments and NPOs
Prevention of childhood disability	Identify medical and social causes of childhood disability	Disaggregated data available on incidence of childhood disability	Causes of childhood disability inform strategies on prevention and planning of services	**Health** Education Stats SA DoSD
	Develop an integrated national prevention programme for identifiable and other causes of childhood disability	Reduce the number of children (presently up to 40%) with preventable causes of disability.	Improve management of preventable and other causes of childhood disability	**Health,** DoSD Transport
	Identify target areas with a higher prevalence of childhood disability.	Decrease the prevalence rate of children with disabilities in under-resourced areas.	Develop resources and programmes in disadvantaged and poor areas Promote general wellbeing of children in under-resourced areas	**Health** DoSD WCYPwD Education
	Increase awareness programmes on disability prevention.	Decrease prevalence of childhood disability through public participation	Improve public knowledge on preventable cause of childhood disability Improve access to services: antenatal care, genetic counselling, developmental screening Improve awareness and attitudes towards disability issues	**Health** DoSD
Promotion of physical, mental and social well being of children with	Promote the physical, mental, and social well being of children with disabilities	Decrease the infant and under five mortality rate.	Promote nutrition and well baby/child programmes. Promote the well being of family system	**Health** DoSD Education

disabilities.	Combat stigma of children with disability	Increase in number of children with disabilities in mainstream activities	Develop awareness and advocacy programmes; rights of children with disabilities and community development programmes focusing on social inclusion Involve FBOs and NPOs in attitudinal change programmes	**DoSD** **Education** WCYPwD

Strategic area 2.

To ensure the optimal development of children with disabilities, with the provision of mainstream and specialised services within an inclusive society

Thematic areas	Objectives	Indicators	Output	Lead departments/ NPOs
Early identification (0-4 years) and intervention	All children with a disability or impairment are identified early.	- Screening protocols and procedures in place in all primary health care facilities, and registered day-care centres - Caregivers, community health workers and community development workers trained to administer screening protocols	To identify children with disabilities as early as possible through screening at primary level.	**Health** Education DoSD WCYPwD
	To support families with a child with a disability	- Increase in outreach programmes to parents and families - Expanded reach of screening that involves parents and families in decision making	To develop a family centred approach to the management of children with disabilities.	**DoSD** Health Education

Thematic areas	Objectives	Indicators	Output	Lead departments/ NPOs
	'One stop' screening for children with disabilities to receive care dependency grants	- Increase in percentage of children with disabilities on the population register - Increase in percentage of children with disabilities who receive social grants - Standardised and viable criteria for eligibility developed - Alignment of departmental assessment protocols and procedures	Better efficiency for CDG applications – increasing percentage of children who receive grants	**DoSD** Health Education
	Tracking of learners that have been assessed between Health and Education	- Align learner tracking systems of Departments - Capture screening information on Road to Health Card and Learner Profile	- Learners who have been identified through early screening systems are ensured of accessing support when they enter ECD sites - Older learners who are identified with disorders have access to intervention and support	**Health** **Education**
	Screen children to identify developmental delays and impairments and plan early intervention as part of the Tshwaragano ka Bana Programme	- All ECD practitioners are trained in early screening, identification and intervention methods - Early intervention programmes in place	- Increase number of trained primary and secondary providers on skills in early intervention. - The number of learners who receive early intervention services increases.	**DoSD** **Education** DPOs Parent Organisations NPOs
Parent mobilisation and empowerment of families	Train parents with disabled children better coping and handling skills	Less abuse (sexual and violence) of children with disabilities Increase of children receiving early intervention and stimulation. Increased parental	Parent training programmes Support groups Peer counselling Group therapy Outreach by special schools and inclusive schools	**WCYPwD** DSD Health DoBE NPO's

Thematic areas	Objectives	Indicators	Output	Lead departments/ NPOs
		involvement in education of children		
Habilitation and rehabilitation services	Develop minimum standards for good habilitation and rehabilitation practice	Increase the number/percentage of rehabilitation services meeting min standards	Train community based rehabilitation workers and health professionals so as to ensure quality service provision	**Health** NPOs Education All depts.
	All children have equal access to rehabilitation services	Increase the number of children with disabilities attending rehabilitation services to above 40%	Establish rehabilitation services that are accessible to all children on an ongoing basis	**Health**
	Improve rehabilitation services at community and primary level	Increase rehabilitation services at clinics and in the community.	Develop a strategy for community rehabilitation that is appropriate and accessible.	**Health** DoSD Professional therapy bodies
	All children with disabilities have access to assistive devices (see below under **Strategy 4**)	Develop and align departmental policies on the supply of assistive devices Increase assistive device coverage above 50%	Clear inter-departmental policies on assistive devices Training professionals Assessment services in place Maintenance of assistive devices	**Health** Education
Assessment	All assessment processes are aligned to international standards as outlined in the ICF	Primary service providers in health, education, social development utilizing a common assessment tool	All service providers understand and utilize a common assessment approach for the benefit of the individual child with a disability	**Health** Education DSD
	Assessment is a tool to provide access to services rather than as a placement tool	Appropriate placements of children with disabilities for care, protection and individual development	Assessment tools are used to monitor growth and development of children with disabilities	**Education** Health DSD
Formal compulsory education in ordinary and special schools and ECD	Improve access to ECD by children with disabilities	Increase attendance of Children with disabilities at ECD centres to above 1,36%	Develop support and training for ECD facilitators to teach Children with disabilities. Disability awareness programmes in	**DoSD Education**

Thematic areas	Objectives	Indicators	Output	Lead departments/ NPOs
(5-18 years)			ECD centres and community.	
	All children with disabilities have access to education and support (grade R) and foundation phase	Increase school attendance for all children with disabilities – specifically in rural and poor areas increase attendance to 60%	Education practitioners are equipped to teach children with disabilities Strengthen district support services through increasing capacity and promoting inter-sectoral collaboration	**Education**
Informal education – day care and stimulation centres	Exemption of compulsory schooling is given in accordance with regulations as outlined in SA Schools Act	▪ No: of children with disabilities at age 7 years who are not in an educational facility ▪ No: of children with disabilities in unregistered and registered day care facilities/ stimulation centres	Identify all children with disabilities who are 7 years for meeting the legislative requirement of educational placement	**Education** DSD NPO's
Identified special needs and related support services	Support services should focus on mainstreaming but ensure developing capacity in areas that require specialised services	▪ Individualized plans for each child with a disability for growth and development	Balance between mainstream and specialized services for children with disabilities.	**DSD** Education Health

Strategic area 3.

To ensure the right of children with disabilities to statutory and legal protection services that is non-discriminatory.

Thematic areas	Objectives	Indicators	Output	Lead department/ NPOs
Protection	Ensure that all children with disabilities are protected from physical abuse,	▪ Legislative measures to protect children against any form of abuse and	Strengthen implementation of protective measures, specifically relating to children with disabilities, as	**DoSD** Justice Safety and

Thematic areas	Objectives	Indicators	Output	Lead department/ NPOs
	violence, exploitation, neglect and child trafficking	violence. ▪ Profile of children with disabilities in child protection system. ▪ No: of convictions of perpetrators involved in cases against children with disabilities. ▪ No: of service providers (probation officers, magistrates, judges etc) who undergo disability sensitive training.	outlined in Children's Act and Children's Amendment Act Provision of alternative accommodation, rehabilitation and access to due legal recourse for abused children with disabilities.	security
Optimisation of social grants for children with disabilities	To improve access to CDG by children with disabilities	▪ Comprehensive data base of children with disabilities as beneficiaries of grants. ▪ Comprehensive data base linked to utilization rates of services. ▪ Gradual increase of eligible children with disabilities receiving CDG from 50% to 80% within MTEF	All eligible children with disabilities have access to grants. Encourage independent living and not dependency on grants through	**DoSD** Home affairs Education Health
Community development	Reduce the levels of poverty amongst families who have children with disabilities through employment opportunities especially in rural areas	▪ No: of parents of children with disabilities who are formally employed ▪ No: of parents of children with disabilities employed in ECD / day-care centres. ▪ Reduction in number of poor families with no	Community mobilization, active participation and empowerment of families who have a child with a disability through community development projects	DoL **Municipalities** DPW – EPWP DSD NPO's

Thematic areas	Objectives	Indicators	Output	Lead department/ NPOs
		income due to full time care of a child with a disability. ■ Access to registered day-care services for children with disabilities at the local community level.		
Accessibility to alternative care for children with disabilities	Alternative care options viz. foster care, group foster care, residential care, respite care and partial care are available and accessible for children with disabilities, according to the Children's Act.	■ No; of children with disabilities who require alternative care – updated regularly. ■ No: of alternative care facilities available per district ■ No: of service providers of alternative care who undergo disability sensitive training	Alternative care protects and promotes the development of children with disabilities who are vulnerable to abuse, neglect, or who simply require additional support.	DSD Municipalities Safety & Security NPO's

Strategy area 4.

To promote the right for children with disabilities to participate in their families, community and society without discrimination.

Thematic areas	Objectives	Indicators	Output	Lead department/NPOs
Integration and reintegration of children with disabilities into	To ensure that all public buildings are accessible to children with disabilities	National building norms and design manuals comply with requirements of universal design	Put in place monitoring mechanisms to ensure that building regulations are adhered to in all public buildings (including all schools)	**Public Works** Health Education

Thematic areas	Objectives	Indicators	Output	Lead department/NPOs
family and community life	To ensure that all children maintain their independence through access to assistive devices	▪ Register of children with disabilities in need of assistive devices per district ▪ 100% of children with disabilities (including rural areas) have access to mobility aids, communication aids and /or any other assistive devices as needed ▪ Monitoring system of children with assistive devices for ongoing assessment and training	Develop and align departmental policies, national and local system for the supply, management and maintenance of assistive devices.	**Health** Education DSD
	To ensure accessible transport for children with disabilities	School and public transport systems in place to provide accessible transport to all learners with disabilities, specifically those who experience mobility barriers	Accessible transport for all community and social activities for children including transport to and from educational facilities.	**Transport** **Municipalities** Education
	To ensure access to information and communication services	Accessible system of communication to children with disabilities –	Children with disabilities are trained and empowered to access and utilize information according to their abilities	**Communications** Education Science and Technology
Preparation for economic and social independence	Transition to work and prevocational skills training for children with disabilities between the ages 15-18 years	▪ No: of centres that offer prevocational training per district ▪ Monitoring (data-base) of children who under prevocational training and are provided employment opportunities	Children with disabilities between 15-18 years are given support in the transition phase between school and employment seeking.	**Labour** Basic Education Higher Education NPO's

Thematic areas	Objectives	Indicators	Output	Lead department/NPOs
Participation in leisure and sport	To ensure that children with disabilities have equal access to art, culture, sport and recreation activities	▪ No: of children with disabilities who participate in local activities ▪ Opportunities for participation in local sport, culture and recreational activities at the local level / per district	Acceptance of children with disabilities to participate in local activities, amongst peers, siblings and friends within all social networks.	**Municipalities Sport and Recreation** Arts and Culture Education NPO's
Awareness Raising	To raise the awareness of the community and social circles of children with disabilities of their human right to have access to leisure, sport and recreational activities	▪ No; of awareness campaigns run at schools and social functions ▪ Level of inclusion of children with disabilities in local activities		

Strategic area 5.

To mobilize resources at all levels (human, financial, informational, institutional including NPO, NGOs and public private partnerships) to ensure that all children with disabilities, with support can reach their full potential.

Thematic areas	Objectives	Indicators	Output	Lead department/ NPOs
Human: production, supply and utilization of human resources	Production, supply, training To clearly identify the human resources necessary for delivering services to children with disabilities in all sectors	▪ Ratio of rehabilitation professionals: social workers, physiotherapists, OT's, Speech Therapists, Medical orthotists etc to number of people with	Adequate number of human resources who provide appropriate and effective services to children with disabilities in all areas of need.	**Health** Education DoSD Transport Training institutions

Thematic areas	Objectives	Indicators	Output	Lead department/ NPOs
		disabilities (disaggregated for children) ▪ No: of posts in the public sector (education; heatlh; social development; labour; transport) to provided services for children with disabilities ▪ Clear strategy to improve coverage of services for adults as well as children with disabilities (e.g. CBR and training of midlevel workers)		NGO's

Financial Information for planning, statistics, dedicated budgeting, monitoring of implementation	Dedicated financial resources to services for children with disabilities within all sectors that provide services to children with disabilities	▪ Targeted programes for children with disabilities within all service sectors
		▪ Costing of disability prevention programmes; rehabilitiation/early identification and intervention programmes; monitoring activities (in comparison to hospital / institutional based care)
			Financial resources available for integrated service delivery within all programmes, targeted as well as mainstream for children with disabilities at local level.	**Provincial departments:**
				    Health
				    Education
				    Social
				    Transport

	Integration of services for efficient use of resources	▪ Common objectives across sectors identified for planning, budgeting and monitoring the delivery of an integrated services		
Systems	Disaggregated baseline	▪ Data-base of no: of	Improved designing, planning and	**Stats SA**

Thematic areas	Objectives	Indicators	Output	Lead department/ NPOs
development for improved informational resources disaggregated disability data collection	data collection at facilitiy/organizational levels, provincial and national spheres of government	children receiving CDG's and no: utilizing available services (both government and NPO's / NGO's) o Early intervention services o Early Childhood Development o Rehabiltiation o Community development	monitoring of programmes for children with disabilities at local, provincial and national spheres of government	Health Education DSD Transport Municipalities Private sector NPO's
	Improved partnerships with private sector; NPO's and NGO's in the delivery of services for children with disabilities	No: of contractual agreements of PPP established in service delivery for children with disabilities		
Availability of physical resources	Planning, utilization, monitoring and evaluating of all physical resources required in the delivery of services for children with disabilities	▪ Procurement, supply and monitoring of appropriate assistive devices for children ▪ Planning and implementation of reasonable accommodations required per facility/organization	Adequate physical resources available for the rendering of appropriate, efficient and effective services for children with disabilities	All service providers

MONITORING AND EVALUATION

5.1 Information management

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

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

5.2 Monitoring and Evaluation

Monitoring and evaluation of services is an ongoing process and is the responsibility of all service providers within all tiers of government and NPOs. Monitoring and evaluation should take place horizontally and vertically Horizontal monitoring and evaluation is when departments and NPOs put collaboration mechanism for evaluation of each other in order to identify gaps and challenges in service delivery as mandated by the INDS. Vertical monitoring and evaluation is where the responsibility of monitoring and evaluation between national, provincial and local level both within government and NGOs. Previously the

Office on the Status of Disabled Persons in the Presidency was responsible for overall monitoring of the implementation of programmes for persons with disabilities (including children with disabilities). All government departments have an obligation to report on an annual basis on progress made on implementation of disability related programmes, the UN convention, INDS and policy development. The new administration still has to indicate how this function will in future be fulfilled by the new Department of Women, Children, Youth and Persons with Disabilities. There is a need to identify priority areas of collaboration which will be translated into achievable strategic objectives that can be implemented over a period of five years. Government and NPOs also have the responsibility to develop monitoring and evaluation systems and tools to ensure effective service delivery.

The national and provincial consultative workshop was conducted to identify comprehensive objectives that should be implemented in collaboration with key departments. From the general strategic objectives identified during the consultations priority areas should be identified by the technical team that will be translated into an implementation plan. The implementation plan will reflect timeframe, key departmental roles and responsibility and will be costed.

5.3. The development of indicators

With evidence of the severe lack of information and disaggregated data on children with disabilities, the development of indicators becomes the most urgent priority for all national and provincial departments. However, there is also caution in the development of appropriate indicators that would be useful for decision makers to evaluate policies, programmes and services and allocate resources. Guidance on the development of core indicators demonstrate five areas based on children' rights as well as addressing the needs of vulnerable groups: (i) child status; (ii) family and household environment; (iii) neighbourhood and surrounding environment; (iv) service access; and (v) service quality (Schneider et al, 2007). While some indicators in section four are based on available data, many have to be generated through the development of original information systems of data collection. National and provincial departments therefore have the responsibility of coordinating this task as a project on its own.

ISSUES FOR CONSIDERATION IN IMPLEMENTATION

- The Department of Social Development should plan, design and implement a **communication strategy** in disseminating this document to all the actors identified.

- Implementation should be done in accordance with the **agreed plan,** resources available and should facilitate an integrated approach.

- A critical factor in implementation is to **assess the capacity to implement** in terms of knowledge, skills, resources, etc. – an integral part of implementation is capacity development at all levels and orientation to a rights based approach.

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

- **Engagement of the service recipients** is critical during the implementation and should also be done within the framework of human rights, respect and ensuring independence and participation.

- Implementers should know what services are available and how to source service providers where and when needed.

- Policy and legislative frameworks need to be aligned across sectors and departments

- Budget priorities need to be determined by National Treasury and allocations monitored – both to wipe out backlogs as well as to ensure expansion of services.

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Terminology

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

with/without hyperactivity (ADHD)	Not all of those affected by ADHD manifest all three behavioral categories. Can lead to difficulty in academic, emotional, and social functioning. May be associated with other neurological, significant behavioral, and/or developmental/ learning disabilities.
Autistic spectrum disorders	Autistic spectrum disorders impact the normal development of the brain in the areas of social interaction and communication skills. Children typically have difficulties in verbal and non-verbal communication, social interactions, and leisure or play activities, find it hard to communicate with others and relate to the outside world. - A medical practitioner, preferably a specialist (paediatrician or psychiatrist) must diagnose learners.
Behavioural / conduct disorder (including Severe behavioural problems)	Learners with behaviour / conduct disorder usually have little concern for others and repeatedly violate the basic rights of others and the rules of society. Children and adolescents act out their feelings or impulses in destructive ways. Offences often grow more serious over time. Such offences may include lying, theft, aggression, truancy, the setting of fires, and vandalism.
Blindness	Loss of useful sight. Blindness can be temporary or permanent. Damage to any portion of the eye, the optic nerve, or the area of the brain responsible for vision can lead to blindness. <3/60 in the better eye, after maximum correction.
Cerebral palsy	Cerebral palsy describes a group of chronic conditions affecting body movements and muscle coordination. Caused by damage to one or more specific areas of the brain, either traumatic, infectious, or developmental. Major types include spastic, dystonic, athetoid and ataxic and they can be quadriplegic, diplegic or hemiplegic. A medical practitioner must make the diagnosis.
Deafness	Learners who experience a severe hearing impairment and who depend on specialised educational support. Hearing must be assessed through an auditory test and the hearing loss should be more than 61 dB at 0,5; 1; 2 and 4KHz in the better ear
Deaf-blindness	Deaf-blindness means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs different from children with deafness or children with blindness.
Epilepsy	Disorder caused by the sudden overactivity of brain cells and characterized by repetitive attacks of a diverse nature. Seizures (or convulsions) occur when there is abnormal electrical discharge in the brain. This may be triggered by chemical imbalance or a structural abnormality. Seizures differ in cause, nature, severity,

	management and long term effect.
Hard of hearing	Learners who experience a moderate hearing impairment and who are in need of additional specialised support. Hearing must be assessed through an auditory test and the decibell loss must be more than 31dB for persons under the age of 15 and more than 41dB for persons 15 years and older
Mild to moderate intellectual disability	Learners with an intellectual disability have significantly lower than average intellectual ability and deficits in social and adaptive functioning, that is, limitations in such areas as communication, social, daily living or movement skills. Learners with mild to moderate intellectual disability are academically functioning on a level below 75% of that of their peers. (See moderate to severe intellectual disability below)
Moderate to severe/profound intellectual disability	Learners with moderate to severe/profound intellectual disability are academically functioning on a level below 50% of that of their peers. Some identifiable causes include: hereditary factors; chromosome abnormalities, such as in Down Syndrome; brain damage before or at birth; brain damage after birth due to illness or accident; malnutrition or other deprivation in early childhood.
Multiple disability	Learners who experience more than one of the disabilities.
Partial sightedness / Low Vision	Low vision is impairment of visual functioning even after treatment, for example an operation and/or standard refractive correction (has been given glasses or lenses) and has a visual acuity of less than 6/18 to light perception, or a visual field of less than 10° from the point of fixation (i.e. 20° across) but who uses, or is potentially able to use, vision for the planning and/or execution of a task
Physical disability	Learners with a significant physical disability that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying.
Specific learning disability	A specific learning disability is a disorder in one or more of the central nervous system processes involved in perceiving, understanding and/or using concepts through verbal (spoken or written) language or nonverbal means. This disorder manifests itself with a deficit in one or more of the following areas: attention, reasoning, processing, memory, communication, reading, writing, spelling, calculation, coordination, social competence and emotional maturity.
Psychiatric disorder	These disorders must be diagnosed by a psychiatrist or psychologist

and could include:

Personality disorders: Mental illnesses that share several unique qualities. While many disorders vacillate in terms of symptom presence and intensity, personality disorders typically remain relatively constant.

Adjustment disorders: Disorders in this category relate to a significantly more difficult adjustment to a life situation than would normally be expected considering the circumstances.

Mood disorders: These include those disorders where the primary symptom is a disturbance in mood. In other words, inappropriate, exaggerated, or limited range of feelings, e.g. bipolar disorder, major depression disorder, etc.

Anxiety disorders: The primary feature is abnormal or inappropriate anxiety such as Acute Stress Disorder, Obsessive-Compulsive disorder, Phobias, Posttraumatic Stress Disorder, etc.

Psychotic disorders: The major symptom of these disorders is psychosis, or delusions and hallucinations. Delusions are false beliefs that significantly hinder a person's ability to function, e.g. schizophrenia

UNACCEPTABLE TERMINOLOGY	TERMINOLOGY THAT IS ACCEPTABLE WITHIN THE NEW FRAMEWORK OF THINKING
Learners with 'Special' Education Needs	Learners who experience barriers to learning
	'Special needs' is replaced with the concept of 'Reasonable Accommodation'
Learners with barriers to learning	Learners who experience barriers to learning Describe the barrier rather than the person, e.g. Deafness, Blindness, Visual Impairment
Remedial	Teaching and Learning Support
The Deaf, the Blind, the Physically Disabled, the Mentally Retarded	People first terminology: People who are Blind, Children with hearing loss, intellectual disability, Down Syndrome, Autism, Physical Disability
	People living with or affected by HIV/Aids
	Wheel-chair users
SMH – Severely Mentally Handicapped/ Mentally Challenged/ Cognitively Challenged	Children with Intellectual Disability
Slow learners	Learners with learning difficulties
Uneducable	Children with Severe or Profound Disability
Sufferers	People with disabilities are not ill and do not necessarily suffer from their disability

APPENDIX A

Classification of Functioning

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

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
Intellectual functioning (concentration, learning new tasks, remembering, applying knowledge)	*Mild (1)* Can master academic skills, vocational skills and self supporting	Inclusive setting with low level of adaptation and support	Requires guidance and support in unfamiliar environment	Nothing specific	- Intellectual impairments such as Down's Syndrome, etc. - Attention Deficit and Hyperactivity Disorder (ADD/ADHD) – which
	Moderate (2)	Inclusive or specialised	Social support and	Transport with	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
	Has difficulty mastering more than basic academic skills	setting with moderate level of adaptation and specialised support	therapeutic intervention needed	supervision	may or may not present with learning difficulties; autism, fetal alcohol syndrome, etc.
	Severe (3) Cannot master any skills beyond systematic habits; responds to stimulation and training;	Eligible to receive support in a special setting such as special school or stimulation centre	Eligible to receive 24 hour care in highly supported environment, respite care for family	Transport with supervision and care facility with stimulation centre	
Mobility *Lower body* (walking, maintaining a body position, transfer from one surface to another)	*Mild (1)* No difficulty, or may need help occasionally	Inclusive setting with access to mobility aids	Access to therapeutic, rehabilitation services and mobility aids needed	Assistance to use public transport, accessible built environment	Physical disability, cerebral palsy, quadriplegia
	Moderate (2) Can move, but must be assisted, is slow, or gets very tired	Inclusive setting with access to specialised/individual support and mobility devices – environmental access	More frequent access to therapeutic, rehabilitation services and mobility aids needed	Accessible bus, assistance to use public transport, accessible built environment at home and public facilities	
	Severe (3) Unable to move alone	Access to individual and specialised support in special or full-service school that is environmentally accessible	Full-time assistance, individually fitted wheelchair, frequent therapeutic intervention, rehabilitation programmes	Assistance to use public transport, accessible built environment, e.g. ramps, lifts, accessible toilets	
Arm and hand use and dexterity (use of both arms, use of fingers and hand to pick up small objects, tie shoelaces and buttons, etc.)	*Mild (1)* If given enough time, ties a knot; ties shoe laces or a bow; cuts on a line and around a curve	Early identification and intervention and teacher support in inclusive setting – adaptation and additional time needed	Low frequency therapy needed	No adaptations needed – physical and built environment complies with principles of universal design	Physical disability, cerebral palsy, quadriplegia and some syndromes that present with low muscle tone and poor eye hand coordination
	Moderate (2) Can do most of these	Inclusive setting with access to	Moderate frequency therapy needed	Moderate adaptations needed	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
	activities, but slow and does not do them well	specialised/individual support and assistive devices that support hand control as well as ITC support		– physical and built environment complies with principles of universal design	
	Severe (3) Great difficulty, or unable to do these activities	Access to individual and specialised support in special or full-service school equipped with trained teachers, support staff and assistive devices that support hand control as well as ITC support	High frequency therapy and family support needed	Extensive adaptations needed – physical and built environment complies with principles of universal design	
Communication – receptive and expressive communication	*Mild (1)* Understands everything that is said or misses just a few meanings Can converse/sign with a stranger, making conversation	Availability of support in inclusive settings – curriculum differentiation, access to AAC devices, speech therapy	Early identification and intervention, therapeutic services, assistive devices	Safe transport	Communication disorders such as aphasia, apraxia, dyspraxia
	Moderate (2) Able to understand basic, simple sentences Able to produce basic, simple sentences	Inclusive setting with access to specialised/individual support and communication devices, trained support staff, speech therapists (on a part time basis), itinerant learning support teachers	Early identification and intervention, therapeutic services, assistive devices	Safe transport	
	Severe (3) Unable to understand	Access to individual and specialised	Early identification and intervention,	Safe transport	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
	any meaningful language Difficulty due to severe disturbance or no voluntary control of speech muscles or Has no voice due to structural impairment	support in special or full-service school that is equipped with communication devices, trained support staff, speech therapists	therapeutic services, assistive devices, family support		
Self care (feeding, hygiene, dressing, toileting)	*Mild (1)* Eats in a socially acceptable way, bathes/washes and cares for hair when reminded, manages toileting independently, needs occasional help	Availability of support such as early developmental programmes, individual support, health care and curriculum support provided in an inclusive settings	Primary health interventions, parent guidance	Accessible school nutrition centres; incontinence facilities; Child friendly facilities that enhance health, dignity and inclusion. Accessible transport	Intellectual disabilities, conditions which entail incontinence such as spina bifida, visual impairment needing daily living skills training, physical disabilities
	Moderate (2) Can do activities but not well; or cannot do one or two of the activities Looses control occasionally; bowel control; no bladder control or vice-versa; uses aids; social embarrassment	Availability of support such as early developmental programmes, individual support, health care and curriculum support, teacher assistant provided in inclusive settings – ordinary or full-service schools with support from district services	Secondary and tertiary medical interventions to prevent deterioration of conditions (e.g. renal failure)	Accessible school nutrition centres; incontinence facilities; Child friendly facilities that enhance health, dignity and inclusion. Accessible transport	
	Severe (3) Unable to do oral hygiene, hair and nails; or cannot do these activities Needs to be reminded	Availability of support such as early developmental programmes, individual support,	Secondary and tertiary medical interventions to prevent deterioration of conditions (e.g. renal	Accessible school nutrition centres; incontinence facilities; Child friendly facilities	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
	regularly; or incontinent	health care and curriculum support provided in an inclusive settings – full-service/special schools equipped with incontinence facility and staff	failure); access to partial care centres funded by DSD and/or DoH in cases where condition is combined with severe and profound intellectual disability	that enhance health, dignity and inclusion. Accessible transport	
Vision Visual acuity e.g. ability to identify objects and shapes at close range and distance; thread a needle	*Mild (1)* Some difficulty that is resolved with use of Spectacles	Support available in inclusive schools – curriculum differentiation and assistive technology	Psycho-social support services, primary medical facilities, regular eye tests, visual aids	Accessible transport and accessible public buildings with appropriate signage	Blind and low vision – Astigmatism Bardet Biedl Syndrome Cataract Chorioretinal Atrophy Cortical Visual Impairment Glaucoma Lazy Eye Macular distrophy Myopia Nystagmus Optic Atrophy Optic Nerve Hypoplasia Retinal detachment Retinitis Pigmentosa Strabismus, etc.
Classification of Visual impairment after maximum correction: 6/24 – 6/36 - moderate	*Moderate (2)* Recognises familiar person across a street; Can see to read and write (incl. learning these skills); Can manage to get around in a low lit area	Support available in inclusive schools – curriculum differentiation, assistive technology, trained teachers		Accessible transport and accessible public buildings with appropriate signage	
6/60 – 3/60 in better eye – severe VI < 3/60 -Blind	*Severe (3)* Cannot recognise any object at arm's length; familiar person across the street; Unable to read or write; Cannot get around other than in familiar situations	Support available in full-service or special schools, access to Braille textbooks and Perkins Braillers for blind learners and assistive technology for low vision learners – training for teachers, orientation and mobility training, parent guidance		Accessible transport and accessible public buildings with appropriate signage	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
Hearing	*Mild (1)* Hears sounds and can usually identify them correctly				Deafness Hearing loss Cochlear Implant Fluctuating hearing loss Otitis media Otosclerosis Sudden hearing loss
Moderate impairment: *Person under 15 years: >31dB threshold for pure tones (0.5, 1, 2,4 and 8 KHz) or Speech awareness threshold *Person 15 years or older: >41dB threshold for pure tones (0.5, 1, 2,4 and 8 KHz) in better ear	*Moderate (2)* Cannot always localise sounds or hear warnings e.g. alarm ringing; traffic	Children must have right to make informed choices to learn orally or through SASL. Teachers have specialised training. Sign language interpreters must be available. Hearing aids must be maintained and sound amplification devices must be available. Early screening, identification and intervention must be available in inclusive as well as special schools and ECD centres	Availability of social and therapeutic services as well as access to audiology services and assistive devices, e.g. hearing aids	Accessible transport and built environment that comply with norms for environmental access, e.g. light arrangements and electricity to accommodate devices	
Severe impairment: >61dB threshold for pure tones ((0.5, 1, 2, and 4 KHz) in better ear	*Severe (3)* Severe difficulty or complete inability to hear warning sounds	Children must have right to make informed choices to learn orally or through SASL. Teachers have specialised training. Sign language interpreters must be available. Hearing aids must be maintained and sound	Availability of social and therapeutic services as well as access to audiology services and assistive devices, e.g. hearing aids	Accessible transport and built environment that comply with norms for environmental access, e.g. light arrangements and electricity to accommodate devices	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
		amplification devices must be available. Early screening, identification and intervention must be available in inclusive as well as special schools and ECD centres, parent training in SASL			
Behaviour (Ranging from transient coping difficulties and occasional disruptive behaviour in class or with siblings and parents to extreme anti-social behaviour)	*Mild (1)* Minimally disturbing to others and not considered deviant by those who know them	Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health, prevention programmes delivered in ordinary schools as well as child and youth care centres, psychiatric hospitals, drop in centres	Psycho-social support services, access to child and youth care centres, diversion programmes, etc.	Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards	Oppositional defiant disorder, etc.
	Moderate (2) Poor or inappropriate social skills, like frequent episodes of aggression, or other antisocial behaviour, with some preservation of meaningful social relationships	Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health, prevention programmes delivered in ordinary schools psychiatric hospitals, drop in centres	Psycho-social support services, access to child and youth care centres, diversion programmes, etc.	Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
	Severe (3) Persistent aggression without clear instigation; *Severe anti-social and injurious behaviour*	Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health, prevention programmes delivered in ordinary schools as well as child and youth care centres	Psycho-social support services, access to child and youth care centres, diversion programmes,	Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards	
Mental-Psychiatric Condition Functioning at home, school and with peers.	*Mild (1)* Some disturbance of behaviour or emotional distress in response to life changing events e.g. separation of parents; deaths; birth of a sibling: these are brief and interface with functioning is transient;	Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health prevention programmes delivered in ordinary schools	Psycho-social support services,.	Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards	These disorders must be diagnosed by a psychiatrist or psychologist and could include: Personality disorders:. Adjustment disorders: Mood disorders: Anxiety disorders Psychotic disorders
	Moderate (2) Suicidal preoccupations and ruminations; School anxiety and other forms of anxiety; Obsessive rituals; Major conversion symptoms; Frequent anxiety attacks;	Availability of support from classroom teachers, school counsellors and psycho-social support staff – including peer support, mental health prevention programmes delivered in ordinary schools	Psycho-social support services	Safe and accessible sites of learning In case of hostels, complying with minimum health and safety standards	
	Severe (3)	Psychiatric care	Psycho-social support	Safe and accessible	

Domain of functioning	Severity of functional limitation	Educational support needs	Social and Health services and support needs (Care needs	Physical environmental needs	Impairment
	Unable to function in one of these areas e.g. disturbed at home, at school, with peers or in society at large; Suicidal attempts with clear lethal intent; Markedly withdrawn and isolated due either mood or thought disorder;	facilities with part time educational support programmes delivered from ordinary or special schools	services, psychiatric hospitals, etc	sites of learning In case of hostels, complying with minimum health and safety standards	

Appendix B

Roles and responsibilities of government departments

Strategic area 1.
To ensure the right to survival and well being of all children with disabilities.
To promote the best interests of children with disabilities to reach their full potential (mental, physical and social).

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp/rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS
Prevention of childhood disability	Identify causes			y	y	y	y											
	Develop prevention programme	Y		y	y	y	y			y								
	Identify target areas			y	y	y	y											
	Awareness programmes prevention.			y	y	y	Y											
Physical, mental and social well being of children with disabilities.	Promote the well being of children with disabilities	Y		y	y	y	y					y		y	Y	y	y	

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp/rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS
	Combat stigma of children with disability	Y		y	y	y					y	y		y	Y	y	y	y

Strategic area 2.

To ensure the optimal development of children with disabilities, with the provision of mainstream and specialized services within an inclusive society

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp/rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS
Early identification and intervention	Early identification of CwD.	Y >3 yrs		y <3 yrs	y	y												
	Support families with a CwD.	Y		y	y	y	y				y	y					y	
	One stop CDG screening			y	y													
Parent mobilisation and empowerment of families	Train parents of CwD coping skills	Y		y	y	y												
Habilitation and rehabilitation services	All CwD have assistive devices	Y		y														
	Good	Y		y	y	y												

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp/rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS
	standards for rehabilitation																	
	All CwD receive rehab services	Y		y	y													
	Rehabilitation at community/ primary level			y	y													
Education (inclusive and special) (5-18 years)	All CwD are educated	Y																
	Prevocational training programmes	Y				y	y	y										

Strategic area 3.

To ensure the right of children with disabilities to statutory and legal protection services that are non-discriminatory.

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp /rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS
Protection	CwD protected from abuse and neglect				y	y									y	y		
Optimisation of social grants for children with	Better access to CDG by CwD			y	y	y												

Inputs	Objectives																	
disabilities																		
Poor families with a disabled child	Financial status of families CwD in target areas				y													
Community development		y		y	y	y				y								

Strategy area 4.

To promote the right for children with disabilities to participate in their families, community and society without discrimination.

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp /rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS
Integration and reintegration of CwD into family and community life																		
	Accessible public facilities	Y		y	y	y	y			y	y	y	y	y	y	y	y	y
	CwD maintain independence - assistive devices	Y		y	y	y	y											
	Accessible transport for CwD	Y		y	y		y											
	Accessible communications	Y		y	y									y				

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp /rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS
Preparation for economic and social independence	Transition to work	Y			y	y		y										
Participation in leisure and sport	CwD have access to art, culture, sport and recreation activities	Y			y	y	y				y	y	y					

Strategic area 5. To mobilize resources at all levels (human, financial, informational, institutional including NPO, NGOs and public private partnerships) to ensure that all children with disabilities, with support can reach their full potential.

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp /rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS	Finance
Human: production, supply and utilization of human resources	Train, recruit and retain human resources to deliver services to CwD	Y	y	y	y	y	y				y	y	y	y					
Financial Information for planning, statistics, dedicated budgeting,	Cost implications: disability prevention programmes.	Y		y	y	y													y

Inputs	Objectives	DoBE	DoHE	DOH	DSD	WCYPwD	Tr	DoL	DoA	Hous	Sp/rec	DACI	Tour	Comm	SS	DoJ	DoHA	CS	Finance
monitoring of implementation																			
	Cost implications: delivering services for CwD at community, centre and hospital level.	Y		y	y	y													
Systems development for disaggregated disability data collection	Data base to track children with disabilities receiving CDG, rehabilitation and education services	Y		y	y	y													

Key:

CwD: Children with disability
Rehab: rehabilitation
DoBE Department of basic Education
DoHE Department of Higher Education
DOH: Department of Health
DSD: Department of Social Development
WYPwD: Department of Women, youth and People with disabilities
DOT: Department of Transport
DOL: Department of Labour
DOA: Department of Agriculture

DOH: Department of housing
Sp/rec: Department of sport and recreation
DAC: Department of Art and culture
Tour: Department of Tourism
DOC: Department of communication
DOJ: Department of Justice
SS: Department of Safety and Security
DOHA: Department of Home affairs
CA: Department of Correctional services
Fin: Department of Finance

Appendix C

PERTINENT INFORMATION FOR ALIGNMENT WITH INTEGRATED STRATEGY

Research based

1. The research report on the needs of people with disabilities - DART
2. Audit report on services to children with disabilities;

Legislation:

International
3. UN Convention on the Rights of Persons with Disabilities;
4. UN Convention on the Rights of the Child

National

5. Integrated National Disability Strategy (INDS 1997);
6. Children's Amendment Act (No: 38 of 2005);
7. DSD - Disability Policy;
8. Policy on Community Based Services for Persons with Disabilities;
9. Mental Health Care Act (No 17 of 2002);
10. Social Assistance Amendment Act (No 6: of 2008)

RESEARCH OUTPUTS		
Document	Year	Data Extract
1. Audit report	2008	Detail incorporated into Situational Analysis (Section 2)
2. DART research report	June 2006	**Findings for children with disabilities:** i. <u>Service Provision</u> • Little research on prevention reflecting the lack of priority given to prevention. An attempt to develop a policy on prevention by DoH has not been finalized. • All research on 'early identification' focussed on specific impairment types. • Research on prevention of specific impairment types is located within a more medical framework. • Significantly limited research on play and recreation • One study to evaluate the impact of Community Based Rehabilitation • No research on violence in relation to children with disabilities or as victims of abuse. • Poor working relations between government and NGO service providers. • Lack of policy guidelines and action plans on particular aspects of service provision – e.g. Assistive devices; CBR; prevention of HIV/AIDS, special and inclusive education, skills development and accessibility to public buildings • Regional and more local research outputs available: i. Gauteng – Orange Farm (Anderson & Phohole, 2001) ii. KZN – Ingwavuma (O' Brien, 2007) iii. Limpopo – Mohlanatsi (Anderson & Pholole, 2001) iv. Mpumalanga – Dept of Social Development, undated. Summary of findings of local research: 1. More than 50% of children with disabilities are not at school 2. Less than 33% of them are receiving rehabilitation 3. Less than 50% of those who qualify for Care Dependency grants are receiving them. 4. Absence of data regarding the prevalence of disability 5. Only 40% of disabled children who require rehabilitation actually receive it. 6. Lack of strong networks and partnerships between all these role-players in dealing with the issue of childhood disability 7. 86% of disabled people identified in Mpumalanga are children a. 67% of children with disabilities do not have the assistive devices they need. b. Access to foster care grants for children with disabilities should be promoted. ii. <u>Needs of children who experience poverty</u> • Only one study on the impact of any kind of social security arrangements on children with disabilities – no research on impact of Foster Care Grants / Care Dependency Grants iii. <u>Education</u>

		- Most research conducted was prior to the White Paper 6 – several other pilot projects were conducted but not yet in the public domain. - Available research: i. Inclusion and needs of learners with specific impairments ii. Skills for employment – do special schools adequately equip school leavers? iv. <u>Psychological</u> - No research on the voices of children with disabilities in relation to their experience of social service provision or the impact of non-provision. **Recommendations for Department of Social Development:** a. More research on prevention and outcomes of early intervention. b. Reviewing the impact of current services for disabled people c. Setting up of systems for monitoring and evaluation. d. Impact of Community Based rehabilitation e. Inclusion of disability in all HIV / AIDS programmes f. Reviewing and improving service delivery: - The need for a formal intersectoral district structure to plan disability and rehabilitation services (IDPs/DHS) **Conclusions** ✓ To make social disability research more available ✓ To develop information systems ✓ To use research as a tool to improve service provision
INTERNATIONAL CONTEXT		
Document	**Year**	**Data Extract**
3. UN Convention on the Rights of Persons with disabilities	2006	The Convention on the Rights of Persons with Disabilities and its Optional Protocol was adopted on 13 December 2006 and entered into force in May 2008 when it was ratified by the 20th country. South Africa has ratified both the Convention and its Optional Protocol. Therefore the convention has legal binding power and the Government of South Africa will have an obligation to report on progress made with the implementation of the convention by the end of 2010. The Convention marks a "paradigm shift" in attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society. The Convention is unique in as far as it is *both* a development and a human rights instrument. It is a policy instrument

		which is cross-disability and cross-sectoral
		Article 1 outlines the purpose of the Convention, namely to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
		The Convention does *not* explicitly define disability. It states that 'Disability is an **evolving** concept, and that disability results from the **interaction** between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others'
		Furthermore it states that 'Persons with disabilities **include** those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.
		The principles of the Convention relevant to children are: a) Respect for the inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; b) Non-discrimination c) Full and effective participation and inclusion in society d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; e) Equality of opportunity f) Accessibility g) Equality between men/boys and women/girls; h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.
		Most articles of the convention have implications for children such as
		Equality before the law without discrimination (article 5) Right to life, liberty and security of the person (articles 10 & 14) Freedom from torture (article 15) Freedom from exploitation, violence and abuse (article 16) Right to respect physical and mental integrity (article 17) Freedom of movement and nationality (article 18) Right to live in the community (article 19) Respect for privacy (article 22) Respect for home and the family (article 23)

| | | Right to adequate standard of living (article 28)
Right to participation in cultural life (article 30)

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

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

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

Requires all signatories to ensure all disabled children and young people can fully participate in the state education system and that this should be an **'inclusive education system at all levels'**
The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential.
This right is to be delivered within **an inclusive primary and secondary education system,** from which disabled people should not be excluded.
Support provided
Reasonable accommodations should be provided for individual requirements and support provided in individualised programmes to facilitate their effective social and academic education.
Article 25 on Health:

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

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

Article 26 On Habilitation and Rehabilitation is also critical for children as it makes provision for comprehensive |

		habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, which begin at the earliest possible stage, are based on the multidisciplinary assessment of individual needs and strengths and support participation and inclusion in the community and all aspects of society. It also emphasises access to assistive devices and technologies
4. UN Convention on the rights of the child.		The need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on civil and Political Rights (in particular articles 23 and 24), in the International Convention on Economic, Social and Cultural Rights (in particular article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children. The Declaration of the Rights of the Child indicates that "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth". The child should be fully prepared to live an individual life in society and brought up in the spirit of the ideals proclaimed in the charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity. The family as the fundamental group of society and the natural environment for the growth and well being of children should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community. Articles 23 and 24 are relevant to children with disabilities. Article 23: 1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in condition which ensure dignity, promote self reliance and facilitate the child's active participation in the community. 2. States parties should recognize the right of the disabled child to special care 3. Recognizing the special needs of a disabled child, assistance extended be provided free of charge whenever possible, and ensure effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation to achieve the child's fullest possible social integration and individual development. 4. States parties shall promote the exchange of information (internationally)in the field of preventive health care and of medical, psychological and functional treatment of disabled children. Article 24 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health

		and rehabilitation.

		2. The implementation of this right includes the following implementations:
		    a. To diminish infant and child mortality
		    b. To ensure the provision of health care to all children with the emphasis on primary health care
		    c. To ensure appropriate pre-natal and post natal health care for mothers
		    d. To develop preventative health care
		
		Article 1: Refers to any human being below the age of eighteen years.
		Article 6: Every child has the inherent right to life, survival and development
		Article 25: Every child has the right to care and protection
		Article 27: Every child has a right to a standard of living adequate for physical, mental, spiritual and social development.
		Article 28: Every child has a right to education
		Article 29 and 31: Every child has a right to rest and leisure, play, recreational, cultural life and art activities
		Article 32: Every child has a right to be protected from economic exploitation
		Article 34 Every child has a right to protection from sexual abuse

NATIONAL CONTEXT		
Document	**Year**	**Data Extract**

5. Integrated National Disability Strategy	1997	**Policy guidelines that pertains directly to children with disabilities:**
		i. <u>Prevention</u>
		  ❖ Primary prevention means trying to prevent the diseases and accidents which may cause impairments and disabilities. Policy objectives: Healthy lifestyle promotion; protective measures.
		  ❖ Secondary prevention means early identification of impairments and disabilities followed by prompt treatment (or early intervention). Secondary prevention results in a cure; slower rate of progression of impairment; prevention of complications.
		  ❖ Strategies:
		     o Decrease in poverty; avoidance of conflict; improved health services.
		
		ii. <u>Public education and awareness</u>
		  ❖ Objectives: awareness raising; decreasing discrimination; putting a value on diversity.
		
		iii. <u>Health care</u>
		  ❖ The development of a comprehensive universal health care system, at primary, secondary and tertiary level, that is sensitive to the general and specific health care needs of people with disabilities.
		  ❖ Strategies: elimination of discrimination; national data base; child health care; computer technology; barrier free access; communication; training in the delivery of the social model.
		
		iv. <u>Rehabilitation 1: Original INDS:</u>

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

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

10 General policy guidelines…

- **Health care** (Dept of Health)
  o "*Health care includes medical, nursing, rehabilitation, psychiatric and other specialist services which are available on an in-patient, out-patient as well as at a community and home care basis*
- **Habilitation and rehabilitation** (Depts of Health, Labour, Social Services, Education)
  o "*Policies relating to key departments must therefore organize, strengthen and extend comprehensive habilitation and rehabilitation services…*"
  o Policy objectives: "*Establish an integrated strategy for Community Based Habilitation and Rehabilitation*"
"*Promote the development of initial and ongoing training of professionals and staff working in habilitation and rehabilitation services*"

v. Barrier free access
  To create a barrier free society that accommodates the diversity of needs and enables the entire population to move around the environment freely and unhindered.

vi. Transport
  To develop an accessible, affordable multi-modal public transport system that will meet the largest needs…and planning for those higher cost features for greater mobility needs.

vii. Communication
  To develop strategies that will provide people with communication disabilities with equal opportunities for access to information.

viii. Education
  Transformation of the education system as a whole to facilitate equal access to education.
  ❖ Components;
    o Early Childhood Development
    o General and further education
    o Higher education

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o   Education Support Services

ix. <u>Social welfare and community development</u>
Policy objectives include
   ❖ Develop social welfare services that aim to integrate people with disabilities within all activities in their communities
   ❖ Develop social welfare services that recognise the differing specific needs of people with disabilities.
   ❖ Facilitate the reorientation and training of social welfare workers.
Components:
   ❖ Community development
   ❖ Social welfare services which include a range of strategies designed to facilitate access by people with disabilities and parents of disabled children to mechanisms which enhance their ability to live independently. These include:
       o   Residential care facilities
       o   Institutions for people with severe disabilities
       o   Personal assistance services
       o   Activity centres

x. <u>Social security</u>
To provide for a co-ordinated and equitable system of social security to meet basic needs and develop capacity for independent living, self-sufficiency and integration.
   ❖ Components include state grants.

xi. <u>Housing</u>
To provide people with disabilities and their families with safe shelter and dwellings through equitable access to a range of options in the housing subsidy scheme.

xii. <u>Sport and recreation</u>
To develop and extend sporting activities for people with disabilities in both mainstream and special facilities so that they can participate in sport for both recreational and competitive purposes.
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<td>6.</td>
<td>Children's Amendment Act</td>
<td>2008</td>
<td>This is the amendment of the Children's Act 38 of 2005

"To give effect to certain rights of children as contained in the constitution; to set out principles relating to the care and protection of children; to define parental responsibilities and rights; to make further provision regarding children's courts; to provide partial care of children; to provide early childhood development; to provide for the issuing of contribution orders; to provide for prevention and early intervention; to provide for child and youth care centres and drop in centres; to make provision for the adoption of children; to provide for inter country adoption; to give effect to the Hague convention on Inter-country Adoption; to prohibit child abduction and to give effect to the Hague convention on International child Abduction; to provide for surrogate motherhood; and to create certain new</td>
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| | | offences relating to children; and to provide for matters connected therewith."

Chapter 5.
1) Early childhood development means the process of emotional, cognitive, sensory, spiritual, moral, physical, social and communication development of children from birth to school going age.

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

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

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

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

Chapter 8: Prevention and early intervention (143)

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

Habilitation programmes are neglected.

Prevention and early intervention programmes may include;
Assisting and empowering families to obtain basic necessities. Promote the well being of the child and the realisation of their full potential.
Chapter 14: Drop in centres. (213)

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

		A drop in centre may offer any programme, which includes primary health care in collaboration with the local health clinic, referral to social workers and prevention and early intervention programmes. Strategy concerning drop in centres (214. 1) The Minister after consultation with interested person and the Ministers of Finance, Health, Provincial and Local government and Transport must include in the departmental strategy a strategy aimed at ensuring an appropriate spread of drop in centres throughout the Republic, giving due consideration as provided in section 11, to children with disability and chronic illnesses.
7. Mental Health Care Act, Act 17 of 2002 and the Regulations		The intention of this Act is to promote and protect the rights of people with mental disorders through a number of legal requirements and safeguards that dictate the procedural flow and clinical management of mental health service users. It requires the establishment of Provincial Review Boards that are to function as appropriately skilled and resourced bodies, and able to act independently and autonomously in ensuring the proper implementation of the Act and its regulations.
SECTORAL POLICIES		
Department of Social Development		
8. Disability Policy – Dept of Social Development		Aim: ❖ Guide and inform the mainstreaming of disability through developing and implementing departmental policies, strategies and integrated service delivery programs. ❖ Facilitate the provision of integrated social services to people with disabilities ❖ Provide guidance to the development in terms of addressing social barriers that exclude people with disabilities which impede full and equitable integration and inclusion into mainstream society. Focuses on the provision of integrated developmental social services through 3 programme areas: i. **Social Security** Management and oversight of financial grants to the poor, the vulnerable and those with special needs. ii. **Social Welfare** Provision of developmental social welfare services in partnership with other role-players such as state funded institutions, NGO's, DPO's etc. iii. **Community development** To enhance and increase the capacity of communities to respond to their needs and improve their capacity for development. **Levels of intervention:** Prevention – aimed at strengthening and building the capacity and self-reliance of service recipients; e.g. awareness raising, advocacy programmes, education and counseling services, addressing attitudes and misconceptions. Early Intervention (non-Statutory) – level of intervention is developmental and therapeutic in addition to above,

		includes social protection programmes, care and support services, promoting sustainable livelihoods, provision of social security services, family support services, community- based rehabilitation programs. Statutory Intervention / residential / alternative care – for individuals who are unable to function in the community and removal to alternative care or a residential facility as a temporary measure. Includes: rehabilitation services, security services, mediation services, assisted living and independent living programs, day care and community based care. Reconstruction and after care – efforts to reintegrate the person back into their families and communities. Includes: rehabilitation services, HIV/AIDS services, victim empowerment.

9. Social Assistance Act		**Objects of the Act;**
		    a) Provide for the administration of social assistance and payment of social grants;
		    b) Make provision for social assistance and to determine the qualification requirements in respect thereof;
		    c) Ensure that minimum norms and standards are prescribed for the delivery of social assistance; and
		    d) Provide for the establishment of an inspectorate for social assistance.
		
		Eligibility for social assistance:
		    5 (1) (c) is a SA citizen or is a member of a group or category of persons prescribed by the Minister, with the concurrence of the Minister of Finance, by notice in the Gazette;
		    5 (2) The Minister may prescribe additional requirements or conditions in respect of -
		        (a) income thresholds;
		        (b) means testing;
		        (c) age limits, disabilities and care dependency;
		        (d) proof of and measures to establish or verify identity, gender, age, citizenship, family relationships, care dependency, disabilities, foster child and war veterans' status.
		
		Care dependency grant
		    7 (a) A person is … eligible for a care dependency grant if he or she is a parent, primary care giver or foster parent of a child who requires and receives <u>permanent care</u> or <u>support services</u> due to his or <u>her physical or mental disability.</u>
		
		    7 (b) A person … is not eligible for such a grant if the child is cared for on a 24 hour basis for a period exceeding six months in an institution that is funded by the State.
		
		Foster child grant
		    8 A foster parent is, subject to section 5, eligible for a foster child grant for a child for as long as that child needs such care if-
		        (a) the foster child is in need of care

		Abuse of social grants
		19 (1) Where the Agency (SASSA) has reasonable grounds to suspect that a beneficiary, parent, procurator, or a primary care giver is abusing the social grant, the Agency may appoint a person to investigate such suspected abuse.
		
		19 (3) (a) The Agency may suspend payment of a child support grant, foster child grant or a care dependency grant to a parent, primary care giver, foster parent or procurator where the parent, primary care giver, foster parent or procurator –
		    (i) is convicted of abuse or neglect…
		    (ii) is found … to be incapable of using a grant for the benefit of the child in respect of whom he or she received it.

10. Policy on the Provision of social rehabilitation services to people with disabilities		This policy reflected international accepted approaches as found in Article 26 of the adopted UN convention on the Rights of People with Disabilities and states that "State Par6ies shall take effective and appropriate measure, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental and vocational ability and full inclusion and participation in all aspects of life."
		
		This policy incorporates national and international directives, best practice to ensure that DSD provides combined and integrated social rehabilitation services that equally address the cause and consequences of disability.
		
		Health, employment, education and social services are organized and strengthened to enable services and programmes to:
		    a. Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths.
		    b.Support participation and inclusion in the community and all aspects of society, are voluntary and are available to persons with disabilities as close as possible to their own communities, including in rural areas."
		Rehabilitation services are comprised of thee key areas, namely: psychosocial support, skills development and environmental modification.
		
		This policy supports and promotes social, vocational, educational and community based rehabilitation (CBR) through the following services and programmes: prevention, early intervention, statutory and rehabilitation.
		
		An Individual Rehabilitation Plan (IRP) is developed for all persons with a disability at different levels; institution, community or integrated, which is integrated in the Individual Development Plan (IDP).

Department of Health		
11. National Rehabilitation Policy – Dept of Health		GOAL: "…to improve accessibility to all rehabilitation services in order to facilitate the realization of every citizen's constitutional right to have access to health care services…" OBJECTIVES: (1) "accessibility…mechanisms for intersectoral collaboration…facilitate appropriate allocation and

		utilization of resources…human resource development…monitoring and evaluation strategies for rehabilitation programmes…participation of persons with disabilities…research in rehabilitation"
		
		HUMAN RESOURCES COMPONENT:
		    (2) <u>Planning:</u>
		        o *"The skills, experience and expertise of all health personnel should be used optimally to ensure maximum coverage and cost effectiveness*
		        o *"That rehabilitation personnel should form part of the Primary Health Care Team…"*
		    (3) <u>Changing the nature of management:</u>
		        o *"Management of programmes should be decentralized to the provincial and district levels…"*
		        o *"Health service managers should be supported in acquiring the skills needed to manage a decentralized health service"*
		        o *"Effective evaluation techniques and procedures should be introduced to assess management efficiency at all levels of the health service"*
		    (4) <u>Building capacity:</u>
		        o *"Management skills at all levels should be developed if substantive health reform is to be sustained"*
		        o *"Institutional capacity to support human resource planning and management should be developed"*
		        o *"There should be a portfolio for disability prevention and rehabilitation services at provincial level to ensure development and coordination of services"*
		
		10 GUIDELINES FOR ESTABLISHING A REHABILITATION PROGRAMME:
		    (1) *Services that are affordable, equitable and accessible to all*
		    (2) *Accountability of service providers and users*
		    (3) *Social reintegration*
		    (4) *Comprehensive service which covers all components of rehab – needs a clearly defined referral system*
		    (5) *Balance between institution based and community based services*
		    (6) *Participation of persons with disabilities*
		    (7) *Optimal use of all resources – services coordinated between various levels*
		    (8) *Physical, social and economic independence and reintegration into society*
		    (9) Inter-sectoral collaboration
		    (10) Minimum norms and standards and indicators for different components of rehabilitation should be basis of service evaluation and monitoring

Department of Education		
12. Inclusive Education –		Education White Paper 6 on Special Needs Education: Building an Inclusive Education and Training System (2001) outlines government's strategy to transform the current system to make it more efficient, more equitable and more

White Paper 6 – Dept of Education		just.
		The policy aims to: • Correct discriminatory practices and imbalances of the past and promote the principles of • Promote human rights, social justice, access, equity and redress • Promote quality education for all – enabling all learners to participate actively in the • Develop and extend educational process and potential • Develop an integrated education system • Infuse 'special needs and support services' throughout the system • Align special schooling with mainstream schooling • Foster the development of inclusive and supportive centres of learning • Ensure a barrier-free physical environment • Develop the capacity of teachers, support personnel and other relevant human resources • Promote the rights and responsibilities of teachers, educators and learners **Inclusive Education and Training involves:** 13. changing general education and training so that they facilitate learning of all learners and that barriers to learning can be identified early and get appropriate support; 14. improving and enhancing skills and knowledge of educators in ordinary schools, and establishing full-service schools so that learners who have mild to moderate disabilities can be adequately accommodated in these schools through appropriate support from district-based support teams; and 15. upgrading the quality of special schools so that they, together with district-based support teams, can provide quality service for learners who need high levels of support, as well as support full-service and ordinary schools.